# PARLIAMENT OF TASMANIA

**TRANSCRIPT**

**LEGISLATIVE COUNCIL**

**ESTIMATES COMMITTEE A**

Hon. Jeremy Rockliff MP

**Wednesday 8 September 2021**

**MEMBERS**

Hon Nick Duigan MLC
Hon Ruth Forrest MLC (Chair)
Hon Mike Gaffney MLC
Hon Sarah Lovell MLC
Hon Dr Bastian Seidel MLC (Deputy Chair)
Hon Meg Webb MLC

## IN ATTENDANCE

**Hon. Jeremy Rockliff MP,** Deputy Premier; Minister for Health; Minister for Mental Health and Wellbeing; Minister for Community Services and Development; Minister for Advanced Manufacturing and Defence Industries

**Health Portfolio**

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| Chief of Staff | Vanessa Field |
| Senior Adviser | Lucy Gregg |

**State Growth**

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| Kim Evans | Secretary |
| Mark Bowles | Deputy Secretary Business and Jobs |
| Lara Hendriks | Executive Director Trade |
| Steve Gilmore | Defence Advocate |
| Dennis Hendriks | Director Defence Industry and Advanced Manufacturing |
| Amanda Russell | Deputy Secretary, Business Services |
| Glen Dean | Director Finance |

**Department of Health representatives**

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| Kath Morgan-Wicks | Secretary and State Health Commander |
| Tony Lawler | Chief Medical Officer / Deputy Secretary Clinical Quality, Regulation and Accreditation |
| Mark Veitch | Director Public Health |
| Craig Jeffery | Chief Financial Officer |
| Dale Webster | Deputy Secretary Community, Mental Health and Wellbeing |
| Ross Smith | Deputy Secretary Policy, Purchasing, Performance and Reform |
| Shane Gregory | Deputy Secretary Infrastructure |
| Francine Douce | Chief Nurse and Midwifery Officer |
| Joe Acker | Chief Executive Ambulance Tasmania |

**Mental Health and Wellbeing Portfolio**

Department of Health representatives:

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| Kath Morgan-Wicks | Secretary and State Health Commander |
| Dale Webster | Deputy Secretary Community, Mental Health and Wellbeing |
| Craig Jeffery | Chief Financial Officer |
| Shane Gregory | Deputy Secretary Infrastructure |
| George Clarke | General Manager - Mental Health, Alcohol and Drug Directorate |

**Community Services and Development Estimates Hearings**

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| Michael Pervan | Secretary, Department of Communities Tasmania |
| Kate Kent | Deputy Secretary, Department of Communities Tasmania |
| Ingrid Ganley | Director, Department of Communities Tasmania |

# PUBLIC

**Wednesday 8 September 2021**

**The Committee met at 9.00 a.m.**

**CHAIR -** Welcome, minister. To give you a bit of an outline of the day, we will let the minister for Health have a break during that period and then potentially continue after lunch.

We have allocated an hour for lunch, but if you and your team want a bit less we are happy to do that, but not too much less, then we will move on to Mental Health and Wellbeing and finish off in the afternoon/evening with Advanced Manufacturing and Defence and Community Service and Development.

We will have a break during the morning, then lunch and a break in the afternoon and hopefully that will work for everyone.

I will invite you to introduce the people at your side of the table. Some people may not know Nick Duigan, the new member here. I think everyone else is known. I will get you to introduce your team.

**Mr ROCKLIFF** - Thanks, Chair. To my right is Kath Morgan-Wicks, the Secretary of Health and the State Health Commander, to my left is Professor Tony Lawler, Chief Medical Officer and Deputy Secretary of Clinical Quality, Regulation and Accreditation. To his left is Dr Mark Veitch, the Director of Public Health.

**CHAIR** - I invite you to make some opening comments about your portfolio. If you want to do both Health and Mental Health and Wellbeing, that is fine, I will leave it to you.

**DIVISION 5**
Department of Health

**Mr ROCKLIFF** - I will do an opening statement on Health and then we will do one when we reach Mental Health at 3 p.m. when we get to it.

Thank you, Chair. Increasing community demand for health services is and continues to be a key challenge across Australia, as it is for governments around the world. While all state and territory governments have significantly increased service levels to meet the rate of increase in demand, the perennial challenge of ensuring that patients receive timely access to care remains.

Each week we read in national newspapers and on websites, the same problems in other jurisdictions that we face in our community, including long waits in emergency departments, ambulance ramping and timely access to elective surgery and outpatient clinics. These problems are the symptoms of the effect of increasing demand on health systems. In addition, we are also currently managing the impact of the COVID-19 pandemic which is stretching the capability of our health system in a way that hasn't happened before.

My focus over the past 18 months has been to put in place the response needed to ensure that we protect the Tasmanian community from infection. While we vaccinate the population, the effects of living with COVID-19 on the delivery and cost of Tasmania's health services will continue to be felt for some time.

This year's Budget provides the funding to support the Government's plans to address these challenges. While this Budget provides for significant increases in service levels needed to meet demand, simply funding more of the same will not, in itself, ensure that Tasmanians get access to timely, high-quality healthcare.

Equally important, this Budget provides funding to support a range of clinician-led, patient-centred initiatives that will improve the way we plan, collaborate and innovate, to address the challenges of meeting demand. For example, a few weeks ago I launched the statewide elective surgery four-year plan.

In coming into this portfolio, surgical leaders within the Tasmanian Health Service told me that while significant additional investment for increasing elective surgery was needed, it was equally important that we take a longer-term and sustainable approach to addressing demand for surgery. For the first time, the four-year plan for elective surgery provides a clinician-led and developed plan, aimed at building capacity in the THS, enhanced collaboration with the private sector for outsourcing surgery and developing innovative approaches to divert patients to more appropriate care rather than defaulting onto the surgical waiting list.

This Budget provides the funding to support the Government's commitment to this plan. The challenges of reducing long waits in ED and ambulance ramping are complex and a range of patient-centred initiatives are funded in this Budget to address these. These include reducing the need for people to attend ED to receive health care through partnering with the primary care sector to increase hours of access and urgent care, increasing our bed capacity so that people can be admitted from the emergency department to hospital care sooner and providing support to enable people to be discharged to their homes sooner through expanding services in the community.

I am of the view that significant investment in health is only as good as the plan for that investment. The next step in our health care future is the development of a co-designed, long-term plan for health care in Tasmania that outlines a vision and policy for a sustainable high-quality health system.

We will also build on and bring together the significant pieces of work already done. I intend that this plan will also incorporate regional clinical service plans that will encompass acute, sub-acute, primary and community health sectors and will enable the development of a statewide clinical services plan, which I know stakeholders have been asking for.

To do this successfully will require the right levels of collaboration with consumers, our healthcare professionals and stakeholders. It is my intention that this long-term plan for health care in Tasmania will be completed and released in December next year.

Finally, I have a strong belief that investment and strong planning for that investment requires good people and great teams to implement it. We know we already have a professional and very committed health workforce, but we are investing further over the next four years to support our healthcare teams to further develop and improve the way we work together to achieve the best outcomes for our patients and improve our attractiveness as the best employer of healthcare workers in the country. I want the Department of Health to be seen as an employer of choice.

Chair, I will finish up by sharing with you the Department of Health's strategic priorities for the next two years, which reflect many of the areas I have just highlighted to you. Importantly, they are patient-centred and we are delivering health infrastructure for the future and prioritising mental health and wellbeing, which I will come to later on in the day. Not sure how I formally do this Chair, but they are the strategies over the course of the next two years. Thank you.

**Output Group 1**
**System Management**
**1.1 System Management - Health**

**Dr SEIDEL** - Thanks for your introductory comments. I am asking the same question to all ministers. As you know in the Legislative Council we have question time as well, we take their questions without notice. The convention is to receive an answer within 24-48 hours, but often it seems to be weeks and sometimes months before we get an answer back.

Would you commit to provide answers to questions without notice within 48 hours, and for whatever reason that is not possible, would you be able to update the House through the Leader of the Government?

**Mr ROCKLIFF** - I appreciate the question and I appreciate where the question is coming from in access to timely information and answers to questions so you can inform your constituents in the Tasmanian community. Myself and our team will do our very best to get back to members as quickly as possible. It's important to understand there isn't a dedicated resource to process questions with or without notice. Sometimes it is challenging, but we do our very best.

Since becoming the minister for Health in May, and I got a few of these figures the other day. My office has received 18 requests in the form of questions with or without notice from members of your House, consisting of 55 questions. I am always happy to answer questions. I'll always answer them as quickly as I can, within 24-48 hours. I can only commit to continuing to process them as quickly as possible. We've already advised the Leader's office if they cannot be turned around in that timeframe. Sometimes the information takes time to access in the department, depending on the nature of the question; but we'll do our absolute best.

**Dr SEIDEL** - How many ministerial advisors do you now have on your staff as Minister for Health and Minister for Mental Health?

**Mr ROCKLIFF** - We have departmental liaison officers, we have ministerial advisors as well. I'm sure someone will be able to sort that through. We all work there at the Executive Building on level 10 and they're all busy.

**CHAIR** - Are you able to provide the number to us later today?

**Mr ROCKLIFF** - Yes, of course. We'll get to it quickly, but I don't want to miss a number and then mislead the committee. Are you including departmental liaison officers as well? We can manage that. They are a very dedicated team and I'm very fortunate to have their support.

**Dr SEIDEL** - You can probably take it on notice and then move on.

**CHAIR** - Get it to us later, whenever it's available during the day. That's fine.

**Dr SEIDEL** - Minister, earlier this week we heard about the tragic death of an eight-year-old boy in the North West Regional Hospital, who unfortunately died from asthma. I am heartened to see that we had a root cause analysis with regards to the death. Can I ask you how many root cause analyses have been conducted in the last financial year and do you have any data on how many root cause analyses have been conducted over the last five years?

**Mr ROCKLIFF** - I acknowledge your question, Dr Seidel, and the tragedy of the eight-year old's death. As Minister for Health - together with the department - I sincerely apologise to the family. I spoke to a member of the family yesterday. He was quite clearly traumatised by the experience from two years ago, and also as a result of the report released on Monday, reliving a tragedy. My heart goes out to the family. In terms of your direct question around root cause analyses, I'll hand over to Professor Lawler.

**Prof LAWLER**- For context, we have a policy that governs the management and response to adverse events that occur within our health service. Such events are characterised on the basis of a severity assessment code which, like most risk management processes, will take into account the consequence and the likelihood of an event. We have a graduated approach to how we respond to those events. We undertake root cause analysis for those that are SAC 1s - which are those that are likely to result in death or significant ongoing permanent disability. We apply an indicator as part of our service planning process, that a report will event-brief, which is an account of the nature of the event prior to a full investigation. It has to be with the department by 48 hours and then a full root cause analysis report should be provided by 70 days to the Clinical Governance Officer within the department.

I don't have the absolute number of root cause analyses that are undertaken here at the moment. However, I think it's important to note that the simple conducting of a root cause analysis is the beginning of the process, if anything. The important thing, as we have seen, in response to the tragic events that have been described and the tragic death that occurred in 2019 is that those recommendations are accepted, enacted, implemented and then monitored - and that's what has occurred in this case.

**Dr SEIDEL** - The question on notice for Jenny would be how many root cause analyses have been conducted in the last 12 months and how many root cause analyses have been conducted over the last 5 years.

**Mr ROCKLIFF** - We are seeking the numbers for you. If we can get back to you before the day, we will do so.

**CHAIR** - The process we are using, minister, is to ensure that both sides of the table understand what the question is, so you are not responding to a question that we think has been asked, or the other way around. When we take a question on notice we are clarifying what that question actually is.

**Mr ROCKLIFF** - Thank you, Chair. I have an answer to Dr Seidel's first question about advisers. I have two department liaison officers; a senior health adviser; a health adviser; a

clinical adviser; a wellbeing adviser; and a mental health adviser - bringing the total of number to seven.

**Dr SEIDEL** - The next question is about accreditation. Minister, how many clinical specialties or departments have lost accreditation over the last 12 months, and does losing accreditation have implications for training and recruitment of medical and nursing staff?

**Mr ROCKLIFF** - Health services in Tasmania are accredited to provide training for a range of medical specialties that fall within the hospitals' role. Medical specialist colleges in Australia set standards for health services to provide safe, comprehensive training for doctors towards their chosen specialty.

The accreditation standards developed and used by colleges are fluid, and will change according to the evidence-based changes in clinical practices. Accreditation standards may relate to staffing, supervision, work environment, formal teaching, training support, trainee support or other matters. Accreditation visits provide an opportunity for colleges and health services to work together to review services, meet required standards and improve the training environment.

The Tasmanian Health Service works in close association with 15 specialist colleges to ensure safe and supportive experiences for trainees.

Did you ask a question around numbers lost?

**Dr SEIDEL -** Yes. The question was, how many departments or clinical specialties have lost their accreditation in the last financial year?

**Professor LAWLER -** I have an account of the training programs that we do have accredited within the Tasmanian Health Service. In the Royal Hobart Hospital, we have training with orthopaedics, intensive care medicine, physician basic physician training, ophthalmology, oral and maxillofacial surgery, gastroenterology with the College of Physicians, full training accreditations with the College of Surgeons for general surgical training, anaesthetic and pain medicine, obstetrics and gynecology, and emergency medicine. Those training programs are fully accredited within the Royal Hobart Hospital.

Within the Launceston General Hospital, we similarly have accreditation with anaesthetic training, psychiatry training, emergency medicine training. There were, as you would be aware, some challenges with the accreditation at the Emergency Department, Launceston General previously, but an accreditation by that College was undertaken on 15 June 2021 and conditional accreditation that has been awarded by the College for 12 months, which includes completion of the paediatric log book requirement.

The College of Physicians has also undertaken a Level 3 Accreditation Review at the Launceston General with an anticipated review of that in 2022. Many colleges have faced challenges in undertaking the accreditation, particularly on-site accreditation, due to COVID-19 and the difficulties in travelling across borders. However, there are significant advanced training opportunities as well, with College of Physicians at the LGH, which includes a maximum year's accreditation of general medicine, cardiology, gastroenterology, haematology, medical oncology and renal medicine and also intensive care medicine within Launceston General Hospital.

With regard to the north-west, which encompasses both the North West Regional and the Mersey Community Hospitals, we have accreditation with the College of Anaesthetists, the College for Emergency Medicine, the RACP, Adult Medicine and paediatrics because RACP covers both adult and paediatric medicine, obstetrics and gynaecology, which provide the provisional accreditation to 30 April and undertook a virtual visit at the end of July. We are awaiting that outcome. College of Surgeons reaccredited the north-west for a further five years until 2026. There was also accreditation by the orthopaedic association, College of Intensive Care Medicine. I would also highlight we also have a number of physicians accredited around the state by the College of Medical Administrators.

**Dr SEIDEL** - To be specific, are you aware of any specialties that have not received or lost accreditation in the last 12 months?

**Prof LAWLER -** I am not aware of any that have come to me. As I have said we have managed to maintain accreditation in those programs I have highlighted. I am not aware of any that we have not.

**CHAIR** - You are awaiting the O&G one, though at the North-West Regional.

**Prof LAWLER -** We are awaiting the review, yes. We are accredited as far as I am aware, yes.

**Dr SEIDEL** - The next question is about staff retention. Can you advise us how many registered and enrolled nurses have left or resigned from the THS in the last financial year? Do you have the number of enrolled and registered nurses who left or resigned from the THS in the last five years? A follow up question would be about medical doctors and medical specialists in the same timeframe.

**Mr ROCKLIFF** - In both last year and five years? We will take those on notice.

**CHAIR** - Further to that question, Bastian, if it is broken down by region would be helpful. There has probably been attrition in the North-West Regional Hospital since the COVID-19 outbreak. That may not be the case.

**Mr ROCKLIFF** - I can go through the award categories. We start with the Launceston General Hospital, in 2017-18 separations in terms of FTE, 47.92, turnover rate 5.08 per cent; 2018-19, 38.84, turnover 3.94 per cent; in the year 2019-20, 46.51, turnover of 4.5 per cent; 2019-20 year, again the LGH. In the 2020-21 year, Launceston General Hospital separation FTE nurses, 49.08 and turnover 4.62 per cent.

Mersey Community Hospital, 8.67, 2017-18; 4.81 per cent, 2017-18 terms of turnover rate. Mersey again 2018-19 year 12.29, turnover rate 6.46 per cent; 2019-20, 10.89, separation 5.52 per cent; 2020-21, 12.3 FTE, separation 6.22. If we go to North West Regional Hospital 2017-18, 10.95 FTE, 4.01 per cent turnover; then 2018-19, which would be 21.24, 7.26 per cent turnover; then 2019-20 with 6.58 FTE, 2.21 per cent turnover; and the 2020-21 year 14.49 FTE, with 4.57 per cent turnover. Royal Hobart Hospital 2017-18-year FTE 80.64, 6.32 per cent; 2018-19 81.6, 5.95 per cent; 2019-20 97.31, turnover of 6.9 per cent, and to 2020-21 year 106.36, with a turnover rate of 7 per cent. Ms Morgan-Wicks, would you like to add further?

**Ms MORGAN-WICKS** - If I may add total FTE nurses for 2017-18 was 3865.23; 2018-19 was 4025.51; 2019-20 was 4229.08; and for 2020-21 was 4460.47.

**CHAIR** - Do you have it for the medical staff?

**Dr SEIDEL** - For medical practitioners and medical specialists?

**CHAIR -** Working in the hospitals.

**Dr SEIDEL** - Who resigned from the THS?

**CHAIR** - Yes, right.

**Mr ROCKLIFF** - I have figures here for rural medical practitioners - salary medical practitioners and visiting medical practitioners. Your question was specifically on who have resigned. My advice is it could be for other reasons such as resignation, termination and the like or for training.

**Ms MORGAN-WICKS** - It could be the way in which medical practitioners are brought on through our training program, in terms of contract appointments and then leaving for example, as interns to go and undertake their other training in another state because that particular area is not necessarily offered in Tasmania. We often have quite high turnover of our interns.

**Mr ROCKLIFF** - So, this would be turnover by award, rather than by hospital. Is that all right? Okay. Rural medical practitioner in 2017-18 0.11, turnover rate 3.08 per cent; salaried medical practitioners in 2017-18 280.09 FTE, turnover rate 31.34 per cent; visiting medical practitioner 3.29 FTE, turnover 7.78 per cent. The following year 2018-19, separation by FTE 0.3 per cent, turnover rate 9 per cent; salaried medical practitioner 268.32, turnover rate 27.8 per cent; visiting medical practitioner 2.58 FTE and 6.03 per cent. In the year 2019-20 we have in the rural medical practitioner 0.24, turnover rate 7.76 per cent; salaried medical practitioners 326.92 FTE, turnover 32.14 per cent; visiting medical practitioner, 2.12; turnover rate 5.23 percent. The last year just gone, separation by FTE for rural medical practitioner 0.21 or 8.55 per cent turnover. Salaried medical practitioners, this is the 2020-21 year, 270.53 FTE and turnover of 24.69 percent. Visiting medical practitioner 1.99 separation by FTE and 5.08 per cent.

**Ms WEBB** - I will go through my set of questions that I have put into each department that appears before us and so I am interested to hear from the Health department.

Firstly, very straightforwardly, were any of the policy matters or election commitments that are in this Budget evaluated for a potential gender impacts, the positive, negative or status quo of the policy intent and the outcome of delivery within the community? Gender impact being just not in relation to women but gender impact more broadly.

**Mr ROCKLIFF** - Thankyou Ms Webb for the question. I am advised that the Department of Health is committed to reducing gendered violence by implementing our watch workplace equality and respect standards. Self-assessment phase is underway and the department will have an action plan in place by the end of 2021.

Health is undergoing sex and gender reform.

**Ms WEBB** - This might come into my next question. Just to bring you back to it, this question is whether a gender impact assessment has been done on any of the policy or election commitments that are in the budget?

**Mr ROCKLIFF** - Health is undergoing sex and gender reform in the collection and use of data. A sex and gender reform group is developing new gender data collection standards. We have a range of flexible workplace options for all staff, many of which benefit female employees, particularly those with young children. Examples might include working from home, flexible work patterns, part-time hours, shift swaps, flex time and time off in lieu and job-sharing. We have information and supports available on discrimination and harassment, including e-learning on discrimination and harassment and bullying in the workplace. Our recruitment e-learning procedures and education materials highlight the importance of diversity.

Under the Tasmanian Women's Strategy 2018-2021 and Gender Diversity in the State Service Policy, the department is committed to developing women's leadership and participation as a key priority to support gender equality for the benefit of the whole community. The senior executive service profile including heads of agency in the reporting period was 50 per cent male and 50 per cent female.

**CHAIR** - I don't think the question has been answered.

**Ms WEBB** - You have jumped into my next question, which is great. So, let me just clarify what that was, because you might want to add to it.

The next question I was going to ask you was about the department's implementation of the diversity and inclusion framework 2017-2020 that had been in place across the whole-of-government and what had been done within that. What are the plans now that framework has come to an end? What going was going to be happening going forwards? Some of the answer you have probably provided there, because you have talked about initiatives within the department. You might like to add more to that in a moment.

If we would come back to the first question that I asked you, I think there was something in there that was related to assessment of gender impact of policy decisions and election initiatives. I think you talked about a new way of collecting data about gender. Could you just drill in on that in your answer to my first question? That was the bit that was relevant and I would like to know a bit more about that.

**Ms MORGAN-WICKS** - We do have our LGBTIQA+ reference group and I co-chair that group together with Ms Newman. We have had some very positive sessions this year, particularly on the data across the health service. We have been unable to drill in or to adequately allow some classification of patients who are using our services so that we can then provide further information back through to that reference committee so that they can then determine, particularly with trying to prioritise policy changes across Health.

One of the big ones that we have been working on is the welcoming of patients and working on our equality and respect approach with all our clinicians, our health professional

teams, but also all our support teams. We want to ensure that anyone who walks into our hospitals or health services are respected and welcomed and not treated just through the lens of the individual who is treating them. That is probably one of the most significant issues that has been reported to us.

When we look at our own patient data, for example, we've been just very male, female, very general in terms of the collection of data that we have across the service. We are attempting to have those improvements coming through out data systems. I note and welcome the $15 million for initiation in our digital transformation program, a 10-year program that we are going to implement across the department to really uplift our digital health systems. That will also include the appropriate categorisation and collection of identification data for each of our patients and individuals interacting with our service.

**Ms WEBB** - That sounds really positive that you are putting in place a more nuanced and accurate way of collecting data about the gender of patients and being able to feed that back in. What I'm taking from that is as at the present time a gender-impact assessment isn't done of policy and initiatives within the department. But you're putting measures in place which, should the Government choose to do such assessments in future, you'll be better placed to do them in a more nuanced way. Can I encourage you to think about actually implementing gender-impact assessments, which would cover the spectrum of people involved and the impact of any given policy decision?

**Mr ROCKLIFF** - You can encourage me. I will listen to that encouragement and discuss that further with our department.

**Ms WEBB** - Regarding the second question, which I think you moved into to some degree, which is about the department's response and activity in the diversity-inclusion framework, the whole-of-government one, is there anything that you wanted to add to that pointing forward, or noting what has occurred under that framework?

**Mr ROCKLIFF** - I have covered most of it, Ms Webb. Of course, I have responsibility with my Community Services and Development -

**Ms WEBB** - No doubt I'll ask you a question about that.

**Mr ROCKLIFF** - when it comes to LGBTIQA+ communities.

**Ms WEBB** - The other overarching question was about data on RTI performance.

**CHAIR** - I'll come back to you on that. It seems to me that you're aware of the need for this more gender-sensitive approach to providing care for patients and the people who use the services. From your answer, I don't believe you've done an actual gender-budgeting exercise with the gender-impact statement on the Budget, the health budget.

Minister, do you have capacity in your office currently, anywhere in the whole area that you're responsible for, to actually undertake a gender-impact assessment and undertake gender budgeting in your budget submissions? You front up to budget committee to argue your case. You've done pretty well this year.

**Mr ROCKLIFF** - Very successfully, thank you.

**CHAIR** - You have. But was there a gender-impact assessment? If there wasn't, is that because you don't have the skills to produce one? Will you look at getting the skills in the department to do that, not just for the service delivery, but for the whole department?

**Mr ROCKLIFF** - I'm open to that suggestion, Ms Forrest.

**CHAIR** - Good. There's an opportunity to support a Joint House committee that's on the notice paper at the moment that may help with some guidance for that if you don't have those skills in your department.

**Mr ROCKLIFF** - I'm sure we have the skills, absolutely.

**Ms MORGAN-WICKS -** In terms the budget submission that we prepared in the department to put to our minister for both portfolios, it didn't undertake a gender-impact assessment. I think it would be fair to say that it was probably prepared on a gender-neutral basis regarding the needs that have been identified right across our health system, clinician-led patient-centred needs that have come up and for critical prioritisation of those individual budget asks. Certainly, I think we would have the skills within our Department of Health, we have some amazing people that actually work right across our budget submissions. Certainly, I can have a discussion with the minister in relation to that formal process that might be recommended that is taken. I also note the Department of Treasury, in receiving all of the submissions from each of the departments, also undertake their own forms of assessment, so that may also be a question for Treasury.

**CHAIR** - And Treasury do not undertake a gender impact assessment that broadly, we did ask the Treasury yesterday. There is a bit of a lack across Government but that is allright, I am glad you are interested and willing to consider it.

**Ms WEBB** - The RTI performance and resourcing within the department, fairly straight forward there is available publicly, the RTI annual report for 2019-20. For health there were 59 RTI requests received, 27 of those were determined in full or in part and 17 took more than the legislated 20 working days. I am interested for an update of figures for the year 2020-21, the numbers, whether they were determined in full or in part and how many took more than the legislated working days?

**Mr ROCKLIFF** - Okay. More broadly, the right to information process is an independent process from the minister and following the establishment of the Department of Communities Tasmania, I can advise the Department of Health continued to provide a shared RTI service to Department of Communities Tasmania. From 15 March 2021, RTI responsibility, for example, Department of Communities was fully transferred to DCT. Now legal services in the Office of the Secretary administers the Department of Health's obligations under the Right to Information Act 2009 and provides advice to senior management and staff in relation to the technical and operational aspects for information through the provision of policy and procedures, training and advice to inform application of information management legislation, in particular, this Act across the Department of Health and the THS. The Department of Health has three full-time equivalent, fully dedicated to the right to information area. In addition, other members of the legal services team provide extra support as required. This equates an additional six full-time equivalents. The number of applications determined in 20 days or within the agreed time in 2018-19 was 19; in 2019-20 was 10 and in 2020-2021

was 22. The number of applications determined outside of the 20 days - the agreed time - in 2020-21 was 30. Average working days taken to assess applications was also 30 in the last financial year.

**Ms WEBB** - Your department's quite well resourced for RTIs, which is good, compared to some others. Is there resourcing allocated for RTI training or updating of skills?

**Mr ROCKLIFF** - Yes. When it comes to our Department of Health RTI officer training, our RTI officers have a legal background. New RTI officers have access to on the job training, shadowing with other team members, Department of Health policies and procedures and the Ombudsman's documentation. Department of Health also participates in the RTI's officers working group meetings convened by the Department of Justice. Due to the focus on the COVID-19 preparedness and response, specific training sessions were not provided in the 2020-21 financial year. Staff were supported and individual staff questions were continued to be answered and Department of Health also provides a number of resources on the Department of Health intranet page for staff, including right to information policy, right to information accessing information, making an application for assessed disclosure, right to information application form, right to information fact sheet, link to the Right to Information Act 2009 at the Tasmanian Legislation webpage and link to the Ombudsman's Tasmania's Right to Information process webpage as well.

**Ms WEBB** - Briefly, an update on the department's allocated responsibilities from the PESRAC recommendations from the interim report from last budget and any allocated to the department from the final report.

Noting the recommendations from the interim report, there are 4, Nos 2, 3, 4 and 5 that were allocated to the Department of Health, I am interested in whether they are completed or whether they are ongoing. If they are ongoing, we are likely to discuss the detail of them in later line items so we do not need to necessarily delve into ongoing ones, but an update on status?

**Mr ROCKLIFF** - The Department of Health is the nominated lead agency for implementation of five of the Premier's Economic and Social Recovery Advisory Council recommendations.

Recommendations 2 to 5 relate specifically to communicating with the Tasmanian community in a way that enhances public understandings and builds confidence in the way in which the Tasmanian Government is preparing for and responding to the threat of COVID-19 and the risks it presents to Tasmania.

Recommendation 30 relates to the way in which the Tasmanian Government supports organisations to ensure they understand their obligations in relation to COVID-19 and are sufficiently equipped with the resources and tools they need to keep their employees and visitors safe.

**Ms WEBB** - Could I get a clarification on that one, because in last year's budget paper, that was allocated as responsibility under DPAC. It is actually a health responsibility, No 30?

**Mr ROCKLIFF** - Certainly, we are taking some action with respect to that matter.

The role of the COVID-19 Coordination Centre's Public Policy Information Unit is critical in supporting the public in communicating information advice on current and emerging COVID-19 related risks, border control, quarantine, contact tracing, testing in preparedness for outbreaks in Tasmania.

**Ms WEBB** - Can I have an update on the status of those recommendations, whether those numbers 2 to 5 are regarded as completed and we are forward looking away from those or whether they are regarded as still open and we will discuss them under the relevant line items then?

**Mr ROCKLIFF** - Recommendations 2, 3, 4 and 5, for example and then 30. Recommendation 2 is explained to the Committee its future COVID-19 strategy including how any future outbreaks will be handled.

Recommendation 3 explained the risk management basis of COVID-19 restrictions as those decisions are being made, including any reimposed or new restrictions.

Recommendation 4 pays special attention to building public confidence in the capacity of Tasmania's health system to deal with the future COVID-19 outbreaks.

Recommendation 5 gives confidence to Tasmanians that the control mechanisms to manage COVID-19 risks are being rigorously applied, particularly in the context of relaxing interstate border restrictions.

As I indicated before, those recommendations 2, 3, 4 and 5 are highlighting the importance of public awareness, management strategies and risk controls and public confidence in the Tasmanian Government to protect the safety of the Tasmanian community from COVID-19 now and into the future.

**Ms WEBB** - It is ongoing.

**Mr ROCKLIFF** - It is ongoing and doing much of that and ensuring for example, we have the required equipment

**Ms WEBB** - Given they are ongoing, we can discuss them under a relevant line item.

**CHAIR** - Most of those will fit under Public Health.

**Ms WEBB** - Great, we can discuss them more under that line item.

**Mr ROCKLIFF** - That could be Public Health, but also when it comes to more operationally, for example it could be PPE preparedness,

**Ms WEBB** - Where would you like to discuss those matters, minister, under Public Health or group them?

**Mr ROCKLIFF** - Yes, we can do that through COVID-19 specific through Public Health, if you would like. Part of that discussion is building confidence in the Tasmanian community that we are prepared for COVID-19 -

**Ms WEBB** - There would be no doubt questions around that.

**Mr ROCKLIFF** - should Delta hit our shores and those sorts of things, the impact on our health system and the consequences et cetera.

**CHAIR** - We can deal with some of those matters under other line items.

I wanted to ask you minister, about the risks associated with the National Health Reform Agreement. I spoke to the Treasurer Premier yesterday about this. There is a description in Budget Paper No. 1, Page 16, Budget Paper No.1, Page 140 and in Budget Paper No. 2, Vol. 1. It is clear, this has been a risk that has been ongoing. I will just read from Budget Paper No. 2 in the health chapter.

> The Australian Governments funding contribution in each year is its prior year contribution plus 45 percent of the efficient growth in the price and volume of activity under the NHRA.

The pricing authority determines that official price.

> Growth in the Australian Government funding to the states and territories is capped at 6.5 percent per year. The NHRA is that cost-sharing arrangement and the amount of funding to be received through the Agreement is dependent on the annual level of activity.

Now, thankfully in Tasmania we have not had a massive increase of activity with COVID 19 in more recent times, but it could happen any time.

My question to the Treasurer and I will repeat to you. In terms of this risk we could push activity above or to that 6.5 percent cap, are we getting anywhere near there? Are we likely to? And what is the plan if we do? As the Treasurer rightly said, it all falls to the state, the increase of funding above that 6.5 cap of official price. This is really about risk mitigation and management in terms of funding.

**Ms MORGAN-WICKS** - Certainly, all states and territories have been closely watching the 6.5 percent cap. We have also been watching throughout COVID-19 and as part of the COVID-19 MPA negotiations as well, which is an extension of the NHRA, the minimum floor. Our minimum price guarantee of the amount of Australian Government health funding that would be paid to states. Particularly, as elective surgery for example, in 2020 was turned off by a decision of National Cabinet and the time then taken to transition back to delivery. Also, the impact on other health services that were not able to undertaken. For example, when we had our regional lockdown in the north-west, we had to reduce our oral health, breast screening and cancer screenings services etcetera, as people were redeployed across health.

At the moment, that is also currently happening in other states dealing with significant community transmission. We are watching the funding very closely. I could ask through the minister if Ross Smith, Deputy Secretary would join the table. He is responsible for our intergovernmental agreement. But we did not get close to the concern around either the minimum floor or the 6.5 percent.

**CHAIR** - I might clarify the partnership payment in regard to COVID-19 was not part of the National Health Reform Agreement but would impact on the 6.5 percent cap. Or did it? It was a separate bucket of money.

**Mr SMITH** - In terms of the cap it is not included in those calculations. So, the cap is only calculated on NHRA in scope activity.

**Ms MORGAN-WICKS** - The COVID-19 MPA was an extension of the NHRA agreement set. Ross you would like to confirm that?

**Mr SMITH** - It is in harmony with the NHRA.

**CHAIR** - Is it part of or is it an addition to?

**Mr SMITH** - In terms of the cap calculation, the COVID-19 MPA is not included in the calculation of whether or not the state has reached it.

**CHAIR** - The calculation of the official price is not considered with the activity that the COVID-19 response provided. Is that right?

**Mr SMITH** - Yes. I think your question is the risk of breaching the cap. Effectively, the Australian Government caps out under the NHRA Agreement its financial exposion to 6.5 percent growth in funding of activity under the National Health Pricing framework. Each state effectively has what is described as a soft cap of 6.5 per cent. Now, if a state actually goes over that 6.5 percent cap, it depends on whether or not all other states have gone over that 6.5 per cent cap. You may well be able to go beyond the 6.5 per cent cap in the event that other states have not increased their activity or their expenditure of efficient activity up to 6.5 per cent. If we look at what we have been through over the last year with New South Wales and Victoria, in particular, in prolonged periods of lockdown that they are -

**CHAIR** - Activity is quite low.

**Mr SMITH** - Quite low. There will be an opportunity, for example, for states including Tasmania -

**CHAIR** - It has smoothed across the country, is that what you are telling me?

**Mr SMITH** - Yes. Effectively, the Commonwealth's hard cap relates to the total expenditure. Maximum of 6.5 per cent. Again, it depends on what other states are doing, how the national funding body measures that and the movement of that which is usually not finalised until 28 February in the following year.

How we manage it and monitor it in Tasmania, we are regularly reviewing our activity levels with a view to maximising Commonwealth funding under the NHRA, but also managing it in terms of the cap and is part of our normal ongoing financial management of funding our hospitals. For example, last year we were able to make sure we were able to manage activity levels or funded activity levels in scope for NHRA to be able to maximise and come pretty close to being spot on that sort of cap.

**CHAIR** - Some would argue with the lack of activity in Victoria and more recently, New South Wales would encourage you to get on and do as much as you can whilst there may be some room in the cap.

**Mr SMITH** - Correct.

**Ms MORGAN-WICKS** - Chair, states were probably significantly worried about the minimum fall because we swung activity under the COVID-19 NPA, probably as much as we could, given that separation from the calculation in the NHRA, but then states became concerned about the minimum. Tasmania actually received a top-up payment for 2019-20 activity of $9.5 million and that is relying on our guaranteed minimum amount of activity base funding under the NHRA.

**CHAIR** - Because we had not had the activity?

**Ms MORGAN-WICKS** - The first part of 2020 swinging significant activity with the north west outbreak under the COVID-19 NPA. We actually did have a top-up amount. We do rely on both the minimum floor to guarantee the Australian Government funding levels, together with that 6.5 per cent of growth on top of the 45 per cent of funding the Commonwealth commits to.

**CHAIR** - Understand all that, minister?

**Mr ROCKLIFF** - Yes.

**CHAIR** - There's a risk of it, yes. Anyway.

**Mr ROCKLIFF** - Steep learning curve in the last three months but nonetheless, we have discussed it.

**Ms MORGAN-WICKS** - And I believe it has been a risk Treasury have put in every single Budget that I have seen since 2013-14.

**CHAIR** - They have. Yes. Since that was signed. Nick?

**Mr DUIGAN** - I am happy with 1.1.

**CHAIR** - System Management Health includes funding for additional key deliverables and one being the public private partnerships to deliver care sooner. Minister, can you tell us a bit more about what the plan is exactly with that? I know we have been purchasing services from the private hospitals for some time, but what is the new initiative part and how is it going to look?

**Mr ROCKLIFF** - Thank you, that was a $20 million commitment we made at the last election. Shortly after I became Minister for Health, I sat down with all the heads of the public hospitals, as well as the private hospitals to set the scene of our willingness to collaborate and form really good partnerships. From that time on the private hospitals have been working with the department and services they could provide to support our health system in collaboration. I mentioned the meeting, which was productive. Incidentally, they were the representatives from the Hobart Private Hospital, Calvary Health Care, north and south, the North West Private

Hospital and the Hobart Clinic as well as our public hospital sector heads. We discussed our elective surgery plan at that time as well moving forward. It has changed slightly with additional funding since it was committed to at the last election and was in the Budget, which you have already acknowledged. We also discussed purchasing beds from private hospitals to improve patient flow, access to care and supporting demand in other areas, including community nursing and home care.

Written proposals were received and assessed by the department. Letters of intention were provided to Calvary south and north, Healthscope, Hobart Private and St Helens Private and Health Care North West Private Hospital in line with our commitment in our first 100 days. All proposals were reviewed by an expert internal panel. I am advised that successful proposals include the purchase of general medical, surgical, rehabilitation and palliative-care beds, the purchase of theatre time, elective surgeries, including endoscopy, gastroscopy and colonoscopy. Also, an agreed escalation able to provide a process to divert ambulances in periods of high demand, private hospital liaison and flow nurses to transfer privately insured patients, where clinically appropriate, and the purchase of the catheterisation lab.

Clinical leaders are currently working with their private hospital counterparts to finalise and agree on clinical arrangements to support implementation of these initiatives. I'm not sure if Ms Morgan-Wicks has anything further to add to update where we are with that.

**Ms MORGAN-WICKS -** We do have very positive relationships with our private hospitals, particularly during the COVID-19 year, where I think within some four to five days - Ross Smith may correct me - we were able to negotiate agreements to stand up and rely on both resourcing and beds in private hospitals to support us should we need it.

The Minister spoke of the meeting, the roundtable, that we held with all private hospitals. That was to look at both access and flow support initiatives. For example, can we access either general medicine recovery or rehabilitation beds to assist with flow, particularly given the number of patients who really are at a sub-acute rather than acute stage that sit within our major hospitals at times. Also, speaking to them about how they could ramp-up on elective surgery delivery, noting that in the last financial year, I think private hospitals delivered an approximate 23 per cent of our elective surgery removals from our wait list. We spoke to them about the opportunities to increase that.

Certainly their feedback was, if you can do that but in a longer plan. Don't come to us and say in the next 30 days can you deliver us 500 surgeries? They find it difficult to either schedule their theatre capacity, but also to recruit to that. We have taken that feedback into the four-year elective surgery plan and shared that also with the privates so that we can try to negotiate those longer-term provisions right across the public and the private system. So that we are able to increase our theatre infrastructure, know the equipment that we are going to be requiring for the types of surgeries that we are going to contract with the private. They can also look at, particularly in the regions where there is sharing of specialist resources, where someone like the North West Private, for example, wouldn't want to take on a one FTA of a particular type of specialist, et cetera, can it be shared across our environments in terms of conjoint or other appointments.

**CHAIR** - Is there an expectation that some of the THS staff would assist in the staffing, or is it for the private sector to grow their own staff to deal with a more consistent stream of patient load? That's what they're asking for as I understand what you're saying.

**Ms MORGAN-WICKS -** At first point, I think they prefer to have their own staffing models under different contractual award arrangements. We have seen through the outbreak that there has been sharing of resources, for example, in our co-located models in the north-west, with North West Private and North West Regional, and as you are aware, in maternity, for example, we do have crossing over of resources.

**CHAIR** - Even medical surgical staff work across both; not all of them but a lot of them.

**Prof. LAWLER -** There is a strong relationship between the public and private sectors, in a number of ways. As the secretary has highlighted, we share a commonality of staff. We find this leads to greater collaboration between the services. It is also a strong attractor with regard to recruitment, that individuals who want to come and work, are able to contribute to the private sector as well as the public sector..

It facilitates better relationships with our research foundations across the state - in the south, at the Royal Hobart and Hospital Research Foundation, and the Clifford Craig Foundation in the north. It also facilitates a better relationship with the University, in terms of being able to have input, not only for senior staff but also the ability to access the clinical placement substrate that is available within the private sector.

We also have strong relationships, and the meetings that occur on an ongoing basis aren't only confined to contractual engagements. There is also a really strong relationship with regard to the response to COVID-19. We have strong linkages with the private hospitals, through the viability for capacity arrangements that we have seen in the last 12 to 18 months, and also the fact that the Public Health directions that impact on hospitals - such as the mask and previously the visitors directions - not only relate to public facilities but also private facilities, private hospitals and day procedure centres. There is a strong interplay.

The public/private partnership goes not only to activity and expenditure, but also to collaboration to provide safe services across the state.

**CHAIR** - One other question on this. Regarding the Health ICT Digital Transformation Initiation phase funding, can you tell us where that is at? It is pretty important we get this done and get it right.

**Mr ROCKLIFF -** It is increasingly important and we have significant investment in this Budget. We all recognise the role digital technologies can play at improving patient care, providing better data on patient management and reducing the reliance on manual processes.

I am pleased to table today, the Health ICT Highlights Report produced by our Chief Information Officer, Mr Warren Prentice; and I thank Mr Prentice for that. The report details the key deliverables our health ICT team have been working on over the last 12 months. I will mention a few of those.

Major upgrades have been implemented to our tracked care system. This system manages Emergency Department patient flow and electronic notes through the state. The team also worked tirelessly to release the Check-In Tas application, which I am sure all members of the Committee are aware of.

Implementation of the COVID-19 mass vaccination system has managed all of our COVID-19 vaccination appointments. This system went live to the staff on the Public Health hotline in March and was opened up to consumers in April this year.

The state-wide roll out of Medtasker is continuing. This system provides a single platform where all requests for staff assistance can be logged. I acknowledge the terrific work undertaken on this project. It is also recognised by winning the TasICT Best Project award for 2021.

The report also highlights that hospital clinicians have accessed patient national My Health records, more than 75 000 times. The viewing portal was introduced in September last year. Additional funding provided in this year's Budget will be used to further develop digital health capabilities, with an allocation of $15 million to support work around electronic medical records, telehealth and virtual care initiatives and cyber security, to name only a few.

Digital health is also recognised in our healthcare future reforms as a key improvement area for the department. Modern digital technology supports better patient care and patient information management, better workforce management and better data to drive quality practice and quality improvements.

We are committed to developing a digital health strategy that will help guide investments in digital health within the health system. The strategy will be clinically led and follow a proven methodology in partnership with information and communications technology professionals.

A broad consultation approach will also include peak bodies, other key delivery partners and healthcare consumer representatives.

**CHAIR** - Do you have a timeline for that strategy, minister? When do you expect to have that finished?

**Mr ROCKLIFF** - Funding of $10 million, together with a provision of $5 million in Finance-General has been provided in this year's Budget to commence progressing the key focus areas of the 10-year digital health transformation plan. The plan is currently under development for consultation. It will be the first time that we have had a strategic document setting the Government's long-term vision for digital technology across the health system. The $15 million in funding will be used as an initiation phase to commence digital transformation in health, with important foundation work to commence, including electronic medical records tranche one, telehealth and virtual-care initiatives, cybersecurity and identity management, hospital wi-fi upgrade and digital foundations tranche one.

Funding will also facilitate a proof-of-concept to allow GP primary care appropriate access to hospital administrative and clinical systems to view key information held by the THS about patients in their care. The funding is in addition to the funding package announced in the 2020-21 State Budget of $23.1 million that included an allocation to modernise the department's human resource systems across the state. I know the Australian Medical Association and others have been -

**CHAIR** - Do you have a timeframe for the rollout?

**Mr ROCKLIFF** - The target date for completing the strategy is December this year and all other deliverables by February next year.

**Output Group 2**
**Health Services**

**2.1 Admitted Services**

**Dr SEIDEL** - I might ask you to have a look at page 160, table 5.4, performance information output, group number two. I will start with hand hygiene compliance. The indicator for compliance is dropping. The standing marker for hand hygiene compliance has been dropping in 2020-2021. I wonder how that could be, considering that we are still under a COVID-19 scenario, where I would imagine I would have seen hand hygiene compliance increasing rather than decreasing. Why is the target for 2021-22 just over 80 per cent? Can we afford a target of less than 100 per cent? What is the thinking behind those targets, considering that this might well be a proxy target of how seriously we take hygiene in our hospital system?

**Mr ROCKLIFF** - I concur with you the importance of hand hygiene compliance, within our hospital system. You're right, the target for the next year is above that 80 per cent figure. There has been a marginal drop in terms of the last 12 months, with an increase since 2018-19.

**Ms MORGAN-WICKS -** Hand hygiene is absolutely critical. It's something that we remind the public and all our staff about being one of the key levels of protection against COVID-19. I've probably walked around every single hospital over the last few weeks to talk to them about our strategic priorities. There is significant signage and reminders and levels of sanitiser, or various forms of hand hygiene aids right across our hospital systems. Our infection prevention and control nurses do roll out a dedicated program and training, not just in relation to hand hygiene, but also our PPE use, which is critical. Certainly we will work to get that percentage up as high as we can.

**Dr SEIDEL** - Considering that you are engaging with public/private partnerships now, how do you ensure that hygiene measure from those private institutions are being held at the same standard as we have for the public institutions? What sort of control or clinical oversight governance do we have put in place?

**Ms MORGAN-WICKS -** I will ask Professor Lawler to comment on our quality and safety standards, which include hand hygiene as a key component.

**Prof LAWLER -** Thank you, and through you, minister. There are a number of issues there. On hand hygiene, we are meeting the national benchmark for hand hygiene compliance. It's worth noting that there are a number of challenges faced by every jurisdiction in the capture of that data, which include the way in which it's monitored through on-the-spot audits and the challenges we face. There's also a challenge that there is a significant arrears factor in how that's reported.

In terms of the monitoring and involvement in private facilities, we are responsible, under the Health Services Establishments Act 2006, as the secretary, who has also delegated that authority to me, to license private facilities in the state. Those licences are extended to eight

private hospitals and 15 private day procedure centres, and also non-emergency patient transport providers, of which there are four.

It is a requirement of licensing for private hospitals, and also for signing up to contracts with most private health insurance providers, that accreditation against the national health and safety standards is maintained. Standard 3 of the eight standards is the prevention of hospital-acquired infections. There is a requirement that those facilities, just as our public facilities, are able to present not only the government structures but the practices and also the ways in which they respond to the challenges that relate to hand hygiene. That's key.

We also work with the individual facilities, where our accreditation challenges are highlighted, to ensure that we support them in that.

Regarding the public sector, we have taken a very strongly standards-based approach to that as well.

The accreditation of public facilities in Tasmania has moved from the traditional periodic assessment - which is that an accrediting agency comes along and has a look every three years and there's a flurry of excitement and demonstration with massive folders being developed and showing how we've been complying - to where we now undertake what's called the short-notice assessment methodology, wherein, with 48 hours' notice, an accrediting agency can turn up and undertake an accreditation.

That will always relate to standard 1, which is Clinical Governance, and up to four of the remaining seven standards. Particularly, as you highlight, Dr Seidel, in these days of the awareness of easy transmissibility of not just COVID-19 but many other conditions, standard 3 is very closely adhered to.

Hand hygiene is very important and, as noted, we are meeting the national benchmark. It sits not alone but also alongside the other mitigating factors, including health screening at the point of entry for staff, patients, visitors, contractors and those undertaking clinical placement, and the wearing of masks in hospitals, as mandated by the Director of Public Health.

Not only is that key at individual facilities but also on a statewide basis. Our clinical executive, which is the peak clinical governance body reporting directly to health executive, and I have the honour of chairing, has a very standards-based approach. In fact, under our safety quality and accreditation sub-committee, which is chaired by my deputy chief medical officer, Dr Jodi Glading, there is a standards-based approach to all activity that occurs through that. That informs the work of our executive, it informs the advice we give to the secretary and health executive and, in turn, to the minister. It is firmly rooted in the national health and safety quality and standards as well.

**Dr SEIDEL** - How many institutions have been subject to an accreditation visit with 48 hours' notice in the last financial year? I know they exist but how many have you actually done?

**Prof LAWLER**- I will look into that. I will also note that one of the challenges faced, not only by the institutions in meeting the standards but by the accrediting agencies as well - we contract a number of accrediting agencies across our services - is that there was a suspension of the national program between 25 March 2020 and 26 October 2020. As a consequence, the

number accredited is potentially lower. There are 38 Tasmanian health facilities required to be assessed against the standards - that's public and private across the state. Between January 2019 and June 2021, 14 assessments took place.

**Dr SEIDEL -** According to the state elective surgery four-year plan, the elective surgery activity in the THS and private hospitals was restored to 100 per cent by early 2020-21. Looking at the performance information of the group 2, the waiting times for category 1 surgery has increased, unfortunately, as well. So, my question is not about the reason why the waiting times have increased, even for category 1 patients again. My question is how many adverse events have we recorded in all our patients who have been waiting for urgent surgery? And, how many patients have died while waiting for urgent surgery in the timeframe?

**Mr ROCKLIFF** - Thank you, Dr Seidel. I will take the last question on notice in terms of adverse events. I do know the Budget provides additional funding of $120 million over four years to deliver an additional 20 000 elective surgeries and 2300 endoscopies, to address the elective surgery demand response to the COVID-19 pandemic. This consists of a State Government component of $66 million and an estimated Australian Government activity-based funding component of $54 million. This funding is an addition to the $36.4 million announced in the 2020-21 budget.

**Dr SEIDEL** - I understand the surgery plan, the commitment. My question was specifically about how many patients actually died while they were waiting for urgent surgery? I understand that you want to take that question on notice. There is probably no need in the interest of time.

**CHAIR** - Did you want adverse outcomes as well?

**Dr SEIDEL** - That would be sufficient.

**Mr ROCKLIFF** - We will take that on notice to clarify adverse events.

**CHAIR** - Dr Seidel was happy to have deaths that have occurred. Is that across all categories you're asking?

**Dr SEIDEL** - Category 1, urgent surgery.

**CHAIR** - How many patients died while awaiting surgery as category 1 patients?

**Mr ROCKLIFF** - Can I also say that many people are saved in emergency surgery in our emergency department. Our health staff do a tremendous job under very difficult circumstances. I have visited every single emergency department of our four major hospitals and I understand the pressures they are under.

I understand the question. We need to be a little careful in our language in terms of not scaring people who need to attend an emergency department, because if they need emergency care, the emergency department is the best place for it. I want to reinforce that fact. Acknowledging the challenges, we have tremendously committed and skilled people across our state in our emergency departments. Notwithstanding that, I understand the question and we will seek to get an answer for you, Dr Seidel.

**Dr SEIDEL** - I appreciate it, minister. The question is not about the care in the emergency department. The question was specifically about patients waiting for urgent surgery. The reason why I am asking this again was because when I asked in last year's Estimates, the answer I got at the time was this data has not been collected. So, as a follow-up this year, I want to know if they have collected the data and, if you do - and I understand now that you collected the data, what is the data?

**Ms MORGAN-WICKS** - Through the minister, if a person is on the waiting list for a category 1 elective surgery, that may very well convert through to emergency surgery and a presentation to our emergency department., noting that the minister spoke about our teams in the emergency department. We will take that on notice in relation to the data.

**CHAIR** - Some people die from a condition unrelated to the need for their urgent surgery.

**Ms MORGAN-WICKS** - That is correct.

**CHAIR** - Is it possible to separate that in the data. I don't think is relevant, potentially.

**Mr ROCKLIFF** - Yes, we can provide some context.

**Dr SEIDEL** - You would imagine the data would be collected for quality control, absolutely.

**Mr ROCKLIFF** - Can I clarify that, not only the Royal Hobart Hospital but everywhere.

**Mr DUIGAN** - Minister, there is constantly discussion around the need for more staff in our health system. The government made a bold election commitment to employ 280 additional FTE staff. How is that progressing and from my perspective, I am particularly interested in the LGH, how that is going there?

**Mr ROCKLIFF** - I understand the reason for the question. Not long after the election, we held our first health recruitment workforce taskforce. We had key stakeholders around the table, including HACSU, the AMA and the ANMF, providing input and ideas - not only the recruiting staff, but also the retention of staff.

You acknowledged we have made significant commitments. Major recruitment campaigns across the Department of Health have been happening in the first quarter of this current financial year.

These campaigns are focused on our major hospitals, including the LGH, to address vacancies and enable increased activity, including our $196.4 million elective surgery plan, as well as to engage staff for COVID-19 testing of vaccination clinics.

I can advise from 1 June to 6 September, 772 people have been engaged across the Department of Health, including 291 nurses, 68 medical practitioners and 58 allied health professionals. More than 330 administrative and support staff have been engaged to support COVID-19 testing clinics and vaccination clinics. I am sure the Committee understands the importance of ensuring we maintain our COVID-19 vigilance when it comes to increasing our vaccination rates.

You mentioned the Launceston General Hospital, and I can advise that 133 new staff have started at the LGH in this period, which is 1 June to 6 September. These new staff at the LGH included 73 nurses, 15 medical practitioners, 13 allied health professionals, 16 administrative staff and 16 support staff; and work is continuing.

As you have pointed out, we are committed to employing 280 FTE to support our increase in elective surgery and other new and boosted services. The staff recruitment taskforce has met three times, so far, and is chaired by the Secretary of Health Cath Morgan-Wicks. I attended the first meeting and learned a lot at that meeting.

Through this taskforce, we are working with healthcare staff, professionals, stakeholders and clinicians on a collaborative, solutions-based approach, to not only attract, but also retain staff to the health system, right across every region in the state. Thank you for the question.

**Mr DUIGAN** - So going well?

**Mr ROCKLIFF** - Yes, going well, but more to do.

**Mr DUIGAN** - Staff is obviously one of the areas that gets plenty of debate. Perhaps the other one is beds. Could you provide some clarity about how many additional beds have been opened since 2018 and could you also advise of any beds funded in this year's Budget?

**CHAIR** - Can I clarify that question. Does the funding of a bed include the staff, not only the physical bed?

**Mr ROCKLIFF** - Yes, it does. In response to your question, Chair; I will come to Mr Duigan's question in a moment. For example, at Ward 6A, the Royal Hobart Hospital committed to opening 24 beds as part of our 50 bed winter strategy. That facility will be permanently open, not only for the winter season. As we get the staff, we will open the beds. In that Trauma and Acute Surgical Unit (TASU), we have 16 beds open of the 24 so far, as I was advised on Monday. Short answer to your question, yes, but we can't open beds without staff, and I think that was the point of your question.

Since April 2018, the number of available beds in Tasmania's public hospitals has increased from 1360 to 1583; that's to the end of June 2021. That's an increase of 16.4 per cent of beds, or 223 beds. According to the Australian Institute of Health and Welfare, Tasmania has the second highest rate of public hospital beds per population in the country. The 2021-22 Budget included funding of $198 million over four years to meet the demand faced by our major hospitals. I've mentioned the 50 additional beds that we announced in June this year to meet increased demand and to support our elective surgery program. We've made progress in that area, as I've touched on, in terms of the TASU.

At the Royal Hobart Hospital, we've increased capacity in our general medical beds on ward 2A. We've opened the paediatric short-stay unit as well. I've mentioned the TASU, which at full capacity will be 24 beds. A six-bed mental health short-stay unit opened in May, and is now operating 24/7 at the Royal Hobart Hospital. Recruitment is underway so we can provide additional beds for the older persons unit at the Royal Hobart Hospital as well.

In the north-west, a stand-alone infectious disease ward is being created and this has allowed four beds to be freed up on the medical ward with a further two beds to be freed up as staffing allows.

At the LGH, recruitment is underway to support the opening of additional beds and the infrastructure works are well underway to redevelop the 28 bed medical ward on 3D. According to the Australian Institute of Health and Welfare between 2015-16 and 2019-20, Tasmania was one of two jurisdictions to increase the rate of beds per 1000 population. Much needed, I acknowledge; but we're heading in the right direction. Thank you for the question.

**CHAIR** - Following on from that question -in your strategic priorities, under the second column - Improving Access and Patient Flow - you mention delivering additional staffed beds, which is what you've just been talking about. I note in the North West Regional Hospital you've said there's an additional seven medical beds returned on the medical ward. You gave some figures about the North West Regional and the beds there, but I didn't think it added up to seven. Can you clarify what this actually means, where the beds have been and where they've returned from?

**Mr ROCKLIFF** - Yes, we can certainly do that. I mentioned six beds. When I announced in June an additional 50 beds, we announced an additional six beds in the North West Regional Hospital as a result of creating the new infectious disease ward, if I can put it that way.

**CHAIR** - Where's that exactly?

**Mr ROCKLIFF** - In terms of location?

**CHAIR** - Yes, physical location in the Burnie Hospital.

**Ms MORGAN-WICKS -** The North West Regional Hospital undertook significant configuration changes in their medical wards and I think in particular Med C. That was through the north west outbreak, and it took beds away from general medical in that ward. By now we've guaranteed the permanent funding for a separate infectious diseases area which I think is quite close to the Med C ward. It means that we can now reopen those beds that had been reconfigured into general medical, so to return those beds.

**CHAIR -** As I understand it, Minister, it was changed to allow donning and doffing areas and appropriate flow through the medical ward, which was a problem that was identified there during the outbreak - it wasn't really suitable for that.

**Ms MORGAN-WICKS** - Yes. The North West Regional Hospital updated those numbers in our strategic priorities document, so they're reflecting numbers that they know that they are recruiting and staffing up to, in terms of their general medical provision.

**CHAIR** - It's part of the plan for the 2020-21 year, it's going to happen this year, as I understand it. This says that the Dedicated Infectious Diseases Unit will be built or established and the medical beds will be returned to pre-COVID-19 levels. Is that right?

**Ms MORGAN-WICKS -** That is correct. We are also undertaking, as part of the North-West Regional Hospital master planning process, a clinical services review to make sure that

we can check and align again the number of general medical beds that would be required. We would take that into our master planning process.

**CHAIR -** Is the master planning process in the North West Regional Hospital underway currently?

**Ms MORGAN-WICKS -** Yes.

**CHAIR -** What is the timeline for completion for that?

**Mr ROCKLIFF -** The master plan as separate to the clinical services plan, you mean? This would be part of the $500 000 commitment, wouldn't it?

**Mr GREGORY -** We committed for the new Spencer Clinic to be completed by 2025.

**CHAIR -** Could it perhaps have a change of name, as a positive step?

**Mr ROCKLIFF -** It's a mental health precinct. I'll take that on board. But more broadly, we also committed to a master plan as well.

**CHAIR -** In addition to that.

**Mr ROCKLIFF -** In addition to that, which will come further.

**Mr GREGORY -** There is a $500 000 funding commitment to undertake master planning for the North-West Regional Hospital. The first component of that is the clinical services plan, and that work is currently underway. That will look broader than just the North-West Regional Hospital campus. There are interactions with other local facilities, therefore we'll take a slightly broader view. That's the first piece of work. Then flowing on from that we will be looking at all the infrastructure needs that support that. The entire piece of work is due to be finished within 12 months.

**CHAIR -** This time next year we are looking at having the master plan. The construction of the new ante-natal clinics is not part of that plan; that's already underway?

**Mr GREGORY -** Construction of the ante-natal clinic is underway now, that is due to be finished in April of 2022.

**CHAIR -** To clarify, the master plan is to look at the new mental health precinct?

**Mr GREGORY** - The master plan will look at the broad demand for health services and how they're provided. Dovetailing into that will be an infrastructure piece. There has been work done already by mental health services around their needs. They will be brought into the clinical services planning piece over the first part of the master plan. We will be running a couple of things in parallel. We already know that there is a demand to improve mental health services.

**CHAIR** - Does the master plan include parking, Minister? There is a car park there that could have another level put on it, on the eastern side of the helipad. It's desperately needed, I might add.

**Mr ROCKLIFF** - I am advised that the whole site includes the master plan, which would include parking logistics.

**CHAIR** - I have raised this separately at different times. Parking is a major problem for people who are accessing the outpatients area and it will be a problem for the ante-natal clinic, when that is built. These are people coming and going and they need to be on time for their appointments - particularly patients attending for radiology treatment at the radiation and oncology centre. The area with some disability parking has been removed from where the ante-natal building is being built and has been put up onto the next level, which means a further walk.

I don't know how many times you have been there in the winter, Minister, but I've been there quite a bit lately. The weather howls through there. There is no protection. Those people are very vulnerable. They are undergoing radiation treatment, or possibly have just come off oncology treatment. There is no dedicated parking for those people. They get a slip to park free-of-charge, which is fine. If you have to park right up the other end, on the western end, as far as you can get, it's probably a 10-minute or 15-minute walk for some of these people. Is that going to be considered?

**Mr ROCKLIFF -** That's very good feedback. I'm sure that through the consultation process that feedback will be provided to the master plan in terms of parking logistics, ease of access, particularly with vulnerable health consumers arriving on site.

**Mr GREGORY** - The master plan will consider all aspects of infrastructure. We will look at the condition of the buildings, the functional use that they can be applied to. We will do a traffic impact assessment. We will understand what the parking demands for all the different services are and all the traffic flow arrangements. It will be a very big picture view and I will take in all aspects of infrastructure.

**Ms MORGAN-WICKS** - We should also note the significant improvements we have made at the Mersey Community Hospital and that it also remains free.

**CHAIR** - The other thing is when you are designing car parking where there are neo-natal clinics or maternity services you need to make them wider. When women are very pregnant have a carpark and the mirrors are nearly touching, they cannot get through. If they are attending for a neo-natal on their own, how do they do that? That is the problem with the North-West Private Hospital. They cannot get through once they have parked their car. It is inconvenient and very difficult.

**Mr ROCKLIFF** - Thank you for raising it.

**CHAIR** - It is a planning thing.

**Ms WEBB** - How many people in 2020-21 were Medicare ineligible and received care at Tasmanian public hospitals? How many of those people were women? That is the first of a set of questions.

**Mr ROCKLIFF** - I am advised we do not have the data here with us to that detail. We will go and search it and bring it back.

**Ms WEBB** - Would you like me to run through the set of questions or would you like us to provide that to you as questions on notice to receive back from you?

**Mr ROCKLIFF** - If we can answer the questions today and provide advice to the committee as soon as possible, we would prefer to do that. You would get your answer quicker. If you run through the set of questions and at the end of the day we can provide those answers and anything we have not been able to provide, we will put on notice.

**Ms WEBB** - In 2020-21 how many people who were Medicare ineligible, received care at Tasmanian public hospitals? How many of those people were women? How many times were people charged for emergency department visits because they were Medicare ineligible? How many of those people were women? How many of these Medicare ineligible people had their fees waived? How many entered into payment plans?

The next set is around peri-natal care. How many Medicare ineligible women had pregnancy and birth care provided in all Tasmanian hospitals in 2020-21? Do the THS figures for the numbers and costs of pregnancy and birth care for Medicare ineligible women include women having babies at the North-West Private Hospital?

If those figures do not include women at the North-West Private Hospital, I have a set of questions I would like to ask about those women.

**Mr ROCKLIFF** - Depending on that answer, there is another set of questions, Okay.

**Ms WEBB** - How many Medicare ineligible women who received pregnancy and birth care from the Tasmanian Health Service in 2020-21, were referred for treatment for diabetes? What was the average cost these women paid for this treatment?

Depending on the answer for the North-West Private Hospital I have some extra questions if it does not include them and extra questions if it does.

**Mr ROCKLIFF** - Thank you. We will provide that. Can I just ask a question Chair? If we do not get the answers - we will finish off at some point in the day and go into other portfolio areas.

**CHAIR** - We can still table and get responses at the end of the day.

**Mr ROCKLIFF** - Just table the responses at the end of the day no matter which manufacturing order it might be.

**CHAIR** - That is fine. Yes.

**Mr ROCKLIFF** - Thank you.

**CHAIR** - I want to talk under this item about the surge capacity we have within the hospitals, particularly in relation to ICU.

I did ask a question about ICU occupancy last sitting week. I had an answer to that, but also asked a question about the availability of ventilators and the properly trained staff.

I appreciate minister, you did not have an answer last week but it has been provided to me through your office and I appreciate getting that data now, but would like to ask more about that.

I did ask about the ventilators available in each ICU. The answer provided the Royal Hobart Hospital had 23, LGH had 19, North West Regional Hospital had 17 and there were more. There were 112 intensive care ventilators in the pandemic stockpile and in the private sector there are 171 in total in Tasmania available.

I did ask about the qualified staff. The Royal Hobart Hospital had 175 qualified and experienced nursing staff. LGH, 95. North West Regional Hospital, 33.

It did talk about other health professionals who possess transferrable skills like in A&E and in anaesthetics and recover and retrieval.

According to the workforce standards of critical care nursing we require one registered nurse per patient per shift to care for a ventilated patient.

Minister, I put it to you that it will take more than one registered nurse to put a patient on the ventilator. I was specific in my question; yes how many does it take to look after them once they are on ventilation if they remain uncomplicated. Theyt are complicated because they are on a ventilator, but do not have further complications that require perhaps more staff to care for them.

My question then is do we have adequate surge capacity in our qualified medical and nursing staff, not just to care for patients on ventilators, but to deal with getting them on and off a ventilator which requires the assistance of medical professionals.

**Mr ROCKLIFF** - I understand the question.

**CHAIR** - Yes, what is the plan for dealing with this should be have a significant number of patients in ICU's that require ventilation. Whether that is COVID-19 or other reasons but particularly if it is COVID-19, because there is a whole heap of other measure to ensure that a risk of a clot infection is managed.

**Mr ROCKLIFF** - I can certainly talk about surge capacity when it comes to COVID-19 and perhaps we will touch on that a bit later on but more specifically to your question Ms Forrest, Professor Lawler.

**Prof. LAWLER** - It is recognised a large part of the challenge facing New South Wales and increasingly Victoria and other jurisdictions as potentially, the spread of COVID-19 becomes more prevalent will be the capacity to provide ventilatory services within an ICU.

What we have managed to do through the last 16 to 18 months in terms of through rigorous border restrictions and through appropriate local practices is to enable us - obviously we're now in the process of increasing the vaccination rate of the population - to increase our ventilator stocks and also incorporate into our planning processes the way in which we will configure our services to maximise our ability to look after ventilated patients.

That codification is through the escalation management plans we undertake in each region and also state-wide. We incorporate a number of triggers which include the number of patients admitted with COVID-19, the number of patients ventilated with COVID-19, the level or presence of community transmission. Also, the impact on staffing because we recognise from the experience elsewhere and obviously closer to home in the north west last year, is staff are particularly vulnerable and in part why the Director of Public Health is going down the path of mandatory vaccination.

One of the things we have done alongside is to develop our COVID-19 surge capacity plan, which has been advanced in accordance with the guidelines developed by the Australian New Zealand Intensive Care Society and locally by our Tasmanian critical care network which has representation from all intensive care units around the state and is being supported by the department through clinical support and also policy support.

It includes strategies to reduce demand, which would include looking at the impact of community transmission and outbreak on our standard business-as-usual activity. It would utilise the consumables and the physical infrastructure that we have.

The current operational ICU beds and the surge beds we have would look to give us a statewide capacity of 114 beds. The challenge, as you outline, with regard to the increased requirement for resources to put people on and off ventilators, to intubate and exudate, initiate ventilation, is not simply a nursing requirement. There is a requirement for medical staff, but also for requirement for orderly and support staff because there is a lot of moving and shifting and that is challenging.

We are comfortable and confident that we have the medical and support staff that we would require to manage the beds that we have outlined in our surge capacity plan and that would also be supporting, the nursing staff requirement that we have outlined.

**CHAIR** - What modelling has been done, particularly for Tasmania, to demonstrate the likely impact on our ICU and thus our capacity to manage it on opening up at various levels of vaccination? Dr Veitch may need to be involved in the discussion, so I am happy to have a break and come back to this if you need to.

**Ms MORGAN-WICKS -** Every single day we are watching the rates of hospitalisation, ICU, ventilation that we are seeing per community transmission case numbers, particularly in New South Wales and Victoria, but also watching a small territory like the ACT, smaller than us but in comparison.

We are speaking to all of the health secretaries and CEOs to obtain information and sharing our modelling. We are also receiving information from National Cabinet processes which are looking nationally at hospital surge capacity and ICU capacity nationally. I understand that Doherty have also been doing some modelling, which is on a state basis but I am yet to receive that information for Tasmania.

When we look at all of those numbers in relation to our own ICU surge capacity plan that we prepared last year as part of our north-west outbreak and learnings, and which we continue to keep updated, we look at that proportion that we are seeing in hospitalisation and ICU and ventilation rates as a doublecheck back to our own capacity. It is noted that those rates still remain low compared to the total number of cases in the community.

At the moment we are still feeling - I don't know if comfortable is an appropriate word in COVID-19 - but we still feel prepared, noting our surge capacity plans and numbers and the rates at which they are hospitalising or admitting to critical care for example, in New South Wales, Victoria and the ACT.

**CHAIR** - Professor Lawler mentioned the mandatory vaccination order that has been made. Has there been an impact on staff wishing to not participate and leave the THS as a result of that directive?

**Mr ROCKLIFF** - We have announced that is our very clear intention for mandatory vaccinations. That was announced last Friday and our expectation is, by the end of this week, there will be better clarity provided by Dr Veitch on those matters.

I am advised that about 80 per cent of our health workforce has had their first dose and we are looking to the date of 31 October for our health workers to either have had their first dose or have a booking for their first dose by that date. Prior to that, we've got 17 September, which is the national decision that has been made for the aged care workforce on those matters as well. We're working with stakeholders that represent employees within the health system, CPSU, HACSU and the ANMF of course and the AMA, who strongly support the mandatory vaccination as well.

Through that process we'll get an understanding of any resistance and how we can support our employees through that process but it's a very critical step, as you'd appreciate, and one that we don't take lightly. It's to protect our workforce and protect the patients as well, particularly vulnerable patients as a result of the very imminent threat of Delta should it hit our shores.

**CHAIR** - Have you had any pushback to date? I know it's not mandatory yet but the plan's pretty clear to make it mandatory. Has there been much pushback or are you feeling people are pretty accepting of this?

**Mr ROCKLIFF** - Perhaps my secretary might be able to comment on key stakeholder representation but we've received some items of correspondence about the decision from individuals. That commenced with aged care when the national decision was made but we've received communication through social media and all those sorts of things. Regarding direct engagement with the workforce and workforce representatives, Kath, would you like to outline some of -

**Ms MORGAN-WICKS** - I'll get Professor Lawler to comment in a moment on a meeting that he chaired yesterday with the employee representatives, but we've had significant support from the AMA, both the national president and the Tasmanian president. They have noted their support for the announcement of the intention to require mandatory vaccination for healthcare workers. We have also received indications of support from HACSU and I note our quite high vaccination rates amongst our paramedics. It is also being offered to our volunteer workforce.

Regarding the ANMF and the CPSU, we are working through that definition of the worker to which the directive is going to apply and also the healthcare setting. We've had some conversations, particularly in relation to the primary care sector, and to whom it should apply.

For example, our GPs and their support teams, our community pharmacies and pharmacists across all of the private healthcare settings in Tasmania. We note that ultimately this is a decision for our Director of Public Health in the actual term of the Public Health directive but a policy decision and intention that we've already announced. So, I might get Professor Lawler to speak to the meeting that took place yesterday.

**Mr LAWLER** - We had a very positive meeting yesterday. We recognise that this is an issue of concern for a number of members of the workforce. Yesterday we met with representatives of the department, including the Chief Nurse and Midwife, the Director of Public Health, the Deputy Secretary of Community Mental Health and Wellbeing and myself, with representatives from our legal and HR and IR teams meeting with the AMA, the ANMF, HACSU, CPSU, Primary Health Tasmania, the Pharmacy Guild and the Pharmaceutical Society. We recognise that this is not just a hospital challenge; this is a whole of health workforce challenge. By health workforce we also don't just mean clinical staff because there's a recognition that this is going to potentially have an impact.

As the secretary highlights, the directive is still in the process of being drafted and the decisions are yet to be made by the Director of Public Health on some of these elements. Clinical staff move between the clinical setting and the non-clinical setting all of the time. Again, we see the example in the mainland but also our experience in the north-west outbreak was that quite early on in the outbreak, significant numbers of non-clinical/administrative back-of-house, however we characterise it -

**CHAIR** - You can't operate a hospital without cleaners.

**Prof LAWLER -** That's right, but also those who are off site and potentially sitting within health administrative buildings who aren't necessarily on the front line, but are still keeping that engineering going. If we were to take out the payroll sector or the finance sector or the data sector, the entire system would be discombobulated and we would struggle to actually keep the whole process going. We had those discussions yesterday. I believe that they were quite positive discussions. Those groups were obviously quite concerned about issues such as do we have the supply to vaccinate those who need to be vaccinated? The answer is clearly, yes. Will we put in the processes? The answer is clearly, yes.

What are the consequences for those who choose not to? We had discussions about medical exemption versus those without medical exemptions. Our focus is absolutely on ensuring that individuals who are vaccine-hesitant, which is the phrase that is used frequently, are provided with the information that they need to make an informed choice and are supported in that. It was a very positive discussion.

The concerns that were raised go to some of the elements that the secretary has raised. We expect GPs and practice nurses and nurse practitioners to already be vaccinated under phase 1A and 1B as high priority groups. But we also have staff who work in the reception or administrative areas of general practices, or are supporting the retail elements of pharmacies.

I think we were able to address the questions that were raised. We will continue that dialogue so that there is a smooth transition into what is, at its heart, a public health protection measure.

**Dr SEIDEL** - I have two follow-up questions. At this stage, have you defined healthcare setting and healthcare worker, or is that still work in progress?

**Ms MORGAN-WICKS -** We have a starting definition. Dr Seidel, we looked at the New South Wales order, which has been out, I think, since 26 August when it was signed by the minister. We are also looking at both the WA and the ACT intentions in their definition.

I note that New South Wales didn't extend to GPs or primary care. Without Dr Veitch being here, I am aware that the Australian Health Protection Principal Committee (AHPPC) has also been considering a national definition of both healthcare worker and healthcare setting, which does include primary care sector. At the moment, we're kind of racing against whether the AHPPC settles a national position which the director can then consider whether he adopts that for Tasmania, or whether we have our own. We do have a starting base that has been discussed with the employee organisations yesterday. I note that Professor Lawler also wanted to add something, minister, if that's okay.

**Prof LAWLER -** If anything, we are taking a bit of a hybrid approach. We also recognise that COVID-19 doesn't recognise the staff-based distinctions. If we have a nurse or a medical practitioner or an allied health practitioner who is infected and moving into an administrative setting, then that doesn't reduce the risk of transmission. As the secretary has highlighted, that work is still being done by the Director of Public Health, but there is a setting approach.

There are also other elements. An example of that is how allied health professionals and allied health practices are defined. We have a significant proportion of allied health professionals who work in a community rather than a hospital setting. There is some work in looking at the Australian Prudential Regulation Authority (APRA) definition of regulated allied health professionals versus the list that has been approved and endorsed by AHPPC, which is a broader list.

**Dr SEIDEL** - You also have non-regulated health practitioners.

**Prof LAWLER -** That is the broader list. That short list is the regulated professions. The broader list as endorsed by AHPPC includes a number of others such as social work, arts therapy, music therapy, that are not regulated by APRA.

**Dr SEIDEL** - My final question is the Catholic Medical Association states that the provision of conscientious objection must be upheld when it comes to COVID-19 vaccination. Do you consider conscientious objection when it comes to COVID-19 vaccination and Catholic medical practitioners?

**Ms MORGAN-WICKS -** I think the Catholic Medical Association Tasmanian branch have made actually a conflicting statement. We were trying to investigate that. They have indicated support in Tasmania was my understanding. I am happy to go back and check that further. In terms of conscientious objection, whether it is on a religious ground or other, an employee is entitled to have that and to maintain it. However, we have a range of options that we will work through with each individual in relation to that. A mandatory Public Health directive at the moment does not include a conscientious objection ground for exemption.

**Dr SEIDEL** - That would include services that are being contracted? For example, if you are contracting service to private hospitals?

**Ms MORGAN-WICKS -** Yes, it would include contractors.

**The Committee suspended at 11.05 a.m.**

**The Committee recommenced at 11.23 a.m.**

**Output Group 2**
**2.1 Admitted Services**

**CHAIR -** Minister, we will continue on with 2.1 of Admitted Services. Can you provide ideally, the estimated outcome for the expenditure line or if not, the preliminary outcome for that line item and the rest would also be helpful?

**Mr ROCKLIFF** - I will call Craig Jeffery who is Chief Financial Officer.

**Mr JEFFERY -** Thank you minister. I have the unaudited agency financial statements here Ms Forrest, so without gazumping the Auditor-General the numbers are unaudited,

**CHAIR** - Unaudited, I accept that, absolutely.

**Mr JEFFERY -** I think the question was 'what was the preliminary outcome for'

**CHAIR** - Or the estimated outcome if you have the estimated.

**Mr JEFFERY -** For output 2.1'. Budget for 2.1 Admitted Services $1 152 110 000 actual unaudited, $1 143 389 000. Do you want the others in that output group?

**CHAIR** - Yes, please.

**Output Group 2.2 Non-admitted Services**

**Mr JEFFERY -** Output 2.2, non-admitted services budget $245 188 000, actual $268 760 000; output 2.3 Emergency Department services, budget $185 629 000, actual $196 182 000. Am I going too quick or are you right?

**CHAIR** - You are right.

**Mr JEFFERY -** Output 2.4 Community Health Services budget $251 536 000. They are straight out of the budget papers from last year or from this year. Actual $255 551 000. Output 2.5 Statewide and Mental Health Services budget $148 366 000 actual $150 358 000. Output 2.6 Ambulance Services budget $134 635 000.

**CHAIR** - What was that one sorry. 134

**Mr JEFFERY** - $134 635 000. Actual $143 019 000. Output 2.7 Public Health Services budget $30 976 000 actual $38 731 000 so for that output group total budget was $2.148 billion and the actual $2 195 990 000.

**CHAIR** - Thank you very much.

**Mr JEFFERY** - My pleasure.

**CHAIR** - You do not know how excited I am to see those figures. I have not been able to get them from any other minister, so thank you.

**Mr ROCKLIFF** - Oh well, there you go. I have been transparent in health, of course.

**CHAIR** - Yes. Good. Because the claims been made year on year prior to you being minister, that you are spending more in health every year blah blah blah and the reality is this year, you actually are. You are budgeting more than was actually spent last year with a quick run through of these figures perhaps, with the exception of some.

**Ms MORGAN-WICKS** - Noting the COVID-19 expenditure also.

**CHAIR** - That includes the COVID-19 expenditure doesn't it?

**Ms MORGAN-WICKS** - Craig when you were reading out those line items noting that in last year's budget there was a separate output for COVID-19?

**Mr JEFFERY** - That is correct.

**CHAIR** - The COVID-19 Output group 90 figures is what we are talking about here.

**Mr JEFFERY** - Yes, they are not included in those numbers I just read out. Would you like me to give you the Output group 90 numbers or wait until you get to that output?

**CHAIR** - We can get them while he is at the table if that is alright, minister?

**Mr JEFFERY** - Do you want them by output or the total for the output group, Ms Forrest?

**CHAIR** - Probably a total.

**Mr JEFFERY** - Budget for that Output group 90 COVID-19 Response and Recovery total budget $58 197 000. Total expenditure $60 262 000.

**CHAIR** - The expense summary year on that page 156 says $56 935 000.

**Ms MORGAN-WICKS** - Statewide Mental Health Services also had a COVID-19 component.

**CHAIR** - Okay, right. It will take some extra time to go through those figures, but I appreciate getting them.

Minister, it would be nice next year if we can actually have them ahead of the budget Estimates to do some comparison work beforehand. I did seek that through the Treasurer unsuccessfully.

**Mr ROCKLIFF** - Perhaps we could have them easily accessible.

**CHAIR** - I appreciate they are unaudited, but that is the issue here and there may be minor adjustments. I am not saying there should not be, but that is the reality.

**Ms MORGAN-WICKS -** Chair, we only signed off in terms of our unaudited financial statements last Friday afternoon. It could have been a timing issue as well if I may offer that.

**CHAIR** - It might have been too. Right. That is helpful.

Can I ask about the Minister's expenses under the COVID-19 output group if it is more appropriate there? In terms of grants and subsidies the COVID-19 financial viability payment do you want me to ask that later under those line items?

**Mr ROCKLIFF** - We have Craig here so ask it now.

**CHAIR** - I am trying to understand the movement of the funds here on page 175. There was a budget of $46 384 000. There was a transfer to the public account of $1.803 million. I am trying to understand whether that is unexpended money that was transferred to the public account or whether it is separate money. Is it part of the national partnership payment to assist private hospitals? I am trying to understand what this payment was for and how it worked.

**Mr JEFFERY** - Very early in the pandemic last year the Australian Government was keen, through the National Partnership Agreement, to make sure that private hospitals were able to continue to function even though they were in partial or, in some cases full, lockdown. So, the Australian Government provided, through the NPA, a series of viability payments for private hospitals to support their ongoing activities. This was basically intended to support the gap between their reduced activity and what their normal level of activity was.

That was estimated in last year's budget, based on the activity when the budget was developed. But in Tasmania we were lucky that the COVID-19 blessing wasn't as strong here, so activity in the private hospitals picked up rapidly. I think they recommenced almost full activity - I am going on memory for this, which is not a good thing - about August or September, something like that. And so, the viability scheme has concluded at the moment.

**CHAIR** - Was all of that money expended? How much was actually paid out to the private hospitals in order to maintain their viability?

**Mr JEFFERY** - There were transactions in 2020-21. The budget was as per page 175, $48 187 000. The actual expenditure $7 668 000.

**CHAIR** - Did the rest have to go back to the Feds?

**Mr JEFFERY** - It was budgeted on expected revenue from the Australian Government and the expenditure matching that revenue. The Australian Government would provide the money retrospectively monthly. So, once the payments ceased, there was no reimbursement.

**CHAIR** - It was a provision, not a payment?

**Mr JEFFERY** - It was a budget based on expected activity at the time the budget was developed. When the COVID-19 situation changed, it didn't happen. So, we didn't draw down money from the Australian Government, so we didn't have to reimburse it.

**CHAIR** - The transfer to the public account, which is footnoted as 'reflects reimbursement to the public account for the National Partnership Agreement on COVID-19 response'. The COVID-19 response and recovery measures funded through appropriation, what does that actually refer to then?

**Mr JEFFERY** - That is the other outputs in output group 90, so some of the money budgeted in the financial viability payments got moved into the other COVID-19 output.

**CHAIR** - That $1.8 million, roughly, was then transferred to assist some of the other measures in 90.1 to 90.5. Okay. We will get to those later. Thank you. You can see how it is difficult to understand how it is moved, when you can have someone who can explain it to you at the table.

**2.2 Non-admitted Services**

**CHAIR** - I know there is additional funding and support being provided, as you alluded to, minister, in your opening comments, to keeping people out of the hospital system, providing care in the community and things like that. I note, in terms of reforming the delivery of our care in the community, the third dot point talks about 'deliver and permanently embed the Community Rapid Response Service statewide to assist GPs provide care in the community and avoid hospitalisation'. I must say, it's a fantastic service and it's worked very well in the north west. In terms of expanding this across the state, because it's not in place in the south yet, is it?

**Mr ROCKLIFF** - Yes, it is. Thank you, I did pass on your feedback about the value of the service. It started off in Launceston, the ComRRS service, then was piloted following that in the north west and the south. About six weeks ago, if my memory serves me correctly, we made the announcement that it will be permanently across the state.

It's working well. Certainly the feedback is that it's been received well. It is one of those areas where not everyone needs care in the hospital setting.

The south commenced operations in 2019, based in the Glenorchy Health Centre, encompassing Glenorchy, Brighton, New Norfolk, Hobart, Clarence and Kingston.

**CHAIR** - That was just the trial, though?

**Mr ROCKLIFF** - It was a trial, for sure. It's now permanent and integrated with Community Nursing services as well in the south. In fact, the south has accepted 327 referrals in the period 1 July 2020 to 30 June 2021 from 138 individual general practitioners.

**CHAIR** - Have you figures for the other regions?

**Mr ROCKLIFF** - I have. In the north, since commencement, there's been an increasing number of referrals, with current active referrals averaging 90 a month, up from 88 the previous year, so increasing the average.

From 1 January 2021 to 30 June 2021, that's six months, ComRRS north accepted 500 new referrals from approximately 100 individual GPs and delivered 4910 occasions of service, or a total of 3700 hours of care - a 22 per cent increase compared to the same period in the previous year.

Into the north west - more familiar territory for yourself and I and Mr Gaffney, ComRRS accepted 700 referrals in the period 1 July 2020 to 30 June 2021, from 122 individual general practitioners.

The model included working across the north west coast, the service was integrated with the Mersey Leven Community Health Nursing Service in Devonport, with a plan for integration with the Hellyer Community Nursing Service in Burnie to follow.

On 3 April, ComRRS were located to the Central Coast Community Health Centre, where I met a number of the team and people who have utilised the service. GP confidence in the ComRRS north west service is increasing. That is evident in the steadily increasing referrals, from 22 referrals received in January 2020 to 56 referrals in June 2021, peaking at 96 referrals received in March 2021.

It's being bedded down in all regions and across the state, which is good and very positive in keeping people out of the acute care setting in hospital.

**CHAIR** - Is it now extending its service beyond Wynyard, west of Wynyard? Someone who lived in Flowerdale couldn't access it. I'd argue that Flowerdale was in Wynyard, but there you go.

**Mr ROCKLIFF** - Yes, the person I spoke to at Central Coast, if my memory serves me correctly, was from Wynyard. So, relocation of the service base allowed service parameters to be extended, covering from Port Sorell to Wynyard.

**CHAIR** - Yes, but it's not beyond Wynyard, and the town boundaries are just short of Flowerdale.

**Mr ROCKLIFF** - Yes, I'm sure it would be Waratah-Wynyard or -

**CHAIR** - No, it's not. It's Wynyard town.

**Mr ROCKLIFF** - Wynyard township? And the question is when will it be going to Smithton, no doubt, and Circular Head?

**CHAIR** - Yes, well even just the surrounds of Wynyard.

**Mr ROCKLIFF** - We will have a look at that. The rapid access is a 30-kilometre radius.

**CHAIR** - That's right, hence the problem. Will consideration be given to extending it further? People who live just outside that 30 kilometre radius were notionally not eligible to access this service. That impacts some of my constituents; they may have been in touch with you, as well.

**Mr ROCKLIFF** - It is working. Of course, we will look at extending it further, given the number of referrals seem to be increasing. Ross Smith, who is largely in charge of this area, might want to comment, if that's all right, Chair.

**Mr SMITH -** In terms of the implementation, following the original trial in the north, our evaluation told us that it could definitely work in the south but we weren't sure about the north-west. I think the commitment around the initial trial in the north-west was probably to fund it well and truly above. The reason the evaluation suggests we don't know whether that could be effective in the north-west is because of the density of population, and whether it would be actually financially viable.

So far, things are looking good. It doesn't mean that we will always stick to that configuration and won't look to be able to extend over time. But we need to be able to make sure that we have the evidence that these things are cost effective and we can make sure that we can provide a reliable service. At this stage, I would say in the early stages, ComRRS, particularly in the north-west, has proven to be a highly effective service in terms of being able to help people stay in their homes. So far, patients are indicating that they like it. It doesn't necessarily mean that we will not continue to evaluate and look at ways in which we can improve and spread it over time. But it has to be viable.

**CHAIR** - We will come back to where you base the services, taking a 30 kilometre radius. If the base one is, say, in Smithton, you pick up a lot of people in that catchment as well. I think these are things that obviously need to be looked at as the model proves up.

**Mr ROCKLIFF** - Looking at the THS north-west ComRRS activity data, the occasions of service has gone from 3057 in 2019-20 to 11 392 in 2020-21. The average visit per referral is 16, and increase of one.

**CHAIR** - This is keeping people out of hospital. What would the cost have been if all those people were in hospital?

**Mr ROCKLIFF** - The number of referring GPs in the north-west has increased from 93 to 122. I think we can all agree on the model in that sense. I guess we need to look at how we can ensure its sustainability.

**CHAIR** - Has there been some costing done on the cost-benefit analysis of that in terms of what it would have cost to keep those people in hospital, as opposed to accessing this service?

**Mr SMITH -** Yes, in the original evaluation for the north. We wouldn't necessarily focus on that for future evaluations, because it's pretty obvious that it does. We would probably focus future evaluations on which bits of the service need tweaking or improving and where can we extend it.

**CHAIR** - It proved itself in that way, sure. How many staff are employed by THS in the ComRRS? They're not employed by the THS though, just the nursing staff predominantly.

**Ms MORGAN-WICKS -** The ComRRS service itself is managed as part of the THS primary care team. I have met two or three people from that team. We would have to get the FTE numbers.

The ComRRS service is a hugely successful rollout. It is squarely within our healthcare future forward looking policy which is about trying to transition to care which is supported between our GPs and our ComRRS nurses. As you rightly point out, it's about keeping patients out of hospital and staying within their home, receiving their care there.

The minister has mentioned the occasions of service per referral. We are still working with our GPs right across Tasmania to remind them of the value of this service and the ability to have the nurses come in, on their instructions, and continuously share information as to the care that is provided to the patient.

We are looking at the number of FTE in making this a permanent service, and we will also look at the geographic spread, noting that we also need the general practitioner referral in relation to that patient.

**CHAIR** - Moving to the bottom dot point in that column, reforming the delivery of care in our community. It says -

> Through a statewide choosing wisely program, support health professionals of the patients to have counter-conversations about health management options and avoid unnecessary medical treatments and procedures.

A lot of costs are soaked up in some of the not necessarily medically evidenced-based treatments and procedures and tests. How is that going to work, with regard to the role of your department?

**Ms MORGAN-WICKS -** Choosing Wisely has been one of the programs that has been supported by our business improvement and reform section that is part of Ross Smith's directorate. Choosing Wisely is a program that has been really positively received across our hospitals. It has worked because we have very passionate clinician champions for Choosing Wisely, who have come and presented to our health executive.

Choosing Wisely is about trying to make sure there is not an unnecessary volume of diagnostic tests ordered per patient. We have had reports, for example, of patients that have transitioned from one hospital environment to another. You might start your treatment at the North West Regional Hospital, receive certain tests with perhaps an ED environment versus being transferred to a ward in the hospital, receiving further tests and then perhaps care transferred to the LGH or the Royal Hobart Hospital where tests may be repeated due to, perhaps, the lack or deficiency in technology to actually appropriately attach those diagnostic records to a patient quickly enough so that it is shared upon transfer.

I am not suggesting that the right information is not shared for the care of a patient, but at times we do have repeat tests or perhaps unnecessary tests that may be ordered when not always following the correct clinical pathway for a particular patient.

**Professor LAWLER -** Choosing Wisely Australia is a program that has been well developed and well embraced across, not only the health professions, but also the community when the community has been engaged and involved in that process.

Basically, there is the development of recommendations by any number of groups, and I am looking on the web page, there are upwards of 30 to 40 groups involved there. They can be professional colleges such as the Australian College for Emergency Medicine or the Royal Australian College of General Practitioners. They can be societies such as Infectious Diseases Society and they can be faculties, such as Pain Medicine and Gastroenterological Society.

They go to issues of over-treatment and issues of testing, but also therapies. Examples would be the over-use of CT when assessing kidney stones or the over-use of proton pump inhibiters without evidence or trial of reducing or ceasing the dosage.

It is a recognition of a number of things. Firstly, that this is a cost to the system that cannot well be borne and should be removed. The fact that increased testing is an inconvenience on individuals and in some instances a danger. Also, over treatment is in itself associated with poorer clinical outcomes because of the risk of complication, particularly in patients who are on multiple medications without regular review.

It is a firmly clinician led process in that the recommendations are developed and refined by clinical leaders. Also, their implementation and monitoring within the health system is overseen and championed by health professionals and is one of the things we have engaged very strongly with our consumer adviser panel and also consumer and community engagement councils within our hospital systems.

**CHAIR** - The other matter in this line item is the waiting times and access issues with outpatient appointments. I still hear, as I'm sure you also do minister, about the challenges with communication around this and the growing wait time to get on the waiting list or even to get an outpatient appointment.

What measures are you taking to actually address this? The latest data is available on the Health dashboard on waiting times, but what is being done?

**Mr ROCKLIFF** - It is available on the dashboard, which we are now releasing monthly for the benefit of those who want to scrutinise our government and keep us accountable rather than the previous quarterly figures and that is a good outcome. I acknowledge there is some interest in outpatient waiting list, which is why to your question, Chair, we are establishing an outpatient transformation program and including the development of a statewide outpatient plan for Tasmania. We are investing some $2 million into a start-up program to complement the recently released elective surgery plan, so we are proactive.

What we have seen in the last 12 months is an increasing demand on outpatient services. Although the pandemic has impacted the delivery of outpatient services, I do acknowledge there are opportunities to improve the systems processes and tools that support the management of our outpatient clinics.

Like the elective surgery plan, the outpatient plan will provide a clear focused roadmap for the delivery of a sustainable outpatient services over the next four years. It will be codesigned, again by clinicians in collaboration with clinicians, patients and other key stakeholders. It will include service improvements which will transform the way outpatient services are delivered to patients and clients in Tasmania.

Part of the transformation program will include the implementation of a statewide extensive audit program to ensure waiting lists are up to date, patients are contacted and current needs confirmed. I think you mentioned that in your question.

Implement consistent referral protocols and business rules. Improve communications. Again you mentioned that. Online booking processes and electronic referrals for all services. Implement clinical prioritisation criteria and reduce unnecessary or low value care and invest in targeted reforms to divert patients to the right care pathway including non-surgical options and consider the case for a centralised referral intake hub.

Delivering this program, our expectation will be to modernise business processes used in our clinics, improve waiting times for patients in the outpatient services, improve patient engagement with the service, and support implementation of more contemporary models of care.

Recognising the challenges there and hopefully that investment, at least the start-up program of some $2 million and indeed the outpatient transformation program will go a long way to address the challenges. The waiting list just came down marginally last month to about 54 000 or so. It was 55 000 at one point but it might not be quite 55 000 but anyway too high, so there you go.

**CHAIR** - Minister, the other consistent feedback I get and assume you would too, is with regard to the timing of appointments for outpatients, particularly patients who have to travel. Patients from King Island, patients from far north west when they have to go to Hobart for an outpatient appointment. They can be on the way and it's cancelled or their appointment is at 8 o'clock in the morning so it means they have to have an overnight stay. Yes, they can claim patient travel assistance but it's the inconvenience of it. Sometimes there's the issue of not being supported by PTAS if there's not a perceived need to stay overnight because their appointment is in the middle of the day. But to drive 10 hours or more, 11 hours, 12 hours, for notionally a half-hour appointment is pretty demanding for people who are often in pain or discomfort; that's why they're going to the specialist in the first place.

In your response, you talked about a centralised intake hub and better patient engagement. Is there going to be a single point of contact? Those things can be considered and understood because I think when these appointments are made they don't really even look at where the person's from, in terms of the geographic location.

**Mr ROCKLIFF** - That would be my expectation but, Kath, would you like to add further, please?

**Ms MORGAN-WICKS** - The outpatient transformation program will include the implementation of a digital outpatient management and virtual care solution. Noting that particularly during COVID-19 we did transition to quite significant virtual care or Telehealth services and we're also trialling different at-home diagnostic or virtual tools to support the monitoring of patients as part of that outpatient service.

The virtual care solution is going to deliver a clinic management solution, a waitlist management tool and a patient access portal. It's probably the last part that is the most relevant to your question. The portal can then allow patients themselves to access and update when

they actually can't attend an appointment. I note that we had some 40 000 appointments last year which were not attended.

**CHAIR** - But anyone with a cold or flu symptom shouldn't be going, so I imagine -

**Ms MORGAN-WICKS** - And not to place any kind of blame on patients because we also use a paper process to write to them to let them know that they're on an outpatient list. Some may also wonder why they're on an outpatient list if they actually haven't understood that they've been referred to an outpatient service. That portal will allow them to also exercise some degree of discretion in terms of timing, so if they're unable then they can move their appointment et cetera. So it will really open up the digital options for patients to better manage.

As part of the outpatient transformation program as well, we will have significant audit teams that will be looking at the number of the 54 000 that are currently on that list. Based on past audits of the outpatient list, we think that quite a significant proportion, whether it's 20 per cent or 30 per cent, actually may be removed from the list because they have received the service already or did not understand that they were actually on the list. We will work through that.

**CHAIR** - Or they've come through the emergency system or the acute system.

**Ms MORGAN-WICKS** - Correct. We'll work through that to actually make sure that we have a true sense of the outpatient demand, give the teams in hospitals the right tools to be able to manage those lists, and also provide greater consumer or patient access in a digital portal.

**CHAIR** - One other question from me and I assume this is the right place to ask because the THS provides the outpatient aspect of maternity services in the north-west, with the antenatal care. Where is the north-west maternity services review at?

**Mr ROCKLIFF** - The review commenced in November last year. I can understand why you are asking the question. The department has received the report and I have been briefed on the report. The report and recommendations will be going to Cabinet and following that we will release the report. It is my expectation that prior to that there'll be a strong engagement with the community and particularly those staff involved as well. I would like all that to have been achieved - where are we now, early September - by early October at the latest.

**CHAIR** - That's the public release?

**Mr ROCKLIFF** - Yes.

**CHAIR** - And the engagement with the midwives and others?

**Mr ROCKLIFF** - Yes. I look forward to providing that certainty for the community across the north-west.

**Dr SEIDEL** - On page 160 you provide the output data for outpatient attendances, but not really performance data. As you mentioned, there is a lot of work that needs to be done to see patients on time. We still have 55 000 patients waiting.

When you go through the outpatient individual list, you are seeing the indicative wait times for patients who are being referred urgently to certain specialities. For example, you will see that urgent neurosurgical outpatient appointments are over 700 days. They are patients who should be seen within 30 days. Colorectal surgery is 150 days. Too many patients were being referred by a GP with potentially suspected bowel cancer.

Would you be considering reporting the performance data on how many patients you are seeing on time within the individual triage category, rather than just the raw number of indicative waiting times? Or even just the numbers of how many patients actually have been seen? Just a more transparent way for the public to see that you are meaningfully improving outpatient waiting times and also improving patient care.

**Mr ROCKLIFF** - It is a good question and I understand why you are asking it. Many members of the Tasmanian community may well be asking the same question. If in actual fact we could achieve that, I could understand that it would be of benefit, so I wouldn't rule that out at all. I will ask that we can do that.

As we implement and prove the tools for managing the waitlist we are also looking at what we can do to improve what we publish regarding performance. Again, in the interests of accountability and informing the Tasmanian community, that keeps governments of the day accountable, the department accountable and gives more relevant data to the Tasmanian community. So, of course we can consider that as part of the project where appropriate.

I am not sure of logistics behind it and what would need to be created to support your request but I will see if that is possible.

**Dr SEIDEL** - On your outpatients' website you talk about the monitoring of patients who are still on outpatient waiting lists and you clearly state it is still the referring clinician who remains responsible for patient care whilst a patient is waiting. It puts enormous pressure on the person who refers the patient in the first place. Just imagine if you were referring a patient to neurosurgery and you have to wait for 700 days. As a GP what are you meant to be doing? There is a reason why the patients have been referred. So how are you supporting GPs who are also waiting? What communication tools will you put in place to advise referring physicians that patients will not be seen within the anticipated time frame triage category?

**Ms MORGAN-WICKS** - The department has been looking at the ways we can better support GPs throughout electronic referrals process. We have had some concerns in relation to referrals to fax machines perhaps that are not picked up in a timely way. So, I think the electronic referral process and also having clearer and more consistent clinical rules on the actual referral through to a particular specialty or not. We have had some issues with a referral being made to a particular specialist or individual they are trying to see within our public service rather than to a group and allowing us to better refer within, to make sure that time limit is managed not just on an individual's workload, but as a group that is managing it within the public service.

Our e-referrals process, which we have been working on very closely with Primary Health Tasmania, will be permanently funded as part of this. We're very excited about that. I might get Tony to speak to the other supports that are provided to GPs, also our specialist in-reach service which we've been trialling in the north as part of Dr Alasdair MacDonald's service

to, again, try and keep that care managed by GPs, but with the aid of specialist advice in the north.

**Prof LAWLER** - I would like to reinforce the work that is being undertaken for Tasmanian health pathways optimisation project. This is a really good example of just one of the many ways in which the public health system is interacting quite effectively with general practice. Obviously it is a slight challenge to directly engage with all general practices around the state. We do that through our work with Primary Health Tasmania. Work on the Tasmanian health pathways project, which itself is an evidence-based online portal designed by primary and acute health professionals in conjunction, in order to streamline the process of referral for clinician use. We have heard for some time that communication is a challenge.

That is a two-way challenge, in terms of discharge information for patients being discharged from hospital back into the care of their general practitioner and community carers, but also the other way, to ensure that we don't get into the process where information is being sent for triage prioritisation and booking in such a way that either incorrect or incomplete information is being provided.

On a condition-by-condition basis, there are actually over about 800 conditions that are usually managed by general practice and frequently have interface with the acute sector. There are information flows to help make assessment management referral decisions. There are benefits in this for patients, clinicians and the health system. There is greater coordination of care to ensure that as much as possible can be done in the community, and to really work to that ultimate goal, which is to keep patients out of hospital for as long as they can.

For clinicians, the platform provides an easy to read and easy to access warehouse, if you like, of evidence-based information that includes the referral process, outpatient and admission criteria and information on post-discharge management. There is also a benefit to the health system that results in a reduced variation in health care, decreased demand on acute and outpatient services and enhanced patient access and flow. In fact, at our last clinical executive meeting we had a presentation from Susan Powell, and also Dr Graham Bleach, who worked with Primary Health Tasmania. At the same meeting, we had a presentation on a clinical prioritisation mechanism that's used elsewhere in the country, most notably in the Gold Coast and Brisbane regions of Queensland. It enables a more effective clinical prioritisation of the referrals that come in. They found that experience was more of an educative than a restrictive tool in improving the quality of referrals for outpatient review.

The process that we are following in the north, which Dr MacDonald, the Director of Medicine at the LGH, has been passionate about for some time, recognises that there is a continuum of care that exists for patients. Patients don't inherently see a difference between the care that they are receiving. When we say a difference, they don't see the structural or governance boundaries that sit between primary, acute and subacute care, and rightly so. They see a single health system that they navigate. The big benefit of an in-reach program that is operating out of Launceston General, is that it serves to further, for want of a better term, homogenise that care that is being provided. It enables the provision of a level of care that facilitates keeping patients out of hospital. We know that keeping patients out of hospital is more efficient, it's more convenient and also it's safer where we can do that.

There are quite a few initiatives in train currently that both streamline the communication and the flow of information between the primary and acute sector, but also serve to provide better services to individual patients and members of the community, close to where they live.

**Dr SEIDEL** - A specific follow-up question, will you advise GPs if and when a patient cannot be seen within the recommended time, considering that the referring GP seems to remain responsible for the care of this patient?

**Ms MORGAN-WICKS -** We have been speaking to the primary care sector about the information they would like to see on particular wait lists for particular specialities. As part of our dashboard and information management tools, we will see if we can give greater visibility to GPs on the current waiting times per specialty.

**Emergency Department Services**

**CHAIR** - If there are no other question on that, we will move to 2.3 Emergency Department Services.

**Dr SEIDEL** - Referring to Budget Paper No. 2, vol 1, page 160 - table 5.4, I note the percentage of Emergency Department patients have been seen within the recommended triage time has dropped in the last financial year. It is now below 58 per cent; but the target for 2021-22 is actually quite ambitious. You say 90 per cent and 80 percent respectively.

Looking at the health dashboard data for June/July the percentage has dropped again, and is now 53 per cent. My question is, what is your plan to catch up to ensure you are meeting your ambitious target as outlined in the performance information?

**Mr ROCKLIFF** - We recognise the ongoing challenges due to increasing demand and the impact of the pandemic on the health system and staffing levels, and the increasing pressure on our Emergency Departments due to continually increasing numbers of people presenting for care at the very least.

During July this year, across the state there were 14 738 presentations to Emergency Departments in our public hospitals. As well as increased numbers of presentations, we are also seeing an increase in the complexity of patients and an increase in the number of patients who need hospital admission.

Our growing ageing population and relatively high rates of chronic disease are contributing to this increase in demand. These are not unique challenges to Tasmania. Emergency Departments across Australia are also facing similar pressures and struggling to meet demand.

In response to your question, we have invested in several strategies to help respond to the demand in our health system. We have the $20 million commitment for prevention and early intervention initiatives. We have mentioned the community rapid response and hospital in the home services as well.

We are investing in strategies to facilitate patient flow through our EDs and to prepare our health system to better manage demand. That includes funding over four years of some $198 million to THS to meet demand and to open new beds, for example.

The Royal Hobart Hospital ED in particular, has been under immense pressure with extraordinary levels of emergency presentations throughout the 2021 year. I have met people within the Emergency Department and understand the pressures that they are under.

In light of these pressures, we will be super-sizing the Emergency Department expansion, committed to as part of the Royal Hobart Hospital stage 2 redevelopment. This will ensure the number of beds and treatment points in the expanded ED can support staff to respond to this new level of demand.

We will accelerate the opening of 25 new Emergency Department beds as a first stage, and we expect that to be up and running by the end of 2022. Work will also occur on level 3 of A Block at the Royal Hobart Hospital to deliver, during this financial year, 24 new general medicine beds, providing additional capacity and improving patient flow through the ED and most importantly, increasing access for patients to timely care.

The Budget supports these initiatives but I understand and recognise the challenges faced within our EDs due to the increase in demand. Is there anything further you would like to add there, Kath?

**Ms MORGAN-WICKS** - We have been looking at strategies which, as the minister has outlined, include those infrastructures, looking at our bed requirements and the clinical service planning for each of our geographic regions and how that feeds into our master plan. Noting the additional beds we are opening at the Royal, which responds to the very significant increase in ED presentations we've had, particularly over the last year at the Royal. So, a combination of beds and infrastructure.

We've just spoken about the ways in which we're trying to increase our care in the community to allow for hospital avoidance, to try and reduce that pressure on the ED, together with our partnership with private hospitals to increase their support and care provision.

As part of our statewide access and patient flow program, we are trying to pick up all of the projects that have been nominated by clinicians, so really a clinician-led program, and looking at learning from each hospital statewide.

We have piloted particular projects, for example, at the Royal which we now believe are successful and can then roll out statewide. We will also start particular projects in the north west or in the north to evaluate and determine whether they can roll out statewide.

We are trying to get that harmonised, and resourced projects, by naming it up within a single program, rather than expecting an ED staff to just roll out their own improvements.

We are also looking at improvements within Ambulance Tasmania. Secondary triage is a critical project we're rolling out as part of access and flow to assist in terms of the number of calls that come through to AT that may not require an emergency ambulance sent to them. I know we'll talk about ambulances in a moment.

It's a very complicated and complex picture, access and flow. The most important thing for all of our staff to understand is that every single person across our hospital and health sector

is responsible for access and flow, not just our emergency department team. That's a cultural change we're also speaking to, to really encourage every member to think about that.

Whether you're a nurse on a particular ward that might be saying yes or no to an admission from the ED. Perhaps that might be at 2 a.m. in the morning and it's often a difficult thing to do. But reflecting right across, whether it's cleaning teams rapidly getting beds cleaned and turned over, et cetera, everyone plays their part in improving flow across the hospitals.

**Dr SEIDEL** - I'll follow up on this one because that's a really important point. When you say unprecedented demand, looking at the data, it's actually not, is it? It's pretty static. We had 14 900 presentations in December 2020, then 14 400 in April 2021, 14 900, 14 700, 14 730 in July 2021.

There's not a huge variation, considering that there is about 14 000 plus/minus presentations statewide every month. We don't have a sudden surge of 20 000 patients per month. It's a reasonably predictable number, isn't it?

**Mr ROCKLIFF** - Yes, increasing though. If I look at the ED presentations by year, just quickly, the Royal Hobart Hospital in the 2019-20 year had 61 743 presentations. Last financial year that increased to 72 325.

The LGH was 42 747 in 2019-20 year up to 44 525 last financial year.

North West Regional jumped some 3 000, from 25 950 to 28 938. The Mersey Community Hospital increased from 23 298 in 2019-20 to 24 857 in the 2020-21 year.

In 2019-20, across the four sites we have 153 738 presentations; in the 2020-21 year it was 170 645. In July alone, I think as you indicated, Dr Seidel, 14 738 across. So, we have increase in presentations. The increasing complexity adds to that further challenge as well. I'm not sure if Tony wants to talk to that at all.

**Ms MORGAN-WICKS** - Through the minister, noting that 2019-20 also had the COVID-19 impact on our emergency departments. With respect to Dr Seidel, there are some static levels, depending on the region. But it's not the case for the Royal, which even from 2017-18 and 2018-19 sat around the 63 000-presentation volume for the year; slightly dropped in 2019-20 to 61 000; through to 2020-21 - 72 000, being a 10 000 increase. We're currently sitting on around 6162 per month, which again will show a big impact for this year.

That is certainly not just the case for Tasmanian ED presentation data. We're having that reported by every single health secretary and CEO around all of the states and territories in terms of the impact and large increase on ED presentations.

**Mr LAWLER** - Through you, minister, I do keep an eye on emergency department activity across the country and this is a phenomenon being experienced across all jurisdictions in Australia. I have to say, people are a bit befuddled by it because there doesn't seem to be a clear indication that this is a bounceback from the COVID-19 experience.

As the minister has highlighted, the level of complexity is certainly at least being maintained from previous to that.

We're actually seeing an increase in presentations.

The admission rate is staying pretty static, which indicates the extent to which individuals are coming into hospital sick or their case is sufficiently complex that they require inpatient care.

Across all the emergency departments, as mentioned by the secretary, we did see a dip in 2019-20. There is some theorising that what we're seeing now is not that people are put off, individual cases of concern, and have consequently left it 12 months later - but what's happened is the difficulty in accessing general practice care, potentially, has led to the deterioration of conditions until they're arriving in hospital and requiring that level of care.

**Dr SEIDEL** - Or patients not being able to access outpatient appointments, for example.

**Mr LAWLER** - There are a number of factors, obviously, that would contribute to that.

The challenge that we see is that there is a steadily increasing demand and, as I mentioned, that's being seen across the country and also in New Zealand. In the month of July, if we just extrapolate that out, noting that July is frequently one of the busier months, we're looking at an annual census that would be greater than 2019-20 for all of the hospitals.

So, there is increasing challenge with presentations, there is increasing challenge with the complexity.

There are, as has been mentioned, significant mechanisms being undertaken to address all of the steps in that. This includes increasing the size of our emergency department at the Royal, and that's factoring as well into the north and north west master-planning process; increasing the capacity within the inpatient wards, as has been highlighted under the access and flow domain of the strategic plan; improving processes of inpatient management through our statewide access and flow program, and the myriad initiatives that sit under that; but also, as has been highlighted by the secretary, the elements of innovation that are looking to keep people out of hospital - ComRRS, which the minister has gone through in significant detail; ambulance secondary triage and greater interactions with the private sector as well.

**CHAIR** - It's an interesting conversation around the increase in presentations and noting the increasing complexity.

You would expect that if a lot of these other mechanisms and programs you're putting in place to treat people out of the acute hospital setting, which is ideal obviously, because we've heard consistently that those people aren't really the problem, they can be dealt with fairly quickly and shunted back out the door, ideally not coming in at all in the first place. But if those measures are effective, then the complexity of patients will only increase because the sickest ones will keep coming because they can't be cared for in the community. I would suggest that is not going to disappear.

**Ms MORGAN-WICKS -** Depending on whether it is our chronic care programs in the community, as part of our ComRRS service if we are able to maintain - as Dr Seidel would well know - the care of those who sometimes can be a frequent flyer to our emergency department should they not be receiving sufficient care, either from a primary care setting or

perhaps from a ComRRS service daily visits from our nursing service, for example. If those conditions are not attended in appropriate times, they will end up in our emergency department.

There is often quite a conversation around, for example, our category four to five, even perhaps category fives that attend our emergency departments and whether urgent care centres are potentially an answer to assist, noting the opening of an additional urgent care centre in the Launceston community over the last couple of months. The department is providing some funding for this and monitoring the uptake and impact on the number of category fives in our LGH attendances, as a pilot.

**CHAIR** - It is only early days, there is no data on that yet?

**Mr ROCKLIFF** - Not that I am aware of, it has only been up and running since April.

**CHAIR** - I talked about the nationwide - including New Zealand - trend with increasing presentations to our ED. The expense summary in the budget for this year is $262 282 million. I thank the minister for the actual. That was on the line of above, it was $187 592 million for the budget. Last year, it was $196 000 million effectively, which is more than what you are budgeting for next year. Is there an explanation as to why you do not expect to need to spend as much this year, without a crystal ball, knowing whether COVID-19 is going to impact on your EDs? It seems to me that from what Professor Lawler just said, it is unlikely demand is going to reduce.

**Mr ROCKLIFF** - It may well be, well, I suspect that is the case. There was a dip in 2019-20, which may in fact all of those areas there may well be a flow-on effect to the last financial year.

**Ms MORGAN-WICKS -** Noting we have only just reached our actual for 2020-21 last Friday and they are yet to be audited, have the audit sign-off, they're being audited, we always look at our actuals versus our budget of line items, then we issue a THS internal budget. We always - I can pretty much guarantee and I think David is also here - we are not reducing in any way our emergency department line item in our THS budget. We do, with all the greatest respect to these budget documents, we do move money around within the health sector according to the demand that is required between the different outputs. But we do need to feed then that back into Treasury in terms of our allocation of the actual budget lines, once we see actuals come through for a particular year.

**CHAIR** - Stepping back slightly to 2.2, a footnote there says increasing non-admitted services in 2021-22 affects a forecast increase in expenditure funded from revenue retained with the department-specific purpose account. Is it likely that funding would be shunted across if the need was greater is what you are?

**Mr ROCKLIFF** - That is my understanding.

**Ms MORGAN-WICKS -** We have a very detailed internal budget for our admitted services, including the emergency department.

**CHAIR** - Is that recorded in your annual report, the movements within that, or is that just internal?

**Ms MORGAN-WICKS -** That is internally managed. Our THS budget is available to all of the leads across all of our departments in our Tasmanian health service. The finance team work very hard to look at actuals. There can be reasons, including expenditure of our own source revenue, which may add to that actual and not necessarily budgeted in these documents. It can be a particular project that has run out within a particular department that may increase the level in one particular year. Certainly, we go line by line through every single department in hospitals to look at their actual in the previous year and make sure we are getting the right budgeted amount for the following year.

**CHAIR** - Minister, you did refer to in your opening comments, around some of the measures taken to try and improve flow and your strategic priorities address some of that and the whole of hospital response, it is not just the ED's problem when you have got access block. You talked about the strategic priorities and mentioned, implement direct admission pathways for patients to avoid ED such as surgical referrals move to hospital transfers. It seems that this is just staggering that has not already occurred. In-hospital transfers have to go through the ED of the receiving hospital, surely, that can be actioned promptly. Why is that still the case?

**Ms MORGAN-WICKS** - I might get Tony to provide an example, but we are working with each of our hospitals who at times will have different transfer or admission protocols are currently operating within hospitals. We are away of some protocols that require, for example where there is a transfer of a patient from the Mersey Community Hospital and North-West Regional Hospital that require then passage through the ED of the LGH and we are working to remove that and move to a direct admission model. So, Tony might be able to provide an example.

**Prof. LAWLER** - There have been some historical challenges working within the one health system we have had since 2014. I have to say and this is to serve as a baseline for what I am about to say. We implemented a new government structure in March 2020 and it was about 16 minutes later that we were hit by COVID-19. There is an argument it made things a little bit difficult, I actually think it helped to accelerate our cohesion and work as a single health system.

I have been sitting on hospital committees in one form or another since the mid-90s and I actually can't remember a time when the hospitals have worked as closely together as they are now. That is not just the public facilities, that includes working with the private facilities and working with the primary care sector. Some other key elements within the system including our community services and also Ambulance Tasmania. There are a number of ways in which we are looking at facilitating that transfer. And it needs to be noted there are different natures of inter facility transfer. There is the retrieval of the particularly unwell, unstable and/or injured patient coming from a district hospital or from an emergency department who really needs to be in Hobart to be stabilised potentially. If they deteriorate en route, they should be going through the ED, they should be there.

Having said that, if they are coming to receive time-critical surgery, if they are coming to Hobart, they go to the helipad, they go to theatre, because that is why they are coming.

There are some instances, as have been highlighted by the Secretary. We have had this discussion with the registrars in the emergency department of Launceston and also with the other medical staff there around the fact there has been a policy requirement for cardiology patients to come in through the ED at Launceston General. That is something we have to look

at. We need to have safe mechanisms in place. We need to working with Ambulance Tasmania, with the staff there who manage inter facility transfers, with both the transmitting and receiving hospital to make sure those transfers are safe, but also, they are as smooth and streamlined as possible so they can get to the wards as quickly as they can. Because we should have situation where in there if a ward bed available, then that should be the process we follow and working through that and that is part of reducing that demand on ED. You mentioned earlier around the fact there is a difference from an access block potentially overcrowding in terms of getting those patients through more quickly and that is certainly key.

The other we have highlighted is the fact we should have pathways for patients who require a bed on the ward, not coming from other facilities potentially, but coming from surgeons' rooms or physicians' rooms or from the community on a pre-arranged transfer to be able to be streamlined straight into sidestep the emergency department. That is all tied up with our access and flow element where we improve the processes so that it doesn't just come about bed numbers, but about the most effective bed utilisation.

**CHAIR** - Most people who are coming from surgeons' rooms or physicians' rooms would come during the day, most of them don't work in their rooms at night. You would expect there would be communication about whether there is a bed available in the first place before they are even sent.

**Prof. LAWLER -** There absolutely has to be, and that communication will be both clinical and administrative. There will be a process whereby a patient-flow manager or a bed manager is contacted, bed availability is ascertained, the bed is booked but there needs to be a clinical handover as well.

The point of clinical handover from a safety and quality point of view is where we frequently run into trouble. Again, that goes to standard six, which is communicating for safety and it actually talks about the safe handover of care within our facilities, but it also goes to transfer from public to private and from private to public facilities.

**CHAIR** - We could argue the more times you have to transfer the patient from one person's care to another, the more risk there is with information falling through the gaps.

**Prof. LAWLER -** It doesn't matter how standardised you are, you have human factors intervening, so you minimise that as much as possible.

**CHAIR** - The other point was implementing criterion-led discharge. Barriers to safe discharge on a weekend or night and extend our staffing, this has often been a barrier cited as an access for bed block, people coming up from the ED. People do front up to the ED 24 hours a day.

Then you hear the other unfortunate side of that sometimes that people are 'kicked out' of their hospital bed at 2 a.m. to find their own way home, often without shoes or things like that because they only have their pyjamas or whatever they are in hospital in.

How do you envisage this working? I see it actually needs to happen and we have talked about nurse-led discharge where a patient is really only waiting to see a doctor to say, 'yes you can go home'. That is ridiculous if that is all it is. Waiting for pharmacy and waiting for something. What is the intention here to try to streamline that discharge process?

**Mr ROCKLIFF** - With regard to nurse discharge or ensuring the patient is cared for?

**CHAIR** - The whole lot. Nurse-led discharge and those patients who may be discharged at an inconvenient time, particularly if they were a patient being discharged from the LGH who lived in Smithton. Find your own way home.

**Prof. LAWLER -** The safe care of patients means providing safe discharge to patients, which includes the mechanism for when they are able to leave hospital and do that safely.

On the issue of criterion-led discharge, this has been a focus for some time and we will be working through that. As you have highlighted, Chair, it highlights the fact that we do have some systems in the hospital - and this is again a challenge that has been faced across the country in relation to how the streamline that process - where patients can wait for a number of things, including allied health, imaging, medical review, when we do know that there is the potential possibly for a clear set of criteria.

We refer to it as a criterion-led discharge because we are actually looking at, is the patient able to attend to the activities of daily living, can they walk, talk, eat and drink and are they safe to discharge?

When we are utilising beds most effectively, it is ensuring that we are providing an environment in which we can care for those patients until the point where they are safe to be discharged into that community and we are not leading to a drop in the level of care.

Work is being done on this and it sits within the suite of initiatives that go to the most effective utilisation of beds. Criterion-led discharge is one of those that we have highlighted that requires some focus. It is going to be useful to remove some of the subjectivity and consequently variants in that process.

We would have that alongside such other issues as estimated date of discharge so that we can actually track the process of patients. It is great that we can get patients out early in the day if we can then make sure that that's happening in line with national length of stay averages that would be great because that indicates we're providing care in a safe and efficient way, accompanied by various markers of safety such as readmission or re-presentation rates. Criterion-led discharge, estimated date of discharge, regular medical rounding and a clear understanding of the patient's position in their care journey are all elements of our access and flow program.

**CHAIR** - Minister, do you have any figures on patients who have been discharged from the ED - within or outside the recommended time period for either their admission or discharge from the ED - and the number of patients who have returned to the ED within 24 hours?

**Mr ROCKLIFF** - I am not sure if that data is easily accessible but -

**CHAIR** - This is a bit of a performance measure like an outcome measure as opposed to just the number of people who present.

**Mr ROCKLIFF** - I understand. We can look for that answer. We will take it on notice and we'll see if we can access the data.

**CHAIR** - That's the number of patients who return to the emergency department within 24 hours in the last 12 months across all four EDs.

**Prof LAWLER** - Regarding that data, we have the challenge that because people present again to an emergency department does not necessarily indicate that they're presenting for the same reason.

**CHAIR** - Or came back for the same reason. If it was within 24 hours you would expect it is most likely to be related. If it was two weeks later it could be something else.

Do you have figures on the number of patients who did not wait to be seen at EDs?

**Mr ROCKLIFF** - Who arrived?

**CHAIR** - They came and checked in but then did not wait to see the medical staff.

**Mr ROCKLIFF** - We'll have to access that information so another question on notice.

**CHAIR** - The question on notice is the number of patients presenting to emergency departments who did not wait to be seen by medical professionals. This is for the last financial year.

**Ms LOVELL** - Minister, also could we get the number of patients or length of stay for patients who presented to each of the EDs in the last financial year for mental health treatment? We asked this the last several Estimates. Longest length of stay and average.

**Mr ROCKLIFF** - Specific to mental health?

**Ms LOVELL** - Specific to mental health. I understand that sometimes patients who do require mental health treatment may be triaged as a medical patient if they also require medical treatment. Are they also triaged as mental health in that instance or just as medical?

**CHAIR** - Are you talking about people with an underlying mental health condition?

**Ms LOVELL** - For example patients who may have self-harmed who require medical treatment for the harm but obviously require subsequent mental health treatment.

**Mr ROCKLIFF** - The first part of your question we'll seek the information for you because that's in the mental health and wellbeing area.

**CHAIR** - We can ask it there.

**Mr ROCKLIFF** - But I'll take that on notice for there. We can seek that information if that's possible.

**Ms LOVELL** - But for emergency department presentations.

**Mr ROCKLIFF** - Yes.

**Ms LOVELL** - Okay.

**Mr ROCKLIFF** - If someone presents and they're self-injured then -

**CHAIR** - They have a medical need to be there.

**Mr ROCKLIFF** - Naturally their physical harm will need to be attended to.

**Prof LAWLER** - My understanding, but I'm obviously happy to be corrected, is that the system that we use to track presentations and patients within the emergency departments which is called TrakCare has a process whereby there's a single presenting complaint and a single principal diagnosis. That's the process, recognising that patients with medical conditions may present with a mental health presentation and vice versa. There is a challenge in capturing that data but having said that there will be a significant proportion of patients who present with one type of condition or the other.

**Ms LOVELL** - In that instance where, for example, a patient has self-harmed and there's a mental health condition that requires treatment but the priority is the medical condition that requires medical treatment, once they're treated medically are they then - I'm questioning the process around that data collection. Are they then transferred to the psychiatric department of the hospital or are they reclassified? How does that work?

**Mr LAWLER** - There will be a single presentation to the emergency department and treatment will be dictated by the urgency and nature of the initial complaint. I know this is all pretty clear but those issues will either be treated in parallel or in a series. That's a different question, to a certain extent, to if that patient is admitted or discharged and if they're admitted or discharged, where they go.

Whether they're admitted to a medical ward or to a mental health setting will be entirely guided by the treatment they require and their response to treatment or whether they're discharged to the community or to the care of their family or carers. A patient may present with a number of medical conditions which could be related or unrelated, to an underlying mental health condition. Once that's managed within the emergency department or potentially on the ward by the medical team, they may then find that the underlying mental health condition, which may have been exacerbated by or caused the medical condition that was the trigger for their presentation, they may then be transferred either directly from the ED or from the medical ward to the mental health ward.

**CHAIR** - We'll move to the next line item which is:

**2.4 Community Health Services**

**CHAIR** - I note that you're implementing a safe staffing level for our rural hospitals. Can you provide some more information about how that's being done and the overall intention? Is it to ensure that we can operate these hospitals at higher capacities? I think your occupancy rates are actually still relatively low, with the exception, I think, of New Norfolk which has a fairly high occupancy.

**Mr ROCKLIFF** - Providing health services in our rural and regional communities is of course a priority and will continue to be increasing, I suspect. Primary health services across

Tasmania have continued to maintain all community-based services since the outbreak of the pandemic. Day centres were closed for a period. Alternative community support programs provided for clients have now reopened and this is a significant achievement and I commend the primary health staff who have continued to provide needed care throughout this time.

Regarding the safe staffing model, there's been a statewide district hospital safe staffing working group. That was established back in February 2018 to research and develop a staffing model for the 13 district hospitals around the state. District HITS is designed to provide the flexibility required to staff individual Tasmanian district hospital sites to meet their specific mix of inpatient, emergency outpatient and residential aged care. It's been funded for 12 months and during this period the staffing model is to be implemented and formally evaluated. Now, the model commenced on 27 June 2021 with work continuing to oversee both implementation and the evaluation. A funded staffing model will improve access to safe and appropriate clinical care and services at rural sites, optimise the use of our rural inpatient beds and assist in the recruitment and retention of staff.

**CHAIR** - Minister, what is the purpose of actually increasing? I assume it will increase the staffing levels to enable greater utilisation.

**Mr ROCKLIFF** - Yes, and we have increasing staff right across our district hospitals.

**Ms MORGAN-WICKS** - We had the 12 months' worth of trial funding and this is now permanent in the budget to make that permanent increase to the staffing levels. In looking at the occupancy rates of our district hospitals, the purpose has been to try to lift those but it does require a conversation with the community in relation to transfers from our major hospitals to our district hospital sites. I didn't mention before as part of our statewide access and flow program, we are also rolling out an MCAP project. That's Making Care Appropriate for Patients to try to really get to the bottom of patients who have perhaps passed through their acute stage of care into a sub-acute stage where it's more about that rehabilitation or supports or access to allied health et cetera. Can that actually be delivered safely within a district hospital environment?

To do that, we need to lift these staffing levels to allow for the potential for greater transfer in use of our district hospital beds and getting the community to support that transfer. Often, we will have that conversation with family members about - we really do need to have access to this acute bed within, for example, the LGH. We recommend the transfer through to whether it's at Deloraine, Campbell Town or other district hospital to support the final part of a person's care. We need to get to the stage where we have to make those decisions and we have to make those transfers, noting that there can be transport difficulties for family.

**CHAIR** - It's been a challenging conversation for years this one.

**Ms MORGAN-WICKS** - Yes but to actually have flow happen through our hospitals and make sure that acute patients are able to access acute beds, that's a community conversation that we do have to have.

**CHAIR** - We haven't really had that yet? I thought we would have been doing that?

**Ms MORGAN-WICKS** - We are having that conversation as part of one of our strategic priorities in making sure that we are increasing the care within the community, including also our use of district hospitals in our access and flow priority.

**CHAIR** - As I understand it, one of the reasons people aren't always transferred from the Royal, the LGH or from the North West Regional to Deloraine or Scottsdale and other hospitals around the state, is the lack of allied health staff to meet their needs in physio or OT or social workers. What's the role for the Government to actually ensure, not just that you've got the nursing staff, a safe staffing model for nursing staff, but also for the allied health staff who are required?

**Mr ROCKLIFF** - In terms of community physiotherapy as part of the community allied health, small community physiotherapy team, that's about 5.3 full-time equivalents continue to provide service to aged district hospitals and four community health centres, along with providing outpatient community clinics and groups. Last financial year, community physiotherapy had 1294 new referrals and provided around 6739 occasions of service for 2145 clients across all aspects of our case load, including inpatient residents, outpatients and groups.

Physiotherapy provides a high value of service in quality of life improvements, which I don't need to go into, you'd be well aware of, but also avoids healthcare costs by reducing waiting times, implementing hospital avoidance strategies and providing education in community allied health more broadly.

**CHAIR** - In enabling patients to be transferred to our rural hospitals, often the barriers are that they don't go there because they haven't got the necessary allied health support. If they're there and need chest physio or they need some other form of physio, if it can't be delivered there then there's no point transferring them.

**Ms MORGAN-WICKS** - That is why we do need to have as part of the MCAP program about making the care appropriate for that particular patient. If they add a high need in relation to for example, an occupational therapist requirement we would keep them in a bed in the LGH for example if it is in Launceston within that precinct. Whether it is using our other rehab beds as well.

**CHAIR -** As part of the safe staffing work that has been done looking at the allied health staffing requirements as well as the nursing staff requirements or is it mostly focused on nursing staff safe levels?

Are you likely to take some kind of review of the allied health requirement because it is hard to get allied health workers? We do not train them in this state. Well, hardly any of them.

**Mr ROCKLIFF** - It is challenge. Although, we are moving to train the state with a partnership with the University of Tasmania. Is that correct?

**Prof. LAWLER -** That is and one of the really exciting developments occurring within that allied health setting is the allied health expansion project in the north. While we recognise we are a provider of clinical placements for allied health and undergraduate and master levels students from around the country, there are a number of services we do not provide training for within the state. The Allied Health Expansion Project, will commence from July 2022 is an

initiative of the College of Health and Medicine within the University of Tasmania and will actually provide homegrown physiotherapists, occupational therapists and speech pathologists. We expect the first graduate output of that to be in mid-2024. There are some issues to be worked through. To provide positive undergraduate and postgraduate experience for these students requires the provision of clinical placements within the public system. We are comfortable the work that has already been done and will continue with the University of Tasmania will do that, across the state.

We are expecting it will be about two to eight placements per year, per profession, per region and we are comfortable we will be able to undertake that, particularly given the success we have been able to demonstrate in providing such clinical placements for interstate students who have come down to use. This is another example of the way in which we worked quite productively and effectively with the University of Tasmania on a number of initiatives and will provide us with the capacity to produce and retain significantly valuable allied health professionals within the state.

**CHAIR -** Hopefully, you can provide some bonded scholarships.

**Mr ROCKLIFF** - It used to happen many years ago, I understand.

**CHAIR -** Social workers - they are not one of the professions you mentioned, but there is a pretty significant shortage of social workers. There is no plan to train or educate social workers in this state?

**Ms WEBB -** There are.

**CHAIR** - We still have challenges.

**Mr ROCKLIFF** - We do.

**CHAIR -** Even those who train here.

**Mr ROCKLIFF** - We recognise that.

**CHAIR -** Do you need to look at that area, it is a significant lack of capacity and social workers.

**Prof LAWLER** - There are quite a few allied health professional fields we train within Tasmania. That includes pharmacy, paramedicine, medical science, social work, psychology and exercise physiology. We also recognise we provide positive undergraduate experiences in those allied health disciplines, but we do need to work toward retaining those, particularly, in rural and regional settings, which is again a challenge faced across the country.

**Mr ROCKLIFF** - Can I add to that answer too?

Part of our commitments include funding of $3.4 million over four years which will be provided to boost staffing at rural hospitals across the state including New Norfolk District Hospital, West Coast District Hospital, St Helens District Hospital, May Shaw at Swansea and the North East Soldiers Memorial Hospital at Scottsdale.

**CHAIR -** This is nursing staff?

**Mr ROCKLIFF** - The staffing mix will examine, as per the site and the need but, that funding commitment is there to increase additional staff.

**Ms MORGAN-WICKS** - As an additional to the safe staffing model, it is also permanently funded.

**CHAIR** - Could you table the current occupancy rates of our rural hospitals?

**Mr ROCKLIFF** - We have the current occupancy rates of our rural hospitals. Would you like me to read through the 2021 occupancy figures?

**CHAIR** - If you are happy to table it?

**Mr ROCKLIFF** - Yes. We have some scribble over this one, but we will print -

**CHAIR** - If you are happy to table a clean copy after lunch will be fine.

**Mr ROCKLIFF** - I will do that. You were right in New Norfolk - 84 per cent total occupancy.

**CHAIR -** There are others which are much less than that.

**Mr ROCKLIFF** - Yeah, Deloraine 56 per cent. So anyway, we will do that.

**CHAIR** - Are there any other questions on this output group?

If there are more questions we will come back after lunch and finish this one and then move on beyond that. We will take 45 minutes and come back at 1.45 p.m.

The room will be locked if you want to leave your things here.

**The Committee suspended at 1.01 p.m.**

**The committee recommenced at 1.48 p.m.**

**CHAIR** - We will keep going with 2.4, Community Health Services.

**Mr DUIGAN** - My question revolves around the services the Government is implementing to help keep people out of hospital. I recognise there has been some discussion about this, this morning. I've heard you speak about the importance of community-based care, so it would be good to get a better understanding of what the Government commitment is in this space.

**Mr ROCKLIFF** - Thank you, Mr Duigan. Broadly, the department's focus is providing our community to get the right health care at the right place, at the right time. That isn't necessarily, as I said this morning, a hospital bed.

In fact, it's been estimated that around one in every 16 hospital beds in Tasmania is occupied by someone who doesn't need to be there and could get the support they need in the community or in a rehab bed.

We know that when people are treated in the community, if that is appropriate, that they recover sooner. As I've said, health care is about more than just hospitals. That's why we are investing in a number of areas to keep people out of hospital and enhance community care.

This includes $27.5 million for our Community Rapid Response Service and the Hospital in the Home services. We spoke about ComRRS more broadly this morning.

There is $10.5 million to significantly strengthen our in-home palliative care and after-hours care services, improving end-of-life care, especially in rural and regional communities.

There's $8 million for our GP After Hours Support Initiative, which will provide support for primary healthcare providers, such as GPs and pharmacies, to provide after-hours services to the local community.

There is $1 million for our Hospital Avoidance Co-Investment Fund, which provides support for providers by seeking assistance, through the after-hours support initiative, to offer urgent care services after hours in the local community.

There is $1.4 million for community transport services to support Tasmanians to access the health services they need.

We've mentioned as well, and we might cover that a bit later, Ambulance Tasmania's secondary triage, which appropriately diverts patients away from an emergency ambulance response and links them with appropriate service providers in the community.

There's a number of initiatives there which I'm very pleased about, and our focus this morning was on the critical rapid response service, which is now statewide. That's one example of the number of areas we're focused on. So, thank you very much for the question.

I have a couple of answers to questions. Firstly, I table the total occupancy rates of district hospitals and contracted sites. There is a table there for you.

And a question from Dr Seidel on how many root cause analyses have been undertaken in the last financial year and the five years prior. There have been 218 events over the past five years where a root cause analysis would generally be expected. Fifty of those were in the 2020-21 financial year.

**Dr SEIDEL** - Thank you, minister. You've just mentioned that the critical rapid response is now statewide. That includes rural areas or just the metropolitan areas?

**Mr ROCKLIFF** - We had a little bit of a discussion this morning about this but it's largely the 30 kilometre radius outside -.

**CHAIR** - From Ulverstone.

**Mr ROCKLIFF** - Yes. From Ulverstone. It's in each region now. The south, the north and the north west.

**Dr SEIDEL** - You mentioned Hospital in the Home programs as well. Do you have any data of how many patients enrolled in a Hospital in the Home program have been admitted to hospital, to any of the four hospitals, within 28 days of being enrolled into a Hospital in the Home program?

**Mr ROCKLIFF** - We could access that data but we wouldn't have that with us right now. It's not the data, necessarily, of the people in Hospital in the Home, which I'm sure we could get that as well, but the people that have been admitted as inpatients within 28 days of -

The Hospital in the Home service is an acute-care service outside of the hospital environment but in the person's home. It will still be categorised as an acute-care service.

**Ms MORGAN-WICKS** - The Royal has a pilot for a Hospital in the Home service and I think that is currently operating at 18 beds, but I will check that number. Usually those patients will transition after an inpatient acute admission to the Royal Hobart Hospital. They are then selected by the general medical team as appropriate for a continuation of their care as a Hospital in the Home bed.

**Dr SEIDEL** - My question again remains: how many of them have been readmitted to a physical bed within 28 days of being transferred, or admitted, to a Hospital in the Home program?

**Mr ROCKLIFF** - If there's a question on notice then we'll take that, notwithstanding that the secretary has just said -.

**Ms MORGAN-WICKS** - I think we do collect data in relation to hospital readmission rates, noting that that would be following already a period in hospital, then transitioning to Hospital in the Home and then back into hospital. We will see if we collect to that granularity of data, noting that's there's only 18 beds in the pilot.

**CHAIR** - The question for our secretary then, Bastian, do you want to reiterate the question?

**Dr SEIDEL** - How many patients been admitted into Hospital in the Home Program are being readmitted to a physical bed in one of the four hospitals in Tasmania within 28 days?

I will ask another question, about the GP after-hours work centred care program you have announced. The figures for the support package you offer, have those figures been discussed with the AMA or the RACGP or any other stakeholders?

**Mr ROCKLIFF** - This is the total in relation of the $8 million investment overall?

**Dr SEIDEL** - As well as the availability of funds for individual practices or providers.

**Mr ROCKLIFF** - My advice is yes, they have.

**Dr SEIDEL** - They were supportive of the figures with regard to viability of the program for individual practices?

**Mr ROCKLIFF** - The individual practices would determine themselves through the grant process, whether or not they would apply. If they see an opportunity to support the program. There may be varying opinions, Dr Seidel.

**Ms MORGAN-WICKS -** The application process remains open, so we have not had a specific comment from the AMA to my knowledge, because no grant has as yet been made, the applications process is open and they have not as yet commented on the suitability of a suitability of a particular grant to a particular GP.

**Mr GAFFNEY** - This is a new line item, $9.2 million over four years. I have to acknowledge the minister's personal input into the Voluntary Assisted Dying debate and also the input through the agencies including the Health Department, both were welcomed. It would have been slightly easier for me if the agency feedback had happened before the tabling of the paper, but we were able to make some amendments to address some of the concerns, so I was fine with that.

It is wise to acknowledge the differing opinions regarding VAD, not only within the wider community but also, the health fraternity and medical profession.

I have met with the manager of the Implementation Taskforce on a number of occasions and I have been very impressed with Lisa's determination to do a good job with this, so I am pleased. She addressed the Tasmanian Dying with Dignity agenda here recently and has provided me with information I can take around to community forums.

Two questions. First of all, could you let me know how many full-time equivalents are necessary for the implementation taskforce team? Are all those positions and personnel in place? I would be interested to know about the commission. The implementation team, one of their roles is to get the commission, the board in place before some of the other things can start. Wondering where the progress is on that?

**Mr ROCKLIFF** - Thank you, Mr Gaffney and thank you for your comments with respect to Lisa's work and I commend you for the work you have done to get Voluntary Assisted Dying to this point, but particularly, the way in which you went about the consultation across our community. It was tremendous to see and I thank you for that.

You are correct. Some $9.2 million has been provided over the budget forward Estimates period to support the implementation of the Voluntary Assisted Dying legislation including ongoing funding of $2.4 million per annum in future years.

The Department of Health has commenced work to ensure Voluntary Assisted Dying is operational in Tasmania by 23 October 2022, in accordance with the timeframe agreed by Parliament this year. I recognise many Tasmanians are anxious to see Voluntary Assisted Dying available as soon as possible. If it is possible to commence earlier, we will, but our first priority is to ensure the implementation is effective and safe.

A dedicated team within the Department of Health is coordinating the implementation work to ensure patients and clinicians are supported through the significant reform for the

2021-22 year. The VAD implementation team establishment comprises of six full-time equivalent positions of which four FTE are currently filled, as at September 6. Additional positions will be filled based on the need. This team works with existing staff across the Department of Health including the THS to maximise the resources and information available to the implementation team.

The implementation team will seek input from stakeholders on operational decisions to ensure service decisions are informed by those who will be most affected, including health practitioners and health consumers.

Tasmanian workers are informed by the interstate experience and we will learn as much as possible from other jurisdictions about the needs. This needs to be considered in the context of the Tasmanian health system and our community.

Some of the work and activities that need to occur before Voluntary Assisted Dying is operational include: developing the training course for health practitioners; establishing the Voluntary Assisted Dying Commission - which I will come to in a moment - including appointment of members; identifying where and how Voluntary Assisted Dying will be accessed through the Tasmanian Health Service, including developing an access standard to ensure Voluntary Assisted Dying for those in regional areas; supporting non THS facilities and practitioners in their decisions regarding delivery of VAD; determining the Voluntary Assisted Dying substance on how it will be distributed and accessed; establishing new information support to support the operation of the law to keep information safe and secure; and drafting regulations to support the operation of the act.

Immediate priorities are finalising the requirements for the Voluntary Assisted Dying Commission including seeking nominations. Progressive release of information to support the increase understanding of how the law will operate in Tasmania by practitioners in the community. Commencing consultation on the service. The department are finalsing details with respect to the commission. There are some details provided there and it goes through the cabinet process and then it will be released and made public.

**Mr GAFFNEY** - Is there a timeline for when the commission might be up and running? Because I know that is very crucial to the remainder part of the bill. Is there any time line suggested when those positions will be filled?

**Mr ROCKLIFF** - That is one of the key activities the department are focusing on from August through to May 2022. We do not have a specific time here, but our expectation is in the next couple of months, before the end of the year.

**Mr GAFFNEY** - I am pleased to hear you mentioned about the education of the community. I have been working with New South Wales, Queensland, the Territories and even Western Australia where they said, one of the things in Western Australia was getting the information not only to the medical practitioners but also to the community as to how the process works. You have mentioned that and it is really important. I am also pleased to hear you have said if it is up and running and everyone is satisfied, it may start earlier. The forums I have attended have made it very clear it is supposed to start by October 23 2021, because in this situation you do not want to get people's hopes up it might commence earlier, if indeed it won't, just because of the nature of the beast. Thank you for that and once again I am very

impressed with Lisa's performance so far and so have the members of the Dying with Dignity team.

**Mr ROCKLIFF** - We will pass that on, Mr Gaffney, thank you.

**2.6 Ambulance Services**

**Ms LOVELL** - How many intern paramedics have been employed across Tasmania in the last 12 months or in that financial year?

**Mr ROCKLIFF** - I want to welcome Mr Joe Acker, the Chief Executive of Ambulance Tasmania who officially commenced his position commenced his position five weeks ago. Welcome to Tasmania, Joe. Your question regarding interns, Ms Lovell, was that in the last 12 months?

**Ms LOVELL** - How many intern paramedics were employed across Tasmania in the past financial year?

**Mr ROCKLIFF** - This question came up a few days ago in the House of Assembly. We tabled the answer and we are just accessing the information now to make sure it's right.

Ambulance Tasmania continued to employ graduate paramedics to support future growth and 14 new graduates commenced on 15 March 2021 with a further 15 on 23 August 2021. Do we have that number for the last financial year, Joe?

**Mr ACKER** - Minister, I believe that is the number for the last financial year and we've also hired 30 more this financial year, 15 started two weeks ago and 15 more will start at the beginning of next month.

**Ms LOVELL** - Thank you. How many of those interns were from Tasmania and did their training here in Tasmania?

**Mr ROCKLIFF** - Yes, Mr Acker can comment on that, although I know that it's oversubscribed in the number of people applying for positions. So what number were from Tasmania?

**Mr ACKER** - For the recent recruitment of 30 graduates we had 620 applications from all across the country and across Tasmania. Of the 15 that we welcomed three weeks ago, 13 of those 15 were from Tasmania.

**Ms LOVELL** - Minister, how many paramedics are currently off work on workers compensation claims? Do you have any information about what those claims are for?

**Mr ROCKLIFF** - Ambulance Tasmania workers compensation claims for the financial year 2020-21 totalled 69 and the previous year 70. The total cost in the 2020-21 financial year was $3.855 million.

**Ms LOVELL** - Minister, do you have any information about how many of those claims were for a physical injury as opposed to either post-traumatic stress injury or other stress-related conditions?

**Mr ROCKLIFF** - We might have to drill down on Ambulance Tasmania.

**Ms MORGAN-WICKS** - We have a figure for psychological claims versus total claims but that's against the whole of the department so we'd have to get that information just in relation to the ambulance service.

In relation to psychological claims, for the year 2020-21 we have 113 psychological claims as part of 642 total claims for the department.

**Ms LOVELL** - While you have those figures in front of you out of interest, Minister, is there any increase or how do those numbers compare to the previous year?

**Mr ROCKLIFF -** In the financial year 2019-20 there were 125 psychological claims, and then previous to that 2018-19 there were 99.

**Ms MORGAN-WICKS** - The number of current workers comp claims for career paramedics by region for stress claims, currently there are 27 career paramedics on workers compensation for psychological claims, including eight in the north, nine in the north-west and 10 in the south.

**CHAIR** - This may be a similar answer to the one I got previously, in relation to the Budget and the unaudited actuals, page 156. The Budget for this year is $135 million, nearly $136 million, and the unaudited actual was $143 million, so that's a $7 million difference, less budgeted than what was spent last year. Can you explain why that is the case? Was additional expenditure needed last year on the basis of COVID or other matters?

**Ms MORGAN-WICKS** - It's a similar answer to the previous one - I think it was the admitted services line. The actuals that our CFO, Mr Jeffery, provided have come through in financial statements which we've signed off last Friday, I think it was 3 September, and those are also unaudited. We're yet to receive our audit certificate for those financial statements but at the point of putting together Budget numbers, it's well and truly before our actual numbers come through. We monitor throughout the year. Usually we will then take that into account in the next budget session where we haven't had to do other transfers between outputs what our actual expenditure is per line and we'll take that to Treasury. We may do output reallocations between and usually you'll see that as a very popular footnote to some of the budget statements, where you do see variations between years.

**CHAIR** - The note related to this expenditure table relates to an increase in ambulance services, reflecting additional funding for key deliverables including new paramedics and additional paramedic crews in Hobart and Launceston. These are the - 16, I think, were just mentioned, 30, sorry. Are their salaries and oncosts included in this line item because it just seems to be a bit short if that's the case? They'll be ongoing costs, you'd expect.

**Ms MORGAN-WICKS** - Yes, the salaries and on costs for each employee are included within output areas but noting that we will separately issue internal budgets following the release of this high-level budget because we're just getting a line item per output. We do our own internal modelling. We're very aware of what they are spending per month, per week really, and we know the salaries and remuneration levels. It is included and I think it was 48

additional paramedics as a total commitment. They've budgeted for that increase and internal budgets will then flow through from that.

**CHAIR** - The leave liability that sits across Ambulance Tasmania, has that increased in recent times, in the last couple of years? General leave, I'm not just talking about workers compensation or stress leave, but general leave. With COVID-19 and other matters, has that increased and what's the leave liability at the moment? If it is rising, how are you managing it? Putting on new paramedics will help.

**Mr ROCKLIFF** - We have the paramedic recreation leave liabilities hours. The total for the pay period ending 26 June 2021, so for the last financial year, is a total of 133 980.7 recreation leave liability hours.

**CHAIR** - Has that been increasing over recent years?

**Mr ROCKLIFF** - Yes, it has.

**CHAIR** - How is that being managed, minister? That is the point. It is a big liability to have sitting there.

**Ms MORGAN-WICKS -** Recreation leave liability has increased across the Tasmanian Health Service. I would be very surprised if it hasn't increased across the entire state sector, particularly given COVID-19. People have cancelled recreation leave on numerous occasions, particularly as there have been sudden border movements or changes, people have just not been taking leave.

What we are trying to do though, is to manage fatigue. We have fatigue management tools and mechanisms in place, particularly in our emergency COVID-19 environment. We mentioned in the House of Assembly the work we are currently doing for mental health and wellbeing for our paramedics, and fatigue management is a significant part of that.

**CHAIR** - What are you doing to support paramedics, minister, not only making sure they get adequate leave and fatigue management, but also in the training space, with regard to COVID-19 preparedness, with ambulance staff being required to be everywhere. I am interested in how you are managing the fatigue, making sure people are getting adequate breaks, and their training.

**Mr ROCKLIFF** - Good question. Mr Acker, our chief executive of Ambulance Tasmania, might like to provide some detail in answer to your question.

**Mr ACKER -** Over the last year, we have done some innovative things to improve the support of paramedics, both in the fatigue space as well as in workforce planning.

Last year, at the start of COVID-19 we hired four workforce planners - the first time we had workforce planners embedded within Ambulance Tasmania, one in each operational region and one in our State Operations Centre. The focus was on managing the rosters in a better way that allows for managing of fatigue and also ensuring that the leaves were well allocated across the system. They have had a huge improvement on getting our rosters in order as well as starting to address some of the leave liabilities.

As the secretary and commissioner have said, we have had an increase in some of the liabilities associated with COVID-19, where paramedics are feeling that they want to stay at work so they can support their communities in a time of great need. We are watching and monitoring that.

We are providing education for all paramedics, and it is mandatory that they do fatigue management training every year. We also have a number of programs in place with our partners in the Department of Police, Fire and Emergency Management, as well as our own organisation, to support mental health and wellbeing, including a focus on fatigue.

We have invested in a new module which is part of our ESCAD, our Emergency Service Computer Rated Despatch System, which monitors the workload of paramedics and will help us manage the fatigue of paramedics to ensure they are getting time off that's in alignment with the award.

A number of things have happened in the last year and a number of things are still to happen in the next few months.

**CHAIR** - With regard to the COVID-19 preparedness, there has been work done last year but we are looking at COVID-19 coming into the state at some stage, we have to be realistic about that. What is the plan for the paramedics now, to prepare them?

**Mr ACKER -** We have an emergency operations centre specifically for Ambulance Tasmania, with an emergency operations centre commander and seven positions allocated to managing COVID-19, as well as other major operational incidents that arise.

Part of their work is communicating to paramedics what is happening in the world regarding COVID-19, but also reiterating a lot of the safety and personal protective equipment reminders for paramedics, particularly as this has progressed over a long period of time.

All paramedics are getting PPE education and that is supported by a newly appointed infection control and prevention nurse, who is managing that side of our work.

**CHAIR** - Minister, you know as well as I do that we've had difficulty recruiting and retaining paramedics in Smithton. I'm interested in where vacancies currently exist for permanent paramedics, in Smithton and places like that, and with this new cohort you have the 600-odd applications for. Surely, we can find someone who wants to work in Smithton. It's not that bad a place.

**Mr ROCKLIFF** - It's a great part of Tasmania. I wish to acknowledge Dale Webster at the table as well. He is deputy secretary, Community, Mental Health and Wellbeing. Are you after vacancies across the state?

**CHAIR** - Yes, across the state.

**Mr ROCKLIFF** - In Ambulance Tas? We've advertised recently for the Smithton station.

**Mr ACKER** - Smithton is an interesting situation. We do have two paramedic full-time positions assigned to Smithton. One of those paramedics is, unfortunately, off on long-term

leave and one just went on a career break leave, so we had to recruit two positions, which we've done. Those positions have been appointed now and -

**CHAIR** - As permanent positions?

**Mr ACKER** - Yes. As permanent interim positions covering for the permanent positions that are there.

To the best of my knowledge, all of our branch stations, or rural and remote stations, do have permanent appointees now that have been hired recently. We do have some attrition, through retirements and other things, which is very low - just over 4 per cent. But we are recruiting for those positions and that's the graduates entering our system, as well as 15 TASOs. A TASO is a trained transfer from another state, and those experienced paramedics will be joining us at a later part of this year. There will be 15 more as part of the commitment for 48 paramedics over the next two years.

**CHAIR** - How many volunteers do we have at the moment? And is there a need to recruit more?

**Mr ACKER** - We have about 420.

**CHAIR** - And is there a need to recruit more? Do we have adequate coverage on the west coast, for example? It's completely manned by volunteers.

**Mr ROCKLIFF** - And King Island would be completely manned, or personed, by volunteers. We do have volunteer support in place.

**Mr ACKER** - We are always recruiting volunteers. Some of our communities are very well staffed and, in fact, have duplicate staff, so there's always backup volunteers available to respond if the ambulance is out. Some of our communities it's more difficult to recruit to.

Right now, we have three permanent volunteer coordinators, one in each region across the state. That sole role is recruitment and retaining of volunteers, so they're constantly recruiting and bringing new volunteers into our system.

**CHAIR** - The specific support for volunteers, particularly in our regions like King Island, when they're the only people on the island who respond to fatalities, and it will inevitably be someone they know and are possibly related to, what support do you provide to the volunteers who are attending pretty traumatic events of, usually, someone they know?

**Mr ROCKLIFF** - I had some further information around volunteers but that's a very important question, so I might throw to Joe to answer that first.

**Mr ACKER** - I'm very proud to say that our volunteer ambulance officers have exactly the same supports that our full-time staff do in terms of access to the resources at the Department of Police, Fire and Emergency Management, as well as their own peer support responders. They are followed up if they've done a difficult case, as you spoke to - a fatality on King Island, for example. They're followed up in the exact same way that our paramedics would be and provided with the same support opportunities.

**CHAIR** - It's a proactive approach to the volunteers involved?

**Mr ACKER** - Yes.

**Mr ROCKLIFF** - We have commenced work with the Volunteer Ambulance Officers Association of Tasmania on a memorandum of understanding to work together on attraction, retention, training and support of ambulance volunteers. We provided a commitment of $50 000 to the association to support that work. That's ongoing and the commitment recognises the role of volunteer ambulance officers in providing that first response emergency health care in the rural areas and remote areas that we've spoken about, and the role of Volunteer Ambulance Officers Association of Tasmania supporting these volunteers as well.

**CHAIR** - Volunteers in our regions are very connected in their community. That is why they are volunteers, they inevitably know the people they are attending. This is even though they say it is a difficult thing, but they do it because they love to be able to support the community in that way.

**Mr ROCKLIFF** - They are, but we had some challenges through COVID-19 because the demographics of the workforce. Volunteer workforce includes a relatively high proportion of people at an older age which you would appreciate and with medical conditions that make them more vulnerable to COVID-19 and presented some challenges.

Many of our volunteers took a leave of absence and some decided to resign through those challenging times of COVID-19, so we have some work to do, but we have provided an action commitment to work with Volunteers Association of Tasmania or Ambulance volunteers.

**CHAIR** - Minister, there is a view by a lot of paramedics they have skills perhaps underutilised in the communities where they operate in terms of providing care to patients and avoiding hospital transfer.

**Mr ROCKLIFF** - Is it paramedics, more importantly?

**CHAIR** - Yes, paramedics in the communities who - from the information I have received from them - have skills underutilised and they could actually do much more in the patient care in the community and avoid hospital admissions sometimes.

I know there is some work being done, could you provide some more information about that?

**Mr ROCKLIFF** - Yes we can and Joe would you like to talk about that.

**Mr ACKER** - Minister, there is a bit going on. There is a number of initiatives happening. The first one is as you said the paramedics are feeling they are able to provide more services than they are providing at this time and that is their scope of clinical practice. We have appointed a Director of Clinical Services leading a number of clinical practice changes.

Those changes will allow paramedics to not only treat patients in their communities and not transport them to hospitals, but also to provide more advance interventions than we have provided in the past.

The other thing we are really excited about is the expansion of the Extended Care Paramedic Program which is also known as Community Paramedics in some states and territories. These are post graduate trained paramedics who are able to provide primary health services in communities.

Currently, we have Extended Care Paramedics in Hobart and Launceston and they are able to do things like administer antibiotics at home or suture wounds and not transport patients to hospital. We would like to expand that program to other appropriate parts of the state, particularly in the north west where we know there is a need for a scope of practice like that.

We currently only about 3.8 FTE associated to that. We have 19 trained ECPs in the state and are hoping to extend that.

**CHAIR** - Thank you.

**Mr DUIGAN** - Question in relation to secondary triage program I briefly alluded to earlier. Minister, are you able to outline the progress and perhaps the value of this program?

**Mr ROCKLIFF** - Yes, I can and I will table a diagram on how it actually works within the system.

This is a very serious question because this started around mid to late February this year in terms of the secondary triage and we have mentioned on-going demand continuing to increase. Presentations to our emergency departments increased to 170 645 last financial year and an issue we are well aware of and we are rolling out initiatives. We have spoken about a number of them, including to [inaudible] and others the secondary triage services began trialling in late February.

That essentially aims to improve integration and connectivity of Ambulance Tasmania and other health and social service providers and to appropriately divert patients away from an emergency department response, ambulance response and when their medical needs can be better met by another care provider for example.

We know not every call to Ambulance Tasmania requires a paramedic led emergency response. Secondary triage is ensuring patients receive the appropriate care, but also means our ambulances and paramedics are reserved for the genuine emergency situations.

Now callers are referred to the secondary triage service. They speak with trained paramedics or nurses, so their medical needs can be assessed and the clinicians can link the caller to an appropriate service provider. The referral services may include Ambulance Tasmania Extended Care Paramedics, general practitioner, telehealth consultation provider, Rural Health Tasmania, Tasmanian Lifeline or community nursing. Where possible and appropriate to do so, calls will be referred to their own general practitioner.

We have seen some success already with respect to the early stages of the rollout as of the end of last month, August 30, approximately 642 000 calls have been successfully referred to an alternate care provider, which has avoided an emergency ambulance response. That means we were able to help 642 people avoid being transported to an emergency department.

Ambulance Tasmania has also secured the services of a clinical nurse consultant. Medical care plans commenced on 18 June 2021, and the primary role will be to review frequent callers and by liaising with key stakeholders, develop a medical care plan for that particular caller. This will assist frequent callers to engage with the services that will better meet their ongoing care and support needs. Again, all this is about secondary triage. Taking the pressure off both emergency departments and emergency ambulances, but importantly it will help patients receive the right care, at the right place and right time.

**Ms ACKER** - This is a very exciting initiative. We are leading the country in terms of states doing this. Victoria is well ahead of us and we have learnt a lot from them. This is something that will improve our service to communities and service to patients, providing the care they need without having to go to an emergency department.

We have some brilliant clinicians in our secondary triage. Nurses and paramedics are all working very hard to make this a successful initiative.

**2.7 Public Health Services**

**Mr ROCKLIFF** - We welcome back to the table Dr Mark Veitch, Director of Public Health, Tasmania. I want to thank Dr Veitch and of course all the team at Public Health for the enormous amount of work they have done over the course of the last 20 months or more on top of their existing responsibilities. It has been outstanding and no doubt very strenuous. Tasmanians very much appreciate the work Dr Veitch and others do. Thank you for that.

**CHAIR** - We would all agree with that.

**Ms WEBB** - We talked earlier about dealing with some the COVID-19 related things in this line item. I am interested to know about the Public Health Emergency Declaration, which is signed on 28 July and goes through to 21 October. What circumstances would there be to either have that extended or lifted? Particularly, when will we know we are in a position to lift that? It has been extended a good number of times and probably will have to be again.

Can you give some clarity, is it to do with vaccination rates only, or other factors?

**DR VIETCH** - The initial declaration for a public health emergency was back in March 2020 and it has been continuously extended since then. Under the Public Health Act, I have to be convinced there is a state of risk to the public from a particular condition. In this case it was clear with a global pandemic of coronavirus, at that stage. The first few cases in Australia and I think a couple in Tasmania, that was a risk to us.

I had to be convinced that the sort of powers that can be activated under an emergency declaration will be useful and effective in containing that risk. That was the rationale for declaring a public health emergency at the time. It was almost coincident with declaration of the state of emergency by the Premier.

As a result of that declaration, it made possible the issuing of various directions that managed the arrival of people at borders, the testing of people, the isolation and quarantine of people, testing of people in various circumstances, the requirement for Check in TAS and contact tracing mechanisms, requirements for workplace COVID safety plans. A whole lot of

consequential directions arise and are enabled by having the state of public health emergency in place.

When will it be possible to step out of that?

**Ms WEBB** - It's hard to imagine when we won't need directions around those sorts of things.

**Dr VEITCH** - That's really a question about the possible futures of coronavirus and how it may play out from this point. I am a little cautious about being speculative but -

**Ms WEBB** - I'm not asking you to speculate on when. I am interested to know about the set of circumstances that we would need to see where we would no longer need that public health order in place so that those powers were there.

**Dr VEITCH** - It would be when we're no longer actively managing each case of coronavirus that comes into the state. It will be when coronavirus is circulating in our state, in all probability, at a number that doesn't cause too much harm to the public health system, to social structures of Tasmania. It will be when we are beginning to live with coronaviruses - one of those viruses that causes moderately severe illness amongst our most vulnerable from time to time. It will be really when it has become an endemic disease and those vigorous measures of control aren't needed.

**Ms WEBB** - Those sorts of mechanisms that are put in place under the power of public health emergency declarations, when you bring it to an end rather than continue to extend it, any of those powers or actions that have been put in place come to an end at that point presumably. Potentially, will they need to put in place in a different way under a different head of power?

**Dr VEITCH** - I think it's likely that as we emerge from coronavirus a number of strategies that we have in place, like requirements of vaccination and so on, will become part of institutional policies and may need to be backed by legal requirements. Even when we step out of a public health emergency state there are still powers within the Public Health Act to deal with case-by-case instances of people if someone is posing a public health risk by having an infection. We are always in a position to deal with that, case by case. It's just much more efficient to do it under a direction that deals with classes of people. I think it's most likely that societal adaptation, the incorporation of various strategies into policies are the sorts of things that we will develop over the next year or so to deal with COVID-19 endemic in our community.

**Ms WEBB** - When we are talking about and reporting on our vaccination rates, we talk about those sorts of overarching figures for the community. Are we also tracking and do we have particular targets that will trigger decisions to be made for cohort groups within that, who we know are at a higher risk or are a particular group? Today we have already discussed healthcare workers and the rates we have with vaccinations, but can you give breakdowns at the moment? Is that data kept so we know the percentage of people over a certain age or what percentage of people in a certain industry other than health?

**Mr ROCKLIFF** - We do have categories for age groups and others, but I am happy for Dr Veitch to answer or Mr Webster, who also heads up the vaccination team.

**Ms WEBB** - It's not so much that I am asking if you'd give me the numbers, I am wondering if you're tracking that. Also, when 80 per cent of Tasmanians get vaccinated certain things could be considered. I am wondering if there are sub-categories as well, where it has to be 90 per cent of this group or at least half of that group.

**Dr VEITCH** - In general, we need to get the population evenly up to a high level of vaccination coverage. We don't want to leave any group behind. If you leave any population group behind, particularly one that mixes within itself, if you like, then that group is going to be at increased risk of spreading disease. We don't want to leave any particular cohort behind.

Mr Webster may want to comment on the excellent epidemiological data that are being used to drive the current vaccination program. This gives a quite granular understanding of age groups by place and by some personal characteristics that enables the program to be targeted to try to minimise the discrepancy between the high and the low vaccinated groups within the community.

**Mr WEBSTER** - As Dr Veitch said, we have a number of epidemiologists attached to the vaccination rollout process and their role is to provide us with data. Unfortunately, we're working off the Australian Immunisation Register which is a 30-year old database, so there are some limitations to what we can get out of that. We're constantly looking at five-year age groups, so from those over 100 all the way down. We're looking at those.

We're also looking at data at a postcode and local government area, so we're looking at areas of most disadvantage in the state. In addition, over the last four months we've rolled out - and we call it our vulnerable groups program - where we're actually focusing on an equity process where we bring up groups that wouldn't normally have access to general health services or might not want to access health services in the way that most of the community do. That's people like the homeless.

We have a specific program going around the state, actually spending time with Loui's Van, for instance, to get to know the people who are coming and then to eventually offer them the vaccine. We're also visiting shelters around the state as well in that same way to gain their trust and then to deliver the vaccine. Whilst we specifically can't track a lot of these groups in terms of the percentage we can do, we're making sure that the rollout includes opportunity for access from as many groups as possible in the community.

Over the next few months, as we're getting towards the target set by National Cabinet, we're also going back and making sure that they're equitable across the state. We're not just getting there because we've been able to do the whole of Hobart. We're rolling out clinics in smaller areas that are lagging behind. For instance, in the next period we're in Campbell Town next week, I think we're in Queenstown tomorrow, Strahan next week, Zeehan the week after. Again, to the smaller centres to try to lift the number of vaccinated in those centres more quickly. All of those centres are also covered by general practitioners but those general practitioners have other workloads as well as vaccinations. The idea is that we'll visit them and help lift the number in those centres where the GPs may struggle to actually deliver the numbers that are required.

**Ms WEBB** - We've discussed this in some other contexts this week, we know there's a lot of misinformation proliferating online and through social media, particularly anti-vaxxer

stuff that's going around. We've had a pretty strong uptake of vaccinations here, so maybe it's not having much purchase in Tasmania broadly but there's probably parts of Tasmania where it may be. What effort and resources the department is investing into monitoring and countering and working against that sort of misinformation that's being put out there in the public domain?

**Mr ROCKLIFF** - Considerable effort in information - or rather counter-information in many respects. Dale, would you like to comment on that?

**Mr WEBSTER** - We are actually running a campaign of focus -

**Ms WEBB** - Can I qualify the question a tiny bit, just to bring the focus in. What are you doing to direct that effort into those spaces where you probably know it might be more needed?

**Mr WEBSTER** - We are tracking that through focus groups and the federal government in particular is doing a lot of polling so that we can get that level granularity to find out where those pockets are.

That's showing us that it's about accessibility as well. There are three groups that we need to target to get the numbers up.

The first group are those that need greater accessibility, and that might be because of health literacy issues, distance or other circumstances. So, we have to increase the level of accessibility, which is why the programs are going around to shelters and places like that.

The second group is the hesitant group. That is the group we need to convince that now is the time. We have been running the 'don't wait - vaccinate' and the 'call to arms' message from the Commonwealth Government, but with local people as well. In our program for example, it's the guy in charge of the Somerset Fire Brigade who's on the billboard in Somerset.

**CHAIR** - And Cooee.

**Mr WEBSTER** - And Cooee. It's a very locally-led approach there. Over the next couple of months as we're getting into these groups, we need to change where we are going. We change from large centres into neighbourhood houses over the next period. Again, through the local networks, we will reach the hesitant.

The third group is the so-called 'anti-vaxxers'. We are probably never going to get them across the line. At the moment, most of the national polling is showing that 81 percent of Tasmanians are committed to getting the vaccine. Another 13-14 percent say they are open to be convinced. We have about 5 percent who are saying there is no way they are getting it.

**CHAIR** - Could you provide the data about the breakdown by LGA and other cohorts that you have the data for today, or as recent as you can?

**Mr WEBSTER** - It is published weekly on the website: health.gov.au. The most up-to-date data is there including by LGA.

**Mr ROCKLIFF** - I do have some vaccination rates by age and sector.

**Ms WEBB** - That's okay, I wasn't asking about those necessarily. Chair, do you want to follow up on that detail?

**CHAIR** - That would be helpful as well.

**Mr WEBSTER** - The age breakdown is published daily. The geographic breakdown is published each Monday.

**CHAIR** - The age data?

**Mr ROCKLIFF** - By age, as at 29 August 2021: in the 70 plus age group, 88.3 per cent have received their first dose and 66.79 per cent are fully vaccinated; in the 50 plus age group, 78.5 per cent have received their first dose and 55.27 are fully vaccinated; in the 16 plus age group, 59.11 per cent have received their first dose and 41.19 per cent are fully vaccinated.

There was a question about sectors. These figures are from 18 August 2021. Aged care residents - 83 per cent have received their first dose and 78.5 percent are fully vaccinated; aged care staff - 60 per cent have received their first dose and 44 per cent are fully vaccinated; Disability residents - 66 per cent have received their first dose and 54 per cent are fully vaccinated; NDIS participants - 47 per cent have received their first dose and 34 per cent are fully vaccinated; disability staff - 61.4 per cent have received their first dose and 47 per cent are fully vaccinated.

That data is probably three and-a-half weeks old now. This type of data is posted every day on the health.gov.au website.

**CHAIR -** Have you broken that down to include Tasmanian Aboriginal people? And is there a lag?

**Mr ROCKLIFF** - As at 29 August 2021, the Federal Government has advised that the number of Aboriginal and Torres Strait Islander people vaccinated in Tasmania is as follows: 6982 first dose, and 4853 both doses.

**CHAIR** - In terms of percentage and geographic spread on those Aboriginal people?

**Mr ROCKLIFF** - The Government has operated clinics on Flinders Island and Cape Barren Island, for example.

**Mr WEBSTER** - The minister quoted the aged care and disability figures and the Aboriginal and Torres Strait Islanders. Those are the three areas that the Australian government has primary responsibility for.

There is a lag in every state and territory. The state is currently at about 64 per cent with having received the first dose. Unfortunately, our First Peoples are sitting at around 40 per cent in Tasmania. In some states and territories, the figure is lower than that.

The Australian Government announced last Friday afternoon a taskforce or a process within their Operation COVID-19 Shield that will be specifically to increase the number of Aboriginal and Torres Strait Islanders who are vaccinated.

We don't have data on why they're lagging behind in Tasmania; but reports in through New South Wales, Queensland, Northern Territory and WA remote areas are that there is a large hesitancy around vaccination in Aboriginal and Torres Strait Islanders.

**CHAIR** - Which I understand is being partly addressed by having culturally sensitive Aboriginal health workers who are out there delivering, engaging, getting the confidence and delivering.

I did mention this to the Premier yesterday. We were talking about engaging Aboriginal people in various other aspects of his portfolio areas. I asked him did we have Aboriginal health workers engaged in working with our Aboriginal community where there is a lag.

Making sure that there are culturally sensitive services provided wherever Aboriginal people live in our state. Obviously, that is all around the state but there are areas of higher numbers of Aboriginal people. Do we have Aboriginal healthcare workers as part of this team, or is that an option we need to note?

**Mr ROCKLIFF** - As of May, the department identified positions that are filled by at least three Aboriginal health liaison officers and one Aboriginal health policy officer in the department. It's more broadly though in terms of health.

**Mr WEBSTER** - The main delivery method for First Peoples in Tasmania is through Aboriginal-controlled health organisations and they employ a number of Aboriginal health officers. They are located across the state. There are three engaged - one in Burnie, one in Launceston, one in Hobart.

We are working with Primary Health Tasmania and with their ACCHOs as they're called, to expand this to include other points of presence across the state. Given the remoteness of both the Flinders Island and Cape Barren Island communities, the state government did go to both those islands to deliver in those areas. However, our primary source is to provide education resources so that they can be delivered by people in the actual organisations like the ACCHOs No. 34 Aboriginal Health Service. We're providing the education materials so they can be delivered culturally sensitively in local communities. Primary Health Tasmania is the Australian government representative in the rollout, and they are also working very closely with each of the organisations, beyond the ACCHOs to make sure that we're reaching all the communities that are involved.

**CHAIR** - Minister, you'd be very aware that our Aboriginal community in Circular Head has a lot of access to federal government funding. There's a degree of mistrust with them and other Aboriginal organisations in the state. I don't know if they'd particularly appreciate someone coming from another region to try and tell them how to do their stuff.

**Mr WEBSTER** - We are engaging with them through their separate group which is called CHAC. We're meeting with them tomorrow to make sure that they are involved outside of those other groups.

**CHAIR** - I'm pleased to hear that because I think you will make a difference down there.

**Mr DUIGAN** - I understand that there are some vaccination clinics coming up. Perhaps you could provide more information about youth and specialist clinics?

**Mr ROCKLIFF** - Yes. We are currently vaccinating Tasmanians through hospital-based clinics at the Royal Hobart Hospital and Launceston General Hospital and the community clinics around the state, all operating as super clinics. Our first super clinic was in Hobart at MAC 02 Macquarie Wharf on the weekend of 28-29 August and we delivered 2416 doses. We had the Burnie super clinic at the Burnie Arts and Function Centre, and we open again this weekend 11-12 September delivering potentially approximately 1400 doses. We will be in Launceston on 25-26 September at the Door of Hope and there will be an additional super clinic at PW1 on Sunday 12 September, which is Super Sunday and there will be 1000 bookings of which 835 are already booked.

I have some updated figures. We are trying to get to the 63 per cent mark by 12-13 September in terms our Super Six vaccination roll out, and we have already achieved that this week at 63.2 percent. We are a week ahead of schedule in terms of our expectations.

We will offer a state clinic four days on 15 September, 600 doses.

A youth clinic on 16-17 October.

A state clinic on two days on 18-19 October.

**CHAIR** - When you say state clinic, what do you actually mean?

**Mr ROCKLIFF** - State run clinics.

**CHAIR** - I don't think people want to come from Zeehan to Hobart to get it.

**Mr ROCKLIFF** - No, I understand that.

A youth clinic in Launceston 2-3 October.

A youth clinic in Burnie 9 October.

A youth clinic in Devonport 23 October.

PW1 16-17 October.

12 to 15-year-olds can also book any standard community clinic after 12 September.

College clinics. College school clinics have been run in the south at Elizabeth College, Hobart College and Claremont College. Rosny College is operating now as well. The rollout will then go to Launceston College, Don College, Guilford Young College, St Francis Flexible Learning Centre, St Mary's College, Hillier College, Launceston Christian College, Newstead College, Southern Support School, the Hutchins School et cetera and the program will include state schools, independent schools and Catholic education.

The Department of Health has engaged with the Moreton Medical Group who provide existing services to the specialist homeless service - including shelters - to be the provider for vaccine administration for those services across Tasmania. They are also undertaking additional work to support vaccinations across mental health, disability, homelessness and age

care. I saw that in action in Launceston recently at the Salvation Army headquarters in Launceston in Elizabeth Street.

**Ms WEBB** - Can you clarify the questions around the youth clinics? Because you mentioned there are those designated in Hobart, Launceston, Burnie and Devonport during October. I think you also mentioned that from a certain date, 12 to15-year-olds can book into the regular clinics, is that right?

**Mr ROCKLIFF** - Twelve to 15-year-olds can book at any standard community clinic after 12 September.

**Ms WEBB** - In terms of the population, those youth clinics aren't very evenly distributed across the state, those youth specific clinics, which obviously will be the easy ones to get your young person into. The south only having the one, and north and north-west between them having three in October, looks like the south isn't quite being serviced as well for youth specific clinics, given the population spread.

**Mr ROCKLIFF** - The rollout of our colleges have started firstly in the south and then in the north

**Ms WEBB** - Twelve to 15-year-olds are the ones I am talking about. It does not look like those youth clinics for that age group are evenly spread around the state according to population. It looks like the south will be trying to get our 12 to 15-year-olds into adult clinics, which are already booking up incredibly quickly.

**Mr WEBSTER** - The size of them changes depending on where we are, the southern are bigger days. The reason we are calling them youth clinics is we really want to target families. We will have bigger booths for the nurses to work in because what we have initially found with young people, is they tend to come with other family members and the booths are set up to take one person at a time.

They just are not big enough, so that was the purpose of those youth clinics to expand the size. We will do that and for instance, this week in Queenstown we have advertised in Queenstown, Strahan and Zeehan for 12 to 60s encouraging youth to come and we can set up the booths because we have not set up there yet to be a bit bigger.

**CHAIR** - A family outing.

**Mr WEBSTER** - Yes, we did find that.

**Mr ROCKLIFF** - I did mention 12 September, but they could have booked them up for 12 to 15-year-olds.

**CHAIR** - Before we go off vaccinations, in the performance information this is not COVID-19 vaccines but childhood vaccination. We do sit at a vaccination rate of about 95 per cent, which is good and compares pretty well across Australia.

I did write about this recently. It shows it is effective in terms, or it used to be effective in terms of controlling childhood infectious diseases, as long as we adults keep up with our things like whooping cough boosters and things like that.

What would be deemed an appropriate overall vaccination rate for COVID-19, looking at these figures, should we be aiming up to 95 per cent or close to in order to have that really well vaccinated community?

**Mr ROCKLIFF** - The most important thing is that everyone in Tasmania needs to have had the opportunity to be vaccinated. That is our number one aim. That everyone has that opportunity to be fully vaccinated. There have been discussions around Doherty modelling of around 70-80 per cent. We all like to maximise the number of people across the state.

There is a national plan to which we are committed. Delta's a new thing and who knows what might be coming down the track? While we are standing at the national plan, we are still very committed to take and be guided by the very good advice of our public health officials when it comes to restrictions and opening up borders and those sorts of things.

**CHAIR** - The question really is minister, should we be aiming for regardless of the plan as the plan has a whole lot of caveats in it about what you can and cannot do?

**Mr ROCKLIFF** - We want everyone that is eligible for a vaccine to be vaccinated.

**CHAIR** - What percentage of people would that be? There are children who are not vaccinated for reasons medically based. Like medical exemptions and there are adults who do not have other vaccines for a variety of reasons.

**Mr ROCKLIFF** - Underlying health conditions and the like.

**CHAIR** - Yes.

**Mr ROCKLIFF** - If you are asking me for a figure above 90 per cent. I do not know. That would be my expectation, but I cannot be plainer than that. The most important thing is if it was everyone eligible for vaccinations it would be into the 90s.

**CHAIR** - You would have to take out all the children under 12, because at this stage we are not vaccinating children under 12, are we?

**Mr ROCKLIFF** - No, we are not. We are still waiting on ATAGI advice around those matters.

**Dr VEITCH** - Children under the age of 12 are currently not eligible for the vaccine. We are seeing circulation of virus in that population when a larger proportion of the older people get vaccinated. We are waiting on advice on which vaccines and when it is appropriate to vaccinate those younger children. As the minister said, it is to our advantage to have just about everybody we can vaccinated and it is important to look at it from two perspectives. When any individual gets vaccinated they give themselves a very high probability of avoiding ending up in hospital and an even higher probability of not dying of COVID-19, so it has a profound individual benefit, something above 90 per cent risk reduction for individuals, even in older people, of the serious consequences.

The other important consequence is to reduce transmission of virus in our community. The vaccine is less effective at preventing mild infection and transmission within the

community, but it does have a significant influence on it. It is one of the inputs into the Doherty modelling that is arguing for higher levels of vaccination coverage to interrupt transmission. We do know from countries that have achieved quite high levels of vaccination - United Kingdom is one example and Iceland is actually another example that feels a little bit more like Tasmania. In those countries with 80 per cent or so of the population vaccination with two doses, they still see circulation of virus, they still see a small number of people admitted to hospital, but they see very few deaths. That population-wide benefit is really what that high level of vaccination is going to achieve for Tasmania, I hope.

**Ms MORGAN-WICKS** - If I could also add from a personal perspective, I would really like to see vaccination rates into the 90s in Tasmania particularly, Chair, as you have noted, the inaccessibility to the vaccine for our zero to 12 population to start with. I cannot tell you from a 12 onwards but certainly, when we are tracking at the 16 plus eligibility, that some 440 000 population for Tasmania from our database that are eligible from a 16 plus perspective. Dale with his wonderful numbers team have got the 12 plus vaccinations. When there are concerns raised, for example, whether it is on religious grounds, whether it is a conscientious objection ground, and noting also Pope Francis earlier this year also commented on every Catholic's moral obligation to take the COVID-19 vaccine as soon as possible. We really do need to have clear information into the market in Tasmania that really encourages as many as possible of the 12 plus eligible population to be vaccinated to help us protect our zero to 12s, but also our over-12s that are unable to receive the vaccine and that will be able to present that certificate of medical contraindication.

**CHAIR** - In terms of pharmacies providing vaccinations, minister, too, originally pharmacies can only deliver AstraZeneca to over 60-year olds?

**Mr ROCKCLIFF -** Correct

**CHAIR -** There have been many pharmacists I have spoken to who feel very frustrated by this. They are getting a lot of people coming in under 60 booking in and turned away. Is that likely to change in the near future so they can deliver it to younger people?

**Mr ROCKLIFF** - We have the Moderna vaccine coming and it is expected in October or earlier than that, isn't it?

**Mr WEBSTER** - Earlier than that. We are expecting the first of it to become available in pharmacies from 13 September now.

**CHAIR** - Younger people will be able to access that?

**Mr WEBSTER** - Moderna is now approved for 12 plus.

**CHAIR** - 12 year olds will be able to get vaccinated in a pharmacy with Moderna, is that right?

**Mr WEBSTER** - We have not yet signed off on that program. It needs a program approval before we can actually confirm the detail, but it would be the intention Moderna would be mainly delivered through pharmacies in Tasmania.

**CHAIR** - To?

**Mr WEBSTER** - To the group from 12 to 60 but there are a number of program approval steps in the legislation and we have not yet gone through them. I do not wish to pre-empt those steps.

**CHAIR** - Have you got an indicative timeframe? I'm not asking for an actual date, I am just asking for a bit of an idea.

**Mr WEBSTER** - We are working towards 13 September given that is when the doses will become available, but it does need that additional step.

**Mr ROCKLIFF** - And to confirm, the TGA have approved 12-year olds to -

**Mr WEBSTER** - Receive Moderna.

**CHAIR** - This is a COVID one again. The Doherty Institute modelling says tracking and tracing is a really important part of the future regardless of what vaccination rate you may get to. I note in your strategic priorities you've got, 'implement the Maven tool to replace our current contact tracing/notifiable diseases management tool.'

How is that going to work? In the media in the last few days with New South Wales, they're changing their COVID Check in app to include your vaccination status. It pops up when you check in. It must be linked. I've seen how it works, which could present some challenges. In order to access a restaurant or a pub or - this is part of their 'do the right thing, you'll be rewarded' approach. I'm interested in the functionality of this new system. How much confidence should we have, or need to have, in the system if we open up?

**Mr ROCKLIFF** - You're talking about -

**CHAIR** - The COVID Check in and the app and whether there's any consideration going down the New South Wales path of including the vaccination status in there. It pops up as vaccine status tick - green tick if you've had it, and yes, you've checked into the Parliament House.

**Ms WEBB** - That's a Commonwealth dataset and a state dataset talking to each other then, isn't it?

**CHAIR** - That's right, yes.

**Ms WEBB** - I don't think we have contemplated that yet in this state.

**CHAIR** - That's what I'm asking about. Is it being contemplated?

**Ms MORGAN-WICKS** - Our CIO, Warren Prentice, has been involved in discussions with the Commonwealth. The lead for the Check in app is actually at the Department of Health in the ACT. They are the first that actually initiated that form of the app; we then spoke to the ACT and they generously provided us with access to the application. We suggested some enhancements and also paid for those, which benefitted ACT and us. Queensland are also now onboard. I think the Northern Territory also use the same Check in application.

**CHAIR** - The one that we've got?

**Ms MORGAN-WICKS** - Yes, that's right.

**CHAIR** - Yes, I know it's the same in Queensland.

**Ms MORGAN-WICKS** - So, we have Check in in NT or Check in Queensland and we have Check in TAS. They are speaking to the Commonwealth about the potential for a vaccination status to be applied but that has not settled. We note New South Wales, which offers their service New South Wales Check in application - so it is separate to ours - they are looking at that. There are conversations that are occurring now in relation to that enhancement to that application.

**CHAIR** - Can you describe how the Maven tool is different to what we already have and why it's better, I assume?

**Dr VEITCH** - There are two quite separate things here, one of which is the Check in TAS app which is a way of registering whether people have been in a place and that's a useful technological tool to get the outer circle of people's contacts. It remains critically important to recognise that the most important contact tracing are the household members, the workmates, the friends of the case. Those people are picked up principally by good contact tracers, human beings, doing the contact tracing. But Check in TAS gives us a broader reach to a kind of lower yield population but something that can be largely automated. That's the contact tracing process that occurs with the contact tracing teams when there's a case.

Maven is a database for communicable diseases and has been in development for some while, initially with the expectation it would be our communicable disease surveillance database for the 70-odd communicable diseases that we deal with day to day. Along came COVID-19 and so the priority has now shifted to make it a database that will manage the case and contact information for our COVID-19 response. It will be the database tool that the contact tracing team is using for their response to cases. It will also be important to have connection between Maven and other sources of electronic information, such as the Check in TAS data.

**CHAIR** - Will Maven also be used for a measles outbreak should there be one or something else, like other infectious diseases, one of the 70?

**Dr VEITCH** - The next phase of the development will be developing modules that bring in all the other communicable diseases. We do have an existing but ageing database for the other communicable disease.

**CHAIR** - You're starting with COVID because of the necessity and then you'll add the others afterwards?

**Dr VEITCH** - Yes.

**Ms MORGAN-WICKS -** As Dr Veitch has pointed out, Maven is the contact tracing database which we'll use to replace the REDCap environment that we have been using since very early in the COVID-19 process, which was also a new implementation by our ICT team.

Maven in itself has just completed user acceptance testing and is now in a production environment and will complete final configuration on 10 September but then allow for a couple of weeks of training with the teams. They have been working on the training package. We have an expected go-live date for our Maven tool at the end of September, noting that we already have a tool that we can use.

The most significant will be new on-line forms that we'll also be implementing to go alongside Maven, which will assist in on-line questionnaires that can be used in contract tracing efforts. So, when there is a positive case detected in Tasmania, we will be able to rollout on-line forms. That means that information can be pulled back and integrated through to a database.

**Ms WEBB** - Earlier, we spoke about the idea of connecting the Check in app data and the vaccination status data, the state level data with the Commonwealth level data and that being contemplated. For what purpose? Is it for the purpose of an individual venue as you check in being able to see and assess your vaccination status? The data on the app is held by the state and doesn't belong to the particular venue. It that the key purpose?

**Ms MORGAN-WICKS** - We are contemplating it. It is probably more in an exercise at the moment, is it possible in an IT land, in Tasmania? Usually we have issues in integrating or data sharing between a Commonwealth old register like the AIR database, that we have just heard is some 30 years old and there are challenges in getting information out of that database. Noting that it already hooks through to our own health records, we are able to prove our own vaccination status using the Commonwealth systems to do that.

**Ms WEBB -** We can choose to show that.

**Ms MORGAN-WICKS** - Regarding a check-in app, we are exploring that at the moment. It hasn't been determined that we will do it. So, our IT teams are trying to work out, is it possible anyway. In terms of the decisions of what would I show it for or what would I use it for? That is in the province of discussions on a vaccine passport. Tasmania is a participating state in the National Cabinet subgroup that is looking at vaccination passports, which is run through first secretaries and the Department of Premier and Cabinet.

**Ms WEBB** - Other than the technical capacity to do it, is there an assessment of the legal underpinning that might have to be put in place? Is there a legislative change or mechanism that will need to be put in place to allow that to happen if it is decided?

**Ms MORGAN-WICKS** - There is always a legal analysis and assessment of the ability to access information; share it and publish it. The same as we took a legal assessment in the privacy laws as they would apply to a Check in TAS application, we would do the same if that is the policy direction that we are directed to take. If there is a policy decision to actual show a vaccination status on a Check in TAS, that policy decision would be aided by a legal analysis and that would be through the Office of the Solicitor-General.

**Ms WEBB** - I am interested in preventative health. We can keep pouring money into acute health and we will be putting a larger proportion of our whole state budget into that as time goes by unless we change fundamental trajectories on key health outcomes. Our acute system won't do that. It is preventative health and social determinants and those other background matters that will do that.

We also know that research would tell us that you would need to spend at least 5 per cent of your total health budget in a jurisdiction on preventative health to make a difference to those fundamental trajectories. Can you tell me what proportion of our total health spend is being directed to preventative health for the time being?

**Mr ROCKLIFF** - It is technically in the next area of mental health and wellbeing responsibility.

**Ms WEBB** - Is it? We can leave it till then if you like.

**Mr ROCKLIFF** - I can talk about our election commitment of around $20 million.

**Ms WEBB** - I am not so much interested in you listing the things been funded in preventative health, I am interested to understand the quantum as a proportion of our total health spend.

**CHAIR** - We will come to that perhaps in the next output group then. Give the minister a chance to determine whether he has that information or not.

**Mr ROCKLIFF** - Yes.

**CHAIR** - Okay. Are there any other questions on public health services then? We will move then and try and move fairly promptly through the output group 90 line items.

**Output Group 90**
**COVID-19 response and recovery**

**90.1 Primary health support** -

**Mr DUIGAN** - In relation to primary health care support fund, minister how many applicants were funded under the program and how these funds have been utilised?

**Mr ROCKLIFF** - The Premier announced some $5 million for the primary health support fund in March last year of which $4 million was distributed by the Primary Health Care Grant Program. This was established to equip the primary health care sector with the necessary supplies including PPE, to protect themselves and the wider community while continuing to provide primary health services throughout the pandemic. The program closed on 24 July last year having distribution $4 million in the four months since it opened in April of last year. Nearly 500 applicants were funded under the grant program, which provided up to $10 000 GST exclusive to general practices and community pharmacies to support the continuation of the central primary health services throughout the pandemic.

I am advised it was well received by general practice and community pharmacies who used the grants for a variety of purposes, including boosting telehealth and pharmacy infrastructure, supporting social distancing and infection control strategies, maintaining PPE supplies, the home delivery of medication to vulnerable clients, training and support for staff members. The remaining $1 million from the fund was allocated to Primary Health Tasmania to increase the capacity for COVID-19 assessment and testing amongst general practice with a particular emphasis on addressing gaps in the rural and regional areas that were previously not well served by existing testing services and PHT's capacity building program has been

operating successfully and has worked with 27 general practices in rural and regional areas and two in city locations with a focus on servicing people living with homeless with COVID-19 assessment and testing capacity now much stronger in rural and regional areas, PHT is now focussing on building capacity up to the 114 remaining general practices across all other states. A total of 497 grants have been paid out to successful applicants, which is positive and has been very well utilised.

**90.2 Health Care and Front Line Workers Accommodation -**

**Ms LOVELL** - Minister, there is no budget allocation for this to continue into this financial year or into the forward Estimates. I am presuming because it is a bit of an unknown, but we are all expecting COVID-19 will be in the state again at some stage. Can you confirm that funding will be available to be drawn from somewhere to provide a similar program, or this program again if it is needed in the future?

**Ms MORGAN-WICKS** - This was under the separate output of COVID-19 Response which has now been rolled into all of our health general budget lines and also a provision within Finance General and the previous item related to the provision of accommodation for healthcare workers who were concerned about taking COVID-19 home. We did it that time and, through our Deputy Secretary for Infrastructure, we make arrangements for accommodation, given that it is now really in standby mode due to the lack of community transmission in Tasmania. As a policy, should there be community transmission in Tasmania, we would consider that against a backdrop of mandatory vaccination for healthcare workers, which will encourage families of healthcare workers to be vaccinated to help mitigate that risk of COVID-19 in people's home.

**Ms LOVELL** - Obviously, we all want to encourage as many eligible people as we can to be vaccinated. We cannot mandate family members to be vaccinated. I hope that the program would be considered if it was required again in the future. Should that be required, have there been any steps taken to ensure it can be up and running quite quickly given the demands on quarantine hotels? We already have other demands on other accommodation providers. Have there been any discussions on that?

**Ms MORGAN-WICKS** - Regarding funding on COVID-19 exact provision there, the Budget chapter notes that given the uncertain environment, the appropriation to the Treasurer's Reserve has been increased to $150 million in 2021-22 and in total to $300 million across the Budget and forward Estimates. This is to provide for unforeseen expenditure during the year which cannot be managed within entity Budget allocations. We have access to that provision and run a constant assessment, working in connection with Communities Tasmania who manage the hotel quarantine environment as to the available accommodation in Tasmania that has changed regularly over time.

It sometimes feels day to day or week to week. Should we require it, we have access to a constant evaluation of the available sites for accommodation. We need to make sure we are trying to segregate healthcare worker accommodation from a COVID-19 quarantine or isolation requirement. We would maintain that under active consideration as it is needed.

**90.3 Health COVID-19 General Allocation**

**Ms LOVELL** - I do not really have any questions on this other than to confirm that allocation has been rolled into that Treasurer's Reserve additional funding and can be drawn upon as required?

**Mr ROCKLIFF** - Correct. I have also, Ms Lovell, an answer to a previous question of yours regarding Ambulance Tasmania workers compensation.

I am advised there are 69 claims. 42 physical claims and 27 psychological claims.

**90.5 Cancer Council Tasmania**

**Mr GAFFNEY** - I imagine this was money for the Cancer Council last year and it was difficult for them to have their fundraisers and that would be money very well spent. If they were in the same situation again, the Government would rethink if they need to assist. Is that the -?

**Mr ROCKLIFF** - Yes, we have been working closely with the Cancer Council of Tasmania and I note they do a fantastic job and we are more than happy to continue to engage with them.

**Mr GAFFNEY** - I think it was in response to not being able to do some of their major fundraisers last year for their walkathons and such and I have no questions about it.

**90.6 Community Healthcare**

**Mr ROCKLIFF** - This year when we look at community healthcare -.

**Ms WEBB** - We can get to that because I am just about to ask if the two things are connected.

**Mr ROCKLIFF** - As part of the community healthcare Cancer Council Tasmania $1.1 million and that is -

**Ms WEBB** - Just to clarify is it 90.6, which is called Community Healthcare in the line item and it was $1.6 million last year and this year it's $2.3 million? Is that the same as the initiative that's described on page 153 of the budget paper under Other Initiatives which is also called Community Healthcare but is actually over four years? It's a larger investment of money, which is where you were just talking about the Cancer Council being funding under that, which I see there $1.1 million over the four years, I presume. Which to some extent follows on from the 500 last year. Is this the same money being referred to but one's over two years and one is over four years?

**Mr ROCKLIFF** - It is the same but it is being funded in a different place this year but for an extended period.

**Ms WEBB** - That initiative described on page 153, which is just the wording that describes it; it's described as being over four years.

**Mr ROCKLIFF** - Yes.

**Ms WEBB** - Yes. When I look at the line item here of 90.6 which also has Community Healthcare, the two years of funding that I see there, - last year and this year - is that the first two years of the four years that's referred to on page 153?

**Ms MORGAN-WICKS -** In last year's Budget, which was under a COVID-19 output, there was a commitment to Community Healthcare under that output for two years, noting that was a COVID-19 funding provision -

**Ms WEBB** - Which is what we see here on line item 90.6?

**Ms MORGAN-WICKS** - What we have this year is a four-year budget under Community Healthcare.

**Ms WEBB** - Are we able to see that broken down over the four years as an allocation? Is it additional this year?

**Mr ROCKLIFF** - Output 1.1 System Management Health broken down -

**Ms WEBB** - It sits within 1.1 and it's just a small component of that?

**Mr ROCKLIFF** - It's $1.1 million, $1.9 million, $1.9 million and $1.9 million going forward. It was for four years.

**Ms WEBB** - The $1.1 million that's allocated there in 2021-22, which is this first year of that four-year commitment, is that additional to the $2.3 million that's here from the COVID allocation? Or is it within the $ 2.3 million?

**Mr ROCKLIFF** - It is in addition.

**Ms WEBB** - Similar area, we're just crossing over this year from the commitment from COVID-19 and then the commitment going forward across the next four years. There's two amounts into the same space for this year.

**Ms MORGAN-WICKS -** Yes, is what we're informed by our CFO, yes.

**Ms WEBB** - Is the amount that's here in the line item, the $2.3 million, is that divided up similarly to what is described for the four-year allocation here under Community Healthcare on page 153? Or is it targeted to different organisations or to different purposes?

**Mr ROCKLIFF** - I am advised it's the same as last year but the only addition is the Cancer Council of Tasmania.

**90.7 Elective Surgery**

**Ms LOVELL** - I think we canvassed that fairly extensively before. I don't have any further questions on that one.

**Ms WEBB** - I would be interested in a gender impact assessment of this boost into elective surgery and the COVID boost to see what it delivers and the procedures and things delivered, what that might look like with a gender assessment. That is just as a comment to take away.

**Mr ROCKLIFF** - So, moving forward?

**Ms WEBB** - It would be interesting to see from this investment that you've made and I guess that could be done in retrospect. I might ask for it next year. It's the sort of thing that might get captured if a gender impact was done broadly -

**CHAIR** - There's a lot of guiding procedures; they'd be fairly gender specific.

**Ms WEBB** - That's what I'm wondering about.

**CHAIR** - Have you got a breakdown of the areas of surgery?

**Mr ROCKLIFF** - I'm advised that there's been quite a focus on women's surgical packages including both Commonwealth and state funding. We will consider that for a question next year.

**CHAIR** - Could you just repeat that response there, Minister, if you wouldn't mind, that you are happy to consider -

**Ms WEBB** - It did not get captured on *Hansard* because it was quiet.

**Mr ROCKLIFF** - Yes, happy to consider for next year. I expect the question next year and so we may be able to provide more detail.

**Capital Investment Program**

**CHAIR** - I think we have asked a bit of this along the way but are there any specific questions on capital investment?

**Mr DUIGAN** - I am happy to do one quickly on the LGH, minister. I understand this is a big project, a big commitment. I would be interested in a brief update to see how the work can be phased and services continued to be delivered at the site.

**Mr ROCKLIFF** - The draft Launceston General Hospital Precinct Masterplan was released for community consultation on 27 May this year. It closed again on 16 July and the feedback that was received through this process has been used to inform the development of the final masterplan. I thank everyone for their feedback and I know it has generated some interest within the northern region and further afield.

Release of the final masterplan is due by the end of this month and we envisage a fully staged plan to be made public in December this year with the construction estimated to be completed by 2031. The final masterplan will then guide the commencement of the next stages of the redevelopment on the site. We have committed some $580 million towards stage two of the Launceston General Hospital Redevelopment and that will include a new Mental Health Services precinct with contemporary facilities to enable safe and therapeutic recovery-focused

care designed to enhance privacy and dignity with a range of spaces for patient, family, carer and staff use. A new tower on the current north side site to provide necessary expansion space to make ward improvements and to meet projected demand for inpatients and ambulatory care services, a new inpatient unit purpose built and designed for the care of people.

Stage two starts with a new mental health precinct for which the 2021-22 Budget includes a $12 million allocation and to commence work, with a total of $80 million. So $68 million allocated beyond the forward Estimates and construction of the new mental health precinct is anticipated to be completed by 2027. The new tower development which is part of stage two will be located on the current north side Mental Health Unit and can only proceed after completion of the new mental health precinct at the Anne O'Byrne site, which you would be familiar with. The remainder of funding for stage two, that is $500 million, will flow from the 2025-26 budget, with the remainder of works for stage two due for completion in 2031 following completion of stage one works which we expect to be in 2024.

**CHAIR** - We will move to Minister for Mental Health and Wellbeing but we might like to have a break now and then we will come back and do that area. We will move through the rest after that so we will take a 15-minute break.

**The Committee suspended at 3.39 p.m.**

**The committee recommenced at 3.55 p.m.**

**CHAIR -** We'll move on to your very important portfolio related to mental health and wellbeing.

**Mental Health and Wellbeing**

**Output Group 1**
**System Management**

**1.2 System Management - Mental Health and Wellbeing**

**Mr ROCKLIFF** - I am joined again by Secretary Kathrine Morgan-Wicks, Dale Webster Deputy Secretary, Community Health and Mental Health and Wellbeing and Dr Mark Veitch, Director Public Health.

Over the last three years, we have thoroughly examined every aspect of mental health services in the state and this Budget includes $108 million additional funding over the forward Estimates, including our 2020-21 election commitments to continue our transformation of the mental health system, alcohol and drug services and boost preventative health measures for the benefit for all Tasmanians.

We have a long-term vision for the Tasmanian mental health system with an increased focus on community support options and a reduced reliance on acute hospital-based services including emergency departments.

We are strengthening the focus on prevention and early intervention and empowering our communities to understand and value their mental health as much as their physical health. This year's Budget investment of $41.2 million enables us to implement the recommendation to the

Child and Adolescent Mental Health Services Review which will be led by Professor Brett McDermott, who recently commenced in the role of Statewide Clinical Director of CAMHS.

Professor McDermott is progressing a number of key priorities at this time including reviewing the current workload and model of care for the pre-natal mental health services, project planning for a service for out of home care for children, project planning for a service for youth working with job design for fast tracking the creation of new positions and working with the University of Tasmania to create a centre for mental health service innovation which is in part a marketing and recruitment strategy.

Other highlights include $5.1 million over two years to pilot an innovative emergency mental health co-response team in southern Tasmania comprising of mental health clinicians who will travel with police and ambulance officers to attend mental health specific triple zero calls and $8.5 million over two years for a mental health hospital in the home pilot in the north west which will have particular focus on youth.

Also, in the north west today I am pleased to announce that Life Without Barriers has been selected as the provider of a new early intervention low to moderate intensity mental health service for the Circular Head region with a focus on young people.

The new service will be delivered one day per week at the Smithton Hospital and two days per week through outreach services from the Burnie office.

The service will initially focus on establishing a service for young people aged 12 to 18 years extending to 25 years within the first year.

Life Without Barriers is working with the Department of Health to finalise the service design and it is anticipated the service will open by 1 November 2021.

To carry our reform agenda forward, we have restructured the leadership of statewide mental health services including the creation of an executive level manager to lead a team in securing and retaining the staff we need now and into the future.

The Tasmanian Government understands the need to prioritise early intervention and why we have made a $20 million investment in this Budget.

The key to this is our continued and increased investment in our Health Tasmania Five Year Strategic Plan bringing total funding to $10 million over five years as well as committing $8 million over four years for the very popular Healthy Tasmania fund grants program.

The next iteration of the Health Tasmania Five Year Strategic Plan will be launched by the end of November. The Government has also allocated $10 million in the Budget for alcohol and drug treatment services. This is continuing support for the community sector organisations, alcohol and other drugs sector as well as a reflection of our ongoing commitment to the 10-year reform agenda for alcohol and other drugs sector in Tasmania launched last year.

Of course, CEOs do a great job in sometimes very difficult circumstances and the reform agenda will provide the framework to build a better integrated and coordinated alcohol and drug service system within Tasmania.

**CHAIR** - I have a few questions, minister. The overarching system management, where policy sits. What modelling has been done to understand the demand that is likely to be in the future, particularly with relation to the impact of generally, as well as an overload of the COVID-19 impact?

**Mr ROCKLIFF** - I can comment on what we perceive as an increase in demand already when it comes to mental health more broadly across the community. There has been a lot of focus in other states of Australia on adolescent mental health services particularly, and the challenges, especially in Victoria and other states. What we are experiencing, particularly in the adolescent mental health area is of course there is an increase in demand reflected in some commentary, particularly in the north west of Tasmania. I would hope the investment we have made with Life without Barriers in the Circular Head region at the very least, will address some of the areas.

I remember as part of our support package when COVID-19 first hit, there were some significant investments into the mental health and support sector then, anticipating as well, as reflected in the election commitments made, what we expect and expected before a latent effect of the initial onset of the COVID-19 pandemic. A mental wellbeing campaign has been launched, when it comes to some of the particular challenges associated with COVID-19.

The Mental Health Council of Tasmania launched the 'check in' website, which encourages all Tasmanians to take some steps in their day-to-day lives to look after their own mental health and wellbeing and that of their loved ones, by answering some of these easy questions on the website. People can find guidance around what support and information is available in Tasmania, to help with the mental wellbeing of themselves or someone they care about. It is important to understand the things we need to do. We need to feel safe and supported to maintain and boost our mental wellbeing and know when we need to reach out for help when we get it.

Some of the COVID-19 specific initiatives -

**CHAIR** - What modelling and forecasting have you done, these are responses. How did you determine where you needed to invest and why? What data were you relying on to guide those decisions?

**Mr ROCKLIFF** - I will turn to Mr Webster, in terms of your question and preparedness with respect to the COVID-19 situation in Tasmania, Statewide Mental Health Services developed the COVID-19 management guideline. This guideline is a whole of service overarching document that was forumulated based on advice from Public Health Services and continues to be updated, as necessary in response to changes in advice.

In addition to this, all individual statewide mental health services develop their own COVID-19 escalation plans which focus on ongoing management of services if there is a suspected or confirmed COVID-19 patient.

We are also in line with public health advice in Tasmania. Inpatient units can receive visitors in line with relevant safety plans for the facility and patients, access to leave as appropriate.

All Statewide Mental Health Service inpatient units are considered a priority of settings with inpatient and residential facilities and work to the planning coordinator by public health unit.

In terms of particular sector support, we're also supporting the Mental Health Council of Tasmania to the tune of $100 000 to monitor and collect information on COVID-19 related impacts in the community, through a recently established sector network to further inform recovery planning. The Alcohol Tobacco and Other Drugs Council has been allocated $65 000 to help with the monitoring and collection of data from its members, which will provide a clearer picture of the real impacts on the community sector organisations and ensure a better long-term response.

**CHAIR** - Has that work actually started from those two organisations?

**Mr ROCKLIFF** - Yes, it has indeed. Would you like to add anything further, Mr Webster?

**Mr WEBSTER** - That work has commenced and both organisations publish that information on their websites. That's available to all community service organisations, as well as to us. That allows us to target funding depending on what the outcome of that survey is, ongoing.

**CHAIR** - How often do they -

**Mr WEBSTER** - The Mental Health Council is doing that quarterly and ATDC now quarterly as well.

**CHAIR** - That's the work that guides your decisions around where to invest?

**Mr WEBSTER** - For part of my work, yes. We've also supported the Tasmanian Lifeline number; Rural Alive and Well; there's been technology grants as well.

**CHAIR** - Do you get feedback from Lifeline about the demand? Do you actually seek that?

**Mr ROCKLIFF -** Lifeline organisation is the 131 114 number. But at the beginning of the pandemic we set up a Tasmanian Lifeline, which is a separate number, a specific resource to support people who continue to be impacted by the changes, in terms of social isolation, loss of employment, alcohol, drug support and the like.

This particular hotline is staffed 8 a.m. to 8 p.m. seven days a week. There are three types of support being offered: a call-in - Tasmanians receive psychosocial support from a trained support worker to discuss their concerns and, if appropriate, be linked to a referral service; a call-out, which is contacting socially isolated older Tasmanians, identified through existing services, family and friends who are concerned, or by other health professionals; and a reach-out service, in partnership with industry significantly impacted by COVID-19, to identify and reach out to individuals who may need support, counselling or linking in with an employee assistance program.

My information is that the service commenced in May 2020 and it's been receiving a steadily increasing number of calls. For example, May of last year one hundred calls; August last year 199 inbound calls, 20 reach-out calls; 271 calls and 80 reach-out calls in September last year. Looking to June this year, 2021, 241 calls inbound and outreach as well. So, well-utilised. In addition to the supports that Lifeline would have with their 131 114 number.

**CHAIR** - The mental health care in the home in the north west, the pilot there, can you describe how that's going to work? I understand where that sits, the planning for that, isn't it? I'm happy to put it into the next one if you prefer.

**Mr ROCKLIFF** - We can talk about it now if you like. The Mental Health Hospital in the Home has improved access to acute-care presentations. Is it specific to the north west?

**CHAIR** - There's the youth one, isn't there? It was a pilot, you spoke about.

**Mr ROCKLIFF** - Yes, from 2023 to 2024 we will provide $8.5 million over two years for the Mental Health Hospital in the Home pilot in the north west. The pilot, based on the existing southern service, will have a focus on youth aged 16 to 25 and will enable people who may have otherwise been hospitalised to receive intensive short-term support in their own home. We're working on developing that pilot now and it will commence in 2023. Dale, is that correct?

**Mr WEBSTER** - The priorities in the CAMHS review for the Youth Intervention Program will be put in place first then the Mental Health Hospital in the Home youth trial, which will be the north west trial, will follow that work being done by Professor McDermott.

**CHAIR** - In terms of resourcing that, we know how difficult it is to get psychiatrists and psychologists in a timely manner in the north west. What are you doing to make sure that the pilot is given a chance of success?

**Mr WEBSTER** - The minister mentioned in his overview the setting up of a workforce unit, and having an executive-level lead for that workforce development unit within stage one of Mental Health Services. Part of their task will be to look forward to what we need, so by the time we get to 2023, we're not then starting a recruitment process, we are starting earlier.

We also will be working with Professor McDermott in terms of building these other elements of the reform program he is rolling out and, through that, building the resources we need as we go. It is really important that the workforce unit projects our needs well in advance because we don't want to get to 2023 then have an eight, nine-month delay which is quite general in looking for a psychiatrist. We need to be recruiting in 2022 for our needs in 2023.

**Ms LOVELL -** Minister, the north west pilot will be focused on young people. Will it be available to adults as well?

**Mr ROCKLIFF** - It will initially focus on young people.

**Mr WEBSTER** - The cohort is actually youth, which is young adults as well. The focus will be on the younger population in the north west, building on the youth intervention program but also looking at that service gap in the north west.

**Ms LOVELL** - I presume that is why it is being run as a pilot, because of that different cohort it is targeting?

**Mr ROCKLIFF** - Yes. In the south we are treating people aged 18-64 years with the Hospital in the Home, as I understand it. That commenced in the south on 25 March 2019. The service originally commenced operating eight of its 12 beds while it was waiting to fully recruit a team comprised of 12 registered nurses, full-time equivalent, two FTE medical staff, three FTE allied health staff and two part-time, 0.5 FTE consumer and carer peer workers. In February 2020, the 12 beds were up and running, according to my advice. That is the 18- 64 age?

**Mr WEBSTER** - That is right.

**Ms LOVELL** - And that only operates in the south currently, minister; is that right?

**Mr ROCKLIFF** - Yes.

**Ms LOVELL** - That has been quite well received and quite successful, has it not?

**Mr ROCKLIFF** - That is my understanding, yes.

**Ms LOVELL** - Are there any plans to roll that out across the state, because I would have thought there would be even more service gaps in the north and the north west?

**Mr ROCKLIFF** - Yes. Mr Webster highlighted a service gap in terms of the young people, which is what we are trying to fill through the Hospital in the Home -

**Ms LOVELL** - But for adults as well?

**Mr ROCKLIFF** - I don't doubt there is a need but we will need to evaluate and see what is possible in the future.

**Mr WEBSTER** - The frameworks we are setting up are statewide frameworks but what we are finding is there are distinct regional differences in need, so we are trying to match our programs to those distinct regional differences.

While Mental Health Hospital in the Home will be a statewide program, it might look very different in the north west to the south, depending on the needs in the region. That will be the same with all of our programs; they will have that distinct regional flavour as well as being a statewide framework. Because it is our first go at doing a Mental Health Hospital in the Home focused on a smaller cohort, it is important we gather the evidence about whether is that an appropriate way to run that particular service.

**Ms LOVELL** - No plans for any pilots or anything in the north as yet?

**Mr ROCKLIFF** - No.

**CHAIR** - I could not see where else this fitted, about the greater access to medicinal cannabis. Can you give us an update on how that is going to roll out and how it will be accessed and where?

**Mr ROCKLIFF** - Yes, I can. I spoke about this the other day. Commencing in 2021-22 we have committed $2 million over four years to amend Tasmania's Controlled Access Scheme allowing general practitioners the capacity to prescribe medicinal cannabis in line with the process in other states and territories, and using the Therapeutic Goods Administration portal resulting in improved access for Tasmanians.

From July this year, Tasmania adopted the national streamlined online application pathway and 48-hour authorisation timeframe. Like all other jurisdictions, Tasmanian GPs are required to seek approval from the TGA to prescribe medicinal cannabis products through this national pathway.

Cannabis will, however, continue to be an illegal plant in Tasmania when it is grown without a licence or a person is in possession of it without a prescription from a medical practitioner and since November 2017 applications have been received for a total of 32 patients. Nineteen of these patients have received an approval to commence a medical cannabis product subsidised through the Tasmanian Health Service.

One application remains deferred for more information. There is a process available for reconsidering applications, should further information or evidence become available to support the use of the product. Twelve of those applications I mentioned have not been approved.

**CHAIR** - There are limitations on it, it is not just a free for all. Can you describe to us the limitations on approval to access?

**Mr ROCKLIFF** - The Controlled Access Scheme requires all reasonable evidence-based therapeutic options to have been trialled and shown to be ineffective or inappropriate to the patient, prior to approving the prescription of the products. These requirements therefore require the relevant specialist medical practitioner seeking approval to thoroughly detail the patient's clinical history, including past treatment, failures, allergies and adverse reactions to medicines. Anything further in terms of barriers?

**CHAIR** - Is the requirement you must have tried every other medication available consistent across the nation?

**Mr WEBSTER** - To finish that first answer, the Controlled Access Scheme is the subsidised access scheme. The minister also described the newer scheme - I'll call it that - which is the TGA scheme. For schedule four you can apply through the TGA and be approved. For schedule eight, you need to apply through the portal and it needs to be approved by both the delegate of the secretary and by the TGA.

**CHAIR** - You mean the patient or the medical practitioner?

**Mr WEBSTER** - In prescribing it, the medical practitioner would handle the application. It is the same as the drugs you need for shingles and go through that sort of process. There are two distinct schemes. There is the unsubsidised scheme which is the TGA portal scheme and then the minister described the subsidised scheme that is administered through the Controlled Access Scheme.

**Mr ROCKLIFF** - I have some figures here as well from 1 July 2021 which may be of interest. We have now joined the streamlined TGA portal. Again, that facilitates a 48-hour approval time and when all the recorded information has been supplied. So, between the 1 July and 2 August this year, the TGA have approved four applications from Tasmanian medical practitioners to prescribed schedule four, a cannabis product to a specific patient.

Between 1 July and 2 August this year the TGA and the delegate of the Secretary of Health have approved two applications from the Tasmanian Medical Practitioners to prescribe schedule eight cannabis products to a specific patient.

**CHAIR** - The question I come back to is the requirement all other drugs have had to be tested and failed before a person can actually become eligible. Is that consistent across other jurisdictions of Australia where there is a scheme in place?

**Mr WEBSTER** - The Controlled Access Scheme, the subsidised scheme is unique to Tasmanians. So other states and territories do not subsidise medicinal cannabis. That rule is unique to Tasmania, we are the only scheme that subsidises.

The TGA approval for schedules four and eight the minister described is the unsubsidised scheme and consistent across the country.

**CHAIR** - You do not have to have tried every other drug for that condition to access the TGA and scheduled eight process?

That is inequitable, when you think you have got a subsidised scheme, some vulnerable people at their wits end, who have tried everything and possibly do not have the financial resources to keep going are now put in a position where they have to access an unsubsidised product? Is it creating an inequity?

**Mr ROCKLIFF** - We are leading the nation in many respects.

**Mr WEBSTER** - I would have thought it was addressing inequity. If you cannot afford it you can apply through the Controlled Access Scheme.

**CHAIR** - You have to have tried every other drug before you can do it.

**Mr WEBSTER** - Most people would have tried other things before they go to a proven medication.

**CHAIR** - The other question is in relation to pill testing. COVID-19 put paid to music festivals pretty nicely, it made the issue less of an urgent matter. Are you looking at a trial for this?

The ACT latest report was recently released and there is growing evidence and support for consideration of this, or at least a trial.

**Mr ROCKLIFF** - We are not looking at a trial at this point in time. We need to see a greater degree of evidence. The last time this came up, the intensities of discussion was through the summer of 2019-20 just before COVID-19 hit. The festivals were cancelled last year but the Department of Health has provided the Government with a review of both the NSW Deputy

Coroners report into festival deaths and the ANU report 2019 into the pill testing trial in the ACT. We have not considered that yet in terms on focus to responding to COVID-19. That is yet to be considered. We did work very closely with festival organisers and put a number of other supports in place for festival goers and I remember some considerable discussions at that time.

With organisers, I had discussions with the Department of Health here and we provided the Link Youth Health Service with a one-off support for $11 500 almost for the 2019 Falls Festival to provide additional staff for early intervention and to help education services. The department is working with Link and other key stakeholders to ensure learning from that summer and be able to consider it as part of any relevant policy development.

**CHAIR** - Did COVID-19 give you time to fully consider -

**Mr ROCKLIFF** - COVID-19 has intervened. COVID-19 is not quite over unfortunately.

**CHAIR** - No, it is not but it would be best to have a bit of a plan before the festival season starts.

**Mr ROCKLIFF** - I appreciate the evidence that you have suggested. We will do what we believe is in the best interests of the safety of our young people, and people who attend these events.

**Mr DUIGAN** - Minister, I notice there is a $500 000 allocation for the implementation of Rethink 2020. Perhaps you could explain for the Committee what kind of actions we will see for the implementation of Rethink 2020?

**Mr ROCKLIFF** - It is an overarching mental health plan representing a shared approach to improving mental health outcomes for all Tasmanians. We recently released the implementation plan for Rethink 2020. That plan maintains the focus on the importance of partnership, to ensure a consistent approach to mental health services and delivery.

Rethink 2020 goes beyond being a state government initiative. It was developed by key experts including Primary Health Tasmania, the Department of Health and the Mental Health Council of Tasmania. It has also been endorsed by the mental health and alcohol and drug leadership group. Rethink 2020 was launched in December last year. It builds on our initial Rethink mental health plan, released in 2015, to take stock of key achievements such as: progress towards mental health integration hubs; improved youth mental health support; the launch of the mental health peer workforce development strategy. Rethink 2020 also enables us to keep pace with mental health reforms at a national and state level.

The implementation plan outlines the new areas of focus, including: suicide prevention; improving the coordination of services for people with severe and complex mental illnesses; improving the physical health of people with mental illness; and providing mental health services across the continuum of care. A major key action was to update Tasmania's Suicide Prevention Strategy which is due for completion at the end of next year and, importantly, will be subject to community consultation. We expect a number of other key actions under the plan will have a positive impact on carers, family and friends and those living with mental health challenges.

Some of those include: review the consumer and carer participation framework for Tasmania and update it as required; review resource allocation to Flourish, which is a mental health consumer group, and Mental Health Families and Friends Tasmania, in line with that framework; implement Your Experience of Service (YES surveys) and care experience surveys into all public mental health settings; increase the capacity of consumers, carers and families to participate in the service system by providing information and training; and develop opportunities for joint training to support an integrated mental health system, including joint training for consumers, carers, public, private, primary health and the community sector.

Many of the actions will require more than one area to implement them; however, there will be one lead organisation on each action. The Department of Health will take the lead for some actions. For others, Primary Health Tasmania and the Mental Health Council of Tasmania will take the lead. The implementation plan will be reviewed and updated every year. This will ensure it remains flexible and responsive to the changing national mental health and suicide prevention environment, and reflects the outcomes of ongoing consultation including, importantly, people with lived experience with mental health and mental health challenges, and people who have experienced suicidal distress, as well as carers, families and friends, priority population groups, peak bodies and of course service providers. I thank you for your question.

**Ms LOVELL** - I can see there is $500 000 for the development of the Rethink 2020 plan, but is there separate funding in the Budget for the actions that come out of that plan? Will there be more actions that will need funding?

**Mr WEBSTER** - A number of them are scattered through the initiatives in the Budget. It's a joint approach with Primary Health Tasmania, so some of them will relate to funding that will come through Primary Health Tasmania from the Australian Government. The implementation plan works on what's already there as well as integration of services, so that we have one service system across community, primary health, and mental health services at the state level. All of those things are in the Budget. The implementation plan and the work done on the Suicide Prevention Plan for 2022 will inform work and budgets into the future.

**Ms LOVELL** - Has the contribution from Primary Health Tasmania and the Commonwealth Government funding already been committed?

**Mr WEBSTER -** Not all of it would have been committed but some has been. For instance, there have been announcements about the adult mental health centre in Launceston, and about Headspace - and in fact, it's commenced in Devonport. Apart from that, you'd expect further announcements from the Australian Government.

**Ms LOVELL** - Minister, you mentioned that the plan will be reviewed and updated each year. Will that be done from existing resources?

**Mr ROCKLIFF** - I imagine so, yes.

**Ms WEBB** - Our spending on acute health care is inevitably increasing. The only way we can address the underlining trajectories driving that is through preventative health. Research suggests 5 per cent of our total health spend would need to be directed to preventative health. What is our proportion currently?

**Mr ROCKLIFF** - I understand ill-health prevention and how important that is and we've used examples around easing of pressure on the acute care sector.

We are having consultation on our first Healthy Tasmania plan. That's been ongoing since it was released. Extensive consumer and community engagement has already taken place with the first plan. This has included numerous groups such as those who received funding through the Healthy Tas Fund grants program but also other groups like the Chronic Conditions Working Group, Health Consumers Tas and TasCOSS. There has also been internal consultation.

Our Budget commitment to trial the rollout of the Tasmanian Community Health and Wellbeing networks is a great example of a community lead project. That is in partnership with Health Consumers Tasmania. We are investing $4.5 million in a new approach for the state to empower communities to improve their health literacy and awareness and to coordinate place-based preventive health initiatives. The first networks will be trialled in Ulverstone, Huonville and Scottsdale. We will see the employment of a local health connector to deliver community-led health and wellbeing services, focused on the needs of local people, using local community resources. This will enable communities to have a stronger voice and say in what services are needed locally.

In response to your question, I was pleased to sign the Tasmania Statement pledge with the Premier, to work across government and communities on shared health priorities that will make a long-term difference. Good health is everyone's business as you would appreciate. It's important that we empower individuals and communities to better look after their health and wellbeing.

I'm focussed on an outcome here. I accept that dollar figures are important in terms of that investment - and our commitment of around $20 million in the Budget is important. However, I believe the most successful projects to improve health and wellbeing are often community-led and at the grassroots level.

I am advised that across government, we invest a minimum of around $70 million in preventative health measures across agencies and government businesses. This preventative health expenditure figure, which is a conservative one, includes our Healthy Tasmania five-year strategic plan, other works like infrastructure and community programs that increase participation and physical activity rates and grants to upgrade sporting facility amenities. The Healthy Tasmania strategy is a $4 million investment provided over four years. It's $1.1 million per annum. Total funding of $10 million is allocated over the next five years to support community based preventative health programs under the Healthy Tasmania policy to improve the wellbeing of Tasmanians. This funding forms part of the $20 million commitment for the prevention and early intervention initiatives that enable the continuation of the Healthy Tasmania five-year strategic plan with Healthy Tasmania 2021-2026 to be launched later this year.

The best we could come up with, which is likely to be an underrepresentation given there are likely to be other costs including grants paid within the Department of Health that may qualify as preventative, is a figure of around $46 million. That Department of Health data is not set up to extract them and it would require a significant amount of time identify that data.

**Ms WEBB** - I would like to just clarify some parts of it, if I may. You mentioned the figure of $46 million in this Budget for this financial year. Earlier you mentioned a figure of $70 million that drew across various or across the whole of government. Was that also a figure for this financial year that the Budget covers?

**Mr ROCKLIFF** - Across each year - minimum, yes.

**Ms WEBB** - Did the $70 million include the $46 million or in addition to the $46 million?

**Mr ROCKLIFF** - It included the $46 million.

**Mr WEBSTER** - The $70 million include the $46 million they're the core things we're doing within Government. As the Minister said, it doesn't include the grants that might be embedded in other programs. For instance, the Good Sports program which is around half a million dollars a year which is aimed at preventing abuse of alcohol across sporting organisations. That is funded from our alcohol and other drugs services and isn't included in that $46 million. There would be a lot of money spent across Government in those sorts of programs. We just don't have the ability to quickly bring those figures in to total that.

**Ms WEBB** - You're asked this question regularly. I know you're new to this portfolio but this is a question that is asked year after year and is asked by external stakeholders year after year also. You have every opportunity to put some thought and just a small amount of effort into being able to provide this figure and to do that work of looking across various programs. If those grant programs you're mentioning are related to the Health department surely you can readily access that? If we take the $70 million as the figure you're provided and I think you mentioned $2.6 billion as the total Health spend, what proportion of total spend is on preventative health?

**CHAIR** - Mr Jeffrey might be able to do the maths for you.

**Ms WEBB** - It would be great if someone could do the maths for me. It sounds like a minuscule proportion.

**Mr ROCKLIFF** - We can take that on notice and we'll try to do the best we can.

**Ms WEBB** - You've obviously done some thinking to put the $70 million figure together. I would like a list of the things that are included in that $70 million. You don't even necessarily have to include the figure against each of the things in the list but I'd like to understand what has been included in that list. That would be for this year. What I would flag for next year is that this question will be asked again and I wouldn't expect that the answer to be that you haven't been able to draw everything together given that there's notice provided.

**CHAIR** - And provide a percentage.

**Ms WEBB** - And I would like to know as a percentage of total Health spend what the investment in preventative health is. At the moment it sounds like it's a very fractional amount. If we take $70 million to $2.6 billion. As I said research suggests it would need to be five per cent to get tangible improvement in our underlying cost trajectories. If I could move on from that.

**Mr ROCKLIFF** - I take it all on board as a question for next year.

**CHAIR -** Is that a question on notice, or next year?

**Ms WEBB** - The question on notice for this year is I would like a list of the things that have been included in the $70 million figure that's been provided.

**CHAIR** - The mental health and wellbeing portfolio.

**Mr ROCKLIFF** - The $70 million was across government as I understand it.

**Ms WEBB** - I've asked about preventative health and that's the figure that's been provided. The things that are included sound broader than just this particular area. That's fine, if they've been considered they must be able to be listed.

**CHAIR** - Across the Health portfolio?

**Ms WEBB** - It sounds like that figure has included things that have been drawn from beyond the Health portfolio. I'm happy for that to be the case but I would like them included in the list.

**Ms MORGAN-WICKS -** If it's a figure of $70 million that is 2.71 per cent of the $2.584 billion total Health budget. We have prepared for these Estimates based on the outputs that are available in the Budget papers and have gone to some considerable work to prepare the data and try to also anticipate the questions. I note that's the percentage.

**CHAIR** - Do you want the list?

**Ms WEBB** - Yes.

**Mr ROCKLIFF** - A list of all the programs, not necessarily the dollar figures, but the programs that will make up the whole of government.

**Ms WEBB** - So it's clear what's been included in that $70 million figure?

**CHAIR** - Are you clear on that?

**Ms WEBB** - I have another question I think would fit here because this is about system management. We're still in 1.2. This area of Mental Health and Wellbeing includes preventative health, alcohol and drug services, mental health services. Why are gambling support services not included in this same portfolio responsibility and in the Health department given the natural synergies, given that gambling addiction is recognised as a diagnosed mental health condition and gambling support is identified as being delivered under a public health response model?

**Mr ROCKLIFF** - We recognise the impact that gambling has on individuals, families and communities. We remain committed to preventing and reducing gambling harm through our Gambling Support Program. That's funded through the Community Support Levy. This continues to provide specialist support services for people impacted by gambling as well as a

broad range of gambling information, education and awareness initiatives to prevent and reduce gambling harms.

**Ms WEBB** - I'll ask you questions about that in the relevant portfolios which isn't this one. The question here is why aren't those things in this portfolio where there are natural synergies with alcohol and drug services which are other areas of addiction and mental health services when it would clearly group into this area?

**Mr ROCKLIFF** - It may well also be relevant in the Communities Tasmania portfolio. I take your point.

**Ms WEBB** - Can I provide an example of where not grouping them together here leads to some unfortunate gaps.

The example would be the very excellent website produced during COVID-19 by the Mental Health Council of Tasmania, the #checkin website, which has excellent resources on it. It has a help page that links to a range of other support services and mental-health-related support services with various helplines.

Under crisis helplines and under a whole range of other areas that are covered there the gambling support helpline isn't included in that website.

The gambling support helpline is a mental-health-related helpline. During COVID-19 this site was set up because of the exacerbation people might have experienced across a whole range of areas in addiction and mental health areas.

Other addictions are covered in there and gambling is absent. I can't help but wonder if that's because we overtly separate them in portfolio areas and how they're regarded, when naturally there would be a synergy to have it here. Is there an explanation for that? If there isn't then I'm asking you to consider the appropriate location of that area and whether it's a better fit into this space.

**CHAIR** - Is there a reason why it's not been included in this?

**Mr ROCKLIFF** - I'm not aware of any reason in particular. The Premier has the administration orders and allocates them but if you're asking me to consider whether it is a better fit in this area of portfolio rather than the Communities, then of course.

**Ms WEBB** - Can you come back in some way at some date when you've had an appropriate amount of time to give it consideration?

**Mr ROCKLIFF** - Yes, I will. We're developing a new budget almost immediately after this one. It is a matter for the Premier, but I'll discuss it with the Premier.

**CHAIR** - The question is on notice in the Chamber too. Any other questions on this one?

**Output group 2**
**Health Services**
**2.5 Statewide and mental health services**

**Ms LOVELL -** Minister, I'll go back to the question I asked earlier about the emergency department. I think we said we'd put that off until now. Could you provide the committee the number of mental health patients presenting to each emergency department? Sorry, I should say patients presenting for mental health treatment at emergency departments across the state. Could you advise the average wait time for admission for those patients and the longest wait time at each of the emergency departments?

**Mr ROCKLIFF** - The number of mental health presentations to emergency departments across Tasmania reached 9621 in 2020-21. This is an increase of 8.5 per cent on the 8870 presentations in 2019-20. We know that COVID-19 is creating additional challenges for many people. So, we're responding by investing across the mental health sector, including community-based solutions, such as the redevelopment of the Peacock Centre, the new facility that is to be constructed at St Johns Park and the related work of the Tasmanian Mental Health Reform Program in response to the Mental Health Integration Taskforce report.

The Mental Health Hospital Avoidance Program, now operational in the south of Tasmania, is a key part of this reform and will help people to access care in the community and reduce the need to present at the Royal Hobart Hospital Emergency Department. This is better for people needing care and for the Tasmanian health system.

When fully operational, the Mental Health Hospital Avoidance Program will include an expanded crisis response functions centre, as an alternative to the emergency department for 24/7 assessment and treatment and expanded adult community mental health services. The six-bed mental health short-stay unit at the Royal Hobart Hospital, which commenced operation in February this year provides an alternative option for some mental health presentations, which will in turn improve patient care and flow and alleviate pressures on the emergency department at this facility.

There will always be a need for acute mental health facilities. We're supporting more community-based mental health support, which we've been touching on. Many of the initiatives under the Mental Health Reform Program will provide more community-based support and additional options beyond presenting to hospital for Tasmanians who require mental health treatment and care.

To identify mental health-related presentations in Tasmania to the emergency department, two main criteria are used.

(1) There is a resulting inpatient admission from the emergency department presentation. There's a need to check for admission to a specialised mental health ward or admission to another ward where admission care-type is mental health care, or the primary inpatient diagnosis is within the F-group of ICD-10AM-codes -

(a) suicidal ideation and self-harm overdose. primary inpatient diagnosis is within the F Group of ICD-10AM codes,
(b) suicidal ideation and self-harm overdose, or

(2) There is no resulting inpatient admission, then ICD-10AM presenting diagnosis code recorded in the ED clinical system must fall within the following group of codes -

(a) F Group of ICD-10AM codes, excluding F05 delirium.
(b) Suicidal ideation and self-harm, and
(c) Drug overdose.

Over the past seven years there has been an increase from 6526 mental health presentations to emergency departments across Tasmania in 2014-15 to 9622 presentations in 2020-21. I might have said 9621 prior to that.

This represents an increase of 3096 presentations or a 47.4 per cent increase across Tasmania during that seven-year period.

**Ms LOVELL** - My question was in relation to the number of presentations at each of the emergency department and the wait times. The average wait time at each ED and the longest wait time at each ED for mental health patients for 2020-21.

**Mr ROCKLIFF** - For Launceston General Hospital, there were 2442 presentations, the Mersey Community Hospital 365, the North West Regional Hospital 1773, the Royal Hobart Hospital 5042 and that brings the figure to 9622.

The longest stay in hours for a mental health patient in the emergency department at the Launceston General Hospital was 88.3 hours; the Mersey Community Hospital, 48.55 hours; the North West Regional Hospital, 38.38 hours; and the Royal Hobart Hospital 122.08 hours.

The average length of stay for mental health presentations in hours in EDs, the LGH 9 hours; the Mersey Community Hospital 4.4 hours; the North West Regional Hospital 5.6 hours and the Royal Hobart Hospital 11.2 hours. That makes a statewide average of 9.3 hours.

Significant delays are being experienced at the Royal Hobart Hospital which is why we opened the short-stay unit this year and we are seeking to expand the Royal Hobart Hospital Emergency Department.

**Ms LOVELL** - You mentioned the Peacock Centre and St Johns Park projects which will deliver a number of mental health beds. Those projects have been underway for quite some time or there have been commitments for quite some time. I can see in the Budget, reference to when they will be commencing but can you give us a time frame for completion for both of those projects, please?

**Mr ROCKLIFF** - I can. I introduce to the table Shane Gregory, Deputy Secretary, Infrastructure. The Peacock Centre project commenced in 2017 following an arson event in December 2016 that destroyed the facility. A tender for the project design consultant occurred in early 2018 and Xsquared Architects was contracted to commence work in October 2018.

The new St Johns Park facility will include the new Tasmanian Eating Disorder Service with the Australian Government providing $10 million over five years for the development of the service; $5 million of the funding has been received to date. Detailed design of these facilities. The Peacock Centre redevelopment build is progressing well with Hansen Yuncken

the successful tenderer. Work is on track for completion of the building in March 2022, with hopefully opening the facility in April next year is our expectation, Ms Lovell.

**Ms LOVELL** - The expectation is with the full complement of beds available at that stage?

**Mr GREGORY** - The Peacock Centre project delivers 12 of the 27 mental health beds and yes, the expectation is when that facility becomes operational it will be the full 12 beds.

**Ms LOVELL** - And the St John's Park timeline for completion?

**Mr ROCKLIFF** - St John's Park - Shane.

**Mr GREGORY** - The St John's Park project delivers the other 15 beds and the eating disorders clinic. It provides us a better opportunity to bring those facilities together and gain efficiencies and drive a lot more value for the investment we have. That is the process we have been working through. The key work that has been done to date is making sure we have got the design correct to deliver the facility and the levels of service required by the mental health team and has been going particularly well. We also had to clear the site as there are old workshops on the site. All the preparatory work. We are expecting to go to the market in December and have that facility operational in March 2023.

**Ms LOVELL** - Thank you. I was going to move onto another topic unless anyone has got a follow-up one.

**CHAIR** - Following on infrastructure, we are covering off the CIP bit as we are here. Is the new mental health unit for Burnie proposed to be on site or offsite?

**Mr ROCKLIFF** - It will be in the precinct.

**CHAIR** - Are there any plans for exactly where that is going to be yet or has that not been determined?

**Mr ROCKLIFF** - We are working on that now but, yes, there is.

**Mr GREGORY** - We are talking about the LGH?

**CHAIR -** No, North West Regional.

**Mr GREGORY** - North West Regional.

**Mr ROCKLIFF** - The Spencer Clinic redevelopment.

**Mr GREGORY** - The plan is the new facility will be on the North West Regional Hospital site. Exactly where on the site is yet to be determined and that will come through the master plan. There is a lot obviously happening on that site and as you mentioned earlier, there are issues with car parking and various things. We have not decided exactly where and that is the piece of work we will be starting.

**CHAIR** - But it will not be a refurbishment of the existing Spencer Clinic?

**Mr GREGORY** - It is stage one of a new facility which will then allow us to decant services out of the Spencer Clinic. Then there is a commitment to refurbish the existing Spencer Clinic wards and repurpose them to other purposes.

**Mr ROCKLIFF** - And also to replace Parkside. Our expectation is it will be completed in 2025 and then the master plan work will also involve how that precinct and integrative services will sit on the precinct for the broader master plan.

**Mr GREGORY** - Yes. That is correct.

**CHAIR** - What is going to happen to my old home at Parkside where I used to live once? It was the nurses' home once.

**Mr ROCKLIFF** - We will come up with something.

**CHAIR** - I used to have the room right along the end when I was living. There are ways of getting in after hours without your late key too. You only got two late keys a week. It was pretty tough.

**Ms LOVELL** - Minister, can you provide us with an update on the number of acute beds in the LGH and the Royal specifically for Children and Adolescent Mental Health Services?

**Mr ROCKLIFF** - I can. Adolescent Mental Health Services - the redevelopment of the Royal Hobart Hospital has included a new 16-bed adolescent inpatient unit which is managed through the paediatric ward. Ward 4K will provide a 34-bed paediatric medical and surgical unit at the Launceston General Hospital at the completion of the current redevelopment. Six of the beds on this units are mental health safe beds specifically designed for adolescents. The service is provided through the new beds at the Royal Hobart Hospital and the Launceston General Hospital (LGH) will deliver an integrated model of care whereby mental health patients and paediatric medical and surgical patients will be supported in the one unit.

Child and Adolescent Mental Health Services patients statewide will have access to adolescent beds within these redeveloped facilities, noting that there may still be occasionally times when a young person's acute needs and linked risks to self or others will require the individual involved to receive treatment in an adult inpatient setting.

**Ms LOVELL** - Of the 16 at the Royal. Sorry, I should have asked this under Admitted Services.

**Mr ROCKLIFF** - Yes, a 16 -bed Adolescent Inpatient Unit, so case 6 is part of the Royal Hobart Hospital Redevelopment.

**Ms LOVELL** - Are all of those beds mental-health-safe beds? Specifically, mental health designed rooms?

**Mr ROCKLIFF** - A small working group has been formed to develop a model of care from an adolescent mental health perspective and ensure it has statewide applications with reference to the LGH 4K and the Royal Hobart Hospital K6, both having an existing paediatric

model of care and work has commenced to extend these departments to incorporate adolescent presentations.

**Ms LOVELL** - I will have to look at previous hearings because I'm sure what we've heard at previous Estimates Hearings is that there's a specific number of those 16 that are designed for mental health patients. In the LGH plan you have six of the 34 beds.

**Mr ROCKLIFF** - Yes, and how many of the 16 is your question?

**Ms MORGAN-WICKS** - There is a new 16-bed Adolescent Inpatient Unit which is not just 16 beds for mental health patients and we have two that are designed for high-risk patients in that 16-bed facility.

**CHAIR** - It is suitable for high-risk mental health adolescents?

**Ms MORGAN-WICKS** - Yes. At the Royal we also have two for high-risk mental health adolescent patients in the new LGH 4K Unit.

**Ms LOVELL** - The adolescent unit at the Royal is open now?

**Ms MORGAN-WICKS** - Yes, I was in it last night with my own daughter, from an adolescent inpatient perspective. I have walked through it. It is all operating and very well.

**Ms LOVELL** - I hope everything is okay there.

In terms of the staffing for those beds and those units, are there mental health-trained specialist staff on staff at all times in that unit?

**Mr ROCKLIFF** - The Royal Hobart Hospital has in inpatient of the Children and Adolescent Mental Health Services (CAMHS) staff who provide in-reach specialist psychiatric care treatment in liaison in conjunction with the Women's and Children's Services for children and adolescents who are inpatients. The CAMHS team also provides psychiatric advice and assessments in the ED when specialist mental health is requested.

**Ms LOVELL** - Will that be the same model in the LGH?

**Mr ROCKLIFF** - CAMHS in the north and the north west do not have staff located at the hospital but staff provide in-reach specialist support and consultation to the Emergency Department and Women's and Children's Services for children and adolescents who are inpatients.

**Ms MORGAN-WICKS** - We are also offering, particularly the nurses under 4K at the LGH and also 6K at the Royal, the opportunity to conduct or undertake mental health training to add to their existing skills and when I mentioned the two for high-risk mental health patients for adolescents in 4K there's also further rooms, for example, for eating disorder patients, et cetera, that are separate from those two high-risk rooms.

**CHAIR** - As far as I am aware and I may be out of date now but there is only one dedicated Mother and Baby Unit in the state and they are private beds that we purchase. Is that still the case?

**Mr ROCKLIFF** - Yes.

**CHAIR** - So, there are no plans to look at a Mother and Baby Unit in the north of the state anywhere? It's a long way from your family when you've got to be admitted in Hobart.

**Mr ROCKLIFF** - I recognise that.

**Ms LOVELL** - The number of public beds at that unit, too.

**CHAIR** - There aren't any public. We purchase them.

**Ms LOVELL** - There's only one, isn't there?

**Mr ROCKLIFF** - Mr Webster visited St Helens and had a look around. Dale.

**Mr WEBSTER -** One of the reforms within CAMHS is to look at perinatal and infant mental health services, so one of the priorities for us is to look at the whole picture, not just the purchase of beds at St Helens Hospital, and how do we actually deliver that service statewide.

We have a large dedicated unit in the south, and very limited resources currently in the north and north-west, but we actually have a project underway to increase those resources across the north and north-west and then, through the CAMHS reform, do further work on what our needs are on a regional basis, as well as statewide.

**CHAIR** - The redevelopment of the north west mental health precinct would be an ideal opportunity to consider that. It's a bed that can be used for other purposes when not being occupied by a mother and baby, surely.

**Mr WEBSTER** - The process by which we'll design the units for Launceston and North West and other units is that we're doing the work alongside the work for the master plan to do a clinical services plan.

What is the need in each of those two regions? What do we need to include in the new unit? That's something that can feed into that, and indeed the child and adolescent mental health beds will feed into that picture as well.

**Ms LOVELL** - How many beds are generally available for public patients through the Mother Baby Unit at St Helens?

**Mr ROCKLIFF** - I'll get that information for you.

**Ms LOVELL** - Minister, in relation to the Emergency Mental Health Co-response Model, what is your intention around staffing profile? How will that be staffed?

**Mr ROCKLIFF** - It's based on a model, I think developed in the ACT, called the PACER model. It has police attending, mental health clinicians attending, and of course paramedics as well.

**Ms LOVELL** - In terms of mental health clinicians, what type of clinicians are you anticipating? Will they be mental health nurses?

**Mr WEBSTER** - Primarily mental health nurses, however it may be a mix of allied health and nurses. Each response has one of each of the categories, so it's a three-person response team drawing a paramedic, a police officer and a mental health professional. We expect it to be running hopefully by the end of this year or early next year.

**Ms LOVELL** - How many staff are you expecting to fund with that allocation?

**Mr ROCKLIFF** - All up, 18.

**Ms LOVELL** - At the end of this year, 18?

**Mr ROCKLIFF** - That is our expectation.

**Mr WEBSTER** - It is 5.1 for the trial over a two-year period. The physical delivery of the trial would be approximately 18 months, and there's 18 staff across that. It's 18 point something. You have to build in relief and things like that, but that's the number required to cover the shifts for it.

**Ms LOVELL** - Thank you. With the funding allocation for mental health service reviews including the CAMHS review, what's the breakdown of that funding between those reviews?

**Mr ROCKLIFF** - Of the CAMHS review implementation?

**Ms LOVELL** - You have $12.5 million each year.

**Mr ROCKLIFF** - The total CAMHS investment is around $41.5 million. Then an additional $8 million or thereabouts - I think it takes it to just over $50 million - will be to support the statewide implementation of Mental Health Integration services. That comes from the southern Mental Health Integration services report, which from memory was completed around August 2019. That report, while focused in the south, found the integration needs had been spread throughout the state, and those reforms will be supported by that $8 million in that line item, with about $41.5 million to CAMHS reforms.

**Ms WEBB** - I have a question on the Rethink 2020 mental health strategy, the fact that it identified three population groups as being at greater risk of mental health issues, including LGBTIQ+ people in Tasmania. Noting that the Government has boosted the funding provided to Working It Out for school inclusion and for the LGBTIQ+ grants program, I wonder if there is still a mental health gap there.

With the Rethink 2020 strategy, given the identification of that group as at risk, what impact do you expect the strategy will have on LGBTIQ+ Tasmanians and their mental health, and how will you measure its impact?

**Mr ROCKLIFF** - I hope it has a positive impact.

**Ms WEBB** - Yes, it is what you hope, but what do you expect?

**Mr ROCKLIFF** - I expect it will have a positive impact. I have had discussions with the LGBTIQ+ community about the impact of COVID-19, and they have advocated to me the need for special mental health supports. With my former education minister hat on, Working It Out is certainly well resourced across our schools. They could probably say they need more, but we are progressing key actions to improve health outcomes for the LGBTIQ+ community. We do have an active LGBTIQ+ reference group, which includes membership across the department, the non-government sector and community representatives.

One area of work responds to legislative changes to the Justice and Related Legislation, (Marriage and Gender Amendments Acts) 2019, so a dedicated resource within health ICT has been secured to support the planned activities under the sex and gender reform project for the next 12 months.

An LGBTIQ+ learning system for all Department of Health staff is under development, and this includes an online introductory module and internet page. The voices of community members feature strongly in these resources, and they will be released before the end of the year.

Through the Department of Health, the Government provides funding to a number of organisations which provide services to the LGBTIQ+ community and advice on LGBTIQ+ matters, including Working It Out, the Tasmanian Council on AIDS, Hepatitis and Related Diseases (TasCAHRD) and Women's Health Tasmania.

Through the Healthy Tasmania Fund round two grant program, Working it Out has also been funded to expand their peer support project, Working it Out Together, which was set up in response to the COVID-19, as I mentioned before.

Recent research such as the Private Lives 3 report informs the work of the department. These findings highlight the ongoing health needs for members of the LGBTIQ+ community, particularly supporting their mental health and wellbeing, and making health services more inclusive.

In line with Reform Direction 3, for reducing stigma, and Reform Direction 7, responding to the needs of specific population groups of the Rethink 2020 plan, the department will be working with LGBTIQ+ Tasmanians to reduce stigma and to ensure that they can access the mental health support they need and when they need it. The Department will also work with the LGBTIQ+ community to understand the gaps, needs and issues within the current mental health system specific to the LGBTIQ+ community. We have also partnered with the LGBTIQ+ community to determine and implement actions to ensure Tasmania's mental health system, at all levels, understands and provides care to meet the specific needs of the community.

PESRAC identified and acknowledged the impact of COVID-19 on the LGBTIQ+ community in their interim report.

**Ms WEBB** - Although there were no recommendations particularly relating to that, I don't believe.

**Mr ROCKLIFF** - Although the group was not named in the final report, the Department of Health acknowledges the impact and concerns of community members.

I have just detailed some very proactive responses there.

**Ms WEBB** - Thank you for that, Minister. I congratulate you on that list of activities that are being undertaken and efforts in that space. They sound very positive. But my question to you was, how will you be measuring the the impact and outcomes in terms of the mental health of our LGBTIQ+ community in Tasmania from the Rethink 2020 strategy? How will we know if it has supported and improved the mental health of that group of people in our community?

**Mr ROCKLIFF** - We intend to host a facilitated consultation with the LGBTIQ+ reference group as soon as possible following the release of the implementation plan. The outcomes of this consultation will further inform the implementation plan, which, as I say, will be updated annually.

**Ms WEBB** - Will you be working with that group on an evaluation of impact and outcomes of the plan?

**Mr ROCKLIFF** - I'm sure that will come up in the facilitated discussion. I attend the reference group; and I have attended a number of working groups in this space, as Minister for Education and indeed with my Communities Tasmania hat on as well.

**Ms WEBB** - No doubt that group will advocate for an evaluation to be able to measure the outcome and impact then.

**Mr WEBSTER -** The basis of Rethink 2020 and the implementation plan, and the reason for the yearly review, is to have an ongoing evidence base developed over time. The evaluation is built in to how we are rolling out Rethink. You're right, we need to work with the community on what that looks like. But really the Private Lives report almost becomes a base line that Rethink is based on, for LGBTIQ+ community and we build from there. The idea of looking at it on a yearly basis is to make sure that we are building the evidence base, and that what we are implementing is also based on that evidence base.

**Ms WEBB** - As long as that is an outcome-focussed evidence base that's fantastic, not just an activity-based measurement.

**Mr DUIGAN** - Minister, the alcohol and drug community service organisations do a great and important job across the state. Can you please detail what the Government is providing for the CSOs in this sector?

**Mr ROCKLIFF** - I touched on this in my opening statement. I thank all those who work within the sector and the challenges that they have had to face over the past year dealing with the impact of the pandemic. In the Budget, we announced an investment of $10 million into alcohol and drug treatment services. We acknowledge we need to do more. We released our 10-year reform agenda for the alcohol and other drug sector in Tasmania last year, with a $4.9 million commitment over two years to ensure we provide timely support and treatment for those impacted by alcohol, tobacco and drug use.

As part of our $10 million investment this year we are providing $7.5 million dollars over two years for the Salvation Army, City Mission and Velocity Transformations to deliver 65 residential rehabilitation beds across the state for those seeking to detox and receive counselling and education. This year's budget also provides $450 000 over three years for the Alcohol, Tobacco and other Drugs Council to employ a fixed-term project officer. This position will support the rollout of the Government's reform agenda for the alcohol and drugs sector in Tasmania and increase the capacity of the ATDC to establish a consumer representative body. The Government is also providing $225 000 to the Drug Education Network over one year, to address the ongoing impacts of the pandemic and the increased demand for resources and education in the alcohol and drug sector and the wider community.

I've also allocated $930 000 over two years for the Alcohol and Drug Foundation's Good Sports program. This is a program that's growing in popularity across the state. It enables grassroots work on drugs and alcohol with local supporting clubs. This is important work, as it helps to improve education, encourage healthy habits and to look out for your mates.

The Tasmanian Government is also providing increased funding of $600 000 over two years to our good friends at Holyoake for the Gottawanna program. This program delivers counselling and support for individuals dealing with alcohol, drug and other addictions. The program is designed to help the individuals recognise and accept responsibilities in life, explore the range of choices that they have and take back control of their life. I know it can be a life-changing program.

Finally, Chair, we've committed a total of $400 000 over two years for the Salvation Army Street Teams. The Street Teams operate on Friday and Saturday nights providing support and help to those out on the town. This is a great service that also helps to alleviate unnecessary pressure on Tasmania Police and visits to our hospitals.

I also thank the engagement I've had with Alison from the ATDC and the work that all the community representatives do in this very important sector.

**CHAIR** - What are the medical and nursing staff vacancies across your acute and community mental health sector?

**Mr ROCKLIFF** - In Mental Health South, the vacant nursing FTE is 24.5; in allied health it is 7.5 FTE; in medical it is 10.5FTE. In CAMHS South, the vacant nursing FTE is 0.8 FTE; in allied health it is 2.5 FTE; in medical it is 2.0 FTE. In Mental Health North, the vacant nursing FTE is 6; in allied health it is 4.7 FTE; in medical it is 3.5 FTE. In CAMHS North the vacant FTE in allied health and medical is zero, respectively.

**CHAIR** - Do you have nurses in the north in the CAMHS?

**Mr ROCKLIFF** - Not listed here. In Mental Health North-West, the vacant nursing FTE is 2.82; in allied health it is 5.28 FTE; and in medical it is 5.0 FTE. In many of these areas, recruitment is underway or ongoing. In CAMHS North-West, the vacant nursing FTE is 0.4 and in medical it is zero.

**CHAIR** - Clearly, there's a bit of a problem in the south with of a lot of vacancies across all sectors. There are issues right across the state but it seems to be fairly significant there.

What measures are you taking to try and attract the necessary staff to ensure that you can have a stable service? The next question is what's the leave liability like in this sector?

**Mr ROCKLIFF** - We'll access that leave liability information for you. Dale?

**Mr WEBSTER** - I would comment that whilst they're vacant in terms of the State Service Act they may actually be filled by locums or by agency nurses to make sure that we've got a safe staffing level in particular areas. We have set up a workforce development unit within Statewide Mental Health Services and recently appointed someone to the role of Director of Workforce Development.

Their role is to fill immediate vacancies but also to look at the long term. We're advertising using different techniques, using search companies, online videos and Facebook, social media, all of those modern ways of advertising. We're trying to actually increase our penetration across the area. Internally, we're taking on transition to practice nurses, Australia's graduates and then training them through mental health programs as well so they can gain their post-graduate.

We've got some immediate things that we're doing in advertising, some short-to-medium-term strategies in developing people inhouse and we've also got some longer term things in terms of a strategy. We're also working with universities to increase the number of graduates in these spaces. The other thing is that building the reforms and changing the reputation of mental health services is also really important so that we become an employer of choice, an attractive employer for people coming into the state. All of those things are underway but they actually have a short, medium and long-term life to them.

**Mr ROCKLIFF** - To provide some context, Chair, in the FTEs for Mental Health Services from 2017 to 2020-21 in the three regions: mental health services in the north in 2017-18 was 100.64 FTE now 107.14; mental health north-west 105.18 in 2017-18 now 107.71; mental health south 381.63 now 411.18. A total of mental health services now 626.03 FTE from 587.45 in 2017-18. Now, on call roster changes in the south -

**Mr WEBSTER** - Part of retaining our staff is to actually make sure that we've got arrangements in place that make it easier for them to do their job. One of the issues in the south is the on-call roster, which has to go beyond the hospitals. You've got community psychiatrists and things like that and as you would appreciate with mental health issues, that on-call can be more than just a phone call to give advice to a registrar. It quite often has people coming in to the hospital, so effectively it becomes the second shift, if you like.

The first thing we've done is to extend the on-call roster to include locums. If you take a locum position in southern Tasmania you become part of that on-call roster. The second part is working with our individual psychiatrists about how we can change it into more of a team activity, if you like, so that we have that greater rotation, greater knowledge of the patients that are the inpatients and those sorts of things. We have that work underway; we commenced that over the last few weeks with our psychiatrists in the south.

**CHAIR** - The leave liability over the last few years, is it increasing?

**Mr ROCKLIFF** - We might have to take that on notice. So, it's health generally but we don't have the mental health split, but we're happy to take that on notice.

**Mr WEBSTER** - Regarding the recruitment task, the focus on vacancies is just in our cam space. We will need an additional 20 staff in year one to meet our reform processes. Our recruitment task is not just filling vacancies, it's growing our workforce.

**CHAIR** - Are you able to provide the breakdown in the leave liability? You gave us the headline things, didn't you?

**Mr ROCKLIFF** - Yes.

**CHAIR** - If you are able to provide the leave liability over the last three years for Statewide Mental Health Services.

**Mr WEBSTER** - Part of the reason we don't have it is that we split it by award. That's why were able to give you paramedic figures, so that may be a difficult figure to do, given we are doing it by awards.

**CHAIR** - If you can't provide that level of detail you might like to respond in that form.

Dale mentioned that some of these vacancies are covered by locums. Have you got the cost of locums over the past two years in Statewide Mental Health Services and medical locums and agency nursing costs?

**Mr ROCKLIFF** - In 2017-18, $9 490 798. In 2020-21 the cost of locums $9 381 069.

**CHAIR** - And agency nurses, have you got those also?

**Mr ROCKLIFF** - No. I am initially advised we don't have agency nurses. We have an overall agency nurse figure but we will see if we can break it down and provide information at a later time.

**CHAIR** - Regarding the medical locums, can you break those down by region?

**Mr ROCKLIFF** - No, not for mental health.

**CHAIR** - In the north-west it's much harder to get permanent staff in mental health.

**Ms MORGAN-WICKS** - We have medical locum costs by service. So, each of the four hospitals plus mental health. We would have to look into breaking down the mental health component into each region.

**CHAIR** - The headline figure was for medicals?

**Ms MORGAN-WICKS** - For Statewide Mental Health Services or medical locums.

**Mr ROCKLIFF** - Medical locums cost by service, Mental Health.

**CHAIR** - Do you have in broken down by region?

**Mr ROCKLIFF** - Not mental health.

**CHAIR** - If you could breakdown those locum costs in mental health services by region.

**Ms WEBB** - I am intrigued. Looking on page 154 the Housing and Accommodation Support Initiatives (HASI), is listed on page 154 under the heading Other Initiatives. It is in the table on page 142. I note that the description on page 154 says that this is additional funding provided over four years commencing this year for HASI and then it builds on the $1 million provided for a trial period that commenced in 2018-19. I'm going to preface this by saying I think this is a great model. I'm support the fact that we're putting this model in place but I think this has been a slippery bit of funding around this program. My memory of it is that when it was initially funded in 2018-19 there was funding provided across two departments - Health and Human Services.

When we looked at it in 2019-20 it had all been shifted to Health and it was unclear at that time what had been spent in 2018-19. It looked like funding was going to begin to be spent in 2019-20. If that was the case and the trial period was actually 2019-20 and 2020-21 and here we are in 2021-22 with new funding post-trial to begin a four-year investment, could you confirm that funding for this program began effectively in 2019-20, had a period of two years that was the trial period initially funded with $1 million, and now we're beginning this four-year post-trial funding?

**Mr ROCKLIFF** - My understanding is - and I will throw to Dale shortly - there was a two-year trial which was evaluated.

**Ms WEBB** - Right. That was going to be another question I had.

**Mr ROCKLIFF** - That evaluation was positive and supported the continuation of the HASI program over the forward Estimates.

**Ms WEBB** - Presumably at the same scope and size that it was funded for under the trial, it would look like, under the allocation.

**Mr ROCKLIFF** - The allocation, yes.

**Ms WEBB** - Again, yes, that's how I interpret this. I'm interested to know when the two-year trial occurred. Was it from 2018-19 or was it from 2019-20?

**Mr ROCKLIFF** - Dale?

**Mr WEBSTER -** From the evaluation report I believe that it started in 2019.

**Ms WEBB** - Once all the funding had been consolidated into the Health department rather than straddling the two departments?

**Mr WEBSTER -** Some of the preparatory work happened, but the trial started in 2019. You're right, yes.

**Ms WEBB** - Yes, I thought so. There was never a gap then between the trial and the funding from this year to continue as a permanent program?

**Mr ROCKLIFF** - No gap?

**Ms WEBB** - No gap.

**Mr ROCKLIFF** - No, my understanding is there was no gap of continuation.

**Ms WEBB** - Thank you. It's good to clarify how that played out in the end. Given that you said that the trial was positive, it's a very robust model, will you consider, if it continues to demonstrate those positive outcomes that presumably it did in the trial, expanding the program. It's very limited in its focus at the moment. Is consideration being given to expanding that to achieve better outcomes with more?

**Mr ROCKLIFF** - It's been good that it has been evaluated positively initially and 28 clients have been supported throughout the two-year pilot program, demonstrating both the need and the success of the program. Consumers are supported to transition to other services and supports when they exit HASI which may include access to the National Disability Insurance Scheme where appropriate. We're funding it continually now because it has worked.

**Ms WEBB** - And it still would just cover the southern region then?

**Mr ROCKLIFF** - It's in the south with a Colony 47 partnership.

**Ms WEBB** - It's not offered in other regions of the state under this new funding across the forward Estimates? It's still focused in the south?

**Mr ROCKLIFF** - Yes.

**Ms WEBB** - There's an opportunity there for other regions to seek some investment.

**Mr ROCKLIFF** - Potentially, yes.

**Table 5.8**
**Revenue from Appropriation by Output**

**Output Group 90 - COVID-19 Response and Recovery**
**90.4 Mental Health Program**

**Ms WEBB** - It looks like these next two output groups have both finished being funded with the COVID-19 money that was provided to them in the 2020-21 financial year because they're not funded in this Budget or across the forward Estimates.

But I presume the efforts might be continued under things that have been put in to different line items.

**Mr ROCKLIFF** - I have detailed some COVID-19 initiatives previously -

**Ms WEBB** - You have a new thing funded called COVID-19 Continued Mental Health Services which might be building on this.

**Mr ROCKLIFF** - Dale, can you confirm that?

**Mr WEBSTER** - That's right. It's moved in the document.

**Ms WEBB** - It's moved, so it is no longer in a specific line item. I presume for this next one, 90.8 Community Mental Health Support, that also is not in this Budget but perhaps has been continued over into the Community Mental Health Addressing Increasing Demand item that is funded elsewhere in this Budget?

**Mr WEBSTER** - Yes. Some of the services will continue. One of the main ones there is the Tasmanian Health Lifeline, which was a major initiative under those two.

**Ms WEBB** - And where is the funding for that?

**Mr ROCKLIFF** - A Tasmanian Lifeline?

**Ms WEBB** - Yes. Which line item is that now in?

**Mr ROCKLIFF** - Output 1.2 - System Management, Mental Health and Wellbeing.

**CHAIR** - Any other questions on either of those two? Capital Investment Program? We have covered quite a bit of this but Shane is still at the table if anyone has anything else in relation to this. Thank you minister and your Health team

**Mr ROCKLIFF** - Yes, thank you to our Health team. I very much appreciate the work and dedication to their task.

**CHAIR** - They are allowed to go but you are not. We will take a five-minute break.

**The Committee suspended at 5.42 p.m.**

**The Committee recommenced at 5.54 p.m.**

**CHAIR -** The Minister of Advanced Manufacturing and Defence Industries. I will ask you to invite your members at the table.

**DIVISION 11**
**Department of State Growth**

**Advanced Manufacturing and Defence Industries**

**Mr ROCKLIFF -** I would like to introduce Mark Bowles, Deputy Secretary and Retired Rear Admiral Steven Gilmore who is our Defence Advocate. I have an opening statement which as there is a lot happening in this area is reasonably lengthy, but I might try and slim it down a bit in the interests of time.

**Ms WEBB** - I have a series of questions which might draw things out.

**Mr ROCKLIFF** - Very good. Pleased to be here with the Advanced Manufacturing and Defence Industries hat on. Since we began our renewed focus on growing our advanced

manufacturing capability and encouraging Tasmanian businesses to explore the opportunities in defence supply we have seen significant success in these sectors.

Since 2016 release of both the Tasmania Advanced Manufacturing Action plan, our initial defence industry strategy we've seen manufacturing turnover rise to more than $7.3 billion a year directly employing some 18 000 Tasmanians and supporting more than 31 400 indirect jobs across the supply chain and support sectors.

We should also be proud beyond that economic activity; these sectors are generating these businesses and organisations continue to contribute to our national and international defence effort.

I am pleased to advise the committee the Tasmanian defence industry companies secured around 40 defence and national security supply contracts in 2020-21 with a total value in excess of $23 million.

The contribution of defence and national security work in Tasmania alone is estimated at well over $200 million a year and an estimated direct employment of over 1300 people.

With a projected Australian defence investment of $270 billion on the table over the next decade and with world-wide allied defence spending at trillions of dollars, this is an aspect of our manufacturing sector we know we can grow further.

Our defence advocate, the retired Rear Admiral Steve Gilmore continues to support and the guide the implementation of the Tasmanian Defence Industry strategy. Steve has played a pivotal role in delivery of outcomes for our defence industry, including millions of dollars worth of new contracts.

We have committed some $900 000 in the recent State Budget to support the Tasmanian defence advocate to continue to work with the Tasmanian manufacturing businesses for another three-year term. His role incorporates strategic maritime advice and national security matters. This has proven pivotal during the visit to the state by senior US coastguard delegation to understand Hobart's Antarctic gateway status.

Steve has also conducted 20 familiarisation tours for senior defence members and primes across the state and has continued to lead engagement outside Tasmania with industry led events including Land Forces 2021 international expedition in Brisbane.

He has assisted many Tasmanian businesses to navigate the complex defence sector and it is complex and to identify opportunities suited to Tasmania's niche industry capabilities. We can say with confidence he had a key role in growing a number of significant outcomes, including with two companies that have not had defence contracts before and who are now a preferred tenderer status for opportunities worth over $40 million.

Advanced manufacturing continues to be one of our bedrock industries coming in at number five on top of our top exporting industries and we will continue to be strong supporters of the sector.

Through this year's Budget we have committed an additional $10 million to support companies to collaborate, innovate, commercialise and scale up to create jobs and further

opportunities for Tasmanian businesses. All this effort across Government, but especially by manufacturing industries business and workforce both build on and add to the Tasmanian reputation on quality.

Whereas that reputation was once largely valued across our food and beverage exports, the world is now taking notice of us for what we can do with innovative ideas, cutting edge products and world class manufacturing solutions.

Thank you Chair.

**Ms WEBB** - I am not overly familiar with this area, so I hope the questions are going to be fairly relevant.

Minister, in the media release from 2 August and also just now you have talked about the fact you have committed to supporting our advanced manufacturers to grow and thrive and you have announced $10 million to the sector over the next three years in this Budget.

In the Budget papers on page 327 in the key deliverables statement, the two things I see there that I think are relevant are the Advanced Manufacturing Accelerating Growth Grants of $3 million over two years and the Advanced Manufacturing Action Plan which is $5 million over three years. That adds up to $8 million. In terms of the $10 million commitment where are the other two- and which-line item or deliverable am I looking to for that?

**Mr ROCKLIFF** - We have the Tasmanian defence advocate included in the $10 million as I advised. The Tasmanian Minerals Manufacturing Energy Council Industry advancement.

**Ms WEBB** - Can you tell me those allocations?

**Mr ROCKLIFF** - Defence Advocate over the next three years is $300 000 a year in terms of the support and the Defence Advocate, that position. That is the $900 000 I spoke of in the opening statement. The Tasmanian Minerals Manufacturing Energy Council Industry advancement is $500 000 over the next three year, $200 000, $150 000 and $150 000. The Tender Incentive Grant Program is $600 000 in total, which is $300 000 each year.

**Ms WEBB** - What was that grant program again, sorry?

**Mr ROCKLIFF** - The Tender Incentive Grant Program.

**Ms WEBB** - Thank you, thanks for the clarity. I was not sure where to look for all the different threads. In terms of the Tasmanian Defence Advocate, it was mentioned in the Budget papers here on page 338. It is listed there in the big long listing of department of election commitments. I wanted to check, given the defence advocate has been in existence prior to now, the election commitment was not to establish the advocate, it was to continue the advocate. Is it continued at the same level it was previously? Have you done something additional? Have you just continued that function and that role?

**Mr BOWLES -** The office effectively was established three years ago for a fixed term. This continues that over the forward estimates.

**Ms WEBB** - And that $300 000 a year is for the position, the salary and operational -

**Mr BOWLES -** And support, yes.

**Ms WEBB -** Okay, thank you. Another question on the resource regarding Advanced Manufacturing and Defence Industries unit, which is drive the implementation of the Tasmanian Defence Industry Strategy 2023, is the staffing allocation and resourcing of that unit included in some of these amounts we have already discussed, or is that something separate and further?

**Mr BOWLES -** The standing operational costs for the unit sit with output 1.2. That is embedded in that large number.

**Ms WEBB -** The industry and business development, 1.2?

**Mr BOWLES -** That is right, they are within industry and business development.

**CHAIR -** We have three minutes in this line item.

**Ms WEBB -** What is the allocation for the function of the unit, the Advanced Manufacturing and Defence Industries unit within that line item total amount?

**Mr BOWLES -** Salary and operations is $2.4 million for 2021-22 and $2.2, $2.2.

**Ms WEBB** - Looking back at the previous two financial years, what would those amounts have been for that same unit?

**Mr BOWLES -** That amount has remained stable.

**Ms WEBB** - The 2021-22 amount was $2.4, okay, thank you. Minister, that Tasmanian Defence Industry Strategy 2023 was released in 2018 and it states, on page 24, that the Advanced Mmanufacturing and Defence Industries unit is to report on the strategies, actions and outcomes progress annually, and the strategy will be reviewed mid-term in 2020. Can you provide an update regarding both the unit's annual progress review that is required and that 2020 strategy review? What did they assess? Who is involved in those reviews? What were the outcomes of them? Are they also available perhaps, in the public domain in any sense, or a report of them?

**Mr ROCKLIFF** - In terms of the reviews themselves?

**Ms WEBB** - Yes, particularly that 2020 mid-term review, but even the annual reports.

**Mr ROCKLIFF** - In 2020-21, we committed $750 000 to the Tasmanian Defence Industry Strategy 2023. This commitment supports a broad range of actions that are proactively supporting Tasmanian defence industry companies in the continued pursuit of key defence opportunities. In the year leading into the COVID-19 pandemic, an independent report was commissioned by the Department of State Growth, through SGS Economics, to understand whether our initiatives under the Tasmanian Defence Industry Strategy were working. This report revealed that the total combined value of defence and national security directly and indirectly in Tasmania was estimated at $211.8 million per annum, as at 2018-19, with an estimated direct employment of over 1300 people.

While comparatively only a small proportion of defence activity, compared to the total Australian Government projected $270 billion defence investment spent over the next decade and the worldwide allied defence spending of trillions of dollars, this is still a significant contribution by our industry. And it is continuing to grow.

In 2020-21, we understand the defence industry companies were awarded over 39 defence and national security supply, in total value in excess of $23 million. Any further on the SGS report, Mark?

**Mr BOWLES -** Subject to final consultation with stakeholders we will be in a position to release the report on the economic value of the Tasmanian defence national security sector.

**Ms WEBB** - Is that the mid-term review that was supposed to be appearing in 2020?

**Mr BOWLES -** That in effect reviews the outcomes of the first defence strategy and forms the baseline for the new defence strategy.

**Ms WEBB** - The strategy released in 2018 the Tasmanian Defence Industry Strategy 2023, required annual progress reports and a mid-term review in 2020. Did the progress reports the mid-term review happen or not?

**Mr GILMORE -** What we decided to do after putting that in the strategy, is to review it more frequently and set up an organisation or an entity that would take that review. That is the Defence Industry Advisory Committee, which is chaired by the secretary of the department. It includes a number of industry leaders, the vice-chancellor of the university and the principal of the maritime college. So, a range of senior leaders across defence industry and organisations, including academia. I provide an update to them against the strategy's initiatives every six months, or more frequently, depending on how often we bring that committee together. But it's at least every six months.

**Ms WEBB** - That committee, as an entity, does that exist in connection with the unit? Is it resourced and provided with secretariat within that $2.4 million allocation for the unit?

**Mr BOWLES -** Yes, the advisory committee are all members from industry so they volunteer their time to sit on the committee and the secretariat are members of the Advanced Manufacturing and Defence Unit.

**Ms WEBB** - Does the committee have a governance function or are they a reference group essentially?

**Mr GILMORE -** It is an advisory committee to ensure that our unit shapes its actions against the strategy. That is how I deliver my six-monthly or quarterly -.

**Ms WEBB** - Given that they are not a governance unit, which is not to dispute their value in the role they have, in terms of reporting and the intention from that initial strategy to report annually and to do a mid-term review, where is that transparent and open and accountable in a more public sense, rather than just as information to your advisory group? Is there a public way that we access annual progress reports or some form of that mid-term review that has obviously pivoted the direction, to some degree, of the work? It's not because I'm suspicious

of anything going awry. It sounds like it's a very positive space. I'm interested in the accountability and the public visibility around the activity.

**Mr BOWLES** - The Defence Advocate's right. That committee, DIAC, the Defence Industry Advisory Committee, provides advice but we also do report on outcomes of the activities that we're pursuing. That is a way of reporting to the secretary of the agency, the activities and the unit.

**Ms WEBB** - Does that then become public and visible in some way that can then be scrutinised or accountable, potentially, to the public or to the parliament?

**CHAIR** - Is it in any report, for example?

**Mr BOWLES** - The Department of State Growth does have its annual report and it reports key deliverables under all of its portfolio outcomes.

**Ms WEBB** - So it would include specific information about the activities and outcomes from this unit?

**Mr BOWLES** - Yes.

**Ms WEBB** - Could I go in and see in terms of -

**CHAIR** - I think we'll be able to go and check.

**Ms WEBB** - We will, I guess. When you say 'in aggregate' does that mean I won't be able to see it clearly that this unit and then some reporting on activity or outcomes?

**Mr BOWLES** - There'll be some commentary.

**Ms WEBB** - Let's move on from that then, thank you.

Regarding the advanced manufacturing and defence grants programs, either those completed or open, because I think there's one currently open, for applicants for Advanced Manufacturing Accelerating Growth Program, I note that the guidelines in relation to the grants programs tend to include the proviso, warning prospective applicants that the department may be required to disclose financial assistance provided as an accountability measure for the distribution of the public funds. Minister, are you able to detail the total number of successful advanced manufacturing and defence grants issued since the portfolio was created or point me to where I might find that?

And, of the total that have been issued, the number of successful applicants that have been publicly disclosed, or perhaps there have been some who have sought to remain confidential?

**Mr ROCKLIFF** - The first four-year Advanced Manufacturing Action Plan concluded in 2020: $51 million in increased sales through the program support, $9.6 million in grants, leveraged $36.7 million private investment - there is $3.81 invested for every grant dollar.

Mark, do you have further information in terms of breaking that down?

**Mr BOWLES** - In terms of the grants that have been announced in the Budget, they are all currently open. There are five grant programs open but we haven't issued any grants at the moment because the closure date hasn't concluded.

**Ms WEBB** - In terms of previously issued grant rounds, there's public visibility around where those grants have been allocated?

**Mr BOWLES** - The department does release grant details above a certain threshold but I don't have the value number with me. From time to time, it does release information on those grants but it's above a certain threshold.

**Ms WEBB** - It's not put into the public domain in some form as a matter of course? It would have to be sought?

**Mr BOWLES** - Above a threshold, it is disclosed.

**Ms WEBB** - Minister, in terms of Tasmania Defence Industry Strategy outcomes, one of the specified outcomes was 'identify and secure new research and investment opportunities in space activities', and details as an action working closely with the Australian Space Agency. That's section 6, page 20. Can you detail any Tasmanian contracts and/or involvement with the space agency or other space activities?

**Mr ROCKLIFF** - Yes, we can. Steve, I might throw to you in respect of that matter.

**Mr GILMORE** - The Tasmanian Government has signed an MOU with the Australian Space Agency to grow that sector, to take the capabilities that we have resident here to make our contribution to the national effort. That has already identified a couple of key areas which are being grown. One is our great expertise in remote and maritime medicine. The Centre for Antarctic, Remote and Maritime Medicine (CARMM), is making that contribution, growing its capacity to work in the space domain.

A contemporary example of where we've been focussed is the opening of the office of Hensoldt Defence Australia, which is a major global company with an Australian corporate footprint in Canberra. Part of the global company's expertise is space and space domain awareness. It uses various sensors and systems to fuse date and information to create a picture of what's out there in space, particularly near space. That is very important to the Australian Space Agency and the Department of Defence.

The UTAS has a very impressive and highly-capable network of arrays that are located within the state and also on the mainland, which network to provide a range of activities, mostly in the research space, but are now working in partnership with Hensoldt, that has relocated a portion of its company in Hobart. The university and the Tasmanian Government have formed this Southern Guardian Space Domain Awareness System. It's harnessing an amazing amount of capability that is resident in Tasmania. In Tasmania through Hensoldt it will reach back to the parent company and provide an enormous capability advantage in the commercial space, but particularly in a major defence project which will be announced next year. That's a very significant contribution this state will make.

**Ms WEBB** - That's really interesting to hear about, thank you. It wasn't something I was aware of before.

**CHAIR** - I'm interested how this area in your portfolio in this regard, minister, intersects with the Coordinator-General. Or doesn't it? You're completely separate. It seems that there's very similar expectations and deliverables.

**Mr ROCKLIFF** - This is specific to the defence industry. My responsibilities include advanced manufacturing as well. The defence advocate takes the lead on engagement with primes and other large defence players.

**Mr BOWLES -** There is ongoing collaboration between this unit, as with all other parts of State Growth, and the Coordinator-General's office. The Coordinator-General would be involved in the attraction of new advanced manufacturing enterprises. He would lead inward investment. Where there's a particular defence angle, because of the defence advocate's specific expertise, then Steve would take the lead working with John Perry.

**CHAIR** - I come back to this cross-over. It seems like there's potentially unnecessary duplication. Is the Advanced Manufacturing Action Plan your responsibility?

**Mr ROCKLIFF** - It is.

**CHAIR** - So, it says Government will support the implementation of the Advanced Management Action Plan, including developing and attracting highly-skilled workforce; supporting the adoption of leading edge design and technologies; and supporting a greater market identification and access, and industry promotion.

I thought that was what the Coordinator-General was doing?

**Mr ROCKLIFF** - More broadly.

**Mr BOWLES -** In terms of workforce, that's also Skills Tasmania. That's a State Growth enterprise. That's a collaborative effort between Skills Tasmania and advanced manufacturing.

**CHAIR** - It's a lot of money going into a hole in the CG's office. It seems to be your group's doing this, he's doing that, Skills are doing aspects of it. It seems to be lots of people doing the same thing or very similar things feeding into the same thing.

**Mr ROCKLIFF** - Indeed it may be.

**CHAIR** - Defence is specialised. I accept that but it's the other aspects of that. I'd reluctantly call them 'lower level', it's not meant to be a lesser aspect but it seems there is a lot of duplication here.

**Mr ROCKLIFF** - I am not sure about duplication. This portfolio responsibility was borne out of the challenges with Caterpillar centralising its operations from Burnie to Rayong in Thailand. They announced that in April 2015. That was at a loss of 280 direct jobs not counting the industries around it that supported Caterpillar/Elphinstone. As a result of that

there was a particular focus in the need to not only built up our advanced manufacturing base but also support it and promote it.

**CHAIR** - We have and we've done a great job at the north west particularly.

**Mr ROCKLIFF** - I remember chairing the Caterpillar Transition Task Force back in those times. A lot of these actions we're still doing, including an advanced manufacturing plan, grant programs to support innovative business, promotion of the advanced manufacturing industry, were borne of that transition task force. The task force was so successful that we ended up created more jobs than we lost at the time, from memory.

**CHAIR** - I'm not disputing that, minister, what I'm saying is that work seems to have been done by this portfolio area and I'm not sure whether there is even a role for the Coordinator-General in any of this. It seems that there was some duplication.

**Mr ROCKLIFF** - The collaboration across government is always important, despite the particular focus of the defence advocate and the particular focus that we might have in terms of the advanced manufacturing.

The Tasmanian Minerals and Energy Council deal also with us directly and the Advanced Manufacturing Centre of Excellence was borne from the Caterpillar transition task force. As distinct from my responsibilities in defence, industry, and advanced manufacturing, the Office of the Coordinator-General is Tasmania's principal entity to attract and support investment right across the state. That would include some collaboration and work within the sphere that we're involved in. I don't necessarily see it as duplication, given the broad responsibility the Coordinator-General has.

**Mr GILMORE** - How I understand the differentiation is that the Coordinator-General is cross-sector and scale-focused. What I've been doing in the Defence Industry area is growing, shaping, mentoring, moulding and encouraging our existing companies to position and participate in the national defence industry arena. I think we've been doing okay.

I might see something that might have a defence outcome but is much more cross-sector. An example is maritime sustainment capability. It's not just defence, it is broader than that. It would involve a number of sectors.

That is an example of a discussion I have had with the Coordinator-General in the last year or two, to talk through how we could do that. That is how I see it, if that is of any help.

**CHAIR** - Maybe it's the appointment of so many ministers in this area.

**Mr GAFFNEY -** I hear what you are saying, Ruth. There was a time we were worried about individual silos leading. In this, it is the cross-collaboration.

**CHAIR** - There is also the risk of size when you have got three ministers. I am trying to look at how it works, because there is a potential for that.

**Mr DUIGAN** - I agree, it is an exciting sector with a lot of opportunity. I was at a function the other evening, Science Meets Parliament, speaking to people involved in space

research and high-level defence, and they were very bullish about Tasmania and the opportunities that exist here.

Minister, my question is, what is being done to promote Tasmania's advanced manufacturing defence industry sector?

**Mr ROCKLIFF** - In 2020-21 we have seen a further increase in the number of Tasmanian companies becoming actively involved in the defence tenders, with two of these companies now having preferred tender status with contracts worth in excess of $40 million.

Under the Defence Industry Strategy 2020-24, seven key initiatives have been identified. The first initiative was to increase the visibility, awareness and reputation of a Tasmanian defence capability across all sectors. This includes creating a greater awareness of the Tasmanian industry capabilities, and promoting their world-class credentials to major defence contractors and key stakeholders.

In June, one of Tasmania's largest contingents of defence businesses showcased their capabilities, products and services at LAND FORCES 2021, the biggest international industry exposition to showcase land-based military equipment, technology and services in the Asia-Pacific region in Brisbane. There, 31 senior representatives of 16 companies, along with Tasmania's manufacturing council, the TMEC, joined the Tasmanian contingent to promote Tasmanian expertise, know-how and products to some of the biggest armies, navies, air forces and defence contractors in the world.

I commend our Defence Advocate, who has continued to steer the way for our defence companies and has been instrumental in changing the story of defence industry activity in Tasmania, while also building confidence within the industry, as well as the advanced manufacturing sector. I mentioned the 20 familiarisation tours conducted.

We are well underway with our maritime brand campaign, which has been developed in consultation with, and complementary to, State Growth's trade marketing team. Components of the maritime brand campaign include the VR tours of eight ship builders and maritime companies, and three maritime prospectuses developed for Indonesian commercial maritime and defence maritime sectors.

The highly successful Defence Tasmania Industry Directory continues to be updated with new businesses looking to get into the defence supply chain, including companies such as globally recognised technologies solutions INSolve, who have recently opened a new office in Hobart, looking to embrace the space and defence opportunities the state has to offer.

We have had double-page articles in every issue of the *Australian Defence Magazine* since October last year, which has received excellent feedback. In the online domain, we have had monthly articles in Defence Connect since late 2020, and have a good social media presence across mediums such as LinkedIn.

The promotional work is already getting attention. I have been delighted to welcome several interstate delegations keen to explore the world-class capability of the sector, and trade activities are critical in supporting Tasmanian defence and maritime businesses to compete on the world stage. We are committed to empowering our world-class manufacturers to take their products and services to the world also. Thank you for the question.

**Mr GILMORE** - Just to finish off that answer. The proof is always in the pudding. The winners of the Australian Defence Industry Awards will be announced shortly, but in the finalists for the defence academic of the year there's a UTAS staff member; defence consulting company of the year is AMC Search; export business of the year, Pivot Maritime; small to medium enterprise of the year is AMC Search; and a start-up defence company of the year is Fortifyedge down here. So, I think it adds to what the minister said. We're getting out there and being known.

**The Committee suspended from 6.31 p.m.**

**The Committee recommenced at 6.33 p.m.**

**DIVISION 2**
(Communities Tasmania)

**Community Services and Development**

**CHAIR** - Minister, I'll invite you to introduce the people at your table and then make an opening statement.

**Mr ROCKLIFF** - Thank you, Chair. To my left is the secretary to the Department of Communities Tasmania, Michael Pervan; to his left is Kate Kent, deputy secretary, Department of Communities Tasmania; and to my right is Ingrid Ganley, director of the Department of Communities Tasmania. I can invite others up as or if required.

As a Government, we're committed to continuing to work with the community services industry to support wellbeing, address disadvantage and embrace diversity. We're backing this commitment with over $10 million in this Budget to further support the community sector, acknowledging the immense contribution made by staff and volunteers who deliver these important services and supports for Tasmanians.

This includes an investment of $5.2 million to support the 34 Neighbourhood Houses across the state, so that they can continue to provide a vital point of connection for many Tasmanians. Indeed, the welcoming and open-door approach of Neighbourhood Houses encourages community connection and participation, and builds trust. We know that since the COVID-19 pandemic began, more people are accessing Neighbourhood Houses with more complex concerns such as mental health, a combination of pressures, food security, digital literacy, financial stress, family violence and relationship breakdowns.

We acknowledge this and our Budget includes $2.8 million over two years for neighbourhood houses to employ support workers across the network to deliver additional practical support to meet increasing individual and community needs. As the peak body, Neighbourhood Houses Tasmania has collaborated and consulted with the neighbourhood house network on the design of this model and we look forward to an announcement on the model in the near future.

Our Budget also includes $400 000 over four years to boost funding for the sector peak NHT to embed the good work achieved in 2020 to extend tailored governance resources and

training through additional resources. As well, $2 million will fund the continuation of the ongoing capital investment program to further improve houses statewide, privatising any urgent upgrades. This is on top of our support throughout the pandemic, where we provided an additional $700 000 to support their COVID-19 response. During this time, neighbourhood houses quickly refocused to support community members through phone, internet and, where essential, face-to-face service delivery.

We thank Neighbourhood Houses Tasmania for their critical work representing, supporting and enabling the Tasmanian neighbourhood house network to do the work they do in the Tasmanian community. We also recognise and thank the houses for their dedicated volunteers and workers for their role in connecting communities across Tasmania and for helping to keep Tasmanians safe and well.

More than ever, Tasmania's community organisations, whether they be neighbourhood houses, men's sheds, multicultural support services or LGBTIQ+ support services are vital in keeping our communities connected and supported. It is important that we continue supporting the care economy. Our recently released Community Sector Industry Plan, backed by over $3 million in this Budget gives us the framework and strategy for sector needs to fill 4000 jobs anticipated by 2024. We will continue to work alongside the people and organisations that help underpin the wellbeing of our community to improve the lives of Tasmanians. Thank you.

**Output group 4**
**Disability services and community development**

**4.1 Community services -**

**Ms WEBB** - There is a range of things funded under that line item, minister, and the one I will start with, perhaps unsurprisingly, is the Gambling Support Program. The Gambling Support Program is there to provide a public health response to the risks and harms of gambling through a range of measures. It is funded by 50 per cent of the Community Support Levy from gambling taxation. It is funded to conduct research into gambling, services for the prevention, treatment and rehabilitation of compulsive gamblers, community education concerning gambling and other health services.

The first thing I am interested in is the quantum of funding that is that 50 per cent of the CSL that was provided to this space in 2020-21, the last financial year, and what is expected for this 2021-22 financial year. How is that funding allocated across the four functions?

**Mr ROCKLIFF** - Thank you, Ms Webb. The Gambling Support Program delivers specialised gambling support for Tasmanians impacted by gambling as well as a comprehensive range of evidence-informed gambling harm prevention and minimisation programs. The Gambler's Help suite of services includes in-person, phone and online support options for people impacted by gambling, including gamblers and people affected by the gambling of others. Gambling-related community education and community development activities are targeted to at-risk communities and groups.

Community Support Levy grants are directed to vulnerable groups in communities through grassroots charitable organisations. The 2020-21 CSL grants round funded over $300 000 of grants to benefit Tasmanian communities. The proportion of Tasmanians identified as problem gamblers has remained steady over several years. The GSP continues to

work to prevent and reduce gambling harms for individuals, families and communities in recognition that harm can occur at many points along the gambling severity spectrum.

In 2020-21, the GSP receives a total of $3 233 701 in CSL funding for the provision of the program. The fifth Social and Economic Impact Study of gambling in Tasmania was released in June 2021 and will inform upcoming community education support services and research planning.

**Ms WEBB** - That $3.233 million that was the total for 2020-21 financial year?

**Mr ROCKLIFF** - The GSP received a total of $3 233 701 in CSL funding for the provision of the program.

**Ms WEBB** - Yes. And the anticipated for the 2021-22 Budget period?

**Ms GANLEY** - I can answer that. We have only just been advised so coming to Communities Tas is $3.8 million.

**Ms WEBB** - In each of those instances, what is the 'divvy up' across the four functions, the research, the services, community education and the other health services?

**Mr ROCKLIFF** - How will the $3.8 million be divided?

**Ms WEBB** - That is right and how the $3.2 million in the last financial year was divided?

**Mr ROCKLIFF** - We will soon be working on the $3.8 million and we can provide that to you at some point in time.

**Ms GANLEY** - We do have the breakdown but not as a combined figure; for individual components listed in our brief but not the combined by research, by helpline.

**Ms WEBB** - Right. So even though there are four distinct functions there, you cannot give me the amount allocated to each of those four distinct functions?

**Ms GANLEY** - We can by service type, yes.

**Mr ROCKLIFF** - Regarding the gambling help support services - and it is statewide support - the individual and group counselling and local community education development provided in business hours by Anglicare in partnership with Relationships Australia, in 2020-21 funding for in-person gambling support services was $509 021; Gamblers Helpline, 24-hour phone based counselling referrals and information provided by Turning Point, Eastern Health, 2020-21 funding for GHT was $152 693; Gambling Help Online which is a 24-hour on-line counselling referrals and information provided by Turning Point, Eastern Health, GHR memorandum of understanding for all the states and territories jurisdictions are currently approaching the market for this service. In the last financial year, funding for on-line gambling support service was $9002, I am advised.

**Ms WEBB** - I am going to imagine that those things that you have just read out cover two of the four functions which is the services for prevention, treatment and rehabilitation of

compulsive gamblers and community education concerning gambling. Would they comprise the entirety of funded elements for those two functions?

**Mr ROCKLIFF** - In addition to the charitable grants program?

**Ms WEBB** - No, that is a separate amount. That is another 25 per cent of the CSL. It is a separate thing.

**Mr ROCKLIFF** - The GSP, Gambling Support Program, $3.2 million.

**Ms WEBB** - Yes.

**Mr ROCKLIFF** - So $1.5 million per annum is drawn from across both categories of GSP-managed CSL funding to provide part of the base funding for the 34 Communities Tasmania funded neighbourhood houses.

**Ms WEBB** - Can I clarify, would that be what is described in the four functions as 'other health services'?

**Ms GANLEY** - Yes, it is a mixture of the other preventative services and community-based organisations.

**Ms WEBB** - Of the four functions for the gambling support program, research services for prevention, community education and other health, you are saying the neighbourhood houses comes from the other health services and the services for prevention elements?

**Ms GANLEY** - And education. It cuts across all.

**Ms WEBB** - What specifically does that fund in neighbourhood houses?

**Ms GANLEY** - It contributes towards their base funding.

**Ms WEBB** - There is no specific gambling parameter connected to that funding?

**Mr ROCKLIFF** - I am advised that it is part of the based funding for the -

**Ms WEBB** - There is no specific gambling parameter connected to that funding?

**Mr ROCKLIFF** - I am advised it is part of the base funding for the 34 community Tasmanian-funded [inaudible]

**Ms WEBB** - So not a particular gambling prevention or gambling service as such. I think that is the case.

**Ms GANLEY** - As an alternative. They are funded as an alternative community-based space.

**Ms WEBB** - Other spaces, yes.

**Ms GANLEY** - Other space, yes.

**Ms WEBB** - The research element then? What quantum was that?

**Mr ROCKLIFF** - I will take it on notice, Ms Webb.

**Ms WEBB** - Okay.

**CHAIR** - Would you reiterate that question?

**Ms WEBB** - What is the allocation for the research component of the four functions for the Gambling Support Program in 2020-21 and 2021-22. A breakdown for that 3.8 that is allocated for this financial year now, across the functions or in whatever granularity you can provide it.

**Mr ROCKLIFF** - We have received information on the $3.8 million, I am advised and we can work through that and provide the information for you. I imagine we will be able to get the 2020-21 figures for you prior to that, given there is work probably still to be done, but as soon as we can provide that information we will.

**Ms WEBB** - In each of those four areas the Gambling Suppport Program delivers on, are they evaluated regularly and is the program adjusted according to the findings of those evaluations and are the evaluations or reports of them publicly available?

**Ms GANLEY** - Yes, certainly, the Gambling Help counselling services have been evaluated through the department in terms of the services we fund and the services purchased with other states and territories. They are undergoing a procurement process at the moment as a result of an evaluation of the current provider and adjustments are made as necessary. The community education programs have their own individual targeted evaluations and then changes are made as to best place awareness-raising and educational activities. Some of those reports are on our Gambling Support Program website in terms of the outcomes of those evaluations.

**Ms WEBB** - The outcome of evaluations from the community education elements, do you mean?

**Ms GANLEY** - Yes.

**Ms WEBB** - And the services?

**Ms GANLEY** - That, I would have to check if that is publicly on the website, but it was certainly undertaken.

**Ms WEBB** - For example, if I wanted to go and look to see in the past year in what ways has the Gambling Support Program increased or built community understanding and awareness of gambling and gambling problems and the degree to which it has reduced the impact of gambling harm, which is a stated aim, could I find that information somewhere?

**Ms GANLEY** - For the community awareness and education you would find it through the particular targeted activities, rather than a whole and then we would be using other publicly available research for other elements.

**Ms WEBB** - Would there be research that demonstrates the Gambling Support Program has, for example, reduced the impact of gambling harm?

**Ms GANLEY** - There are the key performance indicators we get from the providers we fund that compares year-on-year.

**Ms WEBB** - Do they cover outcomes and impact or are they activity-based?

**Ms GANLEY** - Mainly activity-based.

**Ms WEBB** - That would not give us information about the outcomes and the impact of the programs they are connected to.

**Ms GANLEY** - The evaluations of their awareness campaigns do and they are available, yes.

**Ms WEBB** - Right, but not the direct programs that are actually targeted at interacting with gambling harm.

**Ms GANLEY** - They do through the reports they provide to the department in terms of our funding agreement management. There are outcome measures in that, but we do not have a report publicly available.

**Ms WEBB** - So it is not publicly visible. We could not go and see -

**Ms GANLEY** - Yes.

**Ms WEBB** - - that there has been, for example, a reduction. Okay. Moving on. The Know your Odds Program that has been going on for some years now is a flagship of the Gambling Support Program online education. I note from recent checking there are videos missing, for example, info on health workers on the Know your Odds page goes to a missing page. How regularly is this resource, this web page, reviewed, updated? Is it regularly interacted with as part of the administration of the program?

**Ms GANLEY** - Yes, it is. We will need to check what is going on there.

**Mr ROCKLIFF** - Yes.

**Ms WEBB** - Has it been evaluated in some sense in terms of effectiveness or impact?

**Ms GANLEY** - Yes.

**Ms WEBB** - When was it evaluated last?

**Mr ROCKLIFF** - We will check that and if we can provide the outcome of the evaluation we will. I am not aware of the website going down or those sorts of things.

**Ms WEBB** - Pages or videos.

**Mr ROCKLIFF** - I am happy to check that. I am aware of the leaflets I have been reading.

**Ms WEBB** - You will not be able to access it when you are connected to our Parliamentary system because it blocks. You will have to use a private computer as a tip.

The Gambling Support Program supports and conducts community programs addressing problem gambling issues. It works with schools, community organisations and local government to provide information about the risks of gambling, how commercial gambling works and that help is available for people affected by gambling. One of the resources is called *What's the Real Deal* that is used. It is used potentially in schools, but maybe you can correct me on that. That was written in 2007 and it appears to be out of date as it refers to gamblers' help as Break Even.

Are we confident all our resources in this program available for say schools or community organisations or local government are up-to-date and regarded as current practice?

**Mr ROCKLIFF** - My expectation is they should be up-to-date. If it is not the case we can investigate and ensure they are accurate and up-to-date to reflect contemporary knowledge and practice.

**Ms WEBB** - On the interactions with schools and the use of these resources, firstly, how do schools find out about them? How many schools are using the resources in the last year or two year? Do we know what part of the curriculum they are being used in or how the schools have used them?

**Mr ROCKLIFF -** We can take that on notice, Ms Webb. There will probably be some interactions with the Department of Education as well, but we can find out the information and what program within schools this program might well apply.

**Ms WEBB** - The question is - in regards to the resources and programs available to schools in the Gambling Support Program, how do schools find out about them? How many schools are using the resources say in the past two years and what part of the curriculum are they used within in the school context?

**CHAIR** - We have already had education today. It is more an education question.

**Ms WEBB** - I do not know that it is. I would think if we are producing in the Gambling Support Program, specific resources, targeted to be used in schools and putting them and make them available somewhere for schools, this program should be able to tell us how those resources are being accessed and used. Presumably, they will be wanting to also evaluate and know whether they are successful or useful.

**CHAIR** - Is that question for Minister Rockliff or for Minister Courtney?

**Ms WEBB** - I think it is. The question about whether the schools find them useful and the schools feel they are a useful resource is another question that could be for Ms Courtney.

**CHAIR** - I want the minister to reflect on whether this is a question for him or for Minister Courtney.

**Mr ROCKLIFF** - It is certainly a question for me in terms of our interactions with the schools and I can accept that. We want to improve the situation here, Ms Webb. If I can have a conversation with our Minister for Education and see what engagement there is in schools then I am happy to have it. The technicality around me taking something on notice for education, people have to judge that.

**Ms WEBB** - Perhaps, the question on notice could be - from the Gambling Support Programs side of things, having put those resources into the public domain to be available for schools, what does the Gambling Support Program know about their use within schools?

**Mr ROCKLIFF** - We provide the resource for schools and it would be the Department of Education in charge of curriculum to which the resource is utilised. Notwithstanding that, I can still consult with the Minister of Education and see what engagement there is at school level. With respect of this matter, I will do my best to do that in terms of accessing that information. But, certainly, in terms of the responsibility of the Department of Communities, it's the resource that we provide the schools. Our expectation is that the schools utilise that resource as effectively as possible.

**Ms WEBB** - I am imaging, because you have indicated evaluation occurs in other aspects of the Gambling Support Program, that there would be evaluation of this element of the program and also these resources. If there is internal evaluation in the Gambling Support Program of this, you will have some information, I would imagine, about the use or effectiveness from your evaluative perspective.

**CHAIR** - The question is - do you evaluate this aspect?

**Ms GANLEY** - All programs and resources we produce and put out, we evaluate - either external evaluation or internal evaluation. So, we can gather information by the resources and advice.

**CHAIR** - Is that a question on notice? What's the question on notice?

**Ms WEBB** - Information available through your evaluations about the use and effectiveness of these resources provided to schools.

**Mr ROCKLIFF** - We will seek to do our best to find the information.

**CHAIR -** I'm concerned about questions being taken on notice for the Minister for Education when there are avenues to pursue this.

**Ms WEBB** - With all due respect, it is a distinct question for the Gambling Support Program. It's their resource, created for a specific purpose in their program. I have asked about their evaluation of it. They should, if they evaluate it, be able to provide their understanding of its effectiveness, because presumably they would want to know that in order to then adjust or improve or continue as per that evaluation. It is absolutely a question for the line item in this program. I will move onto the next question, though.

**Mr ROCKLIFF** - Did we get that sorted out in terms of what's on notice and what's not? We will do our best to find as much information as we can.

**Ms WEBB** - I am interested similarly because that same area of the Gambling Support Program provides education resources and information resources, not just to schools but also, according to the material, to community organisations and local government. I am also interested to know, similarly, what your evaluation of those resources, their use and effectiveness is? I'll add that to the same question on notice.

How many people are seeking help through the three avenues that the Gambling Support Program provides - that's in person, online and by phone - in the last year?

**Mr ROCKLIFF** - In terms of the Gambling Help service's key activity data, the in-person support, new clients in 2020-21 was 258; in-person support individual support sessions, 456 in 2020-21; Gamblers Helpline, clinical calls 163 in the 2020-21 year; Gambling Help Online, clinical contacts 67.

**Ms WEBB** - Comparing those to the last full normal year, we would have had pre-COVID-19, that would have been 2018-2019, are those numbers consistent? Are they up or are they down?

**Mr ROCKLIFF** - Some are down and some are up. In-person support, new clients: 2018-19 - 249; 2019-20 - 216; and I've said 258 in 2020-21. In-person support, individual support sessions: 2018-19 - 528; 2019-20 - 571; and the figure I've provided is 456 in 2020-21. Gamblers Helpline clinical calls: 2018-19, 155; 2019-20, 168; and 2020-21, 163 is the number I have provided. Gambling Help Online clinical contacts: 2018-19, 107; 2019-20, 85; and the figures I have provided for 2020-21 is 67.

**Ms WEBB** - A final one in this area, in terms of the Community Support Levy and the fact that 50 per cent of that comes into this space to fund the services and activities:

Knowing that in the planned gaming market reforms, there are planned changes to the Community Support Levy, its quantum will be increasing under that model. They are also looking at redesigning the way allocation occurs. What involvement is this department and the Gambling Support Program currently having in the work being done by the Liquor and Gaming branch of Treasury to consider and develop a new model for allocating the CSL.

**Mr ROCKLIFF** - Thank you for your question. Treasury is currently undertaking the public consultation regarding how the increased CSL will be distributed.

**Ms WEBB** - Sorry, just to interrupt there, it's not a public consultation. There is a targeted consultation of an invited very small number of stakeholders occurring. It's not in the public domain.

**Mr ROCKLIFF** - My information is public consultation.

**CHAIR** - It depends how you define public, I guess. The minister might like to keep on going.

**Ms WEBB** - Mr Ferguson confirmed on Monday that it's not an open public consultation. There are limited stakeholders who have been approached.

**Mr ROCKLIFF** - Mr Ferguson is responsible for this area so -.

**Ms WEBB** - That's fine, just allow me to inform you of that.

**Mr ROCKLIFF** - Thank you. The increased funding has the scope to allow for a greater range and volume of initiatives for gambling community education, research and support services, as well as increased funding for programs that reduce the risks of gambling harm, such as community capacity-building and healthy alternatives to gambling. My expectation, as minister, is that our department would be engaged in that process.

**Ms WEBB** - Is your department and this program engaged in that process that is currently underway?

**Mr ROCKLIFF** - My advice is that yes, we are.

**Ms WEBB** - Is that engagement in the form of providing a written submission to that process or working with the group from Liquor and Gaming who are developing it?

**Ms GANLEY -** Through the minister, we participated in the survey that has come through as part of the process.

**Ms WEBB** - The same survey that was provided to the other targeted stakeholders, I'm imagining. There was no communication with this department and this program in the design of that survey and the remodelling it presents?

**Mr ROCKLIFF** - No. That's a question for Treasury.

**Ms WEBB** - Finally on that, would you, minister, as the person responsible for the Gambling Support Program, regard it as essential that any remodelling of the allocation of the Community Support Levy would increase and improve the direct relevance of that funding to tangible reduction of harm and the prevention of gambling harm as its focus?

**Mr ROCKLIFF** - Well, that's its intention, isn't it?

**Ms WEBB** - You would regard it as essential that any remodelling delivers an increase of that, rather than -

**CHAIR** - This is 'do you', rather than 'you would'.

**Mr ROCKLIFF** - When people say 'Is the funding provided to elective surgery waiting lists going to reduce waiting lists', I would say 'Yes, that would be my expectation and I would want to see that happen'. You're asking me a question about the Gambling Support Levy, or CSL, and whether or not that investment is targeted in such a way that would reduce the effects of gambling. Is that your question, or harm minimisation?

**Ms WEBB** - Actually around the remodelling of the way it's allocated, do you believe it's essential that that remodelling is increased in its targeting of prevention of harm, rather than say decreased in its targeting of prevention of gambling harm?

**Mr ROCKLIFF** - I would prefer it to be increased in that sense. My advice is that the increased funding will allow for a greater range and volume of initiatives for gambling community education, research and support services. As well as an increased funding for programs that reduce the risks of gambling harms, such as community capacity building and healthy alternatives to gambling. That is an expanded version of a 'yes' answer to your question.

**Ms LOVELL** - I wanted to move on to another item and that's the School Lunch program.

**Mr ROCKLIFF** - Yes, the $1.4 million investment, is that right? That one.

**Ms LOVELL** - Yes. Also, that line item adds up to a little bit more than that but that's not one of my questions.

**Mr ROCKLIFF** - That was our commitment. I think that might be because -

**Ms LOVELL** - Was there already some money -

**Mr ROCKLIFF** - I stand corrected but it would probably be financial year and school year, there would be a cross-over there, which would be the difference. I stand to be corrected on that but that's what I would think.

**Ms LOVELL** - That's what I've been trying to work out here as well. Minister, how was that funding calculated and what is the cost per meal that that's been based on?

**Mr ROCKLIFF** - Ms Kent, would you mind providing that level of detail, if not we can certainly provide it for you.

**Ms KENT** - The program we're working with in conjunction with the Department of Education, goes across three years. It is starting in this year with the schools coming online at the beginning of next year. We're working through with the various stakeholders in delivering the program as well. The cost per meal may differ through different schools, depending on what part of that program and how they want to deliver it as well.

It's not a one size fits all. We certainly can provide more information on the background as we're still working through some of those details now. The schools have just been announced recently. These were selected through an EOI process as well to see which schools were ready to begin the program and start next year.

**Ms LOVELL** - So, understanding that when it actually rolls out it's unlikely the meals will cost the same across all schools. How did you reach that figure? Was it based on an estimated or an average cost per meal or how else was that reached, if that wasn't the way you worked that out?

**Mr ROCKLIFF** - I can probably take on notice the methodology. At the time, I know that there was some engagement with Julie Dunbabin from the School Canteen Association. I am aware of the policy of the opposition at the time which was $30 million as well which was extensive but our commitment was $1.4 million, not to every school but a selected number of schools at the time. The methodology, I'll have to rack my brain on that.

**Ms LOVELL** - I'm happy for you to take that on notice, given the time.

**CHAIR** - It's the methodology for calculating the funding for -

**Ms LOVELL** - The funding for the School Lunch program. Yes.

**Mr ROCKLIFF** - We've got the figure of the investment. I guess we could provide some more information on how that figure will be distributed to the schools that put up their hand.

**Ms LOVELL** - How it was arrived at was the question but if there's more information that you're able to provide on how it will be distributed, that will probably be helpful as well. Is it the intention that all students in those 15 schools - and then the 30 when it expands - will receive lunch every day of the week? Will there be restrictions or limits on the reach of the program?

**Mr ROCKLIFF** - I am not sure about restrictions and it may well be an operational question for the minister for Education and probably will be school dependent, depending on the school and the school needs. We wouldn't want to be too rigid as to how that funding is distributed to each school, like every single day or two or three days a week or whatever the case may be.

Like a lot of areas across education, there is a fair bit of flexibility in schools, how they spend their SRP, for example, and the like so -

**Ms LOVELL** - In light of that answer I would like some information on how that money will be distributed to schools then if that's available to determine whether there'll be restrictions or limits on the program based on budget.

**Mr ROCKLIFF** - Some schools will need some capital funding in kitchen upgrades and the like.

**Ms LOVELL** - Does that come out of this same line item.

**Mr ROCKLIFF** - That's correct. That's my understanding, it is. I'll stand to be corrected on that but that's my understanding, yes.

**CHAIR** - Two questions. How is the figure arrived at and how is it being distributed to the schools?

**Mr ROCKLIFF** - Some schools might have the equipment and the kitchen already. Therefore, the school distribution would be either less or more depending on that but I can provide that information for you if we can access it.

**Ms KENT** - As the minister said, it is a pilot and the pilot would be working through each of those individual schools to identify their need so that's the current process that's being worked through. The original figures that some of the research showed with the canteen association was around $3.00 per meal so that's how some of those individual figures were determined but the schools will determine that -

**Mr ROCKLIFF** - I can tell you the evaluation was extraordinarily successful and if one spends some time talking through that evaluation and the engagement, that particular program - and there's one example I can think of involving a serial non-attender at school who turned up to school every single day following the availability of that lunch pilot and engaged in education and the school for the first time ever on a consistent basis.

That's a program that has been piloted, evaluated, extended and I would hope its extended further based on the information that I have.

**Ms LOVELL** - As would I. It's had excellent outcomes and we would like to see it extended as broadly as possible.

**Mr ROCKLIFF** - I appreciate that.

**CHAIR** - I wanted to ask a question about the performance information, the number of total funding agreement meetings with contracted service providers annually. I'm pretty sure that has been impacted by COVID-19 because of the inability to do face to face. But what's the actual purpose and what's the outcome you're seeking from that meeting?

**Mr ROCKLIFF** - If I can familiarise myself with the page you're on, Chair.

**CHAIR** - Performance information is on page 65. A footnote is on 66.

**Mr ROCKLIFF -** Perhaps I'll throw to Ms Kent in respect to this matter, or Ingrid.

**Ms GANLEY** - It relates to the formal meetings that staff at the department have with funded organisations to review their KPIs and ensure the services that we've contracted them to deliver are being delivered and seek their feedback.

**CHAIR** - Did you assess the outcomes of the funding they've been provided with not just yes, they've spent it but the outcomes? What they've achieve with that. Is that part of it?

**Ms GANLEY** - Yes, that's part of it and we are in the process of developing a new community sector framework.

**CHAIR** - That will support that?

**Ms GANLEY** - Yes.

**Ms WEBB -** I want to ask about prevention of elder abuse, the funding provided in this Budget and whether that is continuing, the existing funding we have seen very laudably in this area over recent years, since it was first picked up under the elder abuse strategy and the help line was first put up.

**CHAIR** - Is that more under 4.3?

**Ms WEBB** - It can be, potentially I guess, sorry.

**Mr ROCKLIFF** - 4.1 I think.

**Ms WEBB** - Are we continuing funding on as we have been, which would be great or even better, are we adding additional funding for this area and if so, what for?

**Mr ROCKLIFF** - We have committed to $880 000 per year for the next two years. It is okay to ask the question. Tasmanian Elder Abuse Awareness Campaign was launched in June last year and the new Elder Abuse website was launched on 15 June this year to coincide with world Elder Abuse Awareness Day. Our work around safeguarding for older people and improving service systems is ongoing.

The strategy focuses, in regard to the Tasmanian Elder Abuse Prevention Strategy 2019-22 was launched back in 2019 and we committed $850 000 through that 2019-20 budget to ensure the key priorities in supporting actions were achieved, focusing on awareness, empowerment, action support and safeguards.

Key initiatives under the strategy include the provision of a statewide elder abuse helpline, delivery of a contemporary elder abuse awareness campaign, an examination of the Tasmanian Elder Abuse service system and gap analysis of the legislative and oversight system for safeguarding older Tasmanians. The Tasmanian Elder Abuse Helpline provides information advice for referrals.

**Ms WEBB** - More specifically then, are we continuing at the same level of funding we have had in place in recent years under that strategy or are we increasing the funding?

**Mr ROCKLIFF** - I go back to the $850 000 for 2019-20 and there is $880 00 for the next two years.

**Ms WEBB** - Only marginally increasing.

**Mr ROCKLIFF** - Nonetheless, it is increasing, which is good. It is CPI based.

**Ms WEBB** - Is it only a CPI increase?

**Mr ROCKLIFF** - Probably be more than that, more than CPI.

**Ms WEBB** - Good to hear. I would hate to see that lose ground as I had a lot of investment in that when it was being developed, back in the day.

**4.3 Community Development - Policy Advice and Ongoing Community Development**

**Mr DUIGAN** - This may have already been covered by Ms Webb. I do not know whether you asked your PESRAC question?

**Ms WEBB** - I didn't because I was not going to spend time on that.

**Mr DUIGAN** - Minister, how is the Government going implementing the PESRAC recommendations in relation to Community Services and Development portfolios?

**Mr ROCKLIFF** - Many have been impacted by the impacts of the pandemic on their wellbeing and the economy. I am pleased to see Tasmanians in need, featured in the PESRAC

report and the recognition of the critical role of our community sector during the COVID-19 pandemic and response.

We have agreed to implement all 64 recommendations and we are continuing to support the community sector. This budget recognises the need to plan for a new, different and constantly changing community sector.

I am excited about the announcement of our first community sector industry plan which we launched on Monday, supported by over $3 million in funding for initiatives with TasCOSS in the Budget and we have several initiatives well underway.

The critical role of emergency food relief is reflected in the PESRAC report. I commend that strategy to you in terms of not only urgent food relief but also building resilience which is very important. It includes a mapping exercise around the state with recommendations 57 and 58 suggesting the Government carefully monitor and plan funding for emergency food relief to ensure Tasmanians in need can access help.

We are also planning for the future and Food Relief to Food Resilience is the name of the strategy with a number of actions there.

Our Budget includes over $1.4 million - we have been speaking about - to deliver an expanded school lunch pilot and in response to recommendation 33 of PESRAC to develop ways to obtain and attract volunteers. We allocated $351 000 over three years to Volunteering Tasmania to undertake initiatives that support the re-engagement of volunteers across our state.

We are also investing in a new generation of volunteers with $300 000 for Volunteering Tasmania to develop a model based on the New Zealand Student Volunteer Army to help build volunteer numbers across the community sector. We continue to work closely with Volunteering Tasmania to ensure those in the community who wish to volunteer are linked with appropriate opportunities and the volunteer thriving organisations are supported to engage volunteers when they need them and throughout the pandemic.

Mr Duigan, I might have mentioned this, given our volunteer ambulance in the health portfolio as well. We had our more vulnerable older population and lost some volunteers through that process, so there is work to do and PESRAC highlights the challenges we never had to deal with before.

We are delivering on ways to face these challenges alongside the community sector, but we continue to understand this continues to be a very difficult time for Tasmanians. What is important is we continue to build strength and resilience amongst our communities and supporting them and the organisations.

**CHAIR** - Minister, do you have a record of how many volunteers there are in the state or is that something held by Volunteering Tasmania?

**Mr ROCKLIFF** - I know volunteers contribute some $4 billion to the state. I do have an estimated number of volunteers, which I have spoken about before and so I get that figure right, I will make sure I access the information. I think that $4 billion figure is right.

**CHAIR** - How much has dropped away with COVID-19 and whether it is coming back. As you have said you have given funding to Volunteering Tasmania to assist in the task. Do you have any current data?

**Mr ROCKLIFF** - The 2019 State of Volunteering Report commissioned by Volunteering Tasmania and funded by the Government, estimate the value of volunteering to be $4 billion. In just the previous 12 months, it is estimated that over 297 000 Tasmanians volunteer each year which is extraordinary and the volunteering sector is nearly three times larger than the Tasmanian Government sector and 14 per cent larger than the private sector.

**CHAIR** - Do you have any data at all on the impact that COVID-19 had in terms of numbers?

**Mr ROCKLIFF** - I do not have any data directly. I have some anecdotal discussions around the reduction in volunteers, particularly in that age group.

**CHAIR** - Are you also hearing they are coming back or are they still hesitant?

**Mr ROCKLIFF** - I am hearing both. The sort of group hesitancy but think numbers are building back but I have not got any data to support, but that is what I am hearing.

**CHAIR** - Minister, 25 past is our stumps time. That is nine hours of you sitting across the table from me. That is long enough for anybody. Are there any final questions on this before we close? There are other COVID-19 output groups. Some of them have funding this year, some of them don't. Are there any really urgent questions from anyone there?

We'll call it stumps for the day, minister, and thank you for your time.

**Mr GAFFNEY** - On that, Chair, if we have some questions are we able to table those?

**CHAIR** - We can ask for those items to be left open because we don't have time to scrutinise them. Minister, would you rather us leave the item open, or send a question through on notice if there are any particular questions about those COVID-19 response output groups?

**Mr ROCKLIFF** - I'm happy to engage with the method the committee prefers.

**CHAIR** - If there's any questions, we'll send them to you on notice.

**Mr ROCKLIFF** - That's fine.

**CHAIR** - Thanks very much.

**Mr ROCKLIFF** - Thank you; and thanks to Mike and Ingrid from Community Services.

**The Committee adjourned at 7.27 p.m.**