PUBLIC

THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION 'A' MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON MONDAY, 22 OCTOBER 2018

ACUTE HEALTH SERVICES IN TASMANIA

Hon. MICHAEL FERGUSON MP, MINISTER FOR HEALTH, WAS CALLED AND EXAMINED, **Mr MICHAEL PERVAN**, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND **Mr NEIL KIRBY**, CEO, AMBULANCE TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Valentine) - Welcome, gentlemen. As you are probably aware, this committee is being recorded today and is being broadcast as well. The evidence taken is protected by parliamentary privilege. I remind you that any comments made outside the hearing may not be afforded that privilege. There is a copy of the information for witnesses that you would have been provided with, and I assume that you have read that and are aware of its contents. The evidence is being recorded and the *Hansard* version will be published on the committee website when it becomes available. By way of introduction you have the opportunity to make some opening statements as well, minister, and then we can go to questions following that.

Mr FERGUSON - Thank you, Chair, Mr Finch and Ms Forrest. I am pleased to be here with you this morning to provide further clarity or detail that your subcommittee may be seeking. I have provided a submission, which I do not propose to go through with you because you have obviously read it. If we can add extra context or information to that, it will be a pleasure to do that.

As a summary statement we are investing more in our frontline services. Since I last spent time with you we've had an election, a very significant pre-election policy was announced; also since that time we've had our budget, which delivered on the first four years of that longer term plan. In summary I have to say we have focused on improving frontline resources and supporting the health system so that it can meet increased demand.

A critical element of delivering that plan is our infrastructure plan. Clearly we need the buildings and the ability to grow our services is currently limited by our infrastructure - that is particularly the case at the Royal Hobart Hospital where the redevelopment is now in its final year, so we might like to explore that. That is going to be the breath of fresh air the hospital requires to grow into new spaces so that we can expand our services as per our promise.

To a slightly lesser extent that same pressure is at the LGH as well, where we've currently effectively filled our current facilities. We are building a new ward and new women's and children's precinct there, which will also take some time. Again, those extra spaces need to be built and we are building those.

Also since I placed my submission with you, we've made a further announcement - in fact only one week ago in the House of Assembly - around additional improvements to the Royal Hobart Hospital redevelopment, specifically around a combined medical ward on level 10K. That

is something the Government has agreed to do on the basis of some really robust advice, both from the department and from the Royal Hobart Hospital executive.

CHAIR - That is the ministerial statement you are speaking of?

Mr FERGUSON - Yes.

CHAIR - Do you have a copy of that for tabling?

Mr FERGUSON - I will send you a copy of that which I think you will find useful. Additional to that we have made refinements to our plan for the extra mental health beds the Government promised at the election - 25 additional mental health beds. We have taken advice on Mistral Place. There was a better approach on that. Rather than 25 mental health beds, the Government is now building 27 of those and we have announced a brand-new facility at St Johns Park, a 12-bed facility, instead of refurbishing and building 10 new beds at the current Mistral Place. All that will be in the ministerial statement which I will send you a copy of; I think you will find it quite useful.

CHAIR - We have it but for tabling, or if you are happy for us to table what we have off the website?

Mr FERGUSON - More than happy with that. I do not have a copy with me today.

CHAIR - In that case it is easier for us to do that so it is evidence. Thank you. Anything further, minister?

Mr FERGUSON - We could explore your questions.

CHAIR - Can we get a copy of the KPMG report for our evidence?

Mr FERGUSON - My understanding is that is internal for the Government.

CHAIR - It is important for us to have as much information as we can. We do not want to be going down paths where we are making statements covered in a report like that and we have no understanding of what that is. Is it possible for us to get a copy of that report?

Mr FERGUSON - That is my understanding, yes.

CHAIR - I would like to think you could provide that to us and we will have to discuss as a committee what we do as a result of not having that report provided.

Ms FORREST - If we made a formal request, would that make a difference?

Mr FERGUSON - I do not know today. I am happy to receive your request. I am sure you understand the Government needs to be able to commission advice and for that to be able to be obtained so governments - and in this case, the Governing Council - are able to make robust decisions. If it were the case that advice was released, it is a discouragement to obtain future advice because public servants and consultants are encouraged to give advice on a frank and fearless basis.

CHAIR - I understand that entirely, but the important thing - and it was in our interim report - is that all parties work together to get the right outcome, which is what was stated. It is difficult for all parties to work together and to try to take the politics out of it if we do not have all the information available to us. That is the difficulty I see. When setting this inquiry up - forgive me for not introducing my other colleagues, Jenny Mannering and Rosemary - it was important we did not have political party representation, that the committee was totally independent. The whole point of this inquiry is that we could have a good, warts-and-all look at the problem and the issues surrounding the health system in Tasmania, and the acute health services. It makes it difficult for us to make proper recommendations and findings if we do not have all that information.

I ask you to consider that. We will send an official request and then go from there.

Mr FERGUSON - I respect and understand your position and your natural curiosity about a range of reports spoken about in the press. I also ask you to respect and understand that my earlier comment is an important one. It is the same with Cabinet documents. You would have a natural interest and curiosity in the advice to Cabinet. As always is the case, whether public servants provide departmental advice or, at times, consultants provide advice, it is important it be frank and fearless, and it is not usually frank and fearless if people feel it is going to be canvassed in public or scrutinised or debated with a different audience from which was intended.

We are always happy to be transparent as a government and how we can do better. We are a government that is investing in our health system. You did not mention, but I will, the $90 million structural shortfall claims in this reporting that predate our Budget in May; in the Budget for the next four years, there is a $465 million uplift in funding. We can have a discussion about funding if the committee would like to, but we are always pushing for more funding and getting it, and the Government has been very supportive of that. Where any suggestion is made that the health system needs more resources to help with the demand, our biggest constraint on meeting demand is our physical infrastructure at the moment. As you know, the Royal Hobart Hospital, in particular, and the LGH are also over capacity at times. The issue is that there is over-demand on our services. To be able to meet that, it is not a case of just opening more beds because the spaces are not there to open more beds, even though we have actually opened 120.

CHAIR - Opening the beds and staffing them is another thing too, I guess.

Mr FERGUSON - We never open a bed without staffing it. We never open a bed without a safe place to do it.

Ms FORREST - As I understand it, the KPMG report and our RDME report were both commissioned by the Tasmanian Health Service, for the THS to be advised about the financial requirements and the healthcare demand. If that is the case, it is not really an internal document of government, it is a THS document that really, in my view, should be provided to the committee, and we will make the request. It is essential that, as a committee of the parliament, we also have access to that sort of information. I think that is pretty clear: there does not seem to be any argument about the commissioning of those reports, or am I wrong on that?

Mr FERGUSON - No, I am not arguing about that at all; that is not the issue for me.

Ms FORREST - You talk about putting extra money and those reports predating your last budget. We had this discussion over the table not so long ago. I hope last year's Department of Health annual report is on the website now because it wasn't then, and I had to chase your office to get a copy -

Mr FERGUSON - I tabled it last week.

Ms FORREST - It was not on the website and I was not here last week.

Mr FERGUSON - No, sorry, it is required to be tabled by November -

Ms FORREST - It is, but it was not on the website, to get a copy.

Mr FERGUSON - Okay.

Ms FORREST - I spoke to the staff in your office and I hope it has been sorted. I have not gone back to have a look because I now have a hard copy.

Mr FERGUSON - It was tabled in the parliament.

Ms FORREST - Yes, but -

Mr FERGUSON - It was a public document from the moment it was tabled.

Ms FORREST - Well, it was very difficult to find - that is what I am saying.

Let us move on to page 83 of the annual report which talks about the budget and the actual expenditure. This is the point I raised in the last Estimates: There is the claim made all the time that you have been putting record funding into Health; well, there is growth in Health all the time, so if you were not increasing your funding, you would be rightly condemned. However, we continue to see the budgets for each year being less than the actual expenditure of the year before, so how can this be an increase in budget? I explained to someone on the west coast very simply on the weekend that if you say you are going to put in $10 million in this year's budget but you actually spent $20 million, and then next year's budget is $15 million - because it is $5 million more than the budget of the last year - yes, you are increasing on your budget item, but you are not increasing on your expenditure. As I am sure you are aware, there has been a leaked report that makes it pretty clear that there is still a significant shortfall in what was budgeted for and what is being spent. Don't need to catch up? Perhaps we need to talk to the Treasurer rather than you about this.

Mr FERGUSON - We are spending. I can testify that in the last four financial years I have been in this role, each year the Government has provided more money than was originally planned, usually as a request for additional funds, for the former THOs, THS and the Health department. That is evidence of two things: it is evidence we have been very busy and the hospitals have seen that increase in demand you mentioned. Also, it means the Government has supported the extra meeting of that demand without simply saying to the organisations, 'No, you will have to make do with what you have'. We have always met the extra cost and we do that because we understand the health system has been very busy. Last year, the financial -

Ms FORREST - It is missing the point, minister.

Mr FERGUSON - I am not. The last financial year involved that busy flu season and we went to extraordinary lengths to support extra staff during that time; it cost money and the Government provided the funds.

Ms FORREST - I understand that, and we are just lucky we have not had a flu season this year like we did last year. I think all the people in all the hospitals would agree with that. But my point is that every year the budget is less than the actual expenditure. Yes, extra money has been put in, sometimes by way of RAFs, sometimes by supplementary appropriation. We had a significant supplementary appropriation bill this year. There was not much in the RAFs this year, and I said when we had the supplementary appropriation bill that I hoped there would not be. Otherwise you are really out of control, or someone is. Don't we need a significant uplift in the base funding, the base budget, to even get close to meeting demand? There is always an excuse. Last year it was the flu season. This year it will be something else. The year before it was something else.

Demands with the building going on at the Royal - we always knew it was going to be challenging to do it onsite. Don't we need a significant injection or baseline increase? Some people call it a structural deficit. I don't think that is actually what it is. I think we need to get to a point where we are meeting demand without the need for top-ups through RAFs or supplementary appropriation bills.

Mr FERGUSON - I understand the points you are making. The health system in the last financial year cost more than was originally budgeted for, but the Government provided the additional budget.

Ms FORREST - It has every year. That is my point, minister.

Mr FERGUSON - I understand the point. Since we last sat down together, in our last Budget in May the Government put an extra $465 million in over the next four years. That is structural funding. I am confident in saying that if it is not every single dollar, the vast majority of that is recurrent funding, so it does sit as structural funding and, if you like, baseline funding for the health system. We know it is very busy; no-one is denying that.

Ms FORREST - We know, minister, from sitting across the table in budget Estimates that this year's budget is still less than the actual expenditure from last year, in spite of the extra funding you are putting in for this year's budget. So are you sitting here telling me we are not going to see a blowout again this year because you put in extra? It is still less than what was paid last year.

Mr FERGUSON - I have already said publicly on a number of occasions that we expect this year will be no different in that we will be providing extra support.

Ms FORREST - Why don't we budget for that and actually increase the capacity of the system?

Mr FERGUSON - That is exactly what we are doing, Ms Forrest. I have just told you that we have placed an extra $465 million in the May budget. That starts in the -

Ms FORREST - But it is still less than what was expended last year.

Mr FERGUSON - Our biggest challenge is the physical environment. That is the biggest bottleneck on being able to provide the patient flow that we want. We want to reduce the time people are waiting in an emergency department or in an emergency department waiting room, and the best way we can do that is by opening more beds. We have opened 120. It has been very successful but we want to open more. The way to do that - and it is budgeted for - is to get the buildings completed so that we can commission them and start to use them.

Ms FORREST - I support the move you have proposed in your ministerial statement about K Block: having all the medical patients in one space is eminently sensible and it does free up some space in the DEM, but as I understand it even that extra space will not meet the current and projected demand for the DEM.

Mr FERGUSON - How many beds are in the Assessment and Planning Unit? It is 26 or 28? I might just check that figure, but the concept there is that the current APU, which is adjacent to the ED, can be the ED's future expansion space. That will need to be carefully thought through as well after the move into K Block. Thank you for your endorsement or warm comments on those decisions because that has really been a good collaboration.

Ms FORREST - We need the same sort of collaboration with psychiatry, but we will come to that.

Mr FERGUSON - No problem; I am all for it. We have a very positive agenda there and we are very proud of it.

Ms FORREST - Let us go back to the medical side.

Mr FERGUSON - No problem. Where were we?

Ms FORREST - Talking about the change to the DEM, given that space.

Mr FERGUSON - The answer to the Royal's pressure, which we are all aware of, is more beds. That is the answer. We need to be able to open more medical beds on wards so that the ED, having done its job perfectly well, can allow its patients to be admitted in a timely way to a medical ward, not the ED. The expansion is part of future opportunity for the ED to work even better than it currently does, but we're working with what we have at the moment.

Ms FORREST - I'm sure that will be very helpful and positive, but as I understand it, the point is that once that area is repurposed for expansion of emergency beds - and you would hope this hospital is going to last more than the next five years with the amount of money being spent on it - you are still constrained within that site. As to the management of medical patients, while I have said it is really good they are going to be in one area, it makes it much more efficient, but there are still problems with how medical patients are dealt with in the old once-a-day round not having a physician in charge of the ward discharging patients. They are seen by junior residents or registrars on admission. In the DEM you have an emergency medicine specialist there all the time directing and managing, but that change has not really flowed through to the medical side of

it. Doesn't there need to be change there because many patients are there waiting for something and can't be discharged?

Mr FERGUSON - I am sorry, I'm not sure if I understand the question fully. Can you tell me what you are looking for there?

Ms FORREST - I think it is good to put the medical patients in one area rather than having some down in the surgical ward where they often get forgotten.

Mr FERGUSON - They would have been in separate areas, yes.

Ms FORREST - Some of them are in the acute medical unit currently and that will change, but there hasn't been a real change in the way medical patients are managed, from what I'm hearing.

Mr FERGUSON - On wards?

Ms FORREST - Yes. A number of witnesses have suggested that there have been improvements in DEM with the FACEMs being there now on the site running the ward for that area, but we don't have the same flow on the medical ward. The major blockages they see in the DEM and getting patients out of the DEM now and potentially in the future are medical patients, because the beds are blocked up the chain with patients waiting, and psych patients.

Mr FERGUSON - Yes. I think I will ask the secretary to assist here.

Ms FORREST - I assume you've read the *Hansard* of our last few days?

Mr FERGUSON - Of course.

Ms FORREST - We've talked about this in that.

Mr PERVAN - I don't want to put words in the minister's mouth, but I was wondering if you were talking about the movement of patients from the DEM or from the hospital generally.

Ms FORREST - Both, but they can't get into the medical wards because they're blocked.

Mr PERVAN - Access block arises from all sorts of causes, not least of which is demand, which I'm sure you have heard is a phenomenon not only in Tasmanian acute services but in hospitals around Australia - even the new Royal Adelaide. When the minister and I were there for the COAG Health Council - CHC - the largest, most expensive hospital in modern history was access blocked, so it is not simply a matter of building bigger, bigger and bigger.

In respect to the issue you've raised about the flow of patients through the hospital, the Government provided us with some additional funds earlier this year to extend the hours of the pharmacy and medical imaging so we could start working on some of those initiatives. One of the larger problems we have is that, with the exception of a very small emergency resource, medical imaging or radiology and pharmacy tend to be a 9-to-5, Monday-to-Friday business and the hospital isn't. As a consequence, over the weekend the hospital fills with patients and discharges

slow down, and so on Monday morning when the elective surgery starts up again, there is a bed shortage. Those sorts of patterns just become repetitive.

As a consequence, we have extended the hours for pharmacy and medical imaging at the Royal and are watching that very closely. It is funding provided to cover the winter period, not the winter season itself. Our winter tends to go from May to December. We are watching that to see if it has a positive effect on flow. We have the advantage of having Mr Craig Quarmby at the Royal; he has also four years at the Health Service Innovation Unit at UTAS, so he is doing things such as looking at what obstructs flow and working with the clinical staff to extend the hours of those diagnostic and patient support services to move patients through.

Ms FORREST - It is also about having discharge nurses working the whole weekend to move people on so they do not get choked up, when all they are really doing is waiting for something. It is medical patients who wait for something much more than surgical patients. The question was around the flow of medical patients, because we heard in evidence that it is the medical patient block that seems to be creating the biggest problem in the DEMs. Surgical ones are usually are one-off interventions and they are gone.

CHAIR - In regard to the way the Central Queensland Hospital and Health Service has looked at all of this, have you considered engaging people who have had experience, such as Rona Consulting or Kate Brockman and the like, who are experienced in looking at patient flow issues and problems? Have we gone down that track?

Mr PERVAN - Yes, we have. In fact Kate Brockman has been a visitor to our island many times. The work HSI Tasmania was put in place to do was to support the hospitals doing that analysis and redesign work. There is a lot of it done. One of the challenges is that work requires full engagement of frontline staff - that is the model you use - and a lot of detailed analysis, and while that has been done, it is not moving as fast as the increasing demand coming through the front door.

CHAIR - That relates to my statement about opening beds and needing the staff; it is not so much the staff or the bed, but it is staff in other areas that are needed to improve the patient flow. I read about the success the Central Queensland Hospital and Health Service has had. General surgery patients waiting longer than clinically recommended went from 926 to 50 in a year; orthopaedic patients, 1147 down to 94; urology, 342 down to 8; general medicine, 204 down to 16; and gynaecology, 113 down to 8 - clearly very significant successes there. If there is some way of being able to implement that sort of benefit, I think everybody would benefit.

Mr FERGUSON - Are they surgical over-boundary numbers?

CHAIR - It is called the Lean Methodology and is in the Central Queensland Hospital and Health Service report.

Mr FERGUSON - Are the figures you have stated done within clinically recommended times?

CHAIR - I would have to go back to the detail, but it is in their 2014-15 annual report, if you want to follow that through.

Mr FERGUSON - Sounds like it. We have not perhaps been as impressive but we have very impressive improvements in the number of people who have been seen within recommended times. When we came to office - in my case, four years ago - around 50 per cent of people were receiving their surgery within clinically recommended times. We now have that at over 70 per cent.

CHAIR - Toyota brought these Lean Methodology principles into play and it has since been applied with a patient focus. I think it works on the pull principle, so a ward with a spare bed rings up and asks for the patient rather than the patient pushed onto them, which is slightly different to the push approach. I would be interested to hear how you are approaching these things and whether you can do some homework on that and see whether it has value.

Mr FERGUSON - We would be very happy and keen to have a look at what you are referencing there; if you could share it, that would be great. I will ask the secretary to address this. We are familiar with the Lean Six Sigma principles and methodologies and in fact they are the very thinking behind health service innovation. That was the joint project between UTAS and the Commonwealth, and the benefit of that is that Mr Quarmby, who co-led that work at the University of Tasmania, is now one of the two people responsible at the Royal Hobart Hospital. That exact same approach and thinking is about removing those barriers and disruptions and the times, which can be wasted time, to make sure the facility is being utilised and patients are moved through so that their time is not wasted.

CHAIR - Did you want to finish?

Mr PERVAN - Just very quickly, there are a number of methodologies. Lean actually was refined in the National Health Service in the UK and Lean is -

Ms FORREST - Some years ago.

Mr PERVAN - I was going to say about 30 years ago.

Ms FORREST - That's right.

Mr PERVAN - It does have benefit for - I don't want to sound unsympathetic here - but it is at its maximum value with a simple production line model: an admission of a patient, a procedure and a discharge of a patient when they are able to be safely discharged.

Sigma is a different methodology; that is also around 25 years old and is applied for more complex patients. One of the challenges we have is that there are multiple methodologies and people who are very highly trained locally in those methodologies, but we're getting an increasing challenge with the crossover patient. For example, the patient who comes in for hip replacement, but also has COPD, diabetes and osteoporosis, so instead of just a surgical team managing their passage through the health system, you will have eight, nine, 10, 15 different teams interacting with that patient. Their discharge becomes complicated, their medication regimes become complicated, and so coming up with a way that makes their journey as efficient as possible is the real challenge. It is a challenge facing most of Australia.

As we learned with our presentation with the Grants Commission recently, in Tasmania we're either in advance of or slightly worse than the rest of Australia. They are good methodologies and we have a lot of people highly trained in them.

Ms FORREST - The question was about in the medical patient areas, acknowledging that there will be a change of having them all ideally located in one location, but it is not just the location of the patient, it is the way the services are run.

Mr FERGUSON - I totally agree.

Ms FORREST - Is there work being done to make sure the flow does continue? Whether it is the Lean Methodology or whatever it is, this is what we're hearing repeatedly is the problem. It is the blockage with medical patients getting through the system - those who need admission getting admission; those who are in the hospital getting out; the ones who are ready for discharge, progressing their discharge. Even things like when we talk about a psychiatric step-down unit, a medical step-down unit, where they may not need the really acute care, but they need some care. Are these sorts of things being looked at? As you say, the constraints of the physical infrastructure and the beds you've got, but to maximise the access to the sort of care you need when you need it means that you're in the right place. If people are blocking these beds because they are waiting for something that could be provided somewhere else, or should be provided somewhere else and they are not getting there, don't we need to look at this? Is work being done on that?

Mr FERGUSON - I can confirm it is about supply as well as what you do with your supply. I wouldn't want to just focus on supply and the work that we're doing, the amazing work we're doing, to build that new hospital and get more physical spaces that we can staff. Of course, I appreciate where you're coming from. It is also what you do with the supply and how you maximise efficiency. I've sat at this very table at a regular meeting with our key people from the Royal explaining to me exactly what they're doing to remove what you might call wasted time or downtime where there are inefficient waits where a patient could be supported on a ward.

Additionally, again, since I spent time with this subcommittee a year ago, we've actually opened exactly what you've described - a subacute medical ward, just up the road from the Royal Hobart Hospital on Davey Street.

Ms FORREST - The Repat?

Mr FERGUSON - At the Repatriation Hospital. We've converted level 1 of that building, which was previously offices and an auditorium, to a 22-bed subacute medical ward. It is exactly to support the Royal by allowing patients who don't require acute care to be cared for still, but just freeing up the space at the Royal for more acute medical patients. That is a specific example.

Ms FORREST - That's in Hobart, but we're still hearing of problems in the other hospitals as well.

Mr FERGUSON - Sure, but you asked what is being done. That is a specific example of exactly the case you are making for the suite of solutions because there is no silver bullet in health.

CHAIR - One aspect to this too is having the right staff available to do the sign-offs so that people can actually leave - things like that.

Mr FERGUSON - Discharges.

CHAIR - On discharge, yes. Being able to have somebody who can actually sign the paper to say you are okay to leave. Simply not having that person available means that person is sitting around waiting and taking up a space of some sort.

Ms FORREST - Can we talk about what is happening in that same sort of space, if there is anything, at Launceston and in the north-west? For the first time in more recent times I am starting to get complaints about bed block in Burnie, and it usually was not a real problem there. This is for surgical patients as well so clearly it is not just a problem contained to Hobart. What is happening in those other areas, in the north and the north-west?

Mr FERGUSON - We do not quite have the same pressures there, but I will ask the secretary to speak to that. I just want to go back one point and ask the secretary if he can add to the line of questioning on medical discharge and the issues around that. I think we have a subacute facility in the north at the John L Grove Centre in Launceston. I am not aware of one in the north-west but there may be.

Mr PERVAN - Thank you, minister. With respect to having the people there to discharge, a number of actions are underway that will get us to what is called 'criteria-led discharge'.

Mr FERGUSON - Also known as 'nurse-led discharge'.

Mr PEVAN - It can be nurse-led discharge.

CHAIR - Are these nurse practitioners we are talking about?

Mr PEVAN - It is a protocol whereby the care team outlines very specific goals and decision-making points required for a patient to be discharged or to be safe for discharge. As they are met, they are signed off. Once they get to that level, regardless of whether it is a nurse or a doctor, whoever is observing and assessing that patient can discharge them. So that does not require a ward round or something more traditional of that nature. On our way to achieving that, we are increasing the rosters of medical staff in the Royal; we have introduced a weekend roster of senior medical staff at the LGH from about two weekends ago so discharges are happening on Sunday.

CHAIR - There will be people over the weekend?

Mr PEVAN - Yes, with appropriate credentials and authority to keep that discharge rate going.

Mr FERGUSON - That is a more recent innovation of the Director of Medicine, Dr MacDonald, and the team there. That is again a locally identified solution recognising that bed block is something we want to reduce. If we can reduce bed block, we can reduce waiting times.

Mr PERVAN - We have also opened a transit lounge in the LGH. There is one at the Royal. It has been moved around a few times during the works but it is still there.

Mr FINCH - One at the airport too.

CHAIR - Living up to its name.

Mr PERVAN - It is a transit lounge in transit. That transit lounge is exactly as Ms Forrest described it - somewhere where patients who are ready for discharge can go while they are awaiting their medication to be dispensed or some diagnostic reports to take back to their GP. We are doing all these things. In fact recently in terms of patient flow, I went to a meeting of the statewide Surgical Services Committee in Campbell Town where the orthopods at the Royal were proposing a musculoskeletal pathway that would see patients assessed by a physio and others on their way to seeing a surgeon.

That is one of the ways that Central Queensland knocks out those numbers on the waitlist. Instead of the first clinical contact being a surgeon, you see others in that waiting time so that the waiting is not wasted. If it is remediable by physio or by medication or by other interventions, you get those earlier and it prevents the need for surgery down the line.

CHAIR - I mentioned nurse practitioners. The Australian Nursing and Midwifery Federation talked to the committee about nurse practitioners and how they can assist in the general sense of patient flow and all the rest of it and because of their training. Are you looking at expanding those across our health services?

Mr PERVAN - We have been expanding nurse practitioners across the services. I think we have learned they can be a fantastic resource and of immense benefit - and they certainly have been in the EDs - but I have seen the mistake made in other jurisdictions where a nurse practitioner looks like a great solution to a problem of flow or access, so they are dropped into a ward or a service in the absence of a bigger service model and they end up bouncing around without really knowing what their role is and without any clear line of authority or accountability. To incorporate them and to get the most value out of them, you need to actually look at the whole service model you are working with and make sure you have the right puzzle piece to fit into that service model in the form of a nurse practitioner.

CHAIR - And clinicians need to have a proper set of protocols and procedures between them.

Mr PERVAN - Absolutely, and you need the relationships between them to be absolutely crystal clear. The same argument goes to rural generalists, which is a fantastic idea and initiative, but if you don't make sure you have the right service model where they fit into and you haven't done that planning that is very local and contextual, they can be misplaced and often underutilised.

CHAIR - But they can save locum dollars, though, can't they, if they're properly placed?

Mr PERVAN - Anything that saves locum dollars is a good idea.

Ms FORREST - Just on the nurse practitioners, we know in the DEM at the Royal they have been particularly effective in dealing with the category 4 and 5 patients particularly, so what areas are you looking at and what areas do you see most benefit in?

Mr PERVAN - I would rather not talk off the top of my head. I would like to talk to the THS about what they are looking at because I know they are looking at a number of scenarios where nurse practitioners can be incorporated into the service models, but I would like come back with some more details.

Mr FERGUSON - How about we take that on notice?

Ms FORREST - Okay. The questions are: where are they being used, where are they planning to use them, and what is the broadness of their scope? If they are all emergency medicine nurse practitioners that probably does not solve problems in other areas. Can we get a broad response to that? How many there are, how many there will be, their planning, and in what areas.

Mr FERGUSON - I am happy to do so. For example, I can tell you they're at the LGH ED also.

Ms FORREST - Yes, I understand they are, but there are obviously more opportunities here and the ANMF has been making a very strong case on that.

Mr FINCH - I might point out that I just remembered we're being filmed today, and that wink I gave you, minister, was really just a 'Hello'; it was nothing to do with the questions or answers that were unfolding.

I want to double back to the KPMG report. From what you are saying, it seems to me that we are not going to get access to that report. You were talking about how helpful that information is - people being able to be frank and fearless - so what was your assessment of the report when it came to you? Have you been able to utilise that report to be effective in our health service now?

Mr FERGUSON - Thank you, Mr Finch. It is difficult to answer that but we take advice from a large number of quarters on a daily, weekly and monthly basis. Certainly we have taken advice on the reforms we implemented in our first week back in parliament when we put in place the new Tasmanian Health Service Act, which commenced on 1 July. Advice from the department as well as private consultants informed that, and it is now in place, with local leadership being recognised in our legislation as well as bringing the THS into the Department of Health as one unified structure. That has all been informed by advice both from consultants and the department itself. It is difficult for me to speak about budget because that is a Cabinet process so I am not really able to further shed light on advice we receive in that regard.

Mr FINCH - Was that advice you are referring to now contained in the KPMG report? Is that what you are saying? Are you saying you received advice about this, that and the other thing - was that contained in the KPMG report or is this outside the KPMG report?

Mr FERGUSON - I cannot really speak to specific reports; I am not in a position to be able to do that. We have taken advice as a government on systemic issues that have been addressed specifically in the Tasmanian Health Service Act, but I am not in a position to say which report or

what it said because then I would be releasing the report. I am trying to satisfy your very reasonable question because we need advice to be able to make the best possible decisions. That is just part of it, because the unions and the medical staff associations have also helped to inform that policy development. When I last sat in front of this committee it was, I think, in November or October a year ago, and we discussed the Deloitte report, for example, which was in a similar category. I was able to say to you then that we would release advice from a summary and I did so. The point I am trying to make is that we need to be able to take advice to make the best possible decisions. I genuinely believe we have done that and we will always take advice and continue to listen.

CHAIR - Can we receive a copy of that summary? I don't know that we've received it.

Mr FERGUSON - I have publicly released it. I released on the Friday after my last hearing with you, but I will undertake to give that to you.

Mr FINCH - I am interested in how this KPMG report impacted back to you. Was it highly critical? You say you wanted frank and fearless advice to come in. Would it be embarrassing to you or the Government to have that detail unleashed?

Mr FERGUSON - 'Unleashed' is not the word I'd be using.

Mr FINCH - Revealed?

Mr FERGUSON - I can sense the curiosity. I can just say that it is not of that nature but when I start to speak about it, I am breaching my own statement to you that it is internal to government. I can say that is not the nature of the advice; it is not like that. We want to make sure we are financially sustainable and well supported and efficient, and we need to find the best possible use of taxpayers' funds to ensure we are delivering the greatest possible benefit to the public and are not diverting funds into areas that are not efficient, like expensive locums.

Mr FINCH - So would you have found the KPMG report actually gave you good guidance that you have been able to utilise? Are you able to comment on that aspect of the report?

Mr FERGUSON - Look, I'm not in a position to speak to it, but I'm happy to say any consultant report or departmental advice is always taken in good faith and considered to ensure we are making the best decisions for the public, noting that the timing of the advice was post-election, but I could be wrong about that. I don't want to be too definitive but I believe that is when it came. It was also of course after we had made massive commitments in Health that I don't think any of the commissioned advice would have taken account of, and immediately before our May budget, where we provided quite a lot more than the annual amount that was proposed and have more than $400 million over four years and more to come.

I hope that the tenor of what I am saying to you about advice I received is helpful. I receive advice every day from the department and often it is based on advice from outside consultants. It all helps to make good decisions for the public. I wouldn't like you to think the Government is trying to hide reports or anything like that because that's not what we're about, but it is important and, particularly for budget purposes, vital that the Government gets advice. It is also important that advice is prepared for its intended audience because if consultants or public servants believe

their advice is going to be for a broader audience than intended, it changes the way they prepare that advice.

CHAIR - Minister, I turn to a submission we had from Associate Professor Robyn Wallace, a physician in internal medicine and a private practitioner. She told us we have the highest number of people of any state living with a disability - which I imagine is probably not news to you - who are high users of acute hospital care, It is reported in Australian and international literature that they have poor and inefficient outcomes in acute health settings.

Professor Wallace informed us that successful health outcomes are lower, the rates of adverse medical events are higher, and it is speculated to be more expensive and inefficient compared to the care given to people without disabilities accessing acute health services. She said the gap in outcomes between people with disabilities compared to those without is being recognised, standards are being set and benchmarks are being made to improve the person-centred care approach in hospitals, but that in Tassie generally these changes are yet to be implemented or integrated into acute health services at the hospital level, and they need to be.

What can you tell us today about what being done in our hospitals to improve the lot of people with intellectual disability to make sure they have just as high a chance of a good outcome as any of us here around this table?

Mr FERGUSON - I think the secretary and I will both offer to answer this. I am not expert in this area, but I have sat with Professor Wallace. She presents in her role as part of the College of Physicians - I believe she is currently the state Chair; if not, she has been in that role, but also she herself -

CHAIR - This was a personal submission she made; it wasn't on behalf of any organisation as far as I can see.

Mr FERGUSON - In her role with the college she has raised the importance of making sure that people with intellectual disabilities are given strong, effective and equitable access to health services. I looked at some of what she had to say to your subcommittee as well, and I quite respect what she has had to say. It has to be understood that she is an exceptional doctor in her own right as a practising clinician, specifically looking after people with intellectual disabilities.

CHAIR - That's right.

Mr FERGUSON - I just wanted to put that on the record. I think her observations are not intended to be a criticism of anyone particularly or her colleagues, but there is a belief implicit in her evidence that we can be doing better for people with intellectual disabilities. We are always open to the evidence on that. I don't have a specific answer for you today as to how things would be different, but I would defend the system from the point of view that the clinicians do give strong care. If I have the evidence in my mind correctly, she was saying there are times when she felt other clinicians could be doing more.

CHAIR - I think it is all about continuity of care and having the right people in the right place at the right time to give the advice needed for the care of those individuals. That sector has concerns and issues.

Mr FERGUSON - I would like the secretary to add to that.

Mr PERVAN - Once again, this issue is current and emerging around Australia. It was even on the agenda at the last COAG Health Council in Adelaide. Just to pick up on a couple of points, I don't think Professor Wallace is just referring to people with an intellectual disability, but also to people with physical disability. Often we have patients with both, as well as with multiple chronic conditions all at the same time.

CHAIR - And very complex mental health issues as well. It is very complex.

Mr PERVAN - And increasingly so. The other challenge is that it is not just about the coordination of the care but the collaboration. I think the word you used was 'continuity'. It is making sure that when complex patients come there is a lead clinician who has appropriate experience and skills in dealing with or managing the care of those patients and in coordinating what could be multiple teams. There is no-one in the system who would want to suggest we are not providing good care, or that we could not improve the care we are providing for people with disability. It is a question of the capacity of the system to embrace changed practice while they are also dealing with the current demands on the system coming through the front door every day.

It is a matter of finding the space to do the professional education and development required to improve the way they collaborate and coordinate their services for someone with disability.

CHAIR - She also mentioned dedicated outpatient services in relation to them. Do you have any comment on that?

Mr PERVAN - It is something we will need to consider. Part of the challenge all states have with the introduction of the NDIS is that boundary point where the NDIS starts and where the health system ends. That nexus is where we need to put more effort into outpatient services. It also impacts people in some of our mental health beds who have psychosocial disability, and that point at which we can move them into the community safely and with support as opposed to being in a mental health acute bed. It is something we are already looking at; we are looking at it starting in the mental health area, but we will take it broader than that into intellectual and physical disability as well.

CHAIR - She is saying that these outpatient services are virtually non-existent at the moment and there does need to be that service.

Mr FERGUSON - May I say, Chair, I definitely will take that point on board. They exist but they are not in the public system as a specific -

CHAIR - I think she is talking about the public system.

Mr FERGUSON - They exist because she provides them and she does it in the private sector. It is a very effective service that I know is much loved and well utilised, but if there is an opportunity to do more, of course we would look at doing so.

CHAIR - It is a point well picked up. It was about the public system, I am pretty sure.

She makes this statement -

> Although such patients require sub-specialist care, such as from neurologists or cardiologists, the physician in internal medicine is ideally trained to manage the complex bio-psycho-social situations of such patients.

She is saying that sort of expertise might improve things. To hear you say you are looking at some of these points I think would be quite comforting to her.

Mr FERGUSON - I want to take some careful advice on this because I wouldn't like to think we create an idea that people with intellectual disabilities should just come over here.

It is very important that the general workforce develop its expertise and its sensitivity in this area. In my understanding as a non-expert in this, the issue for many people with intellectual disabilities is that when they get sick, just like the rest of us do, they need to access the same expertise in caring for them. For example, it might be a urinary tract infection or a chest infection, things where you or I might easily be able to say our doctor, 'This is what I am experiencing and this is where it hurts', and we would go to the expert in that field. There is an import here I want to place on the broader workforce being equipped and developed in being able to deal with the range of patients who would be coming in front of them. Nonetheless, I also indicate we would be happy to respond to the notion of whether a specific stream is useful in the public system.

CHAIR - I think her point is that because the communication capacity of the patient is not so great, there needs to be a far greater awareness in those who are dealing with them and that the patient is not inadvertently dismissed.

Ms FORREST - And their carers included.

CHAIR - Yes.

Mr FERGUSON - I think we have mutual agreement on the way we want to be able to provide care to people with disability. It is a good point raised by Professor Wallace.

Ms FORREST - I know that the ANMF has put forward a range of suggestions for dealing with the immediate problems. A lot of the measures you mentioned in the ministerial statement are more relevant in the out years, which will be helpful later but may not be so helpful in the short term, where there are pressures - as you read in the newspaper, and I am sure we will get to the ambulance-ramping later. I am interested in a lot of the suggestions the ANMF has made over a period, not just to our committee, but publicly on a number of fronts, about increasing permanent nursing staff to EDs and opening beds that are not currently open at the LGH - for example, wards 4D and 4K, and other areas like that - and the PEN nurses in the LGH and, I suggest, at the NWRH, too. I am interested to know what the barriers are to that. I am aware of a particular challenge of a patient at the NWRH very recently. Unfortunately, that patient passed away after being discharged. It is an ongoing battle and challenge.

The question is around the vacancies or the challenges associated with recruiting additional nurses. You talk about the extra nurses you have, and clearly we need to have more nurses in the system and more permanent medical practitioners, and, as the secretary said, get away from the

reliance on locums, which has been a noose around the neck of the north-west, but it is not only unique to there.

Where are the vacant positions? Are there vacant positions in nursing and the medical profession? What are the barriers to filling those?

Mr FERGUSON - There is a lot in your question, and the secretary and I will jointly seek to answer it. Mr Kirby is getting an easy run at the moment.

Mr FINCH - Don't worry, no, we're right.

Mr FERGUSON - I won't ask him to assist on this particular answer. There is a fair bit in your question, which we will pick up. I would like the committee to know that despite what is reported in the media, we have a good and effective working relationship with the ANMF. The ANMF puts up a range of ideas and solutions and we respond with solutions as well. Not everything put up is always the answer to our challenges, but the ANMF is one of a number of sources of advice, if I can put it that way, and it does a terrific job in that respect.

Ms FORREST - It represents a key part of your workforce.

Mr FERGUSON - It certainly does, as do I as the employer and the secretary. We care about our staff and we want our patients to get the best outcomes. Unfortunately as is the case in perhaps political debates and some media reporting, it seems as though there is conflict between the employer and the unions when actually the daily relationship is very solid. I believe we want the same things.

In terms of 4D, the Government has reopened that ward. It was previously mothballed and the beds were in storage up at Coats Patons. That ward is now a very busy, bustling ward. It is permanently staffed at 24 and with flex capacity for five additional beds, which the THS executive has asked to be retained, so it can be opened when demand requires it and can be a support relief for the busy ED, which effectively means that the hospital is fully operational.

There are no simple solutions to improving bed flow. I believe we discussed it as Estimates as well, but currently recruiting for a psychiatric emergency nurse for the LGH is in progress.

Ms FORREST - Is that to cover 24 hours, or what sort of hours for that position?

Mr FERGUSON - The commitment we made there is for a trial of the PEN - the psychiatric emergency nurse. It is a model that has already been developed in Hobart. It was done on temporary, limited-time Commonwealth funding, but when it ran out, the Government committed that we would not stop it, and that we would fund it, which we did about two or three budgets ago. I know you understand the pressures on psych at the Royal, so that is a particularly important area. While there are pressures in lots of different areas, the psych issues at the LGH are not the same as at the Royal. Nonetheless we are recruiting to that position. I don't think it is 24 hours.

Mr PERVAN - No, it's not 24 hours. It is a 10-hour a day model. These decisions were taken by local management at LGH around when the peak demand for that psych liaison role is. They've been recruiting for someone to work that shift. It is the evening -

Ms FORREST - A 10-hour shift?

Mr PERVAN - It is not a 10-hour shift; it will be split between two people. The challenge with it is that mental health cases tend to come in at unattractive times of the day.

Ms FORREST - Correct.

Mr PERVAN - So they have to target the recruitment and make the package attractive to someone to work that particular shift. If that is when the need is, there is no point in putting them on 9-to-5, five days a week when the cases are coming in at night. They've gone to some length in discussion with the nursing management at the LGH and the ED to make sure that when they get that resource in place, it will actually be there when it is needed, as opposed to just sitting there and waiting for somebody to come in.

Mr FERGUSON - I will just keep going for a second. The other thing talked about is opening more beds on 4K. That is of course a children's ward. While we hear that repeatedly put about as, 'Why won't the Government open more beds on 4K?', I think that you as a nurse would understand why that is not the solution for a busy ED.

Ms FORREST - Before the -

Mr FERGUSON - I would like to hear your response, but can I just make it clear that I am not a clinician and I am not an expert in these areas. I have a literacy around it but I do not profess to have the expertise. Again, these are decisions for local management which we have empowered.

Ms FORREST - We heard from local management that there were demands for additional beds for the paediatric patients, including for the adolescent mental health beds promised for there.

Mr FERGUSON - In 4K, if extra support is required, it is provided, but there are just serious issues around opening up bed capacity in 4K as a solution. We need to exercise caution around it. We are building a new children's ward at the LGH which will for the first time ever specifically have beds for paediatric mental health or adolescent mental health, which is less than one year away from not just practically completed but also from when it is opened.

Ms FORREST - Do you have numbers of positions and that sort of thing that are being recruited or not filled?

Mr FERGUSON - Yes, the service model is being developed and it has been funded in the budget.

Ms FORREST - The question was the number of positions that are not filled - medical and nursing - and what the challenges are. You talked about the PENs and the unattractive hours and it is not necessarily an easy job by any stretch and you do need a particularly qualified person for that. I understand those challenges but I am talking in more broad terms now rather than just specifics.

Mr FERGUSON - The secretary is the expert in this, and I will throw to him in a moment. I can tell you we have been a very good employer of nurses and have been very successful at attracting additional nursing staff. In the last four years we have now picked up over 500 FTE nurses. The head count would be much more than that based on part-time employment as well. We have picked up over 500 in the last four-and-a-half years. You also mentioned medical - we have picked up over 100 additional doctors, including some in those speciality areas we have had a drought in for years. North West Regional has been very successful in getting out of locum use and into permanents, and also in our other hospitals. I think the secretary would be better than me to speak on vacancies and how we manage to recruit when people retire or resign and what the turnover issues are there.

Mr PERVAN - Thank you, minister. You asked us where the vacancies are: that really depends on the day that you ask. There is a number in the public domain about nursing vacancies in particular, not so much medical, and that number is stable so as a consequence it is easy to assume we have had a particular number of vacancies that have been vacant for a long time. There is a lot of movement within that number. It is just a turnover rate, if you like, and Tasmania does better than other states do in that regard. We have -

Ms FORREST - In the turnover or the recruitment?

Mr PERVAN - Both, despite what you might have heard. A study by the University of New South Wales indicated that the average rate of turnover in the nursing workforce in all states and territories is around 15 per cent. We have in the order of 3700 FTEs in nursing. If you look at the proportion who are part-time, there are many more than 3700 nurses in the system. If you are talking about 15 per cent, that would be in the order of 450 vacancies you would be expect to be processing at any one time. Ours is a lot less than that and in fact is quite stable at around 200. Those are jobs are being vacated and filled on a constant basis.

Mr FERGUSON - The problem we have is that it gets used as a way of trying to make the argument that the Government is not employing more nurses, but with such a large workforce and with the baseline level of turnover that any employer would have, the important point is that there is always going to be a number of vacancies being recruited to.

Ms FORREST - I am not disputing that. Also your demographic - there is a big bump at my age, I think.

Mr PERVAN - That is national.

Ms FORREST - I am not so concerned about the other states. They can look after their own affairs - we're talking about Tasmania here. Let's look at how we're going to deal with these things. You are saying there are about 400 vacant positions -

Mr PERVAN - No, there is around 200.

Mr FERGUSON - He said he might have expected about 400.

Ms FORREST - Okay, I apologise. So there are 200. What are the barriers to filling those? We are still seeing agency nurse issues; we are still seeing double shifts; and we are still seeing potentially putting staff and patients at risk with the long hours some people are working. We

know fatigue is like having a blood-alcohol level above the legal limit to drive. What are the barriers and what are we doing in that space?

Mr PERVAN - We are running rolling recruitment. We don't wait for nurse vacancies to start the process; we are constantly recruiting via the media, the internet and targeted recruitment around specialties such as ICU and emergency. We are in a constant process of recruiting nurses to try to keep that turnover rate down. That might be why our turnover rate of around 9 per cent is so much lower than the national average, because we constantly recruit to these positions. That doesn't mean, as you pointed out, that we don't have shortages in some areas that are quite difficult to fill simply because they are difficult to recruit to or there is a shortage nationally and internationally of the specialist skills required in that area.

One of the concerns I have is with the public perception that a nurse is a nurse is a nurse. Our problems are in recruiting ICU nurses who are specially trained and some of the surgical specialty nurses. I can remember way back when I was at the Royal, it took us nearly a year to recruit a specialist neurosurgical nurse to support the neurosurgeon. It wasn't something another nurse could pick up; it required very specific training. We have targeted recruitment campaigns for those specialties. They are hard to fill so we just keep working at it until we fill them. In the meantime -

Ms FORREST - What are you being told the barriers are? There is a worldwide shortage in some of them or shortages of a particular specialty, but what are the other challenges?

Mr PERVAN - The other challenges are hours and the demographic changes around work/life balance and other issues, who wants to work and who prefers to work those shifts, where the skills are, and what the universities and training courses are producing in meeting those demands. As we are getting an older and older workforce, the number of hours individual nurses are wanting to work tends to reduce and incidents of sick leave and occupational health and safety issues are rising. It is a very delicate situation where we are very strongly supportive of the nurses. We are doing everything we can to recruit. There are certainly no barriers or slowdowns being put into recruitment actions, but it is more that the overall demographic and complexity of the nursing workforce is changing rapidly while the patients they are dealing with are becoming more complex.

Ms FORREST - And the medical side of it?

Mr PERVAN - The medical side of it is very similar. We are actively recruiting for all our vacancies and have just begun a process of going through and individually reviewing each locums we are using to put an action in place to target recruitment around whatever the specialty happens to be. There has been a lot of action over the last year or so around particular specialties in both the north and south and we've had some luck, particularly with endocrinologists and neurologists at the LGH, and are cementing those applicants in very quickly.

Ms FORREST - Minister, are you able to provide a list of the current positions you are seeking recruitment for?

Mr FERGUSON - Medical?

Ms FORREST - Yes.

Mr FERGUSON - I would be more than happy to do that.

Ms FORREST - Also the nursing specialty areas where the challenges are.

Mr FERGUSON - I am happy to do that as well. I know we discussed it at Estimates and I will give you an update. I am also able to give you an indication that what you are hearing from me and the secretary are not just words but actions, because I recently visited the ICU at the Royal Hobart Hospital - Mr Valentine will be interested in this - and for the first time in yonks, the nurse unit manager was able to tell me that they had a full roster of specialist nurses. That is important evidence of the Government's employment drive and also the determination to get the right mix of staff and not agency nurses unless it can be avoided. I have no doubt agency nurses will continue to be used across the system where required, but from the results that have come through from some of the interstate and overseas missions to employ people with those skills in the absence of local workforce, it is working and the dividends are there to see. I think that is the first time in many years.

CHAIR - Does a full roster mean no double shifts?

Mr FERGUSON - No, it doesn't mean that, it means a full complement of qualified, ongoing nurses for that unit.

Ms FORREST - You can do a roster.

Mr FERGUSON - You can plan your roster out without planning double shifts and agency nurses. If, for example, somebody calls in sick at the last minute, then of course somebody needs to be found to work, but they have not had a full roster of nurses at the Royal ICU for a very long time, if ever. I think we have to give credit where it is due. A lot of work has gone on there. The Government has even copped criticism for some of the people who have gone interstate and overseas looking for those staff, but the results are there and it means a better service and stronger model.

CHAIR - One of the statements from the ANMF I noted is that the research study on the effects of overtime equates working double shifts of 17 hours straight to that of a blood-alcohol level of 0.05. Obviously the least number of staff we have on double shifts, the better.

Mr FERGUSON - That's right, we want to make sure people are working appropriate hours. Any time over a normal shift is voluntarily entered into, but it is always best if it can be minimised, and that is what we are seeking to do. You also have to factor in what the risk to the patient would be if the staff weren't a full complement on a shift - it would perhaps be a lot worse than has been described. Everybody works hard in this area and we need less of the sort of unhelpful criticism that sends a message to the community that it is not safe to come to hospital. We need not just to thank the staff who go over and above what is expected because they care, but also make sure that the Government and the management of the health system is ensuring that strong and really productive efforts are underway to employ the staff we know we need so we cannot just provide a better service but also better use of taxpayer funds, which I know that you agree with.

CHAIR - What is the situation at the moment with regard to operating theatres at the Royal, for instance? I think we have 14 operating theatres there. How many of those are actually operating at the moment?

Mr FERGUSON - We might be able to get some advice on that. I don't believe it is 14, but I could be wrong.

CHAIR - It was mentioned in one of the submissions.

Mr PERVAN - It was mentioned in one of the submissions and got a bit of airplay. As far as I know, they're currently operating out of 12 theatres because they're doing required maintenance and are rotating the closures. The concept or what was put forward that one or more theatres were permanently closed is not the case; they are going around and doing the required maintenance of those theatres. The HEPA filters - the air filtration system - have to be replaced for safety reasons and a number of things have to happen. It is not something you can delay. It used to be that we would close the theatres down, or the majority of them, over the Christmas period and do them then, but we've been maintaining our elective surgery activity for the last couple of years such that this is now required. We can confirm the number of theatres currently opened, but it is because of that rotating temporary closure while we do required maintenance.

CHAIR - Thank you for that clarification.

Mr FERGUSON - What if we come back and give you a firmer line on that? Of course we are building more surgical theatres in the new redevelopment.

CHAIR - We are.

Mr FINCH - I am concerned about Mr Kirby's lack of involvement in our proceedings here today, so just bring the spotlight onto Mr Kirby, please. Ms Forrest mentioned ramping. Has that terminology changed? Do you still call it ramping?

Mr KIRBY - Yes, it is the common term used.

Mr FINCH - What about internally among the crews? Do they call it ramping?

Mr KIRBY - Yes.

Mr FERGUSON - What is the dictionary language? Ambulance off-load delay I think is the standard definition but it is rhetorically known as ramping, yes.

Mr FINCH - We see reports that the situation - and you might clarify this for me, Mr Kirby - does not appear to be easing. In fact it might even be getting worse. Do you care to comment?

Mr FERGUSON - What if I just offer first of all that it is a nice opportunity to just say that the Government accepts we can always do more and better. We have been probably one of the best employers in terms of the uplift in services in many years. We have increased crews in every region and we have a budget now which provides for 42 additional paramedics around the state. You might like to explore that with us today or you may not. Also ramping is to be minimised as much as it possibly can be and it is usually not a sign that the ambulance service is underdone. It

is usually a sign that there are bed pressures at the hospital. I am sure you know that. Where we can improve ramping, the intention would not be so much to reduce the number of ambulances waiting at an ED. The intention would be to make sure that the ambulance is empowered and free to go to the next emergency case with the shortest possible response time.

Our efforts are around opening additional beds in hospitals, ensuring that, to answer Ms Forrest's questions, we have the efficient use of our beds to maximise patient flow. We also recognise that even absent a discussion on bed pressure, ambulance call-outs are up as well so that indicates that demand is also up. We are supporting Ambulance Tasmania with that. The Government has never ever said that ramping has been fixed. I know that has been said but it has never been said. The Government has never claimed victory on it but we do want to put down the pressure on ramping and that is our goal here. I am sure Mr Kirby will talk about it - our goal is to bring down response times and we have had some very positive news on that as well. Mr Kirby, go right ahead.

Mr KIRBY - Thank you, minister. Obviously ramping is an issue for us. It is particularly an issue for our staff. I would be remiss not to commend our paramedic staff who do the work in ensuring patient care is maintained when we have periods of ramping. It is our paramedics who are with the patients while they wait to be seen at the hospital. I would like to commend the work that is done and the stress that it puts on our paramedic staff. It puts a stress on us as a service and we have strategies in place to manage that. To answer your question in terms of whether it is increasing, the figures are produced in the regular reporting through THS.

We know there are seasonal factors around ramping. In the winter months when there are a lot more people going to the hospital, you tend to see ramping occur. This time of the year we would expect it to probably be more than normal. It can be periodic. We can go several days or weeks without a big ramping issue and then the stars align and we have a period where the hospital is very busy, where we are very busy, and we can have an acute period occur very quickly.

I think what frustrates our paramedics a lot of the time is that it heightens the need for a good use of the ambulance service by the community. It is frustrating when we might have periods of ramping and a number of calls are then waiting that when they get to that call, it was not really a case that required an ambulance. That is a lot of where our energy has been in terms of managing patients' needs - things such as the secondary triage program we have been working to establish over the last 12 months or so.

Mr FINCH - Describe that, please.

Mr KIRBY - Secondary triage is the recognition that some people in an ambulance may in fact not need to go to a hospital. That sounds simple, but the actual process of determining that they do not need hospital care is complex in itself. That is where the term 'secondary triage' comes into being, where in fact the patient goes through a more detailed triage process when we have -

Mr FINCH - Over the phone, do you mean?

Mr KIRBY - Yes, over the phone initially to determine that their condition is not an acute emergency. Yes, they have a healthcare need, and we are trying to explore what their healthcare

need is. In fact, what is the best avenue to have that healthcare need met? It just may be that an emergency department at 2 a.m. in the morning is not the best thing that is going to meet that person's healthcare needs. The concept is called 'secondary triage'. There are a whole lot of different strategies to choose. The person may be referred to an online doctor or nurse, or to a specialty area, particularly in terms of mental health et cetera, where there are specific helplines.

We have what we call 'extended care paramedics', and they have a range of skills to care for a patient where they can deliver care in the home. In the old days that person would have been collected and taken to the hospital with, for example, a blocked urinary catheter. We give the skills to an extended care paramedic so a patient who calls for that can be attended in the home and then does not need to go to the emergency department.

We are building up those strategies so that when we have a period of high demand, be it by ramping or any other factor that causes high demand, my goal is to increase the availability of ambulances to the community. I do not want to see them parked on the ramp; I do not want to see them busy on non-urgent cases. If we can manage all those things, we can ensure our ambulances are going to the right cases.

As the minister indicated, if there is an indication for that on response times, we show we have been doing that in Tasmania and improving our response to acute cases that we can do. It is about getting that focus on what else we can do for the patient.

On the specifics of ramping, I default to the secretary for the 'in-hospital' strategies used to assist us with ramping, but we as the ambulance service work closely with the hospital department. There are a number of places where we meet formally with the hospital through committees to work out a strategy of best managing the situation when we have ramping and we have internal ambulance processes in place to assist with that as well.

The number one priority is to ensure we continue to care for the patient so there is no disruption of care to them; our paramedics continue to provide that care, and we work with all those strategies I have identified to get that.

The other priority for me is to get an ambulance back on the road.

Mr FINCH - As you have mentioned, minister, 42 extra paramedics, extra ambulances: What does this mean in respect of the infrastructure and the number of ambulances you have in service? What would that increase represent if one is considered?

Mr FERGUSON - Mr Kirby would be far better than me to articulate the process around that - these are regional paramedics, the focus is the regions. We have actually increased our city-based crews in our first term of office. We increased every region with at least one extra 24/7 crew and the benefits are there because we have actually seen response times reduce. This is in a period of increasing demand, more call-outs and also busier hospitals; yet if you only took what social media or other reporting might indicate, you would think there is a declining or deteriorating response time.

I can tell you that our statewide emergency response median emergency response time has come down to 12.8 minutes. That is the lowest since 2014 and it is during a period of increasing demand. In Hobart during the financial year, in the department's annual report, the Hobart

response time has come down by 2.8 minutes; in Launceston, it has come down by 2.4 minutes; in Burnie, it has come down by 2.5 minutes; and in Devonport, it has come down by 1.6 minutes.

We should thank Mr Kirby and his team for how have fine-tuned the way the service is provided. It is also a testimony to our on-road teams that have delivered those services and got them out quickly; and it is a testimony to the Government's extra resources, which means they have a bigger capability to get to the job. In a state as regionally dispersed as ours, to think that on the statewide average, including the regional areas, the median response time - that is the middle time given to an emergency case anywhere in the state - is 12.8 minutes is nothing short of phenomenal, and we thank them for that.

We have a plan for 42 more paramedics, and it will include the trucks where required as well. The secretary and Mr Kirby have been engaging with the main union in this area, the Health and Community Services Union, and have been going around the state, sitting down with the local teams and identifying how we will progress this initiative in a way that supports the teams. The measure was intended to support fatigue management and to support more timely care for patients. Mr Kirby, can you update the committee on how we are travelling there?

Mr KIRBY - Thank you, minister. Before I address that question, I commend our state operation centre staff on the response times. We have a communication room in Hobart that looks after the whole state. It is a very busy room. It takes every call for assistance across the whole state. Those staff work under a lot of pressure and they are significant players in the improvement in response times. I commend the work our staff there do every day, managing the deployment of our resources.

With the 42 staffers, the minister said we had two targets for this: to look after our patients better with improved service delivery and to look after our staff better. In the regional areas you often have the situation where full-time staff supplement their hours with on-call work. They work and then they do on-call work in the smaller areas. That opens the door for a lot of fatigue issues. There is also the issue of our volunteers in the regional areas. We rely heavily on our volunteers and we want to support them in a constructive way.

The task given to us by the minister was to ask how best we can use these to service delivery. The secretary and I got on our pushbikes -

Ms FORREST - Literally or figuratively?

Mr KIRBY - Figuratively. We went to Sorell, Deloraine, Wynyard, Burnie, St Helens, George Town and a few other places because we wanted not only to pool the quantitative data - we can get all the statistics - but we also wanted to get qualitative feedback from communities about what will benefit them. We are finalising that report as we speak. There are a number of strategies for increasing the service provision to communities and upgrading some of our volunteer areas to presence of full-time staff.

One of the interesting things put to us by many staff was how we use the medical retrieval for movements of patients between hospitals, particularly in the regional areas, and how that can improve the availability of ambulances that I spoke about before in the communities.

We are digesting all that information into a much more comprehensive service delivery. In some instances that will not require capital works. If you go to a single-branch station now, it has two ambulances and all the resources there. We can just change the balance of the staffing. There may be some areas where we are talking about a new volunteer area, where we will consider the capital required for that.

Mr FINCH - Mr Kirby, would there be a situation where you have ramping and you need to have an ambulance or a couple of ambulances get back on the road, but there are patients in those ambulances and the ambulance is needed? How do you deal with a situation where a patient might best be left at the hospital without the prospect of getting in immediately and the ambulance goes out? Do you need to call on other paramedics to look after that patient while the others go back out on the road, maybe on overtime or something like that?

Mr KIRBY - Great work is being done by our state operation centre, our coms centre, because they manage that. It is their job to manage when we have that conflict, and they do that extremely well. A number of strategies are in place for that scenario. Within our escalation plan for that, we have staff who can go to the hospital to care for the patients and release the crews. We prioritise our patients by ensuring the person in the greatest need gets the ambulance first. If a person of a low acuity is delayed, we will contact that person and make sure they are not in any way threatened, that they are safe and comfortable. Our coms room will be in contact with that patient when there may be a delay and negotiate that. We put additional people onto the ramp to assist with the care of patients there so that crews can be released. Sometimes that includes calling people in on overtime. A lot of the time it includes calling in people who are qualified, competent paramedics - for example, our training department - who will be sent down to the ramp. They will be called off their other duties to assist with those peak periods.

CHAIR - Can I ask a question here about the cost of a ramped ambulance to the Ambulance Service? When an ambulance is ramped, it may have come from, say, Sorell and it has brought in a patient. That ambulance has to be backed up by another further down the Peninsula. Is it right they have to come up to cover for the ambulance that has just left? Can you give me an understanding of the actual cost of an ambulance being ramped and not being able to go back out?

Mr KIRBY - I haven't got that in a dollar figure. I assess it on the availability to cover a community. There is a concept in the Ambulance Service called 'dynamic deployment'. The reality is that I have 54 stations across Tasmania at any one time. We will dynamically deploy resources to provide coverage in broader areas where we need to and provide that coverage in the regional communities, and we have volunteer backup available. In the single-branch stations where there is a single branch officer, there are actually two ambulances and the strategy is to have the second ambulance available for volunteer deployment. We have a number of strategies to continue to provide that coverage.

CHAIR - Obviously it is a complex exercise to keep up the availability, but there is also a cost for having an ambulance sitting around and not being able to move. That is why I asked that question.

Mr FINCH - When will those 42 paramedics be in place, trained up and ready to go?

Mr FERGUSON - As Mr Kirby said, a consulting exercise has been done, and I believe detailed analysis and advice will be coming forward in the very near future. It is not quite mature,

but we have been consulting and we look forward to saying more in the near future about how they will be deployed. The 42 are over four years; that is how they have been planned. The focus of the work has included finding out where the highest priority is right now.

Earlier we discussed the Assessment and Planning Unit at the Royal; the figure there is 28 beds. I also have my ministerial statement from last week and the summary report of the new bed implementation team from December last year for you to table.

CHAIR - Thank you, minister. Finally, on the ambulance side, are there any jurisdictional issues? Where you have ambulances bringing in patients and hospitals needing to take them, are there any demarcations where you have a problem with who has the authority to do what with the patient?

Mr KIRBY - There is a point that is defined in patient handover. If the patient hasn't been handed over to the nursing staff, they are our responsibility. Once they are handed over to the triage nurse at the hospital, it becomes the hospital's responsibility. It is an area where there is support between the staff. If our paramedics who might be caring for a patient need assistance from the hospital staff, the hospital will work together in a team to provide the care.

CHAIR - We have heard that the goodwill gets a bit thin sometimes between the services because of the circumstances they are operating in. Do you want to comment on that?

Mr KIRBY - Look, I won't deny it is a difficult and frustrating time that the paramedics and all the hospital staff are caught in when there is a ramping situation. It is busy for them. It means there are a lot of patients, there are a lot of needs, and I don't step away from the fact that it is a stressful time for them.

Mr FERGUSON - We acknowledge that.

Mr KIRBY - We acknowledge that, and obviously we try to put in supporting mechanisms.

Ms FORREST - There a couple of areas I would like to go to. One is the north-west maternity services. I understand all the reasons and history around that so I don't need to revisit any of that, but there is ongoing concern, in my mind as well as others - and women included - that the lack of continuity of care is becoming a real challenge. There are still midwives who can't work across their full scope, which threatens their capacity in terms of improving their competency, and their job satisfaction is definitely negatively impacted. I absolutely understand that from a personal perspective. It has been suggested over a number of years, including by myself, that it would be preferable to see public birthing back in the public system entirely. I commend this Government for getting rid of the evergreen contract - no mean feat - but that gives us at least a time frame to consider that. Will you consider bringing public birthing back into the public sector so that midwives can work across their full scope of practice within the public system and that women can be assured of continuity of care?

Mr FERGUSON - Thanks, Ms Forrest. I can't give a guarantee about what will happen at the current expiry date of the new contract with the North West Private Hospital but, as you know, we were able to renegotiate a new set of arrangements that arose from the new integrated model. The integrated model enabled the renegotiation of that contract, if I can put it that way. I could not forecast an intention to change.

Ms FORREST - Are you open to the suggestion or proposal to bring public birthing back in with the full suite of services within the THS?

Mr FERGUSON - I wouldn't rule anything in or out, but I would say we would always expect a future minister, government and department would be very mindful of a range of outcomes for any proposed change, because that is one of the biggest parts of what that hospital there does. In fact, I think one of the reasons for the evergreen contract was to enable that hospital to be built in the first place. We wouldn't want to do things that deliberately led to a private hospital being unviable in a regional community. We have a limited time contract for a reason. It allows the Crown at the time of renegotiating that contract to make sure we do what is best for women and -

Ms FORREST - You'd have to start planning before the end of that contract, minister.

Mr FERGUSON - Of course. For us, the important thing we have turned our mind to in the last four years has been what is the safest possible model - and thank you for what you have said about that. Governments do not often get too many compliments for making difficult decisions based on the safety of mums and babies, but it is there for all to see and if we can improve it, we will. As for the contract itself, it would not really be appropriate for me to speculate on it, but we respect and have a good relationship with the North West Private Hospital. The model is working and they are to be commended for their role in that, but we do have -

Ms FORREST - It's working to a degree, minister. There are still challenges in terms of continuity of care for women and full scope of practice for midwives.

Mr FERGUSON - Yes, and thank you for reminding me about that because I was answering another part of your question. I understand that point. I will ask the secretary to swing in shortly but I understand the importance for a midwife to want to feel he or she is providing their full scope of training in the service they provide. As you know, there are two initiatives in play here. One is that in the renegotiation we brought all outpatient antenatal care into the public system, whereas before it was split. That brings more consistency for antenatal care.

Also as part of the new contract, even though birthing and inpatient gynaecology services were consolidated in Burnie - and this was me keeping a promise and the health system keeping our promise to our staff - we wanted to find a way for the midwives who had been practising and were employed at the Mersey to be gainfully continuing to do their wonderful work. Look, you wouldn't blame them to continue to birth at the Mersey, but given they are based at the Mersey and the service was being consolidated to Burnie, we needed to find a way to keep them in a real, material and fulfilling way involved in their practice. We are doing that. For those who are not able to be involved in birthing, I understand the perspective.

The second thing we have done is specifically brought in midwifery group practice, which follows the mother from antenatal care right through to the day of birthing as part of that team-based approach -

CHAIR - The mothers need continuity too, don't they?

Mr FERGUSON - Of course they do.

Ms FORREST - The continuity needs to continue through the postnatal period.

Mr FERGUSON - I should have mentioned that, because they do -that is part of the model. Australia's Midwife of the Year, Carol Nicholas, is a Mersey midwife and she was able to speak to that. I take the point on board.

Ms FORREST - The question was whether you were open to considering bringing the birthing patients back into the public system within the THS.

Mr FERGUSON - Yes, and I've answered that in that I can't forecast what the future will be.

Ms FORREST - No, the question was: are you open to it?

Mr FERGUSON - We're not opposed to it, but I'm not going to render an important hospital unviable at the swing of an answer in this committee. I will say that the Government has shown it is quite prepared to take the difficult decisions based on mothers' and babies' safety and that is exactly what we've done in the north-west coast. I again thank you for your support on that.

Ms FORREST - I want to go back to the funding. Minister, I know we discussed this and went off into another topic, but as I understand from reading the Commonwealth Grants Commission information about how it determined what Tasmania and all states should get based on a whole range of factors, one of the factors it considers is the state's own revenues and the assessment it makes on how much we should get for health considers the fact that we would be raising our own revenue at a similar rate to other states. I can hear treasurers, past and current, bragging about being the lowest taxing state in the nation and that's all very well except if it diminishes the amount we have available from our own revenues which the Commonwealth says we should be making to fund our health services. We are notionally allocated more because of the challenges Tasmania has in delivering health services in a dispersed population, our demographic, the complexity of our patients and things like that.

I am sure you read Martyn Goddard's information - although I'm not asking you to agree with it - and there are other commentators, and one of the recent reports which was leaked referred to this as well. Maybe we need to talk to the Treasurer because that is where the decisions are made around the budget. In reference to the point you made earlier in the hearing, are we being underdone here and not spending as much as we should on Health according to what the Commonwealth Grants Commission says, because we are eroding our own state revenue? On the assumptions they make in terms of determining how much Tasmania gets - because GST is unfunded so we can spend how we like -

Mr FERGUSON - Untied.

Ms FORREST - Untied, sorry; it is not tied funding as opposed to a national partnership payment or specific-purpose payment. Is it a concern to you that you are finding it more challenging to fund the Health budget? In your annual report, the actual for 2018 is $1.62 billion. In the budget it was $1.46 million - $200 million short - and $157 million in 2017 and $161 million this year, spending above what was budgeted. The budget year we are in now is still less than that amount. You are spending more. Is it a question we need to ask the Treasurer rather than you?

Mr FERGUSON - No doubt you have seen this happening for a while. In the last financial year we spent a greater amount of money than was intended or planned through the budget process and the Government has provided the extra funding. I think the additional state Government funding provided was $63 million; I feel was the right number from the last financial year -

Ms FORREST - The difference between the budget and the actual for the last financial year was $161 million.

Mr FERGUSON - Yes, that is expenditure as opposed to funding, which is different because there are revenues involved as well.

What I want to say is that we are a government that does is needed to meet demand. Our biggest challenge, frankly, is capacity to deliver, and that is why the additional buildings and the additional staffing of more beds is so important here.

So many things get said in what passes for political debate in this state and some people just say whatever they want around the GST, but the fact is that the state Government does not allocate its GST. No state government - none - allocates its GST.

Ms FORREST - That is my point, minister -

Mr FERGUSON - Why would you allocate your GST? It is like a person with two jobs who decides they are going to spend the money from one of their jobs differently, how much of their rent and groceries they will allocate to the job A as compared to job B. That is not how any government budgets. We budget our total budget.

Ms FORREST - That is my point, minister. The Commonwealth Grants Commission makes its assessment on how much we get based on a range of factors, and one is our own state revenues.

Mr FERGUSON - Yes, that is our ability to raise funds in the state, yes.

Ms FORREST - Yes, that is right. It has a 'standard' it applies and it assesses it as if you are raising that same amount of revenue. If we are not raising that amount of revenue because we erode our tax base through a variety of Treasury measures - not health, Treasury measures - does that make the challenge greater?

Mr FERGUSON - We are a government spending more money in health. I understand the question and your purpose in asking the question, but if it is true, and I do not concede that, but if it is true that we spend a lower portion of our GST on health, then we must be spending a higher portion of our non-GST revenue on health because we are the second-highest funder of health out of our total budget in the country. That is something that, again, passes for political debate; it is pretty hard to get those headlines up -

Ms FORREST - It is, but in the budget we are still consistently budgeting less each year than we spent the year before.

Mr FERGUSON - I hear you. We are spending more last financial year than was originally intended. When the May 2017 budget came down, nobody predicted the worst-ever flu season which we met with additional staff costs and unfortunately, as was required at times, covering sick leave. Our own staff caught the flu and double shifts, agency nurses or overtime are all measures used -

Ms FORREST - These things are going to happen in a health service, minister.

Mr FERGUSON - Indeed, and we have seen, even this year, even though we have not had the flu season, it has been nearly as busy.

As I have said previously, only in the last few weeks, we expect to put in more funding again this year but we actually planned in the budget because I know you want to see certainty, and you want to see structural funding -

Ms FORREST - I would like to see the money upfront, minister, that we end up spending every year to the tune of about $150 million last year, $161 million this last year, that is more than is budgeted for. It would be good to see no need for RAFs or supplementary appropriation bills because we are funded upfront for the things we know are already there. We did not have a bad flu season this year and we are still spending more.

Mr FERGUSON - I understand the point, but the budget needs to be able to assist the Health department and the health system as needs required; that is really important to us, and that has been the case. If we had not had the budget in such a strong position, we would not have been able to provide those extra funds in the previous year.

Ms FORREST - Then we should make the base funding more realistic.

Mr FERGUSON - In the May budget, which was post that advice that has been reported on -

Ms FORREST - I am talking about this year's annual report, minister, and this year's budget. I am not using those reports; I am talking about what is happening in your own documents. These are now leaked documents from somewhere else or someone else's opinion -

Mr FERGUSON - Can I just make a really important point? We are about to open 298 beds in our health system over the next six years. Those beds will be recurrently funded; they will be structurally funded. The first four years of those six are now in the budget papers and you can see it is there. As those beds become open, it will provide the services we've been trying to provide in our yesterday's hospital buildings, if I can put it that way. We'll be able to grow into those beds and those facilities, and you will see we are in a far better position to be able to meet demand and that the budget planned for meets what the demand will be.

CHAIR - Would that put us in front of the eight ball rather than behind it -

Mr FERGUSON - It is a very good question.

CHAIR - at the end of the day given the growth?

Mr FERGUSON - It is a very good question. I would love to say yes immediately, but I would like to check that. I suggest that the $757 million commitment puts us as the number 1 in the country, but I would have to check. I would say we would be a contender.

CHAIR - Because we've been playing catch-up all the time.

Mr FERGUSON - Tassie is often accused of being the worst in the nation or behind the national average. Actually in many of our indicators, we are leaving other states behind and we're doing really well. I would like to see more encouragement of what our staff have achieved. For example, in elective surgery we have had a stunning turnaround where we have reduced the longest wait patient by 80 per cent. We have people being treated in time from 50 per cent up to over 70 per cent. In some areas, particularly in our EDs, which we recognise are very busy, we want to do better.

CHAIR - We have about four minutes and we have a question on acute mental health.

Ms FORREST - I earlier mentioned the acute mental health beds at the Royal particularly and the redevelopment of K Block. I noticed you've made some decisions around medical patients, and we talked about that earlier. Prior to the election significant concern was raised about the design; and we talked about this in Estimates as well. In your ministerial statement you said you were continuing to liaise and re-look at the structure of the K Block. Is there room for movement to address the genuine concerns of the psychiatric clinicians? One of the key concerns is the lack of step-down, step-up facilities. I know we're talking about the new centre at St Johns Park and so those things are all down in the pipeline, but is there any move to reconsider some of the infrastructure structure there for the acute mental health centre?

Mr FERGUSON - Thank you. I appreciate the time constraints, I will make -

CHAIR - Unless you have extra time, minister, because we do, but it is up to you whether you can provide extra time to us today?

Mr FERGUSON - I need to keep a commitment, but I will try to make it as time-efficient as I can. First of all, as a business as usual approach, where we are building K Block on levels 2 and 3 to accommodate acute mental health, we promised during the election campaign that we will meet the extra demand with 25 additional beds. As you will see from the ministerial statement, which I tabled, we increased that last week in my statement, not to 25, but to 27, and we have found an innovative approach to deal with the disruptions at Mistral.

Ms FORREST - They are subacute beds?

Mr FERGUSON - They are subacute beds, and it is now 27. That is a genuine effort to relieve pressure on the Royal acute service and to meet demand. That is 15 at the Peacock Centre, which we are rebuilding and 12 at St John's Park. We appreciate they are a time away, because they are in the planning stages still and in the case of St John's Park, it is only a new announcement. We will in the meantime stand up the Mental Health Hospital in the Home on the advice of the Chief Psychiatrist, Dr Aaron Groves. He delivered this in Western Australia and it has been done in other states. The advice to me is that we will have that up and running with 12 equivalent beds in the community by March 2019, in six months time.

Ms FORREST - Just the design of -

Mr FERGUSON - I'm sorry, yes, thank you. Additionally during the election campaign while we are committed to the tower and delivering it on time and on budget as promised, we also have committed to a master plan of the whole site. As part of that master planning process we've given an undertaking that mental health will be considered during that process.

Ms FORREST - There is room for some change in that, is that what you are saying in this master plan?

Mr FERGUSON - There is room and it will be considered.

CHAIR - One of those problems was that it wasn't ground floor. Is that still an issue with some of the clinicians?

Mr FERGUSON - It depends who you ask, to be honest with you. I want to be delicate about this but there is definitely a diversity of opinion. Many staff are really looking forward and hoping to move into K Block knowing it is far superior to the current facilities, and I quote the Chief Psych in that regard -

CHAIR - Minister, it is 11 a.m. and you have a commitment. Is there a chance if we gave you extra time to go and do that commitment that you can come back?

Mr FERGUSON - Not today.

CHAIR - That's okay, it was just today we were considering that.

Mr FERGUSON - If you have any other questions, I'm happy to respond.

CHAIR - Thanks for that. We appreciate the fact you've come in, all of you -

Mr FERGUSON - I am the first Health minister in 20 years to be willing to come to your committee and I'm happy to do so.

Ms FORREST - We had a problem with the previous government on that; that is absolutely right.

Mr FERGUSON - If you have further questions, I am happy to receive them.

CHAIR - Thank you.

THE WITNESSES WITHDREW.