PARLIAMENT OF TASMANIA

TRANSCRIPT

LEGISLATIVE COUNCIL

ESTIMATES COMMITTEE A

Hon. Sarah Courtney MP

Wednesday 25 November 2020

MEMBERS

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

WITNESSES IN ATTENDANCE

Hon. Sarah Courtney MP, Minister for Health; Minister for Strategic Growth; Minister for Women; Minister for Small Business, Hospitality and Events

Ms Kathrine Morgan-Wicks, Secretary, Department of Health

Mr Craig Jeffery, Chief Financial Officer

Professor Tony Lawler, Chief Medical Officer

Mr Ross Smith, Deputy Secretary, Policy, Purchasing, Performance and Reform

Mr Dale Webster, Deputy Secretary, Community, Mental Health and Wellbeing

Ms Renee Anderson, Chief People Officer, Human Resources, Department of Health

Mr Matthew Eastham, Chief Executive, Ambulance Tasmania

Shane Gregory, Deputy Secretary, Infrastructure, Department of Health

Kim Evans, Secretary, Department of State Growth

Brett Stewart, A/General Manager Business and Trade Tasmania

The Committee met at 9.01 a.m.

DIVISION 5
Department of Health

CHAIR (Ms Forrest) - Good morning, minister, and thank you for coming. Welcome to Estimates Committee A hearings. If you would like to introduce your team at the table and any new members you bring forward during the hearings, that would be great. I invite you to make a short opening statement after you have done that. We will go through the output groups as listed in the Budget Papers and have a break for morning tea, hopefully around 11 a.m., depending on where we fall with output groups.

When we get to Admitted Services, if you are happy to take questions on 90.7, the COVID-19 elective surgery uplift, that might be helpful because it is linked to Admitted Services.

Ms COURTNEY - We're happy to take them wherever it is appropriate.

CHAIR - Over to you, minister.

Ms COURTNEY - Thank you very much. First, I extend my sincere condolences to those who have lost family members and loved ones through the COVID-19 pandemic.

COVID-19 has touched us all. There is not a Tasmanian who has not had to deal with the issues posed by this virus in some way or another. Our frontline healthcare professionals, nurses, doctors, paramedics, cleaners and infection control experts did an extraordinary job tackling the biggest health threat we have faced in living memory. I particularly acknowledge those who were directly affected by COVID-19 when the outbreak occurred in the north-west.

My message to Tasmanians is we must remain vigilant. Each and every one of us has a role to play in continuing to do the right thing, adhering to restrictions, getting tested if we show symptoms, and making sure that we reduce the risk of further outbreaks.

The Government is focused on continuing to build a better health system for Tasmanians, which delivers the right care, in the right place, and at the right time. This Budget includes an unprecedented $9.8 billion in health spending over the next four years, underpinning record staffing levels, and opening and funding new beds to provide health care for Tasmanians.

There is $600 million additional funding for the Tasmanian Health Service, a $45 million injection into elective surgery, which is expected to provide 8500 additional surgeries during the next 18 months, and more than $300 million to continue the rollout of new beds.

There are now 1500 additional staff in our health system, compared with March 2014, which is indicative of our strong commitment to putting more resources into our system to better meet demand. But we are not just focused on our major hospitals, as important as they are. We are focused on building a better health system that delivers the care our patients deserve.

This is why it gives me great pleasure to make two announcements on further support the Government is delivering to improve access to healthcare services in our community.

The first relates to $5 million which was allocated in March 2020 towards a primary healthcare support fund as part of the Government's immediate response to COVID-19. I can advise the committee that $4 million of this funding has gone towards a primary healthcare grant program which provided close to 500 grants of up to $10 000 to GPs and pharmacists across the state, supporting them to continue to deliver primary health services during the COVID pandemic.

I am pleased to announce that the remainder of the fund, close to $1 million, will be going to Primary Health Tasmania to deliver a program to support GPs with their ongoing outbreak preparedness management. This includes increasing GP access to PPE supplies through the purchase and distribution of surgical gowns for clinics.

Primary Health Tasmania will also engage specialist GP consultants to support targeted practices to establish or increase COVID-19 assessment and testing with a focus on building capacity in our rural and regional areas. The Department of Health is engaging with PHT to finalise the details of the program and funding agreement, with the intention to commence the rollout of this program next year.

This further support for GPs demonstrates our clear commitment to continue to work closely to assist the primary healthcare sector to ensure that Tasmanians are able to access the care they need where and when they need it. I am also pleased that today the state Government has taken important steps in implementing a palliative care policy framework, Compassionate Communities, with the release of the second palliative care progress report.

The Compassionate Communities framework is a five-year strategy that provides a whole-of-community approach to palliative care and aims to embed national standards and best-practice approach to palliative care. The Department of Health works closely with the Partners in Palliative Care Reference Group to develop the report and I thank them for their continued efforts in implementing the statewide palliative care policy framework and supporting the improvements in the key priority areas.

The Tasmanian Government has a plan to build a better, stronger Tasmania and we are committed to building a better health system, supporting our staff, driving better care, and delivering the best possible outcomes for patients. Chair, the palliative care report I referred to has been uploaded to the website but I also have copies here. I will distribute them on the table to members so that we've got those.

CHAIR - Yes, we will table them.

Ms COURTNEY - At the table, to my left I welcome the Secretary of the Department, Kathrine Morgan-Wicks; to her left, the Chief Medical Officer, Professor Tony Lawler; and, to my right, is Craig Jeffery, the Chief Financial Officer. Regarding the attendance of deputy secretaries and others, we have a number of people co-located in other areas so we will get them to come when they're required.

However, I note with regard to Dr Veitch, given he is obviously incredibly busy at the moment, we looked at the schedule and have asked him to be available between 12 p.m. and

3 p.m., taking into account we have one hour in the middle for lunch, and that's a two-hour window which we thought would align with the Budget Papers. However -

CHAIR - We can work around that, minister.

Ms COURTNEY - Is that okay because -

CHAIR - Yes, we can work around that.

Ms COURTNEY - - He has a lot on at the moment.

CHAIR - No, no. We can always come back to an output group.

Ms COURTNEY - Yes. No, that's fine. He will be here at midday.

CHAIR - That's fine. It may be easier that we move to Pubic Health - it is called Public Health Services - when he arrives.

Ms COURTNEY - Yes, when he arrives.

CHAIR - And then come back -

Ms COURTNEY - And there might be some of the COVID-19 things as well that might be for him particularly, around any of the advice, so I will leave that for the committee.e but we'll have him for a couple of hours.

Output Group 1
System Management

1.1 System Management - Health -

CHAIR - We will move straight into line item 1.1, Systems Management in Health. We will ask probably some overview questions here as well. I want to start by looking at this. I note the split from Health and Mental Health and Wellbeing, the footnote in relation to the expense summary related to Output Group 1.1.

It refers to both mental health and health. The actual budget last year was different to what the Budget is - the expense was this year and last year. They're not comparable. Is that related to the separation and spreading out overheads? I would have thought a lot of these services will remain fairly consistent, hopefully, rather than having duplication. I'm looking at the actual last year on this line item, which was $136.3 million whereas the budget was $152.

Ms COURTNEY - Look, I'm happy for the secretary or the CFO to respond.

Mr JEFFERY - Thank you, minister. You're looking at Output 1.1, Chair?

CHAIR - Yes.

Mr JEFFERY - So in last year's budget papers, the forward Estimates for 2020-21 was $141 million. Is that the number you're looking at?

CHAIR - I'm looking at the Budget versus actual.

Mr JEFFERY - Okay.

CHAIR - The actual from the annual report.

Mr JEFFERY - All right.

CHAIR - The actual from the annual report was $136 297 000.

Mr JEFFERY - I've got it actually as $136.7 million; anyway, that's up to your number. The actual expenditure for 2019-20 as to the annual report is $136.7 million, but the Budget expenditure for this year is $168 -

CHAIR - You're right, sorry; that is the annual report.

Mr JEFFERY - It is $168.4 million, so that's $31.7 million higher and the majority of that reflects COVID-19-related expenditure.

CHAIR - So it wasn't the split into departments?

Mr JEFFERY - There's a few minor changes and reallocations of outputs within that output. There are some depreciation updates and there's a number of other movements, but the majority is the COVID NPA.

CHAIR - Okay. We haven't got duplicated services here in the systems management framework? We don't want to be operating in siloes, clearly, in Health and Mental Health and Wellbeing. There will be consistent systems management across both areas?

Ms COURTNEY - Yes

CHAIR - So the differences related to COVID-19 and some depreciation -

Mr JEFFERY - And some minor output restructure.

CHAIR - Right, which was the Community Health Services, which has gone to another area, hasn't it?

Ms COURTNEY - Yes.

CHAIR - We have this every year, minister, where outputs change and it's really hard to compare and follow. Anyway, if we keep working through - I am interested in the additional funding. It is good to see a budget that actually does budget more than was the actuals. It has taken a while to get to there but, congratulations, you've got there. It has been a problem in the past where we're starting from behind the eight ball in terms of spending, and this year's been extraordinary anyway.

If you go to Budget Paper No. 1, page 57, Policy and Parameter Statement, and look at the additional Health funding under National Partnership Payments, it is $150 million in 2020-21, plus the specific purpose payments, National Health Reform in the next three years, plus our own source revenue. What's actually new funding here as opposed to funding that's just been rolled over. Is there new funding?

Ms COURTNEY - Before I go to Craig to go into the detail, earlier in the year we signed the new National Health Reform Agreement after a significant amount of negotiations with other states. There were some good outcomes there for Tasmania and perhaps later on when he comes to the table, the deputy secretary of the department, Ross Smith can outline some of the benefits we've got through that. But I'll go to Craig for the numbers.

Mr JEFFERY - Thank you, minister.

CHAIR - He's just adding something up, I reckon.

Mr JEFFERY - The table in Budget Paper No. 4 is actually produced as the Policy and Parameter Statement produced by Treasury, so that's really the Treasurer's. I wouldn't like to speculate on what's in that, but I'm sure it's right because the good people at Treasury would never do anything wrong.

CHAIR - They don't, do they?

Mr JEFFERY - But it's not my table, so I wouldn't like to say any more about that.

CHAIR - Do want me to tell you how many typos I've picked up in the Budget Papers? Anyway, we won't go there.

Mr JEFFERY - I was always good at picking typos up. As the minister has already said, the 2020-21 Budget delivers a record $9.8 billion for hospitals and health services. That's $1.7 billions more than what was in the 2019-20 Budget, which is a 21 per cent increase.

CHAIR - So this is all new funding and not rollover funding from previous years - it's new funding? That's what I'm trying to ascertain - what is actually new funding? Maybe to you, minister.

Mr JEFFERY - So the new funding is an additional $600 million to maintain the current levels of resourcing. An additional $369.6 million to modernise health infrastructure and IT systems, including the new HRIS, which Kath will talk about later, and that money is across a whole range of regional areas. There is also $45 million new money into elective surgery, taking the additional investment to $60 million in elective surgery. I won't quote the number of surgeries. The minister will -

CHAIR - We'll get to that later.

Mr JEFFERY - Yes, and $50.2 million provided over the next two years to meet demand, and support staff and beds in major hospitals. They're the main new initiatives.

Ms MORGAN-WICKS - Noting that this is a parameter variation. So, these are new to an existing policy, and not included as a policy variation.

CHAIR - Are there policy variations as well, in other areas of health?

Ms MORGAN-WICKS - Health is a parameter.

CHAIR - There some policy changes too, on page 60.

Ms MORGAN-WICKS - Sorry, I thought we were talking about the $150 million.

CHAIR - Yes, that is parameter changes, but there are policy changes on page 60 in relation to the additional THS funding, which would be a government policy decision.

Ms MORGAN-WICKS - Yes.

CHAIR - Can you briefly outline what that additional funding is for? It will probably come into other output groups when we get to them. The extra $140 million in 2021 and $150 million in the outer years - is that targeted funding, or is that additional funding to use as and when needed?

Ms MORGAN-WICKS - I'll just check.

Ms COURTNEY - Is this is in terms of the COVID-19 provision, or the additional funding provided?

CHAIR - It could be the $150 million that was the efficiency dividend that Jen didn't have to find?

Ms COURTNEY - This relates to the additional money earlier in the year. So this relates to the [inaudible] and the RER earlier in the year, and the $600 million over the forward Estimates.

CHAIR - Okay. So, the removal of the efficiency dividend, which is reflected in Finance-General, obviously, because that's where it was sitting as an impossible-to-interrogate figure last year. But that's not extra money for you. That's just a saving you don't have to find.

Ms COURTNEY - By saving, do mean not having to find the efficiency dividend? That’s obviously not an additional amount of money.

CHAIR - No.

Ms COURTNEY - That's a saving. However, looking forward for our planning, it meant we didn't have to find those savings. That is obviously helpful. Then we had the $600 million from the RER earlier on in the year.

CHAIR - Okay. In terms of the national partnership agreements - NPAs - it's only one that is current for health, is it?

Ms COURTNEY - No. We've had various ones. So, there's the one that had been signed around the health funding. This was early on, with the fund-sharing between the different parts of healthcare delivery because of COVID.

There was also a separate NPA for the private hospital arrangements. I will get Kath to run through them. There were multiple. There was a second NPA for the private hospitals, just for COVID.

CHAIR - It's a time-limited one, though, isn't it?

Ms COURTNEY - I'll have to check the detail, because effectively the NPA for the private hospitals - the mechanism for that - my understanding is that when there was no longer a need to have that stood up, it wasn't.

Ms MORGAN-WICKS - My understanding of the private hospital arrangement was that it was an addendum to the COVID-19 NPA and facilitated through that. There were a lot of discussions around expiry or terms, because the NPA was entered into - and I reflect, looking at Ross Smith - in a very short time. I think it was negotiated over a matter of weeks.

At the moment it has an expiry of March 2021, but it is a matter that we do discuss with CEOs of health, in relation to what is currently happening in the COVID environment.

In the last 12 months, the two key NPA arrangements are around the National Health Reform Agreement and the COVID-19 NPA. But we do have existing NPAs, which are detailed in Table 5.4 of Budget Paper No. 1 on page 82.

We have Redevelopment of the Royal Hobart Hospital, Public Dental Services for Adults, Essential Vaccines, Community Health and Hospitals Program, COVID-19 Public Health Response, and some others in very small amounts, listed there.

CHAIR - The funding allocations for those indicate the duration of those agreements, essentially?

Ms MORGAN-WICKS - Yes, as agreed with the Commonwealth.

CHAIR - Some of them won't necessarily be renegotiated. Hopefully the COVID-19 one won't need to be, but you never know.

Ms COURTNEY - Some of the other ones get renegotiated almost on a rolling basis, which is why, for some of them, there aren't the out-years, and also for some of the smaller ones. They are often renegotiated on a yearly basis.

CHAIR - Craig mentioned earlier the depreciation that's included in this. Does this include the depreciation of the Royal Hobart Hospital?

It should be the new K-Block I am talking about; that has a significant value to it.

Mr JEFFERY - Depreciation would be allocated as an overhead across all the outputs. The Royal's K-Block is part of the THS, so part of that depreciation would be output 1.1, System Management.

CHAIR - That's where the depreciation of the Royal would appear, in that line item.

Mr JEFFERY - Part of it, as an allocation. An amount of the THS expenses would be allocated across a number of outputs as an overhead. So, a percentage of the K-Block depreciation would be in Output 1.1, not all of it. The depreciation adjustment I referred to earlier is only $3 million, so just a minor depreciation change.

CHAIR - That's more likely to be in 1.1 then - the Royal's depreciation?

Mr JEFFERY - Yes.

Ms WEBB - I will start with one that I am asking each department that we are talking to, and that is around your RTI requests that have come into the department.

I'm interested in the statistics around that, particularly how many were received, and how that compares; how many were received in 2019-20, and how that compares to 2018-19; the percentage that was responded to within statutory time frames - or the number, it doesn't have to be the percentage - and how that compares to the previous year; and how many were refused, and how that compares to the previous year, as a starting point.

Ms COURTNEY - Thanks for your question. Given the RTIs are done at arms-length from my office, I will get the secretary to respond to that.

Ms MORGAN-WICKS - I've a large table here so I will go slowly through that.

In terms of number of RTI applications for assessed disclosure received during 2019-20, we had 59, compared to 2018-19 when we had 33; accepted for decision, 27 in 2019-20, and the same in 2018-19; not accepted for decision, 12 in 2019-20, compared to 6 in 2018-19 -

Sorry, Ms Webb, could you repeat the rest of your question?

Ms WEBB - It was in relation to how many were dealt with within the statutory timeframes.

Ms MORGAN-WICKS - The number of RTI applications determined in 20 days, or within agreed time for 2019-20 was 10; the number of applications determined outside of 20 days, or agreed time, was 17; the average working day taken to assess an RTI application was 23 days; the number of pages assessed for the period was 2840. Our estimated cost of staff hours allocated to assessment was $23 856; and 19 applications were determined where the fee was waived.

Ms WEBB - In terms of the ones refused, were any of those taken for review to the Ombudsman?

Ms MORGAN-WICKS - Zero were referred to the Ombudsman for external review.

Ms WEBB - Regarding the PESRAC interim recommendations in the table in front of Budget Paper No. 2, Health is lead agency on four of them. and I am interested to hear from you about the status of those four recommendations. They seem to be focused on an early communication with the community over current and future COVID-19 management

strategies. Can you say where those are up to and if they fit into any specific line items or budgetary measures here or within existing resources?

Ms COURTNEY - With the PESRAC recommendations, as you say, recommendations 2, 3, 4, and 5, were related to the Department of Health and are very important. That is why the Premier has obviously accepted all the recommendations. I will answer the question broadly then the secretary might perhaps go to more detail. With the preparedness nature of it, obviously we are continuing our preparedness. We have made significant investment in purchasing of ventilators, PPE and work to ensure we have the right escalation strategies across our acute hospitals, our subacute district as well as our intensive care. These are regularly reviewed against indicators to ensure they remain fit for purpose. The packages we have provided are to ensure there is communication with the community. We have also resourced the Public Information Unit - PIU - to collaborate with all other agencies and through the SCC to ensure we have a consistent and a single source-of-truth message being delivered to the community. There is the COVID-19 website, but ensuring we have a consistent message when there is a lot information and often information changes quite quickly. There has been an unprecedented level of public advertising from the COVID -19 website, as well as TV, radio and newspaper ads.

With communication, we have held earlier in the year almost daily press conferences with the Premier, myself and the Director of Public Health. More recently we are still having those weekly and sometimes more regularly. Every time there is a significant change, particularly one that impacts Tasmanians with regards to COVID-19, whether that is risk from another jurisdiction or changes in our restrictions here, we seek to be able not to only provide a press conference to answer those questions fully and make sure we have departmental resources there to be able to explain the detail, but we back those up with significant advertising campaigns. As we go forward, we will continue to work with the PIU to ensure we are refining our message, taking on board feedback and making sure we are doing all we can to help the community understand the changes. We would all recognise at the beginning of the year there was a high level of engagement from the community with public messaging. As things become COVID-19 normal, perhaps that engagement lessens. We are doing a lot of work particularly on how we can also use social media and targeted messaging. We used that a lot when clinics were being set up in different communities. I will go to the secretary, who will go into more detail.

Ms MORGAN-WICKS - Certainly our efforts to communicate and to build public confidence in relation to COVID-19 were strong and focused and had been increasing from the very early days where information was obviously flying around. The thirst and desire for information in relation to COVID-19 is probably one, from a Department of Health perspective, that we certainly hadn't seen in relation to any other health topic and we have had to take rapid steps to try to lift that communication, but also having a structure for trying to communicate and to increase competency.

The importance here is the four safeguards we have been trying to push and communicate through the Premier's and ministers' daily press briefings that occurred during the early stages of the pandemic. Also, through our Director of Public Health's announcements and communications to our staff on the importance of testing as our critical first safeguard, our better tracing and contact tracing ability, our rapid response capability for outbreak management and our COVID-19 safety plans.

With those four safeguards we are really trying to channel each of our communications. Our testing strategy has well and truly evolved over time and trying to bring the public along the journey of the changes in the testing strategies. The changes that occurred, for example, in the CDNA solely in relation to testing that, you know, a number of attempts -

CHAIR - CDNA?

Ms MORGAN-WICKS - Yes.

CHAIR - What is that about?

Ms COURTNEY - Communicable Disease Network of Australia.

Ms MORGAN-WICKS - And the series of national guidelines in relation to testing and trying to make sure it's clear and understood, we are now at a place where, if there are even the most minor symptoms, people are encouraged to come forward and get tested. We've seen that in the South Australian example earlier last week.

CHAIR - It's a shame the New South Wales Premier didn't take her own advice. Anyway, I don't expect a comment in response to that.

A witness - She got tested.

CHAIR - She got tested, yes, but she didn't isolate.

Ms MORGAN-WICKS - Testing is critically important as it is.

CHAIR - It's the way you await your result also, I would have thought, but, anyway.

Ms MORGAN-WICKS - As is contact tracing and our investment in the resources within our Health Emergency Coordination Centre and the Emergency Operations Centre that sits underneath, in particular, our Public Health Emergency Operations Centre. It's not just the people; we have also taken steps in terms of the technology to try to assist in the management of the outbreaks.

Whilst there has been media [coverage] about the additional Budget allocation - for example, the new HRIS system within Health - we have also been investing in terms of the technology in the pandemic, rapidly implementing a REDCap system in Public Health. We are also now taking steps towards a Maven system to assist in terms of contact tracing, together with other applications to try to assist.

It is about PESRAC's concern to make sure - and very rightly - that the public is able to maintain confidence in Tasmania's handling of the COVID-19 pandemic, but really trying to push out the testing, tracing and rapid response in our [inaudible] management capability and the importance of all our business organisations - and even thinking in the family unit about our own COVID-19 safety, our own plans around these environments.

CHAIR - Could you further describe the new systems being implemented fully?

Ms MORGAN-WICKS - The REDCap system was implemented from ACT. I could bring Dale Webster, if you like, in relation to the technology.

Ms COURTNEY - Dale Webster is coming to the table, he is Deputy Secretary, Community, Mental Health and Wellbeing.

Mr WEBSTER - Initially, the REDCap database system was rolled to allow better contact tracing. While we got that in very quickly, it has a number of shortfalls so we're now looking at a system called Maven, which will improve our ability to further track. They're iterations of the same thing. Maven is being looked at by most governments around Australia, to move quickly to -

CHAIR - Can you tell us how that actually works?

Mr WEBSTER - Yes.

CHAIR - In not -

Mr WEBSTER - In basic terms the system allows us to cross-check and put names in and make sure we're actually tracking. If someone in this room gets COVID-19, we will be up very quickly - put these names in, such as Mr Valentine, what are Mr Valentine's close contacts, put those in and work it out. It's a way of us tracking and making sure that we are picking up all the contacts but, as I said, it has a few limitations. We are now looking at replacing that very quickly as well.

CHAIR - I understand part of it - and again this is from media reports and discussions I have had about the situation in Victoria when it blew out very quickly. I think the chief medical officer there, Mr Sutton, said it was basically a paper-based system to start with. Obviously, that created a heap of challenges, particularly when you are transcribing someone's name. Not everyone's name is spelt Smith, and even if it is Smith, it is not always spelt the same way.

I am wondering how this system actually worked to remove some of the time delays that occurred with such a slow, paper-based full-of-error system, to this, where there is much less risk of missing people and not being able to properly trace.

Ms COURTNEY - Before Mr Webster goes into that detail, I feel confident Dr Veitch will talk through the process of what our highly trained contact tracers do. I have heard him talk about it before, where while we have IT systems that can support the information and particularly help our epidemiologists navigate that and be able to form judgments around it, with the actual contact tracing - phone calls that are made, and those things - even if you have a sophisticated IT system, a lot of the time that information is taken by somebody on the phone with a pen and paper, while they try to do that, and their skill set lies in the fact that they are able to garner from this person the information that they need, so they have a correct understanding of the information.

I have also heard him mention the challenge around names and spellings of names, and the fact that the people involved in this part of the work are very highly trained in that level of detail. While we are looking at a more sophisticated system - and I will get Mr Webster to talk about that - the skill set lies in that bit between the person with COVID (or the close contact)

and the electronic system. The system needs to be robust, but the bit in the middle is the bit we've been resourcing up.

CHAIR -We will talk to Dr Veitch about that when he comes.

Mr WEBSTER - It really is that recording of information that is gathered. You are quite correct. It is quite a manual process that we have experts doing. REDCap is a version of a database that allows us to do that at a very basic level. Maven is a version of a database that allows us to capture even more detail. Maven is currently being rolled out in Victoria and New South Wales. It is the system that Victoria picked up. That is why we are going down that route as well.

CHAIR - Where was it developed?

Mr WEBSTER - It's a US system.

Ms WEBB - I had a question - are workforce questions in the overview?

CHAIR - It depends on what it is related to.

Ms WEBB - It's really a broad question, and it is COVID-related in the sense that the workforce in your department, minister, has borne the brunt of such a lot during this time. Incredibly stressful and incredibly busy.

In a general sense, I am interested to hear about how you are monitoring and supporting the wellbeing and mental health of your workforce, and what you are noting in terms of data on sick leave, stress leave and those sorts of indicators of wellbeing in your staff?

Ms COURTNEY - Absolutely. Our staff and our team have borne the full brunt of this, not just in the hours they have worked, but the stress and anxiety that comes with the type of work that we are doing. At some stage we will talk about health and wellbeing, and at another stage we will talk about the workforce, because we did an expression of interest as well.

With mental health, I might get Kath to talk to the detail, but a lot of the recommendations from the north-west outbreak and interim review also talk to how we can support staff. We looked at presenteeism as well as well as absenteeism, and that is one of the things that has been unique in COVID-19. Often, we talk as absenteeism being a bad thing when we are talking about managing a system, yet we have had challenges with presenteeism and people coming to work when they are not well.

In response to the north-west outbreak, we have now rolled across the system an individualised online self-care resilience and wellbeing program.

This program is ongoing. It an includes online self-care resilience and wellbeing program, weekly support for a minimum of six months, establishment of a peer support network with training, support and mentoring, virtual workshops, and support to help individuals develop a self-care plan during quarantine - that was for the north-west, obviously - and to ensure a safe and sustainable return to work.

We also had the Employee access program, and we have partnered with private providers as well.

As to other support provided, a dedicated social worker was engaged at the LGH to develop more ward-specific plans and strategies, and a peer support program. We are continuing to ensure we are working with the staff in the north-west to keep them supported.

We also have a health and wellbeing consultant employed by Ambulance Tasmania, doing their peer support program.

We have also had strong workers compensation arrangements and comprehensive return-to-work programs, because for the north-west cohort particularly, it was obviously a very difficult time returning to work, and so it was not only about having the right training, but having the confidence to come back to the workplace.

There was a lot of effort put in, and we have embedded the learnings from the north-west across the entire system.

Ms MORGAN-WICKS - Certainly the north-west has had a very large focus, given the outbreak there.

The largest program in 2019-20 cost $228 000, for approximately 1200 workers across the north-west region, in particular those who were required to quarantine. The program is ongoing and includes online self-care, resilience and wellbeing, and weekly support for a minimum of six months, and we have been talking to staff about extending that as needed.

We have found that the establishment of a peer support network has been invaluable in supporting our north-west staff - in particular, with training, support and mentoring.

We have had virtual workshops, noting the need for social distancing in every session, particularly for teams, and the building of that team resilience and support.

Also, support on an individual level, in terms of developing self-care plans, both during quarantine, but also afterwards, to make sure we do have a safe and sustained return-to-work program for those employees.

It certainly was not a one size would fit each of the employees in the north-west situation. It has had to be more an individual engagement, particularly in some of the wards that were impacted.

CHAIR - I'm interested in the leave liability across the whole department. Obviously, people haven't been able to take leave when they expected to. I can't imagine Dr Veitch has had many days off, or your secretary, or even yourself, minister.

I am interested in the leave liability costs to the department. We can ask this during the various output groups if it is easier.

Ms COURTNEY - We will seek to get that information. One thing worth noting, particularly with the north-west outbreak, is that all the people who were quarantined at home for that period were paid by us just as normal. They were paid all the way through.

CHAIR - They didn't use any leave?

Ms COURTNEY - No, they were paid all the way through.

CHAIR - So, that would have increased your leave liability, in that they weren't on leave, they were -

Ms COURTNEY - They were being paid.

Ms MORGAN-WICKS - From a Department of Health perspective - noting that Public Health sits within the Department of Health, as well as our emergency operations centres, and then I will talk about the THS: recreation leave taken to year ending March 2020 has dropped significantly from previous years, largely attributed to - remember, we were preparing from late January - the pandemic response. We've seen many employees in critical roles unable to take leave and others cancelling planned leave due to lockdown and/or the inability to travel. I've had conversations with many clinicians and nurses about wanting to travel to a hot place -

CHAIR - Not a hotspot.

Ms MORGAN-WICKS - a hot place, but not being able to travel, and their desire that they would like to keep their leave for that time. Long service leave -

CHAIR - Has that been facilitated in terms of caring for your staff? Having a large leave liability on your financial records is potentially an issue, but how have you managed that? Have you been conciliatory around that, minister, and allowed them to do it?

Ms MORGAN-WICKS - Through the minister, fatigue-management is a serious issue in relation to emergency situations and pandemics, and we took various approaches to fatigue management. It's probably less related to recreation leave but also to making sure people take weekends or a day off because COVID-19 is a never-ending cycle and the danger was that people were working straight through.

You look back to the Easter period, and we were working through 25 days. I do not want to think about what the Premier and the minister were working through. Fatigue management was critical so we did do rostering on and off, particularly with our health incident controllers, for example. We ran a rostered four days on, four days off with two incident controllers to try to cover and span, with the assistance and support also of the State Control Centre and their vast experience in the emergency environment with commissioner Darren Hine, for example, his focus on the fatigue management and assisting Health, so I also appreciate that -

CHAIR - He's probably had to take his own advice.

Ms MORGAN-WICKS - because clinicians will tend to keep going, which is the concern, so we are really working together with staff to make sure that we do appropriately manage fatigue. It has been difficult and that has been a challenge.

CHAIR - Liability - do have you the figures on that? We can come back to that, if you like.

Ms MORGAN-WICKS - We might do that, just find that data.

Mr JEFFERY - From the departmental financial statements, the total employee benefit liabilities increased only slightly from $325 million to $327 million, but there was a significant decrease in accrued salaries because the pay periods changed. Annual leave increased from $101 million to $121 million and long service leave from $147 million to $164 million.

CHAIR - People have also cancelled long service leave, obviously. Do you have a plan to manage that?

Ms MORGAN-WICKS - Yes, we are monitoring. At a Health executive level, we monitor the rates of annual leave, sick leave, long service leave, and also have the discussion around fatigue management, particularly for key positions within the pandemic response.

Ms COURTNEY - There is also the contributing factor of just having more people, so from a DoH perspective covering everything, it's 1500 more people since 2014. We have had a big ramp-up over the last financial year as well. Some of that is down to COVID-19 but there has also been a substantial FTE investment as well so those uplifts each year will continue to push those levels up.

Ms WEBB - My question follows on from that because it is focusing on overtime data and where things are placed there, which fits in with what you're speaking about to do with fatigue management, to some extent. What has happened regarding overtime figures for your department and how are you managing that side of things?

Ms COURTNEY - Thank you for the question. Overtime is used within the Health system in a range of different areas. Average overtime FTE compared to average paid FTE was broadly consistent with previous reporting periods, increasing just 0.5 per cent between March 2019 and 2020.

Regarding the pandemic response, we saw an overall increase in the final quarter to June 2020, particularly within Public Health. Public Health had a significant ramp-up of overtime during that part of COVID-19. With regard to THS, the average overtime FTE compared to the average paid FTE was largely consistent with that paid in a previous year from March 2019 to March 2020 and that trend is continuing.

CHAIR - We might get a breakdown of the figures, perhaps under Output Group 2.1 in terms of related to the THS.

Ms LOVELL - Minister, is there still an employment review committee to review business cases for filling vacant positions across the THS?

Ms COURTNEY - Yes, there is.

Ms LOVELL - Is that still one central committee?

Ms COURTNEY - I'm advised it is.

Ms LOVELL - How often does the committee meet to review cases?

Ms COURTNEY - Could we get the chief people officer to the table? Renee Anderson has joined us at the table.

Ms ANDERSON - We have two employment review committees. The committees meet weekly but they also review out-of-session requests, if urgent, through the week.

Ms LOVELL - How are the two separated; is it north and south?

Ms ANDERSON - Department and THS. Historical department portfolios, and then there is one that covers the hospitals and the Community Mental Health and Wellbeing portfolios.

Ms LOVELL - Specifically, how many business cases are before the THS committee at the moment?

Ms ANDERSON - Each week there are hundreds of job requests. Business cases are a separate process. If there is a business case asking for additional FTE over-establishment that gets approved through finance area to the secretary.

Ms LOVELL - So hundreds of job requests - 200, 1700? Do we -

Ms COURTNEY - Ranges of requests. Ultimately, they are approved; if these are above-establishment, they go through in a documented form to the secretary for consideration.

Ms LOVELL - So, not talking about above-establishment, talking about funded positions that are vacant and requested to be filled. How many of those requests are before the committee at the moment?

Ms ANDERSON - I would have to come back with the actual number, but it ranges from one-month backfills of leave through to permanent recruitment activities so it changes regularly.

Ms LOVELL - On average, how long are the requests taking to be approved?

Ms ANDERSON - They're approved each week unless further information is sought or the request isn't able to be complied with. One of the process steps is that it complies with our Employment Direction No. 1. If there are any issues with that, it goes back to the area for further analysis, but generally they are all approved each week.

Ms LOVELL - So weekly?

Ms ANDERSON - Unless they are urgent.

Ms LOVELL - We had some discussion around this in Estimates last year and at that stage there was going to be a decentralisation of the Employment Review Committee and the advice was there would be a north and a south committee, to be managed by the executive directors of operation at the local level. Is that not the case?

Ms MORGAN-WICKS - I will start and Renee may also assist. The executive directors of operations are now the chief executives of our hospitals in the governance restructure announced in February this year. That is Susan Gannon and Eric Daniels, who are involved with regard to managing their local establishments and providing advice, particularly on increases of establishments. For example, the increase in establishment in the Mersey

emergency department and the North West Regional Hospital Emergency Department was a business case to increase staff specialists, which was then sponsored by the local hospital manager Eric Daniels and approved by me as secretary.

Ms LOVELL - But there is still only the one employment committee. That decision to split into two wasn't -

Ms ANDERSON - The decision to move to each portfolio area is still underway. We ended up staying, essentially at the start of COVID-19, because the onus on those chief executives was quite high with regard to getting them to do that work as well as the COVID-19 response, but we now have a plan to decentralise each executive, particularly the hospital executives, and the deputy secretary of Community Mental Health and Wellbeing will own and manage their vacancy process.

Ms LOVELL - A question about breakdown of employment. It is an overview question across the THS. Are you happy to take that now?

Ms COURTNEY - I will take the question if we can answer it now, otherwise we can always answer it later or take it on notice.

Ms LOVELL - We were advised by the Premier yesterday that this data was collected at agency level. What I would like for the committee is a breakdown of headcount, FTE and employment status across the THS at a point in time - it can be any point in time of this year - compared with the same point in time in the previous year.

Ms COURTNEY - We will work out what we have now and can give you -

Ms LOVELL - Thank you. Also, a breakdown of part-time employees across the THS, but specifically the number of part-time hours employed, compared to the number of hours paid to those part-time employees, as a whole.

CHAIR -You are asking for the THS, not the whole department, is that right?

Ms LOVELL - Yes.

Ms MORGAN-WICKS - The total number of FTE-paid employees, by award, by category, if I go from 2018-19 to 2019-20 is -

- Allied Health Professional - 1043.13 in 2018-19 to 1086.49
- Ambulance - 423.94 to 487.34
- Dental - 36.87 through to 35.98
- Health and Human Services award - 3674.22 to 3796.76
- Medical practitioners - 988.85 through to 1048.36
- No award - 2.18 through to 3.32

- Nursing - 4027.65 through to 4221.99
- Radiation therapist - 53.36 through to 56.33
- Senior executive service - 19 through to 22
- Visiting medical officers - 44.15 through to 42.17

The total number paid by employment category -

- permanent full-time - 3807 through to 4076
- permanent part-time - 5740 through to 6087
- fixed-term full-time - 1058 through to 976
- fixed-term part-time - 1189 through to 1133
- a Part 6 agreement - 29 through to 31
- casual - 1291 through to 1313.

For totals across that by employment category - 13 114 in 2018-19, and 13 616 in 2019-20.

Ms LOVELL - Thank you. Specifically, with the permanent part-time employees, is the data collected on the number of hours they're employed to do compared to the number of hours they're paid? They've got a set base number of hours -

Ms MORGAN-WICKS - Their contracted hours.

Ms LOVELL - their contracted hours, compared to the number of hours they're actually paid for working.

Ms ANDERSON - Paid hours is what we report on - paid FTE per pay period.

Ms LOVELL - You don't have a comparison of contracted hours compared to paid hours?

Ms ANDERSON - We do.

Ms LOVELL - You do?

Ms COURTNEY - We will take that on notice.

Ms LOVELL - Yes, thank you.

CHAIR - Before we move on, the figures you read were at a point in time, obviously.

Ms COURTNEY - Yes.

CHAIR - Yes. What is the date of those?

Ms COURTNEY - That was at the end of the financial year.

Ms MORGAN-WICKS - That is, 30 June 2019 and 2020.

CHAIR - I noticed a fall away of VMOs, not a huge number, but is that part of the COVID-19 issue? That you couldn't get them in here to -

Ms MORGAN-WICKS - It looks like a reduction of 1.98.

CHAIR - It's only a small reduction?

Ms MORGAN-WICKS - Yes, 44.15 to 42.17.

CHAIR - Okay so it's only -

Dr SEIDEL - I have a couple of overview questions and a couple of Health systems management questions as well. Minister, you recently published the discussion paper 'Our Healthcare Future', I think it was the beginning of the month, and I was surprised to see that the goal of making Tasmania the healthiest state in the nation by 2025 did no longer feature. There was a main KPI in the 2015 white paper released by Michael Ferguson. Could you comment on why the goal is no longer part of government policy?

Ms COURTNEY - Yes, we are still working towards that aspiration. Jeremy Rockliff, in his portfolio of Mental Health and Wellbeing, looks towards the preventative health side of things. The basis of this is making sure we're delivering the right care where people need it.

One of the big goals of Our Healthcare Future - and I'm glad you asked because you're the first person to ask me about this through Estimates - is making sure we're caring for people at the right place and the right time so that their conditions don't deteriorate. We know that in Tasmania we have a significant burden of complex and chronic illnesses.

We know we've often got people being cared for in hospitals and that's not actually the best place for them to be cared for, particularly for older Tasmanians, and so, looking at how we can bolster our response within the community is a really key part of that. One of the things I'm really excited about with this reform piece - and particularly through the discussion paper - is the amount of collaboration we've seen.

You would be aware, Dr Seidel, that there's always a large range of opinions about any matter within Health. However, one of the things I've found really heartening throughout COVID-19 was how everybody with a single common focus came together and worked so well.

COVID-19 has definitely strengthened a lot of the communication channels between the government, through not just the Health minister or the secretary but a whole lot of connections through Health with a lot of non-government agencies, particularly with primary health care, pharmacists around the state, working with our private hospitals and particularly when we were looking at the escalation for COVID-19.

A lot of those plans were done in collaboration of either co-located hospitals or hospitals that were in the same remote geographic locations. I have a confidence around the ability to achieve outcomes with this. I am really hopeful we will have some good feedback through the consultation period.

It is important we look at how we can deliver health care as efficiently as possible. Over a decade we have gone from it being around 25 per cent of the state budget to over 32 per cent this year, with $9.8 billion in Health. We know we can't have a health system that continues to become bigger and bigger but not more efficient. Saying that, it is really important to also understand that, at the core of it, it is not just about doing things more efficiently, it is actually about caring for the patient better. If we can actually work out some of those mechanisms to care for patients in the right setting, not only is there obviously an efficiency benefit for a system that has pressure from bed flow, but these outcomes - and people I have met in the community have benefited from some of these pilot programs and ones we are embedding - have been significant, not just for that patient, but also for their families.

Dr SEIDEL - Thank you, but I will bring you to the question, though: why did you drop making Tasmania the healthiest state of the nation by 2025, as part of government policy?

Ms COURTNEY - We have an aspiration to have Tasmania as the healthiest population, the most literate population. I have high ambitions for Tasmania. I don't think we should ever with any of our targets, whether it is health or education, wellbeing or economic outcomes, settle for mediocrity. It is really important we continue to target high outcomes, and health care is a big part.

With the consultation questions, we actually look at how we can continue to make those improvements. We don't walk away from an aspiration like that. It is a core part of what we want in Tasmania.

Dr SEIDEL - It is still government policy?

Ms COURTNEY - With regards to making sure we can be the healthiest population, yes. Jeremy Rockliff is still working hard to be able to attain that.

Mr VALENTINE - Minister for Health, would preventative health programs work towards the target you are talking about and the policy of being the healthiest state by whenever? What is your thinking there? What are you doing to improve or increase programs in that area?

Ms COURTNEY - This is Mr Rockliff's portfolio, and I would have him talk to that area because a lot of the targeted programs and spending within the Budget are actually underneath his portfolios on preventative health.

He is also doing a lot of work ensuring he is also collaborating those through his ministry Department of Education with things like school nurses.

There are a lot of things Mr Rockliff has worked through. His new portfolio, Mental Health and Wellbeing, and his Education portfolio have a lot of synergies.

We have discussion questions on how we can improve health literacy, because that is a really important part of ensuring people can care for themselves, also we have clear understanding with the community of the pathways to get the right health care at the right place.

It is not only about having a service available in the community, it is about the community understanding where to go for that. That is part of the discussion paper.

We have also, as part of this investment in State Budget, our capital investment for a human resources information system to manage our people; we have funding available for a digital plan across Health. Part of that, through Our Healthcare Future paper, looks at how we can look at health records and use digital information to also help people care for themselves better.

Obviously, we are caring for people with chronic conditions, but also as a general wellbeing element. We are having lots of conversations and feedback, particularly, with how that intersects with primary care in the community and GPs.

There is a lot of opportunity there to make sure we are not only providing the care needed in the community, but are also giving community members the tools to understand, be informed and access.

I think Ms Morgan-Wicks has more to offer.

Ms MORGAN-WICKS - I was at the Estimates hearing with the minister yesterday who confirmed his commitment to the Healthy Tasmania aspirational target and strategy through both ministers in their contribution to Our Healthcare Future and the consultation questions. There are two direct consultation questions we would love to have feedback on from both our clinicians and staff but also the public. In relation to consultation question 10 -

> How can we build health literacy, self-management and preventative health approaches into the day-to-day practices of our health services across the whole of the health system?

And question 11 -

> How can we better incorporate preventative health and health literacy initiatives into current and future care, across the range of settings, including acute, community, primary and private

Mr VALENTINE - Thank you for that. I appreciate that. It would be good to get some of those infrastructure dollars spent there and not in infrastructure which is 50 per cent of the expense.

Ms COURTNEY - One of the important things is making sure as we plan the capital and IT infrastructure that the people, through the release of the workforce planning piece and all those bits of planning, talk to each other with a cohesive plan. I agree, our capital infrastructure is critical, but it needs to be done in a way that understands what type of health care we will deliver in the future, where it will be delivered, what will clinicians need to be able to deliver it? It is important we do all that planning in a cohesive way.

CHAIR - I think Bastian has a follow-up for this and potentially me, depending on what his question is.

Dr SEIDEL - We plan and plan all over again because we had some discussions five years on how we better integrate things. I want to make a point on the digital health transformation you mentioned. Certainly, that is an issue in primary care which doesn't receive essential medical information in a timely way. The last Department of Health annual report stated that less than 60 per cent of discharge summaries were received by general practitioners within your performance time of 48 hours.

How will you move away from an analogue system to a digital system? My question really is: how many letters do we send out?

CHAIR - Or faxes.

Dr SEIDEL - No, we just do letters because it is more expensive. How many letters are we sending out to other health practitioners and patients annually from within the THS? What is the cost of mailing that information?

Ms COURTNEY - With regards to that data, I'm not sure whether we would actually have a cohesive view because it has been sent by different areas in terms of correspondence. We will check and if we do, I will provide it but I don't think we do.

Dr SEIDEL - Cost of mail is very simple?

Ms COURTNEY - Obviously, but often people send mail via an email, so I am conscious correspondence is sent in many different ways. If the secretary has more information I will ask her to do that. That is the very point; I know from speaking to GPs, that with patient information, it is important that it is both accurate and timely, and having a system that talks within the healthcare system - specifically named in Our HealthCare Future - is how we can do that better. We are looking specifically for feedback from the community and primary health care sector on how we can do that better. We have a lot of interactions between different parts and systems of Health that are governed and funded separately, but ultimately the patient moves between all of those. We need to look at how we can do that better and why we have the funding there. Perhaps I will go to Kath; I know this is an area of her passion.

Ms MORGAN-WICKS - The minister is correct, I am very passionate about digital transformation. Throughout my career for many years I have worked in relation to digital transformation in different organisations. It is probably no surprise to Health, I have come with that ambition for our health system and can see many areas in which we need to improve our digital transformation - moving away from paper is a big one of them as much as we love to support the Australia Post system in relation to paper or old fax technology. This year's Budget has a commitment to move away from paper into an investment into our new HRIS system. A significant amount of paper is actually used for time-sheeting, manual time-sheeting, the manual effort. We estimated - and probably very conservatively - that 30 FTE nurses are associated with the rostering and time sheets, and that is time that can be reinvested back in terms of health care.

I am very excited, as secretary, to see the development of the HRIS. It's certainly not just about a HR system; it's one that actually transforms and assists us in our digital foundation.

CHAIR - Does this include electronic records at the bedside, so you don't have to go back and transcribe stuff away from the patient's bedside?

Ms MORGAN-WICKS - Electronic medical records and patient information management systems are key elements that need to be consulted on in our digital transformation strategy and our digital health strategy. We have $1.5 million in this Budget to actually undertake that strategy work.

In relation to the connection between primary care through to our hospitals, we have partnered with Primary Health Tasmania to enhance the interface between our specialists and primary health care with our e-referrals system and pilot, to get away from the old faxing of referrals from GPs to specialists. Fax machines are sometimes not picked up, or fax referrals disappear and are unable to be found in a system - and just the frustration generally. With the patient at the centre of our digital health transformation, our strategy is to get that information through as quickly as possible. Certainly, that pilot has been very successful.

We have been very pleased with our partnership with Primary Health Tasmania, and that is a key component of our initial digital health transformation approach. There is a lot to be done, and a lot has been done, in relation to electronic medical records this year with the introduction, for example, of Medtasker at the Royal Hobart Hospital. A lot of clinicians have been asking for, and now a lot are clamouring for, Medtasker, trying to be the next unit or department introducing it.

CHAIR - We're going to have a consistent approach across the whole THS, aren't we?

Ms MORGAN-WICKS - That is why we have one Department of Health that includes the THS.

CHAIR - It has taken a long time to get there, hasn't it?

Ms MORGAN-WICKS - The strength of any digital transformation strategy is about a consistent and statewide approach, and about garnering the amount of budget we invest into technology and making prioritised, consulted decisions about where that money is actually invested.

Dr SEIDEL - The digital transformation was very prominent in the One Health discussion paper from 2015. May I ask, are you comfortable with the progress you've made in the last five years? Because it sounds to me we are talking about the same thing over and over again, and now we do more consulting, and eventually something may or may not happen.

CHAIR - At least there's money in the Budget, which is a start.

Dr SEIDEL - There's the risk we will still have fax machines in 2025, and still be mailing out letters at a high cost - when information will get lost, and then we will do another consultation paper on how we are going to improve things. Are you satisfied with the progress you've made in the last five years with the digital health transformation?

Ms COURTNEY - Significant work has done on information and communication technology. Approximately $8 million has been expended on two commercial data centres, replacement of critical network equipment, improved regional data linkages, and replacement

of power protection and cooling in all four major hospitals. This work has particularly significantly reduced cyber-risk.

The Government has also invested $1.2 million as part of the VConnect telephone project to implement a whole-of-government VoIP telephone system to all DoHS sites, including hospitals. This project mitigated the risks with copper systems, which were decommissioned.

We've also seen a range of projects undertaken to enable key clinical systems, including the implementation of a new statewide emergency department information system - EDIS; TrackED; upgrades to Ambulance Tasmania core network; and a range of complex upgrade works to maintain a robust, contemporary software environment.

Yes, there is more to do, but we have been looking and working at a lot of the core things that need to be right. Some of these areas aren't particularly sexy, and people don't see them, but you know when they fail. The investment in those key core areas has been critical, and now we look towards what we need to do to make the systems that drive, not just better outcomes for our staff and patients, but decision-making and better management. That is what we are working towards now.

Mr VALENTINE - From my 20 years in the department, the problem was the fiefdoms that exist, not wanting to see them for various reasons, because it doesn't work that way up there.

Ms COURTNEY - As the secretary mentioned earlier, we have the single THS, but we brought in a new governance system earlier in the year. A new governance structure was brought in, and then COVID hit.

That is going to be important to be able to drive a lot of these initiatives. It is also going to be a real benefit in terms of making sure we have good accountability throughout our health system, and also drive clarity and responsibility for decision-making. There will be clarity about who and how that rests, and that will help drive decision-making, because that has sometimes been a criticism - but it will also drive our accountability about how those decisions are actually made.

That is another area that was a key priority for the secretary, when she came to the department not even a year and a half ago now - getting that right.

Mr VALENTINE - A follow-up to that, about a single electronic medical health record - is that in place yet across the state, or not?

Ms MORGAN-WICKS - We have an electronic medical record, and we have been working on their rollout as part of the National Digital Health reforms.

In terms of satisfaction with that record, and the further steps we need to take to ensure we have joined-up and integrated applications right across our hospital environment through to our GPs - patients don't really distinguish between who they are seeing in terms of requesting information and having to continue to send different letters or fill out a different form, for example, to see a variety of different specialists, particularly if they have comorbidities and have to see different specialists.

Trying to achieve, with the administration of patient information, an electronic medical record where we don't need to have duplication of, for example, pathology tests if you are moving from one hospital in the north-west to -

Mr VALENTINE - Just recording allergies that a person has, those sorts of things.

Ms MORGAN-WICKS - It is critical that we receive the feedback. Across the system, people will have different priorities as to where they would like to see investment in ICT directed. The strength comes with having our new strategic ICT subcommittee under our Health executive, which has both clinicians' representatives and hospital managers, and also our Community and Mental Health and Wellbeing portfolio properly represented, so that we can get the value for that combined use of our ICT investment.

Mr VALENTINE - We were working on that in 2012, and that goes to the point we are making.

Ms WEBB - Harking back to Dr Seidel's question around the falling-away of that explicit target to be the healthiest state by 2025, as expressed explicitly as part of the plan. Of course we share your aspiration, minister, that we want to be the healthiest state and see that come about. But without an explicit target - either at that highest level, or even a slightly lower level - in particular areas of community-wide achievement of particular data, without that, we tend to rest back on our laurels saying we are doing better. We have done better than we did last year.

Now you have stepped away from that overarching target, are there some other broad community-wide targets that the Government is setting to hold itself to account for tangible progress, rather than just saying 'Well, our data is better than last year', or 'We have invested more than last year.'. They are fairly meaningless and low-level aspirational targets to set for ourselves.

Ms COURTNEY - It does remain a target. With regard to the implementation of the target, a lot of the work underpinning that target is managed through the minister for Mental Health and Wellbeing.

He has a range of initiatives funded through the Budget that not only go to how we can achieve our target, but also how we can make sure that more Tasmanians are able to get better access to health care. To be frank, it would be better to target these questions to the minister for Mental Health and Wellbeing. We have made progress. We have had our five-year strategic plan to develop collaborations and partnerships. However, when talking about another minister's portfolio, it is better for those questions to be directed to him.

Regarding the Our Healthcare Future document, in the foreword I talk about using this as a mechanism to be able to get a shared vision and plan for a pathway ahead for health. I wrote that quite deliberately. That wasn't just jargon. Part of what is really important to come out of here is ensuring that as a government, the plan and targets we set for the longer term are shared by the community.

It is important we speak to the community and speak to clinicians on how we best map out that plan, but the target of the healthiest Tasmania remains. However, I suggest that you direct those questions to Mr Rockliff as the minister.

Ms WEBB - My question isn't about activity or plans. My question is about things you can measure, and say, 'Yes, we have achieved this measure that we said was our specific intention', or 'We have gotten a certain distance towards it.'.

So, accepting that some of those things would be captured in a different portfolio, in your portfolio what specific measures are you now holding yourself to account for, so we can - when we measure them - know to what extent we have progressed. Not whether we have undertaken activity, but actually achieved a measure.

CHAIR - An outcome.

Ms WEBB - Yes.

Ms COURTNEY - Again, this is not about my portfolio. Regarding the targets and aspirations within Mr Rockliff's portfolio, through the Tasmania Statement and the next years of Healthy Tasmania, as Ms Morgan-Wicks just discussed, that has a range of key areas of identification that will improve a range of different initiatives to ensure we are measured against.

With regard to our plan set in 2016 and our targets, we have the valuation reporting against a number of different areas within that. Regarding the specific reporting of another minister's portfolio, it is best to direct those to that minister.

Ms WEBB - I was asking whether, in your portfolio area, there were any measures that we are holding ourselves to account for? Not activities, but measures.

Ms COURTNEY - Of the measures we have, whether they are activity or measures, depending on how you want to frame them, some of them are outlined within the Budget Papers.

All those are set with the target of better patient care. Many of these, and I am sure for different targets, are particularly around the clinical areas that we have; Professor Lawler would be happy to talk about those. Many of the targets for clinical care throughout our acute care system are predicated on research and are set from a basis of research.

We also, each year, publish our service plan, which sets out our agenda for the year and what are we seeking to achieve. Within the THS, the targets are set based on research and evidence to ensure we're getting the best outcomes for patients.

Ms WEBB - I am not talking about that granular level. That's fine. Thank you, I don't think I have anything further.

CHAIR - One of the outcome measures that used to be in the budget paper, but no longer is - under 1.1 - was the readmission rate. That's actually an outcome measure because, if people are being readmitted within 28 days, that means that things have gone wrong one way or another.

Dr SEIDEL - You could [inaudible] life expectancy for example, couldn't you? That would be a nice target as well; we are failing to -

CHAIR - We all need to put submissions into this review, obviously.

Ms COURTNEY - I wrote to everybody about that so -

Dr SEIDEL - I do have follow-up questions.

CHAIR - Mr Gaffney has too, so we will go to him and then come back to you.

Mr GAFFNEY - It's on that area, but there is a question at the end that I think is one that you could take back to Cabinet.

First of all, yesterday we acknowledged the Premier's work over COVID-19; I would also like to acknowledge the work you and your staff did, because I think you were announced as minister in late June or early July last year, and to go into that pandemic and to watch - I'm not trying to pat you on the back here - you grow into that was really good and I think it was a good chance for you to understand your department.

Ms COURTNEY - Thank you.

Mr GAFFNEY - The area that is confusing for the public is that they don't care which minister has the responsibility for Health, but when you had the statement 'Healthiest state by 2025' - whether that was part of your doing or not - people don't really care whose responsibility it is, they just want to see it.

Now, you've said that the growth in your annual revenue has gone from 25 per cent to 32 per cent. I think that indicates to the public, yes, there is further spending in Health but to make a statement that we will be the healthiest state by 2025, leads me - the layperson - to say they must be putting more money into Health to be able to meet that goal and I think that -

CHAIR - Is there a question coming?

Mr GAFFNEY - There is a question coming and lots of people have had lots of time to say things.

CHAIR - Yes, no, no,

Mr GAFFNEY - We've had other ones like 'fast planning, 'quicker', 'simpler', that sort of thing. But when you go back to Cabinet, I think it makes it harder for future ministers if governments come out with logos or slogans for 10 years down the track, when you get to 10 years down the track and it's an unattainable target.

So, if you can say 'Our next target is to spend 35 per cent of our gross revenue or whatever on Health' or to make it more realistic, and people would be happy to say 'We've moved up one spot - we don’t have to be the healthiest state, we could just not be the second or third' - where we are.

My question is: what advice will you take to Cabinet about the position you find yourself in now, having to defend a policy statement that is a target now, from five years ago or whatever?

Ms COURTNEY - I take the point. However, I'm a believer in having aspirational targets. I think it's important, as a state, that we set those and not just for government, but for our community. I think if we don't set our aspirations high, we're sort of targeting mediocrity. I believe you set a target and then make sure you've got a plan to be able to work towards those initiatives.

We've seen those across many portfolios and some targets are easier to achieve than others - I will accept that. However, in something as important as Health - and I mentioned education, safety - as a member of the Government, I would always want to aspire to have Tasmania a leader, not just middle-of-the-road, in these areas. We have work to do across portfolios.

Mr GAFFNEY - Yes.

Ms COURTNEY - With regard to the split, yes, there are sometimes challenges around something like budget Estimates. However, one of the reasons this ministry was stood up was so that we could have a specific focus, particularly on the mental health and the preventative health side of things. It is sometimes - and has been historically - a criticism about the focus and making sure you have a minister completely focused on those areas, ensuring they are getting the absolute attention they need and deserve as priority areas for our Government.

Dr SEIDEL - Again, prevention and mental health is mentioned almost 50 times in your report and you are the sole author. Mr Rockliff is mentioned once. You mentioned, fair enough, you have one minister who can focus on mental health and prevention but you also cover quite a few other areas. You are the minister for Small Business, and Hospitality and Strategic Growth. Do you think it is a challenge for you to split yourself up? Wouldn't it be easier to have one Health system and one Health minister who is covering not only the clinical aspects of treatment, but also prevention and mental health? Do you believe that is an unnecessary burden or barrier you are facing now in order to implement your vision of a potentially healthier Tasmania by 2025?

Ms COURTNEY - No, I actually think it strengthens the portfolio having two ministers being able to focus on it. I know how passionate Jeremy is around those areas and they collaborate very well with his other portfolio areas, particularly Education and how we ensure we are using those relationships with the Department of Education to their maximum benefits. A lot of the things Jeremy does across those portfolios are aligned particularly with the outcomes he is seeking to achieve as the Minister for Mental Health and Wellbeing. It strengthens the portfolio having the collaboration and also having two ministers being able to focus upon it. We have a single dedicated secretary who works across both those areas. Part of the Government's restructure earlier in the year ensures those areas that sit below Mr Rockliff and myself have appropriate oversight and governance from a deputy secretary level going up to the secretary.

Dr SEIDEL - I want to move on and ask a few workforce questions. Can you please advise us of the cost of locum doctors and agency nurses currently working within the THS?

CHAIR - Do you want to do that under 2.1, which is specifically related to the THS? Anyone else got any other overview?

Ms WEBB - I can slot them in other places.

CHAIR - We will move on to 2.1, Admitted services.

Dr SEIDEL - Because it is workforce and it might also cover outpatient, not Admitted Services, that is why it is under 1.1.

CHAIR - We will go back to 1.1 because you are looking at right across.

Dr SEIDEL - That is correct. I will repeat it. What is the cost of locum doctors and agency nurses who are currently working in the THS?

Ms COURTNEY - I will get Kath on the data. In terms of our expenditure across 2019-20, medical locum expenditure was $33.7 million, locum expenditure for March 2019-20 was lowest. In the most recent March to June quarter 2020, noting the impact of COVID-19, it is important to note that if we look across these figures, we have had a large increase in staffing numbers and an increase of 59.5 FTE medical practitioners. We also announced the increase in permanent positions in the north-west to support the Mersey ED. As to the specific data, I will get the secretary to answer.

Ms MORGAN-WICKS - The split of medical locum costs by service in the THS - at the Royal, is it just for 2019-20?

Dr SEIDEL - Thank you.

Ms MORGAN-WICKS - It was $5 340 446; at the LGH, $13 345 497; at North West Regional Hospital, $8 640 859; and at Mersey Community Hospital, $6 645 510.

Dr SEIDEL - Do you have the data for agency nursing staff?

Ms MORGAN-WICKS - I have a total not a breakdown with me. Agency nursing usage, particularly through COVID-19, increase to $7.5 million in the 2019-20 financial year, up from $6.3 million in 2018-19.

Dr SEIDEL - How many medical staff employed in the THS also do private work in private medical facilities?

Ms COURTNEY - I don't know if we have that data.

Ms MORGAN-WICKS - We collect data in relation to engagement of medical workforce in the public system.

Dr SEIDEL - Are the medical staff on contracts employed through the THS also allowed to work in private medical facilities?

Ms MORGAN-WICKS - Yes, I believe that is the purpose of a visiting medical officer and the VMO award.

Dr SEIDEL - How many full-time medical practitioners working in the THS would be also doing private medical work outside the THS?

CHAIR - Are you talking about full-time VMOs?

Dr SEIDEL - Yes.

Prof. LAWLER - We don't have full-time VMOs under the award. My understanding is the maximum fraction you can have as a visiting medical officer is 0.4. But the VMO structure is intended to attract private practitioners to provide services within the public system and balance that.

Dr SEIDEL - With regards to career medical officers?

Prof. LAWLER - Career medical officers or salaried medical practitioners?

Dr SEIDEL - Both would be fine

Prof. LAWLER - Career medical officers don't necessarily have an equivalent within the award structure. We are talking about high-level medical practitioners. Career medical officers would tend to be employed within specific clinical settings and are predominantly not of specialist qualification. Their capacity to work in the private sector obviously, as you would understand, would be limited. In terms of salaried medical practitioners who are undertaking work in private practice - I don't have that and I am not sure we capture that information.

Dr SEIDEL - So the contracts they sign would stipulate whether they are allowed to do salaried medical work?

Prof. LAWLER - The award arrangements and the industrial arrangements for salaried medical practitioners governed under a number of instruments provide for the capacity for rights of private practice. Again, I don't know we would necessarily have that data to hand.

CHAIR - If the salaried medical officer is engaged by the THS in a full-time capacity - which I am not sure if they all are or whether some are engaged in a part-time capacity - wouldn't it be an unsafe work practice to enable them to also work in private settings?

Ms COURTNEY - With regards to the detail around this question, considering we are talking about contracts we don't have here today, perhaps we can take that on notice? We will provide an answer that actually reflects those contracts.

Dr SEIDEL - I would be happy with that.

CHAIR - It would be good to know how many salaried medical officers are on full time. Are they able to work outside the THS? Not that you would necessarily know if they are. How many part-time salary medical officers are there?

Is there anything else, Bastian?

Dr SEIDEL - Not on this. Just one more workforce.

My next question is about the Tasmanian Rural Generalist Pathway - TRGP. How many positions are currently funded through the department and how many rural generalists do we currently have employed?

Prof. LAWLER - Thank you for the question. The challenge in terms of training is that many of the individual training experiences occur within the public system. As we are working towards the process of preparing homegrown Tasmanian rural generalist practitioners, a lot of that is undertaken through the THS, and they are employed against RMO or medical practitioner training contracts.

The other challenge is that we don't have a classification under the award for rural generalists; indeed, we don't have a national specialist qualification for rural generalists, although that is in the process.

Dr SEIDEL - We do, actually.

Prof. LAWLER - We do not have a recognised specialist qualification or field of specialty practice for rural generalism under the recognised qualifications under the AMC and under the Health ministers, but we can have that discussion.

The challenge is that rural generalists are employed under other industrial classifications. As rural generalists are general practitioners and are specialists in their own right under appropriate classification, many of them are employed under the Rural Medical Practitioners Agreement. Many of them are employed as salaried medical practitioners or as career medical officers.

The challenge about asking that is a definitional one around how we classify rural generalists under it. I am not sure we can necessarily give that as a clear answer.

Dr SEIDEL - How many trainees do you currently have who are envisaged to become rural generalists?

Ms COURTNEY - One thing I would add - part of our model in the north-west, with the Mersey and the North West Regional, is about strengthening our pathways into these areas to ensure we have that capacity. We will take that on notice.

CHAIR - With the Mersey, are you actively progressing that as a model of care?

Ms COURTNEY - The model of care at the Mersey and the North West Regional is very exciting. A lot of work was done on the ground with staff at both sites to take on board their concerns, and also with those two sites working together, because some staff work across both those sites. As the secretary mentioned earlier, there is a business case and additional positions embedded into that. There is also work being done to further support that, to ensure we have good rostering, and to ensure the rosters are filled more regularly and are robust.

I will get the detail for you.

Ms MORGAN-WICKS - We recognise the impact COVID-19 has had on our emergency department at the Mersey Community Hospital, which has been operating between 8 a.m. and 6 p.m. since 24 August, and will return to 24-hour operations on Monday 30 November 2020.

We have been able to commit to that 24-hour day roster by providing additional staffing for both the North West Regional Hospital ED and the Mersey ED. This includes an additional six specialist doctors and 10 mid-grade training doctors across the north-west region.

We have been successful in recruiting three additional permanent senior staff, and five long-term locums to support the service reopening.

We will continue to focus on recruiting permanent staff, including staff specialists, registrars and career medical officers, to build a sustainable workforce and provide appropriate support for the ED.

However, this type of recruitment does take time to complete, particularly given the interest from candidates currently based overseas.

Sustainably staffing the Mersey ED means ensuring the workforce is appropriately skilled to manage a level 3 emergency department, but it is also about providing the environment to actively train and support a workforce, hence the conversation around the rural generalist pathway. To do that, we are continuing to build our rural generalist emergency specialist workforce in the Mersey ED. This will provide support for training and pathways for local doctors, who will not only support the ED, but will also support a range of other services in the Mersey, such as palliative care and community general practice.

As part of our ongoing work, we are consulting on the appointment of a specialist rural generalist emergency doctor clinical lead, a nurse practitioner candidate ED position, education and training support for our ED nurses at the Mersey Community Hospital, and also involvement in our new statewide emergency care network that, among other things, can be a forum for improving our transport and also our transfer policies.

We have also recently appointed acting clinical directors for the North West Regional Hospital ED, and the Mersey ED.

CHAIR - Who are those appointees?

Ms MORGAN-WICKS - For our acting clinical leads?

CHAIR - Yes.

Prof. LAWLER - We have Dr Muhammad Khan, who is himself working as a generalist at the Mersey Community Hospital, and Dr Michael King, who has a FACEM, who is employed at the North West Regional Hospital.

CHAIR - How many rural generalists do you expect to have?

Prof. LAWLER - As the secretary highlighted, we have recruited three permanent senior staff and five long-term locums, by which we mean they're not fly-in, fly-out; they are there for some months and contributing to the stable senior staffing.

In terms of how many, we recognise there is a benefit to having a mixed senior staffing model. We have FACEMs who are very keen to work in that department. The department is

very keen to have FACEMs. It makes for a strong blend and network between the Mersey and other hospitals.

We also see the strength of a predominantly rural generalist model. This is a specialist model; when rural generalism is recognised nationally as a specialty under the register of specialties and field of specialty practice, that will be recognised appropriately, but it does provide a benefit, not only to emergency but also to the community. These are general practitioners with advanced scope of practice in emergency medicine.

CHAIR - Yes. I didn't realise they weren't recognised as a specialty yet.

Dr SEIDEL - We can talk about this forever, Professor Lawler and myself.

CHAIR - Yes, let's not talk about it now.

Prof. LAWLER - There is a clear definition, a clear agreement between a number of colleges. There is a process in place to have it recognised as a field of specialty practice under general practice, and that's well underway.

Dr SEIDEL - Certainly it's recognised as an industrial specialist by quite a few other jurisdictions, including Queensland.

CHAIR - It has to be a nationally recognised thing before we can actually -

Ms COURTNEY - Obviously, we have confidence in the model. This is why we have put in additional resourcing at the North West Regional Hospital and at the Mersey Hospital, not just with those people, but making sure there's support and the pathways.

CHAIR - There's strong support for it.

Ms COURTNEY - There is.

CHAIR - Any other questions in overview? Let's go to 2.1 then.

Output Group 2
Health Services

2.1 Admitted Services

CHAIR - Sarah, you're the leader on this.

Ms LOVELL - I might start with some questions around inpatient beds for major hospitals. Could you please provide the committee with an update on the number of staffed and operational inpatient beds available for use at the Royal, the Launceston General Hospital, the Mersey Community Hospital and the North West Regional Hospital?

Ms COURTNEY - We have made substantial investment in our Health system over the last six years, not just in the capital side but, importantly, also in substantial recruitment across the different areas of specialty and, indeed, the regions.

Since 30 June 2014, the number of available beds in Tasmania's public hospitals has increased from 1187 beds to 1463 as at the end of June 2020. That is an increase of 276 beds, or 23.3 per cent. I remain committed to providing 250 additional beds for the Royal Hobart Hospital by 2024, as well as 40 beds for the LGH and the eight we have already opened at the North West Regional Hospital, and new funding and staffing at the Mersey Community Hospital.

At the Royal Hobart Hospital, we have now provided funding to support 69 beds since the commissioning of K-Block. There is $299 million provided in the 2020-21 Budget and forward Estimate period for the continued rollout of this commitment. In addition, the 2020-21 Budget includes additional funding of $50.2 million over the next two years to deal with both demand and beds. In all more than 100 beds are supported with this funding, including additional openings, also supporting new services opened earlier this year, including the Transit Lounge and the Hospital in the Home - HITH - service. This includes the additional doctors and nurses to staff these beds.

With regard to our bed numbers, according to the Australian Institute of Health and Welfare, Tasmania has an average rate of available beds per 1000 population of 2.68 per cent in 2018-19, which is well above the national rate of 2.53. With regards to some of the data, I will get the secretary.

Ms MORGAN-WICKS - A comment on definitions of bed numbers which no doubt have been travailed through many Estimates hearings, but available hospital beds being a measure of the average number of fully staffed and funded beds available to provide admitted patient care. It is measured in accordance with the national definitions and using Tasmanian hospital bed census numbers. If I can comment on the major hospitals for 2019-20, Launceston General Hospital - 408; Mersey Community Hospital - 107; North-West Regional Hospital - 136; and the Royal Hobart Hospital - 545.

Ms LOVELL - Does that include Hospital in the Home beds?

Ms MORGAN-WICKS - No, it does not.

Ms LOVELL - Are those numbers at the end of June or is it current?

Ms COURTNEY - End of June.

Ms LOVELL - From the numbers we were given at Estimates in June last year, that is an increase of 40 beds at the Royal and an increase of four beds at the Launceston General Hospital?

Ms COURTNEY - Correct.

Ms LOVELL - And a decrease at the North West Regional Hospital of nine?

Ms COURTNEY - The North West Regional Rehabilitation Services transferred to the Mersey where we also had the recruitment of a rehabilitation specialist, which was very good. At the North West Regional Hospital, there was some reconfiguration through the COVID-19 period based on infection prevention control and staffing feedback where we removed beds to ensure we had a safe working environment during COVID-19.

Ms LOVELL - With bed numbers across the north-west, with those changes, if we look at the combined numbers between the Mersey and the North West Regional Hospital, in June last year there was 240 and now we have 243 across the two hospitals: is that correct?

Ms COURTNEY - It looks like 243 is correct, if we add up 136 and 107.

Ms LOVELL - Across the north-west, that is an increase of three beds?

Ms COURTNEY - Correct.

Ms LOVELL - We heard the commitment around 250 new beds at the Royal since the election. We've had 40 since June last year; of the 250 committed at the election, is 40 the number delivered so far?

Ms COURTNEY - There has been additional beds since the start of June so that's one thing to recognise because obviously, they were the end of June. K-Block has obviously continued to commission past that date.

Ms LOVELL - Do we have a figure to date, if there have been significant changes since the end of June?

Ms COURTNEY - I'm not sure where we have that. I will take that on notice and see if we can provide it.

Ms LOVELL - Thank you. Going back to my question on the 250 beds, is that right, since -

Ms COURTNEY - An extra 250 beds.

Ms LOVELL - Yes, an additional 250 beds was the commitment at the Royal?

Ms COURTNEY - Yes.

Ms LOVELL - How many of those 250 additional beds have been delivered to date since that commitment was made?

Ms COURTNEY - We remain committed to the 250 additional beds for the Royal and additional beds at the LGH and the North West Regional Hospital. As I outlined, Royal Hobart Hospital now has funding provided to support 69 beds since the commissioning of K-Block. Also, $299 million is provided over the Budget and forward Estimates period for the continued rollout of this commitment.

In addition, the 2020-21 Budget includes additional funding of $50.2 million over the next two years for demand in more beds. In all, more than 100 beds are supported with this funding, including additional bed openings and supporting the new services opened earlier this year, including a transit lounge and Hospital-in-the-Homes.

Ms LOVELL - Providing funding is one thing, but actually having the beds open and operating is a different thing because you can commit to funding and the staff might not be there yet. I appreciate you may need to take this on notice because you don't have the current

to-date figures here, but my question is: of those 250 beds committed at the election, how many have been delivered now, to date, at the Royal?

Ms COURTNEY - I'm happy to take that on notice.

Ms LOVELL - Thank you.

Ms COURTNEY - Obviously, as we continue to commission that hospital - and it's important to note that throughout the commissioning and, indeed, prior to commissioning, we already started recruiting for the additional beds.

Ms LOVELL - Specifically, how many beds are available for patient use now is the question I'm after, and how does that compare to when that commitment was made?

Ms COURTNEY - We will get that on notice for that time.

Ms LOVELL - Thank you. I don't know if anyone else has questions on bed numbers. I wanted to move onto elective surgery.

CHAIR - No.

Ms LOVELL - Thank you. Obviously, there was a period based on a decision made that national level elective surgeries were put on hold -

CHAIR - Before we get into this, we might have our morning tea break. It is just after 11 and rather than start another area, if we could.

The Committee suspended from 11.03 a.m. until 11.19 a.m.

Ms LOVELL - Minister, we were just moving to some questions about elective surgery. During the period from 25 March to 27 April - just over a month - there was essentially a pause on elective surgery. That was a national decision.

Can you provide the committee with an update on how that pause was implemented in Tasmania? Did surgery cease completely? Did we continue some? If we did continue, can you please provide an update or a number - and I appreciate you may need to take this on notice - of surgeries performed at each hospital in each category during that period and how that compared to the same period in the year prior?

Ms COURTNEY - Thank you for the question. I acknowledge that the pause in elective surgery had a huge impact. It is important to recognise that for Tasmania it was a lot longer than the nationally stipulated pause because of the impact of the north-west.

When we had the closure of those two hospitals, it meant there was a significant load on the Mersey Community Hospital but also on the LGH and the Royal. Getting the North West Regional Hospital cleaned and reopened took a period of time, and then it took time to move patients back from the LGH and the Royal to those sites. There was a longer term impact than those dates you talked about.

We know there was a significant impact particularly on categories 2 and 3, so we kept category 1, emergency, and category 2, urgent. That was a clinically directed model. We also had a good partnership with all the private hospitals. The model I saw, particularly at the LGH, meant that - because we have doctors who work across both the private hospitals as well as the public hospitals - we worked hard to look at how we could have staff working at one site and not the other sites, so they effectively split themselves in two, and then we could purchase procedures through those private hospitals.

With regard to the data around that period, I will go to the secretary and perhaps Professor Lawler to talk to that. We only have the year-on-year data at the moment, but we can take it on notice and provide an update of how that happened, how that surgery was during that period of slowdown, and how it played out across the system.

Ms LOVELL - Can I add to that also? My next question may need to go along with that. How do those numbers compare to the number of surgeries being performed in each category in each hospital in the last month?

Ms COURTNEY - We'll take that on notice. We will be able to look at how we do that. With regard to the funding provided in this Budget, the $45 million, there is also $15 million from the federal government which was brought forward and wasn't expended because of COVID-19. There is significant planning underway at the moment as to how we can ramp that up in the most effective way to get those additional surgeries for Tasmanians because I know it has been a difficult year for them.

Ms LOVELL - I've some questions about that funding, regarding -

CHAIR- The COVID-19 funding, or the other funding?

Ms LOVELL - We might need to come back to that.

CHAIR - My question has that line item, so -

Ms LOVELL - I will ask about the $15 million the minister just referred to. The $15 million was brought forward - that was the Commonwealth commitment to deliver endoscopy surgeries. In the communication that came out following that, I think in the service plan, the vast majority of that funding was going towards endoscopy procedures, or that was the intention at the time. I appreciate we have had a period when COVID-19 took precedence. In terms of endoscopy and colonoscopy waiting lists, what are the current numbers on that list now?

Ms COURTNEY - I will go to Kath to talk to the numbers of those. With regard to funding that was brought forward, one of the other priorities we have had is ensuring that we are targeting the most over-boundary patients as well as children. They have been two other target priorities in the additional funding that we've had. Regarding the data across those areas, I will pass to the secretary.

Ms COURTNEY - Some funding was provided by the federal government, and I understand it was around the $5 million initiative for more endoscopies. There was also $15 million brought forward that Greg Hunt and I announced late last year or early this year,

targeting the children and those who had been waiting longest. For waiting lists and your question, I will go to the secretary.

Ms MORGAN-WICKS - With the additional elective surgery funding, the Government is funding 11 516 endoscopic procedures in 2020-21. This is higher than the levels of endoscopy delivered over the last seven years, and represents an increase of 1667, or 16.9 per cent, on the 9849 admissions delivered in 2019-20.

The hospital breakdown for 2019-20 for endoscopic procedures - we have the Royal at 4082; the LGH at 3248; the North West Regional Hospital at 2250; and the Mersey Community Hospital at 269.

Ms LOVELL - What was the total delivered in 2019-20?

Ms MORGAN-WICKS - It was 9849.

Ms LOVELL - And the intention is to deliver 11 516 in 2020-21?

Ms MORGAN-WICKS - That's correct.

Ms LOVELL - How many people are currently on the waiting list?

Ms MORGAN-WICKS - Did you want that by hospital?

Ms LOVELL - Just the total at this stage.

Ms MORGAN-WICKS - The census as at 30 June for the number of patients waiting for an endoscopic procedure is 7685.

Ms LOVELL - Last year, the number we were given for March was 5799. That is a significant increase.

Ms MORGAN-WICKS - Last year, same date, the census totals at 30 June were 6836.

CHAIR - Last year's budget was earlier. Is that the reason for the difference?

Ms MORGAN-WICKS - The data was collected on the same date.

Ms LOVELL - With the increase in the waiting list, I want to see whether those additional procedures will have any impact on the list moving forward.

Ms MORGAN-WICKS - There was an 11 per cent decrease in the number of over-boundary patients at the Royal over the same period. In terms of the allocation of the elective surgery monies, they are focused on rolling out more than 11 000 procedures for 2020-21.

Ms LOVELL - Can you provide an update of the percentage of time each hospital has spent at each of their escalation levels over the last financial year?

Ms COURTNEY - We have the escalation levels across each of our hospitals. These are here to make sure that when we do have times of increased demand, we are able to have a clear mechanism for how triggers are implemented, but then also what other work needs to be done to ensure they are dealt with.

Ms MORGAN-WICKS - For the percentage of time in a high-level escalation, I have here five hospitals. The Royal Hobart Hospital: 2018-19, 68.1 per cent; and 2019-20, 57.6 per cent -

Ms LOVELL - Can I clarify, which level is that?

Ms MORGAN-WICKS - This is the highest level of escalation that's applied to that hospital. For the Royal, that is escalation level 4.

The LGH: 2018-19, 67.4 per cent; and in 2019-20, 62.1 per cent. North-West Regional Hospital: 2018-19, 46.5 per cent; and in 2019-20, 44.4 per cent. Mersey Community Hospital: 2018-19, 6.7 per cent; and 2019-20, 7.4 per cent. An improvement across three hospitals, except for the Mersey.

Ms COURTNEY - With regard to the pressure we've had across our hospital system with patient flow and bed block, a range of initiatives are being implemented across the state. My predecessor, Michael Ferguson, did access solutions last year. We've had significant progress, including the rollout of Medtasker and pharmacy charting, implementation of the transit lounge, and we've also seen the private hospital in Hobart open its ED 24-7.

We have also conducted a forum with staff at the LGH to look at how we can implement those, and we are implementing and working with staff around Medtasker and pharmacy charting across the north and north-west. Indeed, we have a lead now who is tasked with ensuring that the solutions led by clinicians are implemented across the state.

Ms LOVELL - Minister, are you notified when the hospitals reach their highest escalation level? Is that something that happens as a matter of course?

Ms COURTNEY - I'm not notified, but the secretary of the department is. That is for the Royal.

Ms LOVELL - Just the Royal?

Ms MORGAN-WICKS - Sorry, if I may clarify. I should correct myself. I receive a patient flow update at 7 a.m., 11 a.m., 3 p.m. and, I think, 9 p.m. in relation to the escalation levels of every hospital.

Ms COURTNEY - It's important to note that while it doesn't embed the trigger of notification to me, I'm regularly updated, particularly at times when escalation levels are at high levels for long periods.

Ms LOVELL - I'm glad to hear that, after the same question last year. Going back to the access solutions meetings, one of the positives of that meeting at the Royal was that it involved a broad cross-section of staff. It involved staff from various levels, it involved unions. Opposition members of parliament were present at that meeting. I am aware there is a

commitment to roll out some of those solutions across the LGH, but specifically who was involved in the consultation at the LGH, particularly in terms of staff?

Ms COURTNEY - I actually attended part of the LGH meeting, as did the secretary of the department.

Last year there was a meeting with Alasdair MacDonald with a range of stakeholders from across the hospital. I don't have a list of stakeholders who attended that meeting, but it was very well attended, and a number of initiatives were raised by different areas of the hospital through that. A body of work was implemented, and I will get the secretary to outline the work that has been done.

It was an important opportunity, because there were lessons we learnt from access solutions, but some of those were unique to the Royal Hobart Hospital. The LGH has its own unique challenges. It also has its own unique opportunities, particularly through some of the district models that we have. Indeed, I announced earlier this week some further resourcing for the district hospitals to enable high-acuity patients to be cared for there.

Ms LOVELL - Before we do that, minister, if I may, I am really interested in who was involved in the consultations. When you say a range of stakeholders? Were they senior clinicians? Was it management? Were nurses involved? Unions? Who specifically?

Ms COURTNEY - I'll get the secretary.

Ms LOVELL - Thank you.

Ms COURTNEY - Further, I can take it on to provide further feedback. I am sorry, I just can't remember who attended a meeting pre-COVID-19 at the moment. I remember the meeting, but I can't remember who everyone was. I'll take that on notice and get back to you.

Ms LOVELL - Thank you.

Ms LOVELL - There has been some discussion around the escalation protocol at the Launceston General Hospital compared to the protocol in place at the Royal. Will the LGH be adopting the four-level escalation protocol in place at the Royal?

Ms COURTNEY - There was some commentary around this earlier in the year. The feedback I received - and I'll go to the secretary or the CMO to talk to this further - was not the outcome desired by the clinicians.

Ms MORGAN-WICKS - Certainly, the full-day workshop held at the LGH in December was to try to explore what initiatives should be prioritised from the efforts from the initial the access solutions meeting with the Royal staff and what could be applied statewide either to the LGH and, potentially, through to the north and north-west, although the meeting did focus on the LGH.

Escalation levels were not identified as a critical option for an improvement - I did note some of the discussion, but I am trying to remember if it actually occurred in that meeting or in other meetings.

There were many forms of consultation in relation to different options to improve flow through the LGH and our hospitals with up to 10 levels of escalation, for example - and I just pulled 10 out of the air.

Their main concern was actually about the improvements we can make with protocols; the transfer protocols, direct admission protocols, for example, from the emergency department - trying to come up with a list of initiatives we can address and that's being prioritised for the statewide access and patient flow program. While we note we're taking on notice the exact attendees at that meeting at the LGH in December - from my recollection it was a variety of clinical staff together with management and right across the hospital, including into our primary care - I remember having a long conversation with Fiona Young in relation to the ComRRS and how to better utilise beds in our district hospitals, particularly in the north, which is why I am pleased to see that funding is actually going to be directed to increasing FTE in our district hospitals.

Key actions have been taken since then and different levels of consultations have occurred in relation to these actions. But our ability to flex open beds during times of high demand at LGH - including by using beds in the short-stay surgical unit, day procedure unit and additional beds on Ward 4D. We have the development of our integrated operations centre. The patient flow team at the LGH was made recently permanent following a successful trial. That means the LGH now has a substantive full-time nursing director of patient flow who leads a team of patient flow managers and afterhours nurse managers, 24 hours a day, seven days a week, with daily bed management meetings with senior hospital staff to ensure the best utilisation of inpatient beds and a review of the current escalation protocols and implementation as part of our regular hospital processes.

The opening of a transit lounge hub at the LGH is to assist with patients awaiting discharge and improving patient flow and making beds more easily available to be turned over. Increased pathology hours of operation with changes to our medical scientist rostering and increased staffing levels in the past 12 months have improved pathology turnaround times, particularly for the ED and inpatient care areas to assist with facilitating safe discharge. We've had our LGH redevelopment and master planning process considering the future infrastructure needs as part of the $87 million redevelopment. The subacute rehabilitation model of care, as the minister mentioned, is a key priority for trying to reduce the demand on the LGH ED and to improve patient outcomes. This is particularly providing better care options for our frail and elderly people with multiple chronic and complex conditions who might not be sick enough for acute hospital care, but too sick to be managed only by general practice and would benefit from specialist support in the community.

In addition, our quite successful Community Rapid Response Service - ComRRS - with 869 referrals from 109 GPs in the northern Launceston area. They delivered 9877 occasions of service in the north in 2019-20, so really trying to push hard on our hospital avoidance strategies to make sure the care is in the community when it is needed.

Ms LOVELL - I had some questions and unsure if it is this outlook group, but you have that data there in front of you. There were 9877 occasions of service through the Community Rapid Response Service in the north: How many of those resulted in either a presentation to the ED or an admission to hospital? Do you have that data in front of you?

Ms COURTNEY - I am not sure whether we have that data. With the Community Rapid Response Service, we have data on how much avoidance and the benefits, because through the trial we looked at what the impact this was having. Surveys from GPs showed 96 per cent of patients referred would have needed to attend hospital had they not been seen through the ComRRS.

A substantial number of people who were seen by ComRRS avoided hospital. They would have had to go to hospital had they not had ComRRS.

Ms LOVELL - That was essentially my question. You have data on avoidance based on GPs surveyed saying 96 per cent would have had to go to hospital were it not for ComRRS but you do not have the data of the patients referred to ComRRS who did end up in hospital.

Ms COURTNEY - Did not go into ComRRS or went into ComRRS and then still had to go to hospital?

Ms LOVELL - Yes.

Ms COURTNEY - I do not know whether we will have the data on that because sometimes people who use ComRRS have complex conditions or comorbidity factors. I do not know whether we will have that data because we may have been able to support them in the community through ComRRS with part of the illness; however, another part of their illness at some stage may have escalated and so they may have had to go to hospital.

Ms LOVELL - I guess that is the question. That is not really hospital avoidance then because they needed to be in hospital anyway so how effective is it in terms of hospital avoidance?

Ms COURTNEY - I will see whether we have the data. I will take it on notice, but we do not actually collect the data that way. The survey with the GPs responded that 96 per cent - so most of the people who used that service - if that service had not been available, would have had to have been cared for in hospital for the condition they were being cared for by the ComRRS.

I am not sure whether Professor Lawler has anything further to add on that.

Prof. LAWLER - I would make two comments. One, it is valuable for us to know obviously the perception of primary care positions and general practitioners about the value of the service. This will go not only to how effective it is on hospital avoidance, but also to its acceptance by and utilisation in the community.

In addition to providing a hospital avoidance process, there is also a screening element. If significant treatment is provided in the community, but the patient still ends up in hospital, I do not think that should be perceived as a failure of the service or indeed of the inappropriateness of referral. There is a clinical assessment going on there.

I also think any data that's provided would have to be looked at with an element of caution because we're potentially talking about a group who have significant parallel comorbidities and so what presents them to hospital subsequently may not in fact be what they've been referred to ComRRS care in the first place.

Ms LOVELL - I appreciate that. To be clear, I'm not suggesting that it's not a valuable or worthwhile service, but in terms of hospital avoidance, and given that we have significant problems with patient flow in our hospitals, how effective is this particular solution?

Ms COURTNEY - I would argue it has been extraordinarily effective. That's from the surveys that we've done of GPs and from the number of referrals we're having into the system, and that's why the pilot was so successful and why we're looking at rolling it out in other areas.

I answered in one of the earlier questions from Dr Seidel that one of the big benefits is it's a better outcome for the patients, particularly those who are elderly and could be cared for, because we know when they go into an acute care setting, it can be very distressing for them. I have also spoken to people who were cared for in their home, and had they had to go to hospital, the flow-on effect for the people they cared for in their household would have been substantial. There are broad positive flow-on effects for the people around the patient as well as other service providers.

Ms LOVELL - To be clear again, I'm not arguing whether it's a better health outcome for people or a better service for those patients, just in terms of the impact it's having on the hospital and that data - that's what I wanted to have a look at.

Prof. LAWLER - One thing I would say is that hospital avoidance isn't just about keeping people out of hospital. It's actually about making sure people are in the right place at the right time, which includes having exhausted all community treatment options. Again, I just caution that. The rate of ComRRS participants who are ultimately referred to hospital is an imprecise link to how effective the service is.

Dr SEIDEL - You are able to report the data for readmission rates for patients who had wanted the HITH program, so you're also reporting whether these patients are ending up in the hospital system within 28 days. It's actually quite easy enough to do, isn't it, because we capture the patients who are part of the Community Rapid Response Service and you also capture them in case they present to the emergency department while being admitted. Are you able to provide the data? It's a simple question, really.

Ms COURTNEY - I don't have that data here and -

Dr SEIDEL - No, but can you take it on notice and provide the data?

Ms COURTNEY - I will take it on notice under the caveat but I'm not sure what data we have available to be able to respond to that question.

A witness - Nor do we agree it's simple.

Ms COURTNEY - No, it's not necessarily easy. As I said to Ms Lovell, if we have the data captured, we will provide that on notice.

CHAIR - Just clarify the question, you're asking for information relating to patients who have been in the ComRRS system, if you like, who eventually end up in hospital, even though it might not be related to the condition they were being treated by ComRRS for?

Dr SEIDEL - You can do a time line within 14 to 28 days; it's just the standard practice.

CHAIR - I don't know what level of data, but we will see if the minister -

Ms COURTNEY - As I've said, we will if we can provide it, but the initial advice I'm getting from the secretary is we don't keep that dataset. so we will have to look to our systems to see whether we can extract that. If we're able to, we will provide that on notice and we're happy to do so, but I just don't want to create a commitment on the dataset that I don't know whether we have or not.

Ms LOVELL - One last question on Admitted Services in relation to some of the measures put in place around patient flow and the role of the associate nurse unit manager - ANUM. It is my understanding this is role was established to help with the patient flow and facilitate transfers, admissions and discharges, but those associate nurse unit managers are also expected to take a patient load as well to assist in a clinical perspective, which is having an impact on their ability to conduct those other duties in terms of managing patient flow. Will there be an allocation from, well, any of the Budget lines really, to allow those vacant roles to be backfilled so that they can fulfil the full scope of their essential role in managing patient flow?

Ms COURTNEY - As to the substance of the question with regard to the role, I will get the secretary to answer that in a moment. With regard to the impact that and other things have on patient flow, it is very apparent to everybody that for patient flow through a hospital, the things that cause bed block are multifaceted. A range of things contribute to it and a range of solutions.

Through the access solution meetings in the south and the further work done in the north, steps and initiatives were identified that specifically would assist those, and we are progressing each of those, as the secretary has outlined.

As to the ANUMs, I will ask the secretary to respond.

Ms MORGAN-WICKS - We have a dedicated team at the LGH in relation to patient flow. I read the positions out before; they include a nursing director of patient flow, patient flow managers and after-hours nurse managers. It is certainly the core business for any managers of our wards in relation to the flow of patients through their ward, the discharge and early discharge planning that needs to be undertaken, the appropriate bed utilisation on the ward and to have an open conversation with the emergency department in relation to available bed capacity and when we believe can move patients requiring admission from the ED up to that particular ward.

The important thing about access solutions is that this is not only a problem that is presenting in the emergency departments. This is a problem that is shared right across the hospital and it is everyone's job to work through and make sure they are supporting the initiatives and that we have appropriate flow happening from the ED.

Ms LOVELL - Yes, absolutely, and that is one of the reasons why these roles are so critical, as one of the many solutions. It is a complex whole-of-hospital problem. Is it part of the ANUM's role to take a patient load? Would that be a normal expected practice?

Ms COURTNEY - I have to seek advice in terms of different role positions and what the requirements are.

Ms MORGAN-WICKS - Depending on the ward and depending on the level.

Prof. LAWLER - We are discussing senior nurses with senior clinical expertise, so there would be an expectation at times to provide assistance in issues of particular clinical patient care, but as to whether there is a standard expectation taken on patient load, I couldn't comment specifically on that.

Ms LOVELL - I guess maybe a better way to put the question is in regard to ratios and nurse-to-patient ratios. Are the ANUMs included in those ratios or are they an additional person on the ward to focus on those other ward management roles?

Ms COURTNEY - We will take that on notice to get the correct answer.

CHAIR - To see whether they are included in the nursing as per patient day.

Ms MORGAN-WICKS - In relation to the annual benchmarking that we undertake in relation to nursing hours per patient day - NHPPD - per each ward, yes.

Mr VALENTINE - I am interested in some of the workforce management issues that you may have across the hospitals. With respect to hours worked for nurses and clinicians, do you have any figures on the amount of overtime worked for each of those categories, and can you clarify for me whether a double shift is treated as overtime or not?

Ms COURTNEY - I will get the data for you.

Mr VALENTINE - It would give a reasonable indication of how stretched the workforce might be.

Ms COURTNEY - The overtime usage across the THS is highest amongst the clinical staff that are providing care. Average overtime FTE compared with average paid FTE was largely considered with that paid in the previous year from March 2019-20. That trend is continuing for the remainder of the reporting period.

CHAIR - Do you want it broken down?

Mr VALENTINE - No, just those two categories, the nursing staff and the clinicians.

CHAIR - Medical staff.

Ms MORGAN-WICKS - THS average overtime FTE to average paid FTE and by award - just nurses and medical practitioners. For nurses, the average overtime FTE is 87.52; for salaried medical practitioners, it is 60.63. This is for the pay period year ending June 2020.

Mr VALENTINE - To clarify, what does the figure 60.63 mean?

Ms MORGAN-WICKS - I might invite our chief people officer up to interpret the calculations.

CHAIR - Did we get the clarification of what the number relates to?

Mr VALENTINE - Can we table that or not?

Ms COURTNEY - For nurses, the average overtime FTE to average paid FTE for year ending June 2020 was 2.09 per cent. Because of the different year end and last year's budget, the average overtime FTE to average paid FTE ending year March 2020 was 5.91 per cent for the salaried medical practitioners, and 2.09 per cent for the nurses.

Ms LOVELL - Can we clarify what that means for hours worked?

CHAIR - The number of hours of overtime worked - is that available?

Ms MORGAN-WICKS - We usually capture average overtime as an FTE equivalent so that we could determine the number of people, full-time equivalents, which is why I read out the first statistics of 60.63 for SMPs and for nurses, 87.52. The minister has provided also the percentage of overtime per pay period.

Mr VALENTINE - I am interested in what the 87.52 means?

Ms MORGAN-WICKS - That is FTE.

Ms ANDERSON - The number, for example, for our nurses - that is the FTE equivalent over the year. The equivalent of 80 approximate nurses in FTE were employed as overtime through that year, as at the end of June 2020.

Mr VALENTINE - And the percentage of hours worked as overtime for nurses?

Ms ANDERSON - The percentage of paid FTE, or how many we paid through that year, 2.09 per cent of FTE.

Mr VALENTINE - So 2.09 per cent of all hours worked by nurses was overtime?

Ms ANDERSON - Of the paid FTE.

Mr VALENTINE - Of the paid FTE. To clarify, when a nurse does a double shift, is that considered overtime?

Ms ANDERSON - Yes.

Ms COURTNEY - The ratios for those two areas are lower than they were in March 2019 for nurses and slightly higher for medical practitioners.

Mr VALENTINE - Your workforce management is bringing that down, you are saying?

Ms COURTNEY - It would be difficult to draw that with COVID-19.

CHAIR - Staff equally important as nurses and medical staff are the cleaning staff. Do you have figures in relation to those staff, particularly those working in our clinical settings?

Ms COURTNEY - Their ratio is 1.18 per cent.

CHAIR - Is it possible to table that, minister?

Ms COURTNEY - We can take it on notice and we will provide the data with an explanation of the calculation.

CHAIR - Across all the staff, because the hospital does not operate with just nurses and doctors.

Ms COURTNEY - Across those different awards is how we have it here.

Mr VALENTINE - Do you have administration staff as well? It would be interesting to know whether they are doing extras.

Ms LOVELL - Do you have the FTE equivalent for cleaners in the same way that you have given us SMP and nurses?

Ms COURTNEY - We will be able to get that for you on notice.

CHAIR - We might just pull this up because I know Dr Veitch has arrived and we did make a commitment we would hear from him while he is available. We will come back to 2.1 and we will move to 2.7.

Output Group 2
Health Services

2.7 Public Health Services -

CHAIR - Did you want to make any comment about Public Health, minister? Are we happy to go straight to questions?

Ms COURTNEY - My only comment is what an extraordinary effort they have done this year. The response and preparations began very early in the year. In January preparations were already starting. It has been an extraordinary year for Dr Veitch and his team. We are very grateful for his and his team's hard work. They have been very dedicated. Tasmania's response and our success today has been demonstrated by the advice that we have been provided. It bodes well for our future; however, all Tasmanians need to remain vigilant.

Ms LOVELL - Thank you.

CHAIR -Are you ready to go? You said, minister, that Dr Veitch would be happy to describe more fully some questions I was asking you about our contract tracing process and the use of technology and the important person in the middle who is the interface between the affected person or the known contact and the electronic systems. Could you describe for the committee how that actually works?

Dr VEITCH - Thank you for the question and thank you for your comments, minister.

It is helpful in considering contact tracing to remember that there are two broad categories of contacts we trace. The first are the close contacts. They are the households and the

workmates of the case. The second are the casual contacts who have had more remote contact, perhaps chance contact, at a venue or some such thing.

The close contacts are overwhelmingly where most of the secondary cases arise within the household, within the workplace, within people's small group. The casual contacts are much less likely to get infected. There will be many cases who infect no casual contacts. The close contacts are the people we concentrate on first of all. As you note, there is a very critical dependence on the speed and effectiveness of that process on the skills and experience of the people who do the contact tracing. We were lucky to have a very good contact tracing team on place used to tracing measles, meningococcal cases and the like.

CHAIR - How many were in that team before COVID-19?

Dr VEITCH - The Communicable Disease Unit had around 11 FTEs at that stage. By the time COVID-19 was kicking off and we were contact tracing people, we had brought in a number of people through interoperability arrangements and other people into that group to support them. I don' have the precise number of the people who were there at the time, and it did change a bit from day to day as the epidemic evolved.

The contact tracers were principally experienced Public Health nurses. They would typically get a case some time in the late afternoon and they would usually have contacted the case and identified all their close contacts by later that evening. That was partly a consequence of Tasmania being fairly shutdown at the time, which limited the number of close contacts that there were, but they were very efficient and were a tremendously significant factor in reducing the transmission from multiple sources, both from arrivals from overseas and during the north-west outbreak into the community.

CHAIR - Anecdotally in Victoria there was a problem a close contact would receive communication from a number of staff. One of their recommendations they have now implemented is having effectively a case manager for a family. They had issues with non-English speaking background families and things like that, which made it more complex at times. Is that the approach taken with a case and the immediate contacts arounds them? Is there only one person who deals with them or could it be multiple?

Dr VEITCH - It can be multiple, particularly the first case - the case is contacted by one of these relatively few numbers of specialised nurses who identifies the close contacts. They then get handed over to the monitoring team, which subsequently follows them up to see they are in quarantine, not sick and don't have any needs. That is done by a different team. It is an absolute necessity because by the time you start chasing down and contacting contacts, you are getting quite a large number of people.

The other category of contacts are the casual contacts, which are the more remote contacts. Even as this outbreak has occurred, there were different levels of recommendation for pursuing those casual contacts. We initially tried to contact all casual contacts, then midway through the epidemic, about April-May, there was a stepping back where we no longer tried to actively pursue casual contacts directly and put out a notice that they could have been at risk. Now, we have swung back in the other direction where we do try to make formal contact one way or another with most casual contacts. That reflects the wish to try to extinguish every possible source of transmission. It is a much more labour-intensive exercise.

CHAIR - Possible when you don't have many cases, but not so easy when you have a lot.

Dr VEITCH - As cases increases, the task is flat. That is the aspect of tracing we would historically manage by saying 'If you have been to such and such a place, please contact Public Health', and we would do that through the media and announcements. Now we are moving towards using techniques such as recognising when people have been into particular venues. We have established the requirement for people to capture information about people attending hospitality venues.

CHAIR - Is everyone doing that?

Dr VEITCH - I'm sure not everybody is doing it, but it is an assistance to what we are doing. It is part of the process. It won't stop us from putting out the message if you have been to such and such a place, you should be vigilant and get in touch with us, but it will help us. As you may have heard this morning, there is the development of a very simple app that just does the job

CHAIR - Rather than the QR code?

Dr VEITCH - The QR codes.

Ms COURTNEY - Also, Ms Forrest, what you were saying there, along with Public Health Services, they have partnered with Department of Communities Tasmania. We established a migrant support network in March this year to engage with migrant communities and support organisations. Outbreak planning processes include formalised arrangements to rapidly connect and communicate with migrant communities.

Dr VEITCH - I might just leave it there to note we have these additional processes in place to help us with the casual contact identification.

CHAIR - It is helpful in terms of the strategy or PESRACs recommendation effectively to instil public confidence. These are really important things to have on the record so that people actually understand.

Ms COURTNEY - I was thinking before - more talking about the PESRAC recommendations. There is a careful balance between making sure everyone has confidence in the systems, but through having that confidence, that we do not have complacency in the community, that people do not still have personal responsibility throughout this process.

Ms LOVELL - I want to get an update on our current testing rates, so what is the current number of testing rates that have been conducted in the state?

Ms COURTNEY - We have published these on our coronavirus website. In the past 24 hours, and this is up to 6 p.m. on 24 November, 572 in the past 24 hours, with total tests, 127 286. They are the tests processed through the laboratory at the Royal Hobart Hospital.

Ms LOVELL - Sorry, so 572 - was that tests conducted?

Ms COURTNEY - Laboratory tests performed as at 6 p.m. last night, and the 24 hours prior.

Ms LOVELL - What were the two figures you gave following that?

Ms COURTNEY - The total tests performed to date to that time is 127 286.

Ms LOVELL - So that is to date since we started - 572 in the 24-hours prior.

Ms COURTNEY - Laboratory tests.

Ms LOVELL - Does that include the tests conducted by the Primary Health respiratory clinics or is that only THS?

Ms COURTNEY - We have our own respiratory clinics and we also collect from the various quarantine hotels as well. We have a range of tests of these. Those all go through the Royal Hobart Hospital.

With regard to the ones that go through the clinics, they go through -

Ms MORGAN-WICKS - We have GP respiratory clinics, for example, and private pathology, but we receive the data in relation to those tests conducted.

Ms LOVELL - So that 572 is basically tests collected in Tasmania across all of those options?

Ms MORGAN-WICKS - It is my understanding, yes, but I will get back to you with that.

Ms LOVELL - Thank you. Of the tests collected in Public Health clinics, the THS clinics basically, and the quarantine hotels, are all those tests processed in Tasmania at the Royal?

Ms COURTNEY - All the ones we do across our fixed testing sites as well as our mobile buses - we have THS staff manning those - are all done through the Royal Hobart laboratory. There is capacity through the private laboratory as well; however, the vast majority are done through the Royal.

We have expanded that capacity enormously this year. We have moved the footprint within the Royal and purchased new machines. The machines we have purchased are complementary to some of the existing machines and the benefit of that is, particularly when we saw the surge earlier in the year, we have different speciality supply chain or consumables coming in, so that was helpful to have a redundancy.

With regard to the collaboration with the private sector, we have seen a very strong collaboration. When we had the outbreak at the aged care facilities in the north-west, that was a collaborative effort. Sonic deployed its staff to go into the clinic to do all the swabbing and we then processed those through the Royal Hobart Hospital laboratory.

Ms LOVELL - What is the capacity of the Royal, essentially the clinic there, to conduct or screen the tests?

Ms COURTNEY - We have significant surge capacity there with regard to the current capacity. It is about 1000 a day and can surge up to 2000. We have also worked very closely with the University of Tasmania to ensure we have surge workforces we can bring in so when we do surge, we've good collaborations with other organisations.

Ms LOVELL - With that surge workforce and capacity of up to 2 000 a day, how long could that be maintained for?

Ms COURTNEY - We can maintain it for a number of weeks. If we had a sustained outbreak, we would be utilising either cross-agencies through forensic services or through our partnerships with the university to bring in more clinical support. I might get the secretary to talk about that a bit further.

Ms MORGAN-WICKS - There are also various methods the laboratory can use depending on the numbers of tests that [inaudible] through a day, for example, pooling of test swabs within the machines. My understanding from speaking to Lou Cooley, in charge of the COVID-19 testing program at the Royal, we have used up to three, for example, in different periods but they need to make sure they are actually validating the pooling and volumes they're applying.

Certainly, in Victoria, for example, they were pooling at much higher rates, given the volume of tests during their latest wave. We have the pooling, and surge capacity, which we used in the north-west outbreak, which was interoperability through forensic laboratory assistants coming in and actually training and doing, so we're very grateful to receive that assistance.

Similarly, if it is getting to such a rate, the 2000 is overwhelmed, certainly through the Commonwealth we have the ability to call on interstate assistance with the laboratories. We have the private pathology for up to 500 to 600 tests a day on top of the 2000. That capacity has expanded over time. I don't believe that has actually gone to the 500 to 600 at this point in time, given the caseload in Tasmania.

Ms LOVELL - Hopefully you won't need to.

CHAIR - There was the period, though, when we had the scare at the aged care facilities in the north-west where there was a significant number done over those [two days] [inaudible].

Ms COURTNEY - We got them all done.

Ms LOVELL - They worked very hard.

CHAIR - That was in the order of those sort of numbers, wasn't it?

Ms MORGAN-WICKS - I remember that Saturday very well and certainly the number of calls we made to the laboratory.

CHAIR - The SES just ran them down the road.

Ms MORGAN-WICKS - They ran on a 24-hour basis to achieve some 1400 tests through the Royal in 24 hours, which was an amazing effort for the team.

CHAIR - And the support of the SES to drive them down the road. Yes.

Ms COURTNEY - It was a great collaborative effort with a lot of organisations to get that done so quickly.

CHAIR - Yes.

Ms LOVELL - In terms of the Communicable Disease Unit, Dr Veitch has told us there were around 11 staff within that unit pre-COVID-19. Was that at a full establishment and is there any ongoing commitment to additional resources? I understand people have been pulled in from other areas throughout the pandemic, but for a more permanent and ongoing commitment, are there additional resources there?

Ms COURTNEY - I will get Kath to go through and outline the staffing.

CHAIR - Can I add to that? The expense for last year for this line item in the Budget was $25 849 000 and the actual was $38 million, which is not a surprise - I'm not suggesting that should be a surprise - but then the forward Estimates show - going back to $30.9 million, then $26.3 and $27.1, so obviously we're hoping we don't meet the same level of activity, but that sort of flows on. The numbers there need some explanations.

Mr MORGAN-WICKS - If I start with paid FTE for Public Health - staffing is currently 135.54. I will just check if that's a 30 June figure, but I'll continue to read out - so this includes the Coronavirus Directorate of 35 FTE; Communicable Diseases Prevention Unit, immunisation surveillance, 20 FTE; Environmental Health, 12 FTE; and Health Communities, 12 FTE, with the remaining FTEs spread across units such as the Needle and Syringe Program, Pharmaceutical Services, Radiation Protection unit, and other project-specific roles.

In relation to the financial increase, in the 2020-21 Budget, Public Health Services is sitting at $30.976 million, with a movement of $5 127 000. The increase of $5.1 million primarily relates to the COVID-19 National Partnership Agreement funding.

CHAIR - Which is time-limited?

Ms MORGAN-WICKS - Under that NPA, but obviously given the COVID-19 pandemic, we will be watching it very closely. I should just confirm the FTE was as at the last pay period for Public Health.

Ms LOVELL - Will those positions be maintained long term, or are they still seconded from other areas? In terms of an ongoing permanent staffing profile for Public Health, what is happening there?

Ms MORGAN-WICKS - I don't have before me the combination of permanent versus fixed-term arrangements for the 135.54, but I can speak to the Health Emergency Coordination Centre environment, where we have been looking at either 12-month or two-year periods for appointments, and also getting quite a bit of interest from the University of Tasmania, in

relation to arrangements that at the beginning of the pandemic probably came across in a very flexible and more informal way in terms of secondments to Public Health.

We are very grateful to UTAS for quickly providing those specialty FTEs to come across to Public Health. I might get Mark to talk about, for example, if he experienced, or other Public Health physicians have come over.

People don't always want to make a permanent move, I should add. They do want to continue to pursue their positions, for example, in a university environment

I might get Mark to talk about the different types of experience we have been aided by.

Dr VEITCH - We started out with a small but very experienced staff in communicable diseases.

The people we supplemented our team with included people from the university from academic epidemiology backgrounds. We brought in a range of recently retired clinicians and academic clinicians. We brought in some junior people as well, which were also very useful to bring into our midst.

Some of them had previous experience in communicable disease control; for others, it was a completely new discipline to work with our tracing and contact management team.

We had a very rich mix, and I think one of the most remarkable things was how well everybody got on together, and how much they actually enjoyed working in this stressful situation.

One thing that has emerged from the experience nationally - and I think we understand here, too - is that it can be very valuable to bring people in from other related disciplines, to work with you in these crises, but you absolutely have to have the skilled and experienced Public Health practitioners running and leading each of those groups. Australia-wide, there is actually a shortage of people in that domain. Experienced epidemiologists in communicable diseases and public health positions are in short supply.

I hope that one of the national outcomes from this is enhanced training of those people, so we have the ability to build up establishments with these people with expertise.

Then they can work well with these people who are, if you like, new to communicable disease control, but bring other relevant skills.

Ms MORGAN-WICKS - May I add, we also have our rapid response funded positions. That was for 21 positions for the rapid response strategy.

In terms of recruitment, Public Health Services currently has arrangement for up to 9 UTAS secondments to increase epidemiology and surveillance capacity for surge activity in relation to COVID-19, if required. Noting the FTE I read out, as at the last pay period, we are not currently in a surge, for example.

We have made quite a bit of effort in our nursing pools as well, for potential surge capacity through into Public Health, and continuing to train those resources as well, and stay

in touch. Whilst we might not be at the height of, for example, the staffing we had during the north-west outbreak, we are able to maintain that capacity to then lift back up.

CHAIR - If I could follow up around staffing, we do not have a vaccine yet but it is looking slightly more promising than it was 10 months ago. Vaccination is an area that's covered under this output group. I presume - and the Prime Minister is committed to providing it free-of-charge to all Australians - Public Health would have a role in administering it, actually setting up the clinics and commencing giving it? Would that be funded through the Commonwealth, if that were the case? You might have to use your surge staff there, perhaps, minister; I don't know. I am interested in how that will work if we are fortunate enough to see a vaccine come into general use.

Ms COURTNEY - This is obviously a very big topic with AHPPC at the moment with regard to vaccinations, and I've had a lot of conversations with the federal minister around that. There are the logistics around that and Dale Webster, the deputy secretary, can talk to those. Dr Veitch can talk to, perhaps, where we are in terms of his views on a vaccine and the service delivery of that within Tasmania.

We know that Public Health is very experienced at delivering mass vaccinations. We saw that with meningococcal. There is significant planning underway and indeed we already have a planning team dedicated to rolling out vaccinations because an enormous amount of logistics is involved and obviously consumables and all sorts of other -

CHAIR - And storage - some of them require significant storage.

Ms COURTNEY - Storage, transport in certain conditions, conditions of how you dispense them - there are going to be a whole lot of clinical requirements as well that are still unknown. There's a whole range of things. Perhaps I will get Dale to talk about some of the logistics under his remit and then perhaps I will pass to Dr Veitch.

CHAIR - Thanks.

Mr WEBSTER - We have formed a Tasmanian working group to support our efforts and that is being supported through the Public Health Service's team. At the moment we're working closely with the Commonwealth and we have a deadline of 7 December to have an agreement in place with the Commonwealth about how we will implement within Tasmania.

Some of that will, by necessity, need to wait until we confirm which of the vaccinations are coming, and when they are coming, so it will be very much a high-level document. Regarding the logistics to the point of vaccination, the Commonwealth will take responsibility for those.

CHAIR - The logistics of getting the vaccination itself to the state?

Mr WEBSTER - From the company to the point of vaccination, so to -

CHAIR - Including the storage requirements?

Mr WEBSTER - Including the storage requirements to that point.

CHAIR - Right.

Mr WEBSTER - The most problematic of the vaccines is the one that needs to be stored at minus 70. We are assured by the Commonwealth that the contract with Pfizer requires Pfizer to solve the logistics problem of the freezing.

CHAIR - I understand they are working on it.

Mr WEBSTER - So it's part of the logistics that Pfizer will have to deliver that product in a way that can stay frozen. That deals to the point of vaccination. It is then a state responsibility, as we understand it at this point - we're still negotiating. From the point it's delivered to the injection, we will need to manage that part of the process so that may -

CHAIR - The rest of the question I have is: do we fund that?

Mr WEBSTER - and fund that.

CHAIR - Right.

Mr WEBSTER - We're in the process of putting together our state taskforce which will include logistics people, specialist nursing staff and a number of other resources so that we can do that into the new year.

CHAIR - I did hear that there was not an intention to use pharmacists. We do use pharmacists for other vaccines. So, we're just going to rely on the Public Health team or -

Ms COURTNEY - That's probably better in terms of the critical mode of delivery, but it's perhaps better for Dr Veitch to talk to that, depending on the vaccine.

CHAIR - Just talking about the use of pharmacists, can you tell me who is going to administer a vaccine?

Mr WEBSTER - In terms of how we deliver it, that again will depend on the actual vaccine. We need to work through. If we receive the Pfizer one, it is different to the Oxford one. We are at the high level of 'This is the vulnerable cohort.'. We are trying to work out that number, and then we go down to the local government area about that number and we look at how we put it out.

One of the complications of all the vaccines is that they will be in 10-dose vials, so there is actually some specialist knowledge we need to train people in. That will be part of what we do. At the moment we are also working through -

CHAIR - Is that all brands will be 10-dose vials?

Mr WEBSTER - The Commonwealth has advised they will all be delivered in that form. That is part of the planning. Part of the planning is also to make sure we are not wasting. If there is a need for one person to have it, we will need to direct them to where we can do 10 people, to make sure we are not wasting. All those things are being worked through over the next few days to have a high-level plan in place by 7 December. They will then be informed as each of the delivery dates is brought forward.

Dr VEITCH - I will just make a few comments. At the moment we are in a situation where it is not completely clear what vaccine or vaccines we are going to be using and when. The vaccines have different mechanisms by which they work, different storage requirements, different dosage requirements, so our planning has to consider those unsettled considerations.

Also, it is important to note that while some initial promising data is coming out from about three of the vaccines, it is still quite preliminary, and we need to see the published data and understand the assessment of the regulatory and scientific advisory bodies on the use of the vaccine.

The sort of considerations that are important when we think of our planning are first the characteristics of the vaccine. The deputy secretary has talked a bit about the logistics, the distribution and storage, which are important, and also the matter of prioritisation of who gets the vaccine first. That is something that has been considered over the years in relation to pandemic influenza. The ethical, practical and clinical aspects of that is a familiar area, but it will depend upon which vaccine comes. The prioritisation may vary a little depending on the vaccine and the evidence for who it works best for.

The workforce is another area. We need to make sure we have an adequate workforce that is skilled and can deliver vaccines with multi-dose vials. Some of these vaccines are very new, and the way they work is unfamiliar to most people, so there is going to be a very cautious approach to their administration, at least until we are quite confident that the vaccines are safe for delivery by perhaps a wider range of vaccine providers.

That is because these vaccine trials are only done in tens of thousands of people, so a truly rare side effect that might only happen in every hundreds of thousands of cases or doses, or millions, may not be apparent until a vaccine -

CHAIR - Which does occur now with vaccines generally, potentially. Some vaccines now can have those rare -

Dr VEITCH - Sure they can. We absolutely need to bring the population along, encouraging them that this has been done in the safest setting, and when we have additional information about the safety of the vaccine, it would be desirable to be able to expand the providers who are using it.

CHAIR - Is that training going on now, minister, that planning ahead in the hope we do have them? It will depend on what the vaccine is and how it works. There is some talk about some needing two doses, rather than just the one.

Ms COURTNEY - They are things the working group is currently contemplating in terms of what training will be needed. Also the ultimate model will depend on that, because there are efficiency differences between distribution through GPs and, say, mass vaccine clinics. We learned that through the meningococcal rollout. That is also what we go to with the experience we learnt from those rollouts.

Dr VEITCH - We'll also be working to get the process of documentation of vaccines as good as it can be, so we need to be able to document each dose given through the Australian Immunisation Register. We are also looking to a new mechanism for capturing adverse events with the vaccines.

CHAIR - The other thing. Alan Joyce, who makes a number of statements from time to time, has declared if you want to fly on Qantas internationally, you will have to have certification of vaccination. How that plays out remains to be seen.

Is that part of the work you would be doing? If I have my vaccination, can I get a certifiable app or something on my phone I can show at the airport if I want to go overseas on Qantas?

Ms COURTNEY - I did notice Mr Joyce's comments. He did go to the fact that would be needed and how you would do that from a logistics and a patient privacy perspective for what is ultimately a patient medical record.

Not sure whether Dr Veitch has any further comments to that, but making sure we have good recordings is definitely important.

Dr VEITCH - There is a precedent with this with the yellow fever vaccine. But, I think there are, as the minister notes, some ethical and practical issues, and we also need to say what the purpose of such a requirement is: Is it to protect people on a plane? Is it to protect people in the country, where they are going to? Those sorts of considerations are important.

It will also depend, a bit, on the vaccine. If we find a vaccine that is highly effective at preventing transmission, the requirement becomes a bit stronger. But if we have a vaccine that protects against illness, but doesn't necessarily prevent transmission, having certification you have had a vaccine may not even necessarily preclude the possibility of getting infected and spreading it.

We need to know those additional pieces of information.

CHAIR - Still a lot more work to be done for Alan to impose his restriction.

Any other questions on Public Health?

To go to non-COVID-19 matters. Public Health still has to continue to do the work it is required to do. It is almost hard to say, the 'everyday work' of Public Health, but you know that still goes on. How you have managed to do both? I am not sure; Dr Veitch has probably been involved, pretty much focusing on the COVID-19 response.

In terms of the other roles: the screening undertaken and I assume that still fits under your area. Cancer screening -

Ms COURTNEY - Not Public Health, but we can talk to that.

CHAIR - The Public Health performance information relates to breast cancer screening.

Mr WEBSTER - It doesn't sit under the -

Ms COURTNEY - It is reported as a Health indicator but it is actually conducted through the THS.

CHAIR - That's all right.

If you come back to the other communicable diseases then, that's okay. Issues like meningococcal and measles, which is always a risk and the preparedness for those sorts of outbreaks. That hasn't been impacted by the COVID-19 response, because they are still there in the background. Whooping cough. All those things.

Ms COURTNEY - There is a number of other responsibilities the Department of Public Health has. Obviously, meningococcal is one and there are a range of other reporting mechanisms Dr Veitch can talk to.

Those have continued throughout this time. We have seen things like the data collection around influenza has been a lot lower, so there have been some really interesting things that have come out.

Dr Veitch is probably best placed to talk about the team and how the other

CHAIR - Particularly on that, because there was a really (cont)

Dr VEITCH - That will certainly prompt people. It is worth noting that the most important thing in terms of protecting a child is actually the mother's dose of vaccine during the third trimester of pregnancy. That provides almost all the protection the child needs. It is good for grandparents and others to have a dose to reduce the risk of introduction.

This year, fortunately, has been a relatively quiet year.

CHAIR - Yes, we haven't even been able to see our grandchildren.

Dr SEIDEL - Are you considering setting up a sentinel surveilling and testing network for Tasmania in view of COVID, influenza and other infectious diseases?

Dr VEITCH - You mean through general practice?

Dr SEIDEL - Primary care.

Dr VEITCH - There is already the Australian Sentinel Practices Research Network - ASPREN - with a modest uptake in Tasmania. I will admit, I haven't given that much thought in the last very short while.

Dr SEIDEL - Would you consider this to be beneficial for the Tasmanian context?

Dr VEITCH - I think we need to see what it would add to existing surveillance mechanisms, but anything that engages general practice in both delivery of care and participation surveillance is generally a good thing. As long as we use the data and it is an efficient process.

CHAIR - Any other questions on Public Health? I think we can let Dr Veitch go back to his important work. I hope you get to have a break at some stage.

Ms COURTNEY - Ms Lovell, just to clarify the number of tests I gave you before, they were for both the private lab, as well as our lab. That is the addition of them.

Output Group 2
Health Services

2.1 Admitted Services -

Dr SEIDEL - I have a few short questions, and short answers are perfectly fine. The first relates to bowel cancer screening and colonoscopies for bowel cancer. The rates for the last five years are quite low for colonoscopies done on time, for patients who have been referred by their GP with a positive faecal occult blood test - FOBT. It is about 30 per cent every year since 2015.

Minister, are you comfortable with that performance for patients who have a positive FOBT test, or who have already been seen by their GP and have been referred for colonoscopies?

Ms COURTNEY - According to the Australian Institute of Health and Welfare report in 2017-18, Tasmania's participation rate in the National Bowel Cancer Screening Program of 47.8 per cent was the highest in the country. The national participation rate was 42.4 per cent. According to the AIHW, Tasmania's age-standardised incidence of rate of bowel cancel is high, and this is why early screening is important. As to the data you were asking for -

Dr SEIDEL - I have the data, minister. You already provided the data. I am not concerned about the data. I am concerned about whether you are comfortable with the level of patients we are getting on time within 30 days of being referred to the THS with the positive FOBT test.

Ms COURTNEY - Obviously, we are always looking at how we can improve the screening participation, and also to ensure that we are able to quickly act upon the information from we have from screening.

Dr SEIDEL - We have five years, so the data hasn't changed - in 2015-16, 31 per cent; in 2016-17, 22 per cent; in 2017-18, 37 per cent; and in 2018-19, 34 per cent. So when you are saying you are always looking at ways we can improve it, nothing has really changed in the last five years.

Ms COURTNEY - We are targeting more endoscopies and colonoscopies this year. In an earlier answer, the secretary outlined our target of 11 516 procedures for this year, so we are looking at how we can increase the numbers of procedures we are doing to respond to the screening.

Dr SEIDEL - A follow-up question. How many patients who have an endoscopy for a positive FOBT test eventually end up having stage 2 bowel cancer? Do you capture the data?

Ms COURTNEY - I will take it on notice and see whether we do capture that.

Dr VEITCH - That will certainly prompt people. It is worth noting that the most important thing in terms of protecting a child is actually the mother's dose of vaccine during the third trimester of pregnancy. That provides almost all the protection the child needs. It is good for grandparents and others to have a dose to reduce the risk of introduction.

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Ms COURTNEY - I'll take that on notice and see whether we did capture that for you, Dr Seidel.

Dr SEIDEL - Thank you. How many surgical procedures referred to the THS have been outsourced to private providers?

Ms COURTNEY - I don't have that on me at the moment; I will take it on notice. With regards to the private sector in Tasmania, it provides an important partnership for many procedures. Particularly during COVID-19 earlier in the year, the partnerships we have with the private sector allowed us to continue to deliver a lot of elective surgery we would not have been able to deliver without them, so they are an important partnership.

We've seen that particularly with the agreement signed earlier in the year with regards to Hobart Private Hospital and the co-located facility there - some of the benefits of that partnership are about how we can work together. If we're able to get an outcome with regards to the co-located private hospital at the LGH, it's important they work in partnership together.

Dr SEIDEL - Are you able to provide the data to me?

Ms COURTNEY - I'll take that on notice, if we have that data.

Dr SEIDEL - Because you just said you have a partnership so I imagine you would have the data with regard to that. If you have a partnership, you're doing this with regard -

CHAIR - Or purchasing agreement.

Dr SEIDEL - What's the point of having a partnership if you're not going to use them, if you can't provide the data of any procedures they [inaudible].

Ms COURTNEY - As I said, Dr Seidel, I'll take that on notice and provide that to you.

Dr SEIDEL - Excellent. How many private patients are being seen in the four THS hospitals in Tasmania?

Ms COURTNEY - And treated as private?

CHAIR - And treated as private.

Ms COURTNEY - Because many people obviously present and aren't treated as private. We will see if we have that data and are able to provide it.

Dr SEIDEL - Do you have the data on how many patients are being referred from private hospitals - private emergency departments, for example?

Ms COURTNEY - We will have to take that on notice and see what data we provide. As you may have heard the secretary say, we know other presentations obviously into the public hospital system. We don't have oversight of what the presentations are in the private. With any transfer from a private to a public hospital, depending on the mechanism with which a patient is transferred or goes from one site to another, I would have to see whether that dataset was actually captured, because people may present in different ways. As the secretary just clarified, because this is not admitted care, that dataset may not be captured in the way you're seeking, but if we have that dataset, I will provide that on notice.

Dr SEIDEL - But you would receive patients from private emergency departments - for example, inpatient admission for mental health issues or patients being referred to intensive care units at the Royal Hobart from the Hobart Private Hospital?

Ms COURTNEY - I will get Professor Lawler to talk through the detail of the actual logistics of how patients are transferred between the private and the public.

Prof. LAWLER - Obviously, patients are transferred from private to public and there are a number of reasons for that, as you would be aware, and maybe because the nature and level of their care is not covered within private hospitals.

It may be because there's a preference to be treated by a specific doctor who is not available, but it's also worth noting, as the minister has highlighted, we do have an understanding both from ambulance transport, but also if we are able to capture source of referral or source of arrival of patients coming from private services.

If they come from a private hospital, that doesn't necessarily mean they will subsequently be managed as a private patient in the public hospital, so those datasets will not be linked but, as has been highlighted already, an episode of care in a public emergency department cannot, by its nature, be private and it is not until a patient is actually admitted that it becomes a private episode of care.

Dr SEIDEL - That is what I asked, really, didn't I? How much revenue has been generated from private health insurance?

Ms COURTNEY - We don't have that information with us, but we can take that on notice.

CHAIR - This is the unsourced revenue garnered from patients admitted to the public system treated as private patients because their private health funds then pay you? Is that what you're looking for?

Dr SEIDEL - Yes.

CHAIR - Yes, the amount of money.

Ms COURTNEY - We will find that with our CFO. Do you have that on hand or -

CHAIR - I'm surprised if you don't.

Mr JEFFERY - I am looking to see if it's in the financial statements.

Dr SEIDEL - I couldn't see it, that is why I was asking, because it would be revenue for the THS.

CHAIR - Maybe it is all with other sources of own revenue.

Minister, can I have a list - maybe you can table this because it is probably easier than reading out a whole heap of numbers - of the categories of surgery where there are waiting times, per region, and per category of wait, 1, 2 or 3.

Ms COURTNEY - I will see whether we have that data here; if not, we can definitely provide that.

CHAIR - I imagine it would easier to provide it in a table form, because it is a lot of data.

Ms COURTNEY - Just so that we can provide the right data, is it numbers on the waiting list, per category, per region?

CHAIR - The number and the times. The number of people, the average waiting times and the category of surgery.

Ms COURTNEY - First of all, I will ask our CFO to go to the last question with regard to the private hospital revenue.

Mr JEFFREY - The financial statements are showing private patient revenue for the 2019-20 year of $31.8 million. The previous financial year was $35.6 million. Was there a question about Medicare?

Dr SEIDEL - Not yet, that will come later.

Ms COURTNEY - The data we have with us is by region, but they are not broken down by category, so we can take that on notice.

CHAIR - Do you want to start your questions on elective surgery now, under the COVID-19 response, because this is related to elective surgery, this discussion we are having.

The Committee suspended from 12.58 p.m. until 1.58 p.m.

Output Group 2
Health Services

2.2 Non-admitted Services -

CHAIR - Welcome back. We will go straight to 2.2, Non-admitted Services.

Dr SEIDEL - Minister, I want to ask you about outpatient waiting times and the categories with regards to urgent, semi-urgent, and non-urgent cases. What is your understanding of the urgent category? How many days is the target for patients to be seen in outpatients?

Ms COURTNEY - With regard to outpatients - like some of other services - it was impacted by COVID-19 towards the beginning of the year, particularly in the final quarter of 2020. We have implemented a range of initiatives to assist the reduction of outpatient waiting times. We have $9.3 million for a range of new services and staff at the Mersey Community Hospital - $160 million over six years for better care in northern Tasmania, and $459 million over six years to boost health services in the south, with a recruitment of over a thousand new hospital and Health staff.

With regards to the delivery of outpatient services, we are also implementing the provision of telehealth for outpatient appointments for various specialists, which will improve patient access to services and reduce travel times. We are also developing a program of work to improve efficiency within outpatient clinics; this will focus on waitlist management, ensuring referrals to outpatient clinics contain the required information to prevent unnecessary delays and getting more patients to attend their appointments by ensuring booking processes are patient-focused and meeting the needs of patients.

With regards to outpatients' attendances, they decreased in 2018-20 from 2019-20. We also had a waiting list increase - and I will get Kath to refer to the data you are looking for with regards to outpatient waiting lists.

Dr SEIDEL - The question was really about what your understanding is what the urgent category implies. Is that, I would imagine, 30 days - right?

Ms COURTNEY - Yes [inaudible].

Dr SEIDEL - That was the question so thanks for confirming that because -

Ms COURTNEY - No, no. I have asked the secretary to respond to the detail.

CHAIR - The waiting times.

Dr SEIDEL - Yes.

Ms COURTNEY - Yes.

Ms MORGAN-WICKS - Outpatient clinic waiting list priority as at 30 June 2020 and by category of urgent, semi-urgent, non-urgent and by hospital, we have just the urgent category. The urgent category for: the LGH is 1281; Mersey, 214; north-west, 247; and the Royal, 3379. That makes a total of 5121.

Dr SEIDEL - Thank you. My understanding is the indicative waiting time really should be 30 days for urgent cases and I'm just reading out from the dashboard from this morning. For the south, the burns list, 429 days; for cardiology, 351 days; for gastroenterology and liver, it's 347 days; for new surgery, urgent cases, 615 days; for the northern region, gastroenterology urgent cases, 420 days; and respiratory 417 days. What is the department and what are you doing, minister, to reduce waiting times for urgent cases that need to be seen in outpatients and have been referred and assessed by the GP as urgent cases?

Ms COURTNEY - As I outlined in my earlier remarks, range of initiatives are being undertaken. Obviously, telehealth is part of that. There is also a program of work to improve efficiency with outpatient clinics, which includes a number of different initiatives. We also have a high target as regards to our outpatient target - of the number of patients to be seen this year, acknowledging a lot of people are waiting for those services. I'm not sure whether Kath wants to add anything to that.

Dr SEIDEL - I might ask a follow-up question. Telehealth is a nice initiative; it's just not going to make any difference for cardiology investigations, which is specifically for investigations not for assessments, and for urgent cases, it's 51 days, so they are patients who potentially have heart disease, who have angina, who need to be seen urgently. The THS has assessed they need to be seen urgently. What are you doing for these patients - and their referring practitioners - who have been assessed as urgent, but are then on waiting lists for literally years. Are you advising the patient? Are you going to find alternatives? Are you finding the practitioners?

Ms COURTNEY - With regards to the management of outpatient lists, we have a range of initiatives. It's important to recognise we're now delivering a substantial increase in the number of outpatient appointments. This has been a longstanding challenge of the Health system and has been for a long time. Perhaps the CMO might be able to provide some more detail with regards to it.

Dr SEIDEL - To follow up then - how many outpatient appointments have been cancelled in the last year?

Ms COURTNEY - We don't have data on the number of cancellations and range of clinics that had appointments cancelled because of COVID-19. We can provide further information. Sorry, but the secretary has one data point -

Ms MORGAN-WICKS - Outpatient attendances, excluding COVID-19 clinics, decreased from 576 650 in 2018-19, and to 532 802 in 2019-20.

Ms COURTNEY - The number of presentations we have had across our outpatient clinics has increased substantially over the past six years. It is well over 500 000 now, up from,

I think, around 430 000. We have a target of 581 000 attendances. We also have more clinics now [inaudible] the list, when compared with 2015.

Dr SEIDEL - How many patients currently waiting for urgent outpatient appointments are ending up in the Emergency Department, or how many of those patients actually die while they are waiting to be seen as urgent patients?

Prof. LAWLER - I don't have the data on that. There would not be a one-to-one correlation between waiting for an urgent appointment and presenting to the emergency department. It is quite difficult to pull out the data to say that a presentation to the Emergency Department is associated with the condition that has had somebody on the waiting list, and the same would be true for mortality.

Dr SEIDEL - Would it be worthwhile following up, because, again, there are patients who are waiting for urgent heart investigations, and they are waiting for a year or more. Wouldn't it be worthwhile following up what is going to happen to them?

Where is the duty of care, considering they have been referred by a primary medical practitioner. Isn't it worth looking at in terms of performance markers, performance indicators, outcome markers, any marker?

Prof. LAWLER - Certainly, it is worth considering. The focus is on improving waiting lists and improving times between referral and presentation to the outpatient clinic, which includes a process of clinical triage on arrival, and receipt a referral.

Dr SEIDEL - While we are talking about telehealth, there was a major initiative in a 2015 white paper. How many telehealth outpatient consultations have you had in the last five years, including the COVID-19 period?

Ms COURTNEY - We can take that on notice in terms of the numbers that have presented. We have seen a significant increase in our capability to deliver telehealth appointments. My recollection is that our capacity has increased, with infrastructure, more than 1000 per cent in terms of the number of people who can be seen.

I acknowledge it is not appropriate for a range of appointments, but it is appropriate for a lot of appointments, and it is a significant benefit particularly for Tasmanians from regional areas. I have met some patients who have had care, including cardio care, being able to be done by telehealth and in conjunction with some of our district sites. It has been a big benefit to them not having to travel into some of the major regions, and the stress of that.

I will get the secretary to find some more data on telehealth.

Mr VALENTINE - I don't know whether you gave the figures, but the people that actually turn up for a clinic -

CHAIR - We'll come back to that. We will just do the telehealth answer first, then come to that.

Ms MORGAN-WICKS - Rural communities have been supported through Telehealth Tasmania, which has delivered 39 000 telehealth consultations from March to June 2020. These include both phone calls and videoconferences.

Telehealth services resulted in a 10 per cent increase in completed appointments, a 36 per cent decrease in missed appointments, and reduced patient travel by 3.63 million kilometres, when compared to the same period in 2019.

Outside specialist outpatient appointments, telehealth has also been used for many other services, including the Child Health and Parenting Service, for antenatal classes, preoperative patient education, nursing and pharmacy assessment, allied health rehabilitation, diabetes education, community nursing assessment, care and review, allied health therapies, and by Hospital in the Home, to support community palliative care and district hospitals, the Virtual Visitor Program, and for family meetings for inpatients when visitor screening prevented that occurring.

Mr VALENTINE - My question was about whether you have any statistics on the number of people who actually turn up. You may have given it, but I don't think you have -

CHAIR - Turn up, or fail to?

Mr VALENTINE - No, who actually turns up, and can't be seen because the clinician is not available.

Ms COURTNEY - I will take that on notice and see whether we have that data.

We have data in relation to missed appointments. We don't know whether the data breaks down the reason, but we will have a look.

Mr VALENTINE - I would really appreciate that.

Ms COURTNEY - We will absolutely do that.

Dr SEIDEL - Do you receive any Medicare funding for outpatient consultations?

Ms COURTNEY - I am advised, yes, but I don't have the data here.

Dr SEIDEL - You would be able to provide the data on how much revenue is being generated by the THS through outpatient appointments?

Ms COURTNEY - Yes, I believe so. That is the department indicated to me. Do you want me to provide that?

Dr SEIDEL - Absolutely.

Ms LOVELL - I have a question on outpatient clinics. We've heard that there's an elective surgery blitz, and I am sure there will be more questions about that, but one of the concerns raised by clinicians is that if their focus is to be on delivering additional surgeries, they won't be able to maintain the level of activity through their outpatient clinics. So with those waiting times and waiting lists for outpatients, what measures are you taking to ensure

these don't worsen while the focus is on delivering surgery, and that we don't just get another spike in a couple of years when everyone who can't get to their outpatient clinic now, gets seen, and then needs surgery?

Ms COURTNEY - I can get the secretary to add to this. We have the money in the Budget for elective surgery, and we also have a significant uplift in funding for beds and demands, so as to be able to provide more services across the Health system. We have seen that in the number of new staff, around 1500, I think, since coming to government, so that is built into the funding. That funding for additional staff in our system is separate to the funding provided for the additional elective surgery.

Ms LOVELL - Specifically, what additional specialists will you be recruiting, and who do you have already? What gaps are being filled to enable that work to continue, because you can have the funding, but if you don't have the people -

Ms MORGAN-WICKS - I might need to come back with the specific number of particular specialists that a $45 million investment, for example, will buy in terms of additional staff or time. Working with the surgical committee on the allocation of elective surgery through the four acute hospitals, and also through our private hospital arrangements, we will be looking at balancing that. Certainly, through that clinical network, we haven't had concerns recently raised with us about trying to balance their outpatient work and elective surgery time. I am willing to speak to that network to raise that issue with them, but we will be balancing additional specialists in terms of buying that surgery time, balancing both the public and the private environments, and monitoring both elective surgeries and our outpatient numbers to ensure both are adequately catered for.

Ms WEBB - I want to ask a question about a matter raised with me during this COVID-19 time, about pregnant women who are here on temporary visas, and their access to pregnancy and birth care. Because of their visa status, they are not covered by Medicare. They may have health insurance, but it generally doesn't cover the full cost of their pregnancy and birth care. They are not able to go home overseas to complete their pregnancy, and in many cases have lost income.

We have some service providers who can assist within that situation with the cost of a termination, but not with the cost of a termination, but not with the cost of pregnancy or birth care. If these women are being put off receiving care, that could be dangerous to them and their babies. My questions are on that. They may be told to use the clinics at the Royal, for which they're billed $320 for a basic antenatal appointment, more if more complicated care is required, and then there's the hospitalisation and delivery, so it could be thousands.

They can have a payment plan. How many payment plans have been issued for women in this circumstance during this calendar year - during COVID-19 - to cover cost of antenatal, delivery and postnatal and associated elements? What is the average cost of the payment plans issued? What plans do we have to support women in this situation to ensure they're as safe and well as can be and not unable to afford the care they may need?

Ms COURTNEY - Thank you for that really important question. Earlier in the year we had a number of visa holders who were pregnant. These were temporary visa holders who were agricultural workers and the Government worked with those women to support them

through their pregnancies. Obviously, they didn't have the circumstances of being able to be covered for care or to be able to return to their homes.

We covered that cost. I don't have data on me at the moment of what that would have been, but we can get it on notice for you. I am aware a number of people who are not covered receive care in our system for pregnancy and maternity services each year. We do have payment plans, and there are also compassionate grounds at varying times, particularly for women in those circumstances. I don't have the data on the funding allocated to them, but I would be happy to provide it.

Ms WEBB - Thank you.

Ms COURTNEY - As a health system and obviously in COVID-19, we had quite a few specific cases and employers were speaking to us about it. From time to time - because I often am advised of things like this - there are other compassionate grounds where we can waive payments or provide payment plans for people. I can get some data on that for you.

Ms WEBB - Thanks. I would appreciate that. The ones we have covered entirely or who have payment plans put in place would be great.

Ms COURTNEY - I'm happy to provide that data.

CHAIR - In terms of number of women?

Ms WEBB - Yes, number of women. That's right.

Ms COURTNEY - We can do that for you.

Output Group 2
Health Services

2.3 Emergency Department Services -

Dr SEIDEL - Minister, you mentioned Australian Institute of Health and Welfare data earlier and I want to refer to the institute's emergency department presentation by type of visit data. The most recent one is from 2018-19. One of the categories is patients who are dead on arrival. In Tasmania in the reporting period 445 people were dead on arrival to Tasmanian emergency departments. That's substantially higher when compared to Victoria, 95, and Queensland, 32. Why do you think that is?

Ms COURTNEY - I will ask the CMO to go through that from a clinical perspective. I understand there are a range of reasons around particularly when somebody is actually declared deceased, but I will get Professor Lawler to talk about that.

Prof. LAWLER - As you would be aware, there are classifications and within our emergency department information system we classify on the basis of arrival which includes those who are, unfortunately, dead on arrival. Transfer to hospital and dead on arrival do not

necessarily indicate misadventure en route. They do not indicate necessarily indicate that there was a preventable condition.

One of the primary reasons for people to be brought to the emergency department dead on arrival is for the simple expedient of conducting the 'life pronounced extinct' process. A medical practitioner is required to pronounce life extinct, and that's on the basis of an external examination and a separate process to provide a certificate of death, but is a necessary process.

Unfortunately, one of the factors affecting this is potentially the lack of availability of community practitioners to provide the pronouncement of life extinct, and so it has traditionally been the case that it has fallen to Tasmanian emergency departments to undertake that. There are a number of reasons for this. It could be the time of the day; it could be the time of the week; and it could be the ready availability of a medical practitioner to pronounce life extinct, and this is particularly the case with the challenge in having onsite or ready access in aged care facilities as well.

Dr SEIDEL - I imagine something quite similar in Queensland and Victoria as well, yet the numbers are substantially higher in Tasmania. Do you think that it is just a reporting issue?

Ms COURTNEY - In Tasmania we have made lots of gains in recent years around our provision per capita of GPs. That has increased in recent years, but we also know that we still have challenges around GP provision, particularly in those regional areas. As we look to different jurisdictions, Tasmania is one of the most regionalised states in terms of its population away from its capital city.

Dr SEIDEL - You are providing GP Assist with substantial funding, so that is a 24/7 GP availability through online measures, phone services as well.

Prof. LAWLER - A couple of things on that. I believe there are significant differences in terms of general practice and primary care provision between Tasmania and other states. As has been mentioned, the proportion of Tasmanians who live outside the capital cities is higher than in many other jurisdictions, and I understand the reference to GP Assist, but the pronouncement of life extinct is not a service that can be provided over the phone.

Dr SEIDEL - Why do you think it is so different in other states? Do you think it is good use of a doctor in the emergency department to pronounce somebody dead? Do you believe it is good use of the ambulance service to transport dead people to the emergency department?

Prof. LAWLER - I agree that it would be much better if we were able to have such pronouncements undertaken in the home, in the community, or in a residential aged care facility, but clearly issues and factors that lead that to not be occurring and that is why people are being brought to emergency departments.

Dr SEIDEL - Are there any initiatives you are considering, to make sure people who are dead are not turning up in Tasmanian emergency departments?

Ms COURTNEY - What we are doing is looking at how we can further bolster care in the community and we have worked very hard in the provision of GP services; while funded by the Commonwealth, we work hard to look at how we can support recruitment of GPs into regional areas. We do that through our district hospitals as well, to look at how we can further

support that. We acknowledge that it is a longstanding challenge. We have made clear gains in recent years; however, it is something as state we continue to work on.

CHAIR - Is it possible to get a breakdown of how many DOAs arrive for the purpose of declaration of life extinct? Do we know how many they are out of the total as opposed to those who arrive who have died en route, or the only purpose they are coming is for the certification of life extinct?

Prof. LAWLER - From my understanding of emergency department information systems and how they work, we pool the data on dead-on-arrival based on the triage category provided. In some instances, if they are presented by a mortuary vehicle rather than an ambulance, it would be difficult to pass that information based on whether they are dead on arrival, pre-hospital or en route. It would be difficult to obtain that data.

CHAIR - Not all of them arrive by ambulance. Some of them arrive by mortuary vehicle.

Dr SEIDEL - It wouldn't, because you have the declaration of life extinct for it, so it has to be an ambulance, otherwise you wouldn't be able to move the body from the scene.

Prof. LAWLER - It would be a mortuary vehicle or an ambulance.

Ms COURTNEY - If we go back to what we talked about before lunch, regarding the digital strategy and the feedback we looking at in terms of the datasets, there is a range of areas within our health system where our technology does not allow us to collect the data that helps us with good decision-making at times. So, we recognise the importance of data to help drive decision-making and also efficient decision-making regarding expenditure of money across a large system. What we are hoping to achieve through the digital strategy is to be able to get that information so that we can get good decision-making.

Dr SEIDEL - Six thousand people did not wait to be seen in Tasmanian emergency departments or they've presented, registered and then left. Is the department going to follow up to see what happened to them? Is THS receiving Commonwealth funding for patients who have registered but haven't been seen by a clinician?

Ms COURTNEY - I might see if the CMO can comment on what happens with patients and I will seek some further advice on the funding.

Prof. LAWLER - As the minister highlighted, the second question will come through. It is not my understanding that patients who did not wait are followed up on.

Dr SEIDEL - No follow-up on the 6000 patients who have been registered and then -

Prof. LAWLER - That is not my understanding but I highlight when patients do arrive, there is a process of triage based on a clinical basis. Those who are most acutely unwell or have the greatest clinical priority for the potential for deterioration will be triaged and categorised higher and will be seen earlier.

Dr SEIDEL - Because you capture them so you report the data to the AIHW - 6884 - so somebody will have the data;. You must have the contact details; you have triaged them and they disappear, so I imagine there was a clinical need for them to attend, otherwise you would

have said, 'Well, there is no need for you to be here, go back home.'. I am wondering who is going to do the follow-up?

Prof. LAWLER - I take the point. I highlight though under the National Healthcare Agreement, there is no option to say to people, 'You have no clinical need to be here, you should go home.'.

We have five triage categories. We categorise those on the basis everybody should be seen within two hours and, obviously, we categorise and triage on that basis, but indicating to someone that they don't need clinical care and should not be at the emergency department is not one of those options.

Dr SEIDEL - Do you receive any payments for people who have registered and then do not wait to be seen?

Ms COURTNEY - Not without treatment, no, we do not get any payment for those people.

Dr SEIDEL - Looking at your annual report for 2019-20, page 22, there is some performance information on ED services, and it looks like for 2019-20 actually fewer patients were seen in emergency departments. However, when we look at the other data for how many patients were actually seen, admitted or discharged within four hours, that performance marker actually drops. We have seen fewer patients, but still have not seen, admitted or discharged them on time.

Why do you think this is, minister? It is not a higher workload, it is a lower workload.

Ms COURTNEY - COVID-19 saw an enormous drop-off in presentations across our emergency departments. We also saw a different configuration in our emergency departments across the state, particularly during those more acute times of COVID-19 in terms of the hot and cold that did impact the flow within each emergency department because of the way they were treated because of screening.

As to being seen on time, those figures remain relatively static from previous years. It's balancing around a very small band. I think Professor Lawler wants to add to that.

Prof. LAWLER - I offer three potential reasons behind that.

First, there was a drop-off in numbers, but, as we see at times when there is a significant ongoing community event, and whether that's a brief transient episode or a prolonged episode such as this, the drop in numbers tends to be the patients with lower complexity not coming. As a result, while we had a drop-off in numbers, there was a retention in high acuity and high complexity.

Second, as the minister has already highlighted, there have been reconfiguration changes which occurred not only in the emergency department with a COVID-19 response phase which had us, in all EDs, with a - we can call it a hot and cold ED or we can call it acute respiratory illness and a standard ED, that configuration carried with it certain inefficiencies and inevitably

impacted on flowthrough in the ED, but also reconfiguration on the wards and reconfiguration in preparedness for a potential outbreak.

The third issue that I would highlight, particularly for patients who come through the acute respiratory illness, or hot ED, is that there were entirely appropriate high-level infectious disease precautions undertaken there - gowning, gloving, face masks, and so forth. That adds a significant and unavoidable delay to the expedient treatment of patients and disposition to home or to the wards.

While we have had a reduction in number of patients, we haven't had a reduction in the number of the most sick patients, and our entirely appropriate responses to the COVID-19 pandemic and potential outbreaks impacted inevitably on the inefficiency of the service.

Ms COURTNEY - Also, with the table you are referring to, Dr Seidel, there is a footnote for that section that the indicator for emergency department services was impacted by the closure of the Mersey Community Hospital, and that emergency department had limited opening times as well.

Dr SEIDEL - I will just follow-up the Mersey then. How many patients are being transferred from the Mersey Community Hospital, from the A&E department, or when the A&E department actually closed, to the other hospitals in Burnie, Launceston and Hobart?

Ms COURTNEY - As we look for that data, even in normal times when that emergency department is open 24/7 - which will be returning in a week's time - we already have transfers that occur because of high-acuity patients. It is not unusual for high-acuity patients to be transferred from the Mersey to the LGH, or the North West Regional Hospital, or indeed the Royal Hobart Hospital.

With regard to management of the emergency department, the staff there did a really good job, and Ambulance Tasmania - AT - did an amazing job as well, managing people who would come into that emergency department, to make sure they were directed to the hospital, and the best care for them, depending on the clinical care required, and knowing that the emergency department was closing in the evening.

We did see a step-up in activity for AT and they did a very good job. We provided more resourcing to AT across the north-west, including via flight paramedics, to ensure we could move those patients as needed, particularly to Royal Hobart Hospital if required.

Ms MORGAN-WICKS - We have three types of transfers from the Mersey Community Hospital: Mersey Community Hospital to North West Regional Hospital - 377 by ambulance, one by fixed wing; Mersey Community Hospital to Launceston General Hospital - 436 by ambulance, one by fixed wing, two by helicopter; and Mersey Community Hospital to Melbourne - 11 by fixed wing.

Dr SEIDEL - How often do the emergency departments in Hobart, Launceston and Burnie and at the Mersey find themselves at level 4 escalation?

Ms COURTNEY - We provided that data this morning, noting the fact that there is level 4 only at the Royal Hobart Hospital, but we provided for the highest level of escalation at the other emergency departments.

CHAIR - I want to just follow up some of the comments by Professor Lawler, talking about the inefficiencies created in the emergency departments with the COVID-19 outbreak, or around that period. I assume that occurred not just in the north-west - we actually shut North West Regional, anyway.

If a patient presents now, and they fail to read the signs and they actually end up in the ED with symptoms, regardless of whether it is COVID-19 or not, what is the process?

Ms COURTNEY - I will go to the secretary for the escalation claims. There are processes in place for the emergency department. We also have triggers in place for the emergency departments - even at times when we are at low escalation levels - if we get a higher number of people in the room. If we are starting to have too many people in an enclosed space, we have provisions of PPE to ensure people stay safe.

Perhaps I will go to Kath on the escalation and the outbreak management plans currently in place.

Ms MORGAN-WICKS - We have an escalation management plan for each of our four acute hospitals, but also for our district hospital environments, which contain triggers according to the context and environment, which then triggers a movement through particular levels of escalation. I note all four acute hospitals remain at level 1 escalation at the moment in terms of COVID-19 but, as they move through the response levels, that will trigger different configurations through the hospital.

For example, if we were moving to a level 2 response activation stage, we have the plan and commence the reconfiguration of our clinical spaces with discharge of patients relocating to alternative treatment locations; the planned preservation of surgical and medical capability through our engagement with our private hospitals and private day surgery; our planned staffing, rostering, and management of additional resources and equipment requirements enabling an anticipated move to a level 3 response; preparing for the separation of ED entry points and triage in relation to acute respiratory and non-respiratory -

CHAIR - That doesn't happen if you have a person arrive with symptoms.

Ms MORGAN-WICKS - No. This is actually talking about the escalation levels of hospitals according to the stage of pandemic. This is information that, for example, Tony, as our both CMO but also as our THS Emergency Operations Centre Commander, would be convening our THS EOC. It meets regularly now in different levels of our escalation management. It would meet on a daily basis, for example.

CHAIR - With the borders open mostly and hopefully completely soon, I know people in my community were very anxious about borders opening and may have stayed away from health care as a result. This is a shame, particularly if they have chronic illness. People often - not only just older people but anyone - don't think this could be COVID-19 and have a sniffle, a bit of a cold. They go to the hospital because they may have another condition. What happens at that point? Obviously, they would have to be segregated and tested, but what's the response at that point?

Ms MORGAN-WICKS - I might get Tony to comment on the maintenance of our acute respiratory, so RE capability in terms of RED.

Prof. LAWLER - The emergency departments maintain, as is appropriate and as outlined even in the lowest level of our escalation plan, a capacity to stream patients to acute respiratory infection sections within the ED. As you say, we can put up the best signage in the world but when people are in a state of distress, as people almost inevitably are when they turn up at the emergency department, they can miss that.

There is a great level of diligence that occurs at the triage point. I can assure you all emergency departments in the state are very vigilant and diligent over the potential for cases to come in. That includes not only cases symptomatic but cases that are asymptomatic, which obviously need a high index of suspicion. So, questions are asked around whether there has been a recent history of travel, whether there has been recent contact with individuals. That occurs not only as part of the clinical assessment, but also as part of the screening for visitors and staff who attend the emergency department.

If there is identification at triage of a patient who has respiratory symptoms or symptoms suggestive of COVID-19, which could be anything from a sore throat, runny nose, headache, fever, loss of taste, loss of smell, there are processes in place that include the immediate utilisation of a mask and the appropriate isolation of that individual to the area of the emergency department that's designated for the care of those presentations.

Mr VALENTINE - With respect to people presenting at emergency departments with mental health issues, do you have numbers on that for each of the major hospitals?

Ms COURTNEY - With regards to the data on mental health, that falls under Mr Rockliff.

Mr VALENTINE - No, I realise that -.

Ms COURTNEY - But I will see whether -

Mr VALENTINE - But this is ED, so it's before his service gets to it.

Ms COURTNEY - Once patients transition into the care of Mental Health Services, even if they're within the THS or within a hospital, it is still under the stream under the minister, Mr Rockliff, but I will see whether the secretary is able to provide some information for you.

Ms MORGAN-WICKS - I was just going to say the reporting I mentioned earlier in relation to escalation levels of hospitals - that I receive roughly on a four-hourly basis throughout the main part of the day - also includes the numbers of mental health patients waiting for admission in the ED.

Mr VALENTINE - Can we get those numbers for the year?

CHAIR - What sort of numbers are posted on a daily basis?

Ms COURTNEY - We will take that on notice.

Mr VALENTINE - Per major hospital.

Ms COURTNEY - We will take that on notice.

Mr VALENTINE - For the last 12 months. If 12 months is too difficult, I am happy to take six months.

Ms COURTNEY - We will have a look at the way the data is captured and provide the best information that we can.

Mr VALENTINE - I appreciate that. I can also appreciate that during the COVID-19 time, it may well be elevated.

Ms LOVELL - I was going to ask for the average length of stay in the emergency department for mental health patients and the longest wait in the ED for mental health patients.

Ms COURTNEY - I will take that on notice. The only challenge we may have with the data is when we have people presenting who have significant acute medical challenges as well as mental health.

Mr VALENTINE - Takes the highest priority.

Ms COURTNEY - And we often have both needs within one individual because of their circumstances.

Ms LOVELL - Then they would be admitted as a medical patient, presumably.

Ms COURTNEY - We will see how the data is captured and we will provide that.

Ms LOVELL - Can I add to that? In addition to mental health, I was after the number of patients who have presented to the emergency department and waited for admission longer than 24 hours. I don't know if you have that.

Ms COURTNEY - For the year at the Royal Hobart Hospital it was 1940; at the LGH, it was 2616; North West Regional, 221; and Mersey Community Hospital, 162.

Mr VALENTINE - We did get the emergency department presentations split up by major hospitals, didn't we?

Ms COURTNEY - I don't think we provided that.

Mr VALENTINE - Can I get that too, please?

Ms COURTNEY - In terms of presentations by year, in the last financial year at the Royal, it was 61 743; LGH, 43 747; North West Regional, 25 950; and Mersey Community Hospital, 23 298. All those figures are lower than the year before because of the impact of COVID-19. I have an expectation they will increase substantially at the end of next financial year as we see that wash out of the system.

We have seen a strong trajectory not just of increasing presentations across our entire system over the past six or seven years, but there has also been a strong increase in the number of people who require admission. At the LGH, I think the figure was over a 100 per cent increase. I will get the data for you.

It is not just more people turning up. It is more people who are sicker and require admissions to the hospital, which is why we are continuing to see a lot of challenges that we are. That's the reason we are doing the policy work on Our Healthcare Future because that trajectory is quite dramatic.

Mr VALENTINE - What period of time has that been over?

Ms COURTNEY - I will get that for you. For the period from 2009-10 to 2018-19, the total number of presentations to our emergency departments at our four hospitals increased by 17.3 per cent. At the Royal Hobart Hospital, it increased by 35.3 per cent. This increase in demand has been met with annual numbers of patients admitted to hospital growing by around 67 per cent from just over 29 000 in 2009-10 to more than 48 400 in 2018-19. The largest growth in hospital admissions was at the LGH - since 2009-10, that has been 112 per cent, so it has been a significant increase.

CHAIR - Has this come in more recent years? Has it sort of been tracking along and then had a sudden increase?

Ms COURTNEY - I don't have that data. We would have to look at the trend.

CHAIR - It would be interesting to see that because you wonder whether people have stayed home and avoided accessing care during the COVID-19 period and have ended up being a lot sicker by the time they present.

Ms COURTNEY - I've worked really hard with PHT to get strong messaging about how people can continue to receive the care they need during COVID-19. There is also the years where we have a bad 'flu season. However, there's definitely a strong trend there and particularly with those increased numbers of patients who have complex and chronic needs, that puts huge pressure on the hospital but - from a patient perspective and the fact we've got many Tasmanians who are unwell - the point of this is how we can look at helping them earlier in the community.

CHAIR - Maybe the feds need to stump up in primary health.

Mr VALENTINE - It would be interesting to be able to correlate what's happening in EDs with the extended care services happening out there, and the 'Call the doctor' services and those sorts of things. It would be interesting to look at that.

Ms COURTNEY - Yes and as part of this one, we're looking at the model of urgent care centres as well. We know that some have already been established and we can get through this and how we can further support those.

Mr VALENTINE - I was just thinking of the extended care services - paramedics.

Ms COURTNEY - Yes, paramedics, they do a wonderful job.

Mr VALENTINE - We will get to that on ambulance services.

CHAIR - We will get to that, yes. No other questions on that line? Sorry.

Ms LOVELL - I've two questions. The first one, to clarify, are psychiatric emergency nurses funded under this line or is that Mr Rockliff's list?

Ms COURTNEY - I'm getting nods that it's Statewide Mental Health.

Ms LOVELL - Are there any current FACEM vacancies in the LGH or the Royal Hobart Hospital, and are any of the current FACEM positions filled by locums and how many?

Ms COURTNEY - I will check. Regarding locums filling positions, while we have seen a difficulty getting locums because of COVID-19, that has also meant it has been difficult finding permanent staff for the additional positions embedded in the system at the beginning of the year. We had the challenge of the Royal and the concerns raised by the junior medical staff, and through that we provided additional resourcing for additional positions. For example, when that has happened, for many positions that are new positions, finding a permanent person at the moment has been challenging, so there has been a need to use locums for them.

Ms LOVELL - Can you get a breakdown of the contracts in the Royal please.

Ms MORGAN-WICKS - We don't currently have a FACEM level with us but we have three vacancies in relation to LGH ED registrars -

CHAIR - All FACEM positions are filled?

Ms MORGAN-WICKS - out of an establishment of 18 FTE.

CHAIR - So all FACEM positions are filled?

Ms MORGAN-WICKS - I don't have the data in relation to FACEMS.

Ms LOVELL - You will take that on notice?

Output Group 2
Health Services

2.4 Community Health Services -

CHAIR - We will move into 2.4, Community Health Services. This also includes our regional district hospitals. Are you able to provide details of the occupancy rates of all of them around the state?

Ms COURTNEY - Yes, I can do that.

CHAIR - Would it be easier to table the information? I mean, you can speak to it or table all the data.

Ms COURTNEY - I can run down these relatively quickly -

CHAIR - All of them?

Ms COURTNEY - Yes, or I can provide them for you.

CHAIR - Just provide them, I think. I assume they are still pretty similar levels to previous years, which are still fairly low.

Ms COURTNEY - There are similar levels. Some of the levels have been impacted by COVID-19 as well. In terms of some of the models of care we have through COVID-19, one of the things worth noting is we recently announced, indeed on Monday, with regard to our district sites, a nursing model that will see higher acuity patients being able to be cared for at our district hospitals.

One thing we recognised from the work we did earlier in the year with regard to the LGH and access flow was the opportunity to use our district sites more. Having spoken to all our district sites, I know the staff there are very keen to be able do that, because it also means that they get to use their full scope as well.

I might get Kath to talk to that because she has got the detail around it.

CHAIR - I would be interested in your comments, Kath. I am not sure if you have this detail, but I know we have asked many times in the past about using this step-down type process. We have often been told that patients won't go there. I am just interested in whether that is an issue you would like to address in your comments?

Ms MORGAN-WICKS - The Tasmanian Health Service District Hospital Safe Staffing Working Group was established in February 2018, to research and explore an alternative workload model for district hospitals. As the minister noted, it has been approved for a 12-month trial and evaluation.

They have worked through and developed staffing models for the 13 Tasmanian district hospitals, and fully funded staffing models will improve that access to safe and appropriate clinical care and services at these rural sites and optimise the use of our rural inpatient beds.

Certainly, that was one of the key areas that came up in the LGH ED workshop on improving access and patient flow. The team, led by Fiona Young, has done an immense amount of work in actually examining it. It is quite a detailed business case, but it does involve an increase of some 20 FTE across the 13 district hospital sites.

CHAIR - Are you able to table that data now, minister, or will you send it to us later?

Ms COURTNEY - I will send through a notice.

CHAIR - In terms of the reason given in the past - that patients don't want to move, they might have family closer to the major hospital, whatever - how do you seek to address that, if that really is still a problem?

Ms MORGAN-WICKS - The last time I visited the Deloraine District Hospital, for example, and the conversations I had with a couple of patients there - in particular, the efforts they have gone to with palliative care and making it such a positive and warm environment for them, in what is a hospital. They actively monitor each day and try to look for cases, for example, in the LGH. In talking to the head of operations and nursing manager there, they are

not just waiting for LGH, for example, to try to identify a transfer, they are actively pulling, operating. LGH is also doing that within our patient flow, but Deloraine is too.

In terms of patients wanting to go there, I think this is a conversation we actually need to have as part of our healthcare future. These are beds available in Tasmania for the appropriate care of people, and we have to have an open and honest conversation about the location for that care. Where we have hospitals operating, at times, at different levels of capacity, that will include care that may also be provided in a district hospital.

Ms COURTNEY - In terms of that additional staffing, we have around 20 FTE who know about this model, and the sites we have identified that will benefit from it are Beaconsfield, Campbell Town, Deloraine, Flinders Island, George Town, Scottsdale, St Helens, St Marys, Oatlands - well the Midlands Multi-Purpose Health Centre - New Norfolk, King Island and Smithton as well as the west coast at Queenstown.

CHAIR - Just a couple of other matters and then we are going into performance information. The numbers attending the eight-week child health assessment, I assume some of those were done by telehealth during the COVID period?

In the past, we have reported breastfeeding rates. Do you have the breastfeeding rates on discharge from the hospital and also at the six-week and six-month points?

Just while you are looking for that, minister, if I might in regard to the denture waiting list, we know how important dentures are for people who need them. I note the footnote says the denture waiting list has increased in 2019-20 due to the reduction in Australian Government funding for the Tasmanian Denture Scheme. Are you lobbying the federal minister to address this? People cannot eat without decent teeth. The health implications of that are much broader than just your smile.

Ms COURTNEY - I understand that and indeed it was one of the topics I addressed during the week when we were looking at some of the barriers for Tasmanians seeking employment and accessing opportunities.

The team within dental services does a very good job at managing very efficiently and being able to use the funding they have. We have made some really important gains with young people and their outcomes and also with their engagement with schools. With regard to the funding agreements we for those, as with other funding agreements, we always work hard to be able to get as much Commonwealth assistance as possible. We know how important they are. In Tasmania it has been a long-term challenge and the team works hard to be able to prioritise the people within that.

There has been an impact from COVID-19 as well. Earlier in the year, both private and public dental services were severely impacted by COVID and also the provision of PPEs. That has also had a substantial negative impact on the list we have.

CHAIR - A patient cannot wear PPE when they are having dental work done.

Ms COURTNEY - Not all of it.

CHAIR -I will just wait for the breastfeeding rates.

Ms COURTNEY - We do not have the breastfeeding data with us, but we can provide that.

CHAIR - Let us go back to oral health.

Ms LOVELL - Minister, I have been advised by a constituent just in the last couple of days that they have been advised by Oral Health Services, south, that they no longer have an orthodontist practising at the service. This young person has been wearing a plate for 12 months to facilitate some movement in her jaw. This young person has since grown and needs a new plate because it is no longer suitable. She has been told that she cannot be seen by an orthodontist through Oral Health Services any longer. They can only offer her a standard dentist appointment but they will not be able to provide her with a new plate. Her only option is to take the plate out and lose the progress she has made over the last 12 months or seek treatment through a private service.

Can you provide an update on that please, and whether that is the case and what the Government is doing about that?

Ms COURTNEY - Thank you for the question. As I mentioned in the last response, we have seen a significant impact from COVID. I know you would not expect me to, but I cannot comment on an individual case.

With regard to any changes in resourcing we have seen at Oral Health Services, I will need to seek advice on whether we have had any changes in the provision of clinical care.

We do not have that level of detail with us regarding the clinical provision but we can take it on notice and provide that for you.

Ms LOVELL - I have a general question about Oral Health Services. Looking at the performance information on page 141, occasions of service across the board are down and obviously there has been an impact of COVID-19, but if we look at the waitlist, waitlists are up again. There has been an impact on that through COVID-19, but our targets are significantly down. In fact, targets for 2020-21 are lower even than the actual occasions of service in 2019-20.

Can you explain what your intention is there? The waiting lists are blowing out and we are not even able to try to aim for higher. They are pretty concerning stats.

Ms COURTNEY - I will get the department in a moment to comment on the targets you note there. Tasmanians are currently waiting four months less for general care as at June 2020 than they were in June 2013. The waiting times for general dental care have decreased. The waiting time for denture care has also decreased in that time from 11.9 months to three months. There have been some improvements with regard to treatment.

With regard to the targets outlined, Dale Webster will provide some detail about that.

Mr WEBSTER - A significant proportion of the occasions of service within the Oral Health Service are actually delivered, because we provide training for dentists through two universities, one is James Cook University.

Because of COVID-19, we have not actually been able to have those people come into the state and the workforce has been significantly reduced because of that. The target for this year reflects the fact we will not get those students until February 2021. We have effectively had an eight-month portion of the year when we did not have the workforce to deliver the occasions of service, so the target was reset.

Ms LOVELL - So people have to miss out or wait longer?

Ms COURTNEY - We have a recovery plan in place to return to normal service delivery which involves rebooking the patients whose care was postponed during the pandemic, because we know there was an impact during the pandemic.

Mr VALENTINE - Back to the mental health issue, the number of people who have been presenting at the community hospitals with mental health issues who have had to be referred somewhere else. I can appreciate the local hospitals that people might not want to go there, but I am interested to know whether you do have any figures?

Ms COURTNEY - That is in statewide mental health, so I understand that data falls to Jeremy Rockliff.

Mr VALENTINE - Again, the same deal before they get there.

CHAIR - You can send the question to Estimates Committee B, which has Mr Rockliff tomorrow - a steady stream of questions for Estimates Committee B.

Output Group 2
Health Services

2.6 Ambulance Services -

CHAIR -Do you need a change of the guard, minister?

Ms COURTNEY - Matt Eastham has come to the table; he is Chief Executive, Ambulance Tasmania.

CHAIR - I acknowledge Paul Templar, who passed away this year. Paul would often appear before our committee. It is a very sad loss, a friend of mine, but still a very sad loss so I would like to acknowledge Paul's contribution.

Mr VALENTINE - I am interested in touching on operations during COVID-19 so is that going to be a problem for further down or not?

Ms COURTNEY - We can do that now. The money might fall in a different bucket but we've got the right people to talk to.

Mr VALENTINE - That's okay. I appreciate that you had extra funding for Aeromedical and Medical Retrieval Service back in 2018-19 and extra funding this year of $10.1 million going through to $10.9 million up to 2023-24 for extra staffing, five paramedics and specialist

retrieval doctors. I'll get to that aspect a bit later but I'm interested in the employees first, the permanent paramedics in particular at this particular point.

Are you able to cover any real operational challenges and issues faced there because of COVID-19, understanding that officers obviously are in very close contact with people? It is very difficult to socially distance from them and all of those sorts of things. Maybe, for the record you might cover this?

Ms COURTNEY - I will make some opening remarks around that and then perhaps I will go to the secretary to direct traffic with the officials.

Obviously, AT was impacted a lot. As part of the emergency management structure, we have a range of emergency operation centres. One for THS, one for Public Health, we now have one for Aged Care, we also have AT EOC -

Mr VALENTINE - EOC?

Ms COURTNEY - Emergency Operation Centre. Lots of acronyms, trust me.

Mr VALENTINE - It's not as bad as ICT, but nevertheless.

Ms COURTNEY - That helped us do a lot of the planning and the management we regarding COVID-19.

There were a number of things implemented including, most particularly, protocols around how to ensure our paramedics were kept safe. How we ensured through the dispatch system the information was collected so paramedics knew as much as they could before they arrived to understand and be prepared with the right PPE. They also did an enormous amount of work with transfer protocols. We obviously saw at times people who were COVID-19 positive being transferred between hospitals. We saw them being transferred early on from quarantine hotels to hospitals, and the protocols for transport required an awful lot of training enacted through AT. I will get Kath to detail the additional resources for AT particularly when the north-west was put under an enormous amount of pressure. There was deployment of unwell Tasmanians to other hospitals. Additional pressure on paramedics as a lot of our volunteer workforce tends to be older Tasmanian who were in vulnerable cohorts. A large number of our volunteers were unable to volunteer; it wasn't safe for them at that time given their underlying risk factors and put additional pressure on our paramedics.

I will get to Kath in the first instance to work through those questions.

Mr VALENTINE - We rely volunteers no doubt because they would step up to fill the gaps?

Ms COURTNEY - It was extraordinary and, as Ms Forrest said before, those volunteers across SES and other areas did an extraordinary job through COVID-19 and the Government's response, and we really did rely on our volunteer organisations coming and partnering with us.

Ms MORGAN-WICKS - I might provide an update on the 42 additional paramedics and also the north-west coast initiative for COVID-19. This initiative commits to the employment of an additional 42 paramedics over four years across the state. Placement of the

additional paramedics was subject to the broad statewide consultation. The sessions were attended by paramedics, volunteers, local council representatives and community members plus members of the Health and Community Services Union. The recruitment and rollout of the additional 42 paramedics is on track, according to the four-year schedule, with 30 paramedics recruited to date. Twelve paramedics will be recruited in the 2021-22 financial year, which will complete the 42-paramedic initiative. I might just note that in terms of the placement of the paramedics in 2018-19 we have had three BSO positions, which were allocated to Wynyard -

Mr VALENTINE - BSO?

Ms MORGAN-WICKS - Branch station officers - allocated to the Wynyard ambulance station, with the station upgraded to a double branch station, providing 24-hour rostered paramedic coverage. In early 2019, BSOs were recruited to support single branch stations at Dodges Ferry, Bicheno and St Helens. Deloraine was to commence as a double branch station at that time, but concerns were raised which were then worked through in terms of consultation with the Deloraine community, volunteers, BSOs and HACSU, and Deloraine commenced operating as a double branch station on 9 March 2020.

In April 2020 George Town and Beaconsfield were upgraded and commenced operation as double branch stations. Longford was upgraded from a volunteer station to a single branch station in May 2020, and as part of this we also have our initiatives for upgrades to accommodate the additional staffing all of these changes require.

Ms COURTNEY - I was going to add in terms of some of the aeromedical - did you want me to go through that?

Mr VALENTINE - No, I've got that a bit further down, actually.

Ms MORGAN-WICKS - In addition, we also have the north-west coast initiative for COVID-19. That was $11.6 million supporting the employment of 24 paramedics and 12 intensive care paramedics across the north-west coast as well as three duty managers in Devonport.

Ms COURTNEY - We have had an increase in staffing of more than 170 additional FTE, which is around a 55 per cent increase since 2014. That is across paramedics and dispatch officers as well.

Mr VALENTINE - Thanks for that. Could you give us an understanding as to how much occupational health support is available? Can officers readily access it and how much is that being used? I also have some questions on statistics.

Ms COURTNEY - I might get Matt Eastham to provide some more details but it is an incredibly important part of our paramedic service and providing support. We have a range of professional support but also structured peer support to support our paramedics. We know that it can be an extraordinarily challenging role, both physically and mentally, and we need to continue to look at whatever we can do to improve outcomes for our paramedics' mental as well as physical health.

Mr EASTHAM - Ambulance Tasmania works closely with the Department of Police, Fire and Emergency Management, particularly in the area of mental health and wellbeing for first responders and co-responder models. We have a well-structured peer support program that is accessed quite readily and that service provides peer support and further advice and referral on to other services.

Mr VALENTINE - Do we have any numbers on those that have accessed it?

Mr EASTHAM - I don't have any numbers with me today in relation to peer support contacts.

Mr VALENTINE - Can you get that?

Mr EASTHAM - I can have a look at the data for you and see what we can supply.

Ms COURTNEY - We will see if we have that data in terms of how it is reported.

Mr VALENTINE - Workers compensation injury claims per region, if you have that data? Can we split it up into those associated with stress?

Ms MORGAN-WICKS - In terms of all workers compensation claims for 2019-20 for Ambulance Tasmania, 71 was the claims number, and we also have a cost of claim of $5325.

Mr VALENTINE - Do you have them by region, by any chance?

Ms COURTNEY - We'll see if we've got it by region. If we do, we will provide that on notice.

Mr VALENTINE - If you're going to look for that other workers compensation per region, I'm also interested in those currently absent on workers compensation who have been off work for greater than three, six and 12 months. They were questions asked last year so I reckon some work might have been done on them.

Ms COURTNEY - Good comparative figures from last year.

Mr VALENTINE - That would be interesting. Also annual and long service leave deferrals or liability and what the levels are like there.

CHAIR - We did ask for that information on what it cost the department for leave liability, didn't we?

Ms COURTNEY - Yes, we can do that as well.

Mr VALENTINE - Volunteer ambulance staff - there are 500 of them. Are you likely to have workers compensation for volunteers or not?

Ms COURTNEY - Yes, I might get Matt to talk in a moment. We have a lot of work in place not only to encourage recruitment of volunteers but also to support volunteers when they are volunteering with us. I will pass over to Matt to further outline that.

Mr EASTHAM - Volunteers are able to access workers compensation and are deemed an employee of Ambulance Tasmania when they're undertaking their duties.

Mr VALENTINE - I think I remember it going through.

Ms WEBB - Just to clarify, though, not if they're over 65 - correct?

Mr EASTHAM - That I will have to seek clarification on.

Ms WEBB - My understanding is volunteers over the age of 65 are not able to access workers compensation. How much of your volunteer workforce would be in that age bracket, minister?

Ms COURTNEY - We'll take that on notice.

Mr EASTHAM - I'll follow up on volunteers as well.

CHAIR - Do you have anything else on volunteers as well?

Mr VALENTINE - Yes, I certainly do. With respect to volunteers, if they are on workers compensation or have accessed workers compensation, exactly the same information if you can provide it, being off for greater than three, six and 12 months as a volunteer.

Ms COURTNEY - Yes, we can provide that.

Dr SEIDEL - Is there a CPD allowance for ambulance volunteers and what is the allocation per year for volunteers?

Mr EASTHAM - There's not specifically a monetary allowance for CPD although there are regular training nights that volunteers attend and certainly program training throughout the year. As part of compensation to assist volunteers there are certainly mechanisms in which they can seek reimbursement for out-of-pocket expenses in relation to attending training.

Dr SEIDEL - Can you give us an example with regard to the out-of-pocket expenses they can claim back?

Mr EASTHAM - It might be fuel costs or some other type of out-of-pocket expense.

Ms COURTNEY - We also have an $800 000 package to support volunteer training to ensure that we have training and equipment as well. Also in terms of the volunteers, the Government in recent years has done legislation around PTSD and presumptive PTSD. They are deemed employees and so are covered under that provision as well.

Mr VALENTINE - I remember that passing through this House and them coming along and listening.

Ms COURTNEY - With regard to support, we also have three positions of support and training coordinators who are employed to provide dedicated statewide resources to volunteers within the three regions.

Mr VALENTINE - With regard to overtime rates, hours worked by paramedics and the percentage of overtime? By region if you have it.

Ms COURTNEY - This is that percentage we were using before. Percentage average overtime FTE to average paid FTE, in the year ending June, is 8.5 per cent.

Mr VALENTINE - Nothing by region?

Ms COURTNEY - No, we don't have that breakdown by region here. If we have it, we will provide it. I don't know whether we have it or not.

Mr VALENTINE - Extended care paramedics for treatment at home. Do you have any statistics on service utilisation for each region on that score? Or the north-west and south not operating long enough to record any information?

Ms COURTNEY - I'm advised we don't have that data with us. If we are able to source that, we can put that on notice.

Mr VALENTINE - Is that a possibility then?

Ms COURTNEY - I just don't know. I've indicated that we should have it. We believe we have it, so we should be able to get you that.

Mr VALENTINE - You had 52 ambulance response locations and two aircraft response locations. Do you have any statistics on the cost of running each aircraft response location? You've got two locations. Do you have any statistics at this point regarding the operation of those areas? The number of callouts, for instance, for each location, and the number of users by region? Hospital destination numbers and time in the air, average time for case, all those sorts of statistics?

Ms COURTNEY - I might take that on notice and see how we monitor that data, because we would have information on flight numbers and where they are going and what they are doing. As to how they are captured and how they are reported, I would have to look at the system and actually understand what that is. We've obviously put additional resources into this, in both staff as well as aircraft capacity. I don't have the performance and utilisation statistics on me, and with those breakdowns you were talking about, we'd have to see how it is presented, because without having seen the data I wouldn't be able to commit to exactly how we will. We will be able to look at that utilisation effectively, and we'll see how we can do that demand profile around the state with regard to different hospitals.

Mr VALENTINE - The reason I'm asking is because it's a very expensive service, and obviously you would need significant statistics to be able to test whether it's effective. We know it's effective because people's lives get saved - but the cost of running it, and the cost of taking on contracts with third-party providers instead of the department running its own. It may well be -

CHAIR - In terms of time, have you got a question you want to -

Mr VALENTINE - No, I'm just giving the reasoning behind why I'm asking that. Do you ever envisage the north-west and west coast gaining a facility such as Air Ambulance?

Ms COURTNEY - Our air facilities need to be in a location where we can resource them appropriately, so they can be deployed where they need to be, and be deployed flexibly.

A good example is during the north-west outbreak, when we deployed aircraft to be permanently stationed in Launceston, to be able to respond to the north-west. We can respond regarding where the aeromedical or helicopters are stationed during that time. When looking at where things are around the state, a range of facts need to be looked at, particularly the different types of aircraft, as well and things like their refuelling and staffing.

Mr VALENTINE - My last question is on defibrillators. You have 1007 community-registered defibrillators, 829 readily available for despatch. Is that 829 included in the 1007, or is that extra to the 1007?

Ms COURTNEY - I will check for you.

Mr EASTHAM - I do not know. I am not sure where that figure came from, but we have two large -

Mr VALENTINE - It is out of your annual report.

CHAIR - It is the community people, not the ambulance.

Mr VALENTINE - It is under Ambulance Services.

Ms COURTNEY - I believe it is included, but if that is incorrect, we will provide clarification.

Mr VALENTINE - Do you service these very often? There must be a significant expense in the servicing of them.

Mr EASTHAM - Community AED is the responsibility of the owners within the community.

Mr VALENTINE - Okay.

Mr EASTHAM - Ambulance Australia provide defibrillators, through a community defibrillator fund, to certain community groups and organisations, and then those organisations will be readily available for us to track, within the app and within our state operations centre, where those defibrillators are.

At that point the servicing and upkeep of their defibrillators becomes the responsibility of the community group.

Dr SEIDEL - My first question is about the median emergency response time. It is currently listed at 13.8 minutes on the Health dashboard. Is that just for the regional centres such as Launceston or Hobart, or does it cover other regional areas, or all of Tasmania as well?

Ms COURTNEY - I understand that is a state median time.

Dr SEIDEL - Could we get a regional breakdown, or based on [inaudible]. Any classification that is appropriate in that context would be fine.

Ms COURTNEY - Dale, I might get you to run through that.

Mr WEBSTER - The statewide median time, as the minister said, is 13.8 minutes. The emergency response time median in Hobart is 13.1 minutes; Launceston, 12.3 minutes; Devonport, 11 minutes; and Burnie, 11 minutes. I do not have a breakdown beyond that for the regional centres.

Dr SEIDEL - Do you collect data for regional areas such as the Huon, Bruny Island, and the east coast?

Mr WEBSTER - We collect data on all emergency response times.

Dr SEIDEL - Would you be able to report on the response times for those regional areas? You can use any classification system relative to Tasmania.

Ms COURTNEY - We will look into the data we have for that.

Mr VALENTINE - To clarify, with workers compensation, it was particularly the stress I was interested in finding out about. Not only stress, but if it could be broken down to look at that.

Ms COURTNEY - Kath has the number for those workers compensation claims.

Ms MORGAN-WICKS - In terms of psychological workers compensation claims for Ambulance Tasmania, the number in 2019-20 is 17, with a cost associated of $3321 per claim.

Mr VALENTINE - Do we have them by region?

Ms MORGAN-WICKS - It is the same answer I provided before. We do not have it by region ,but we are happy to look into that.

Sorry, I am missing the zeros. I think I need to correct them. Let me just check. Sorry, I have misread the table and that is $3.321 million total cost in terms of the 17. If I could start again, there were 17 claims at a total cost of $3.321 million, and in terms of all workers compensation claims for 2019-20 for Ambulance Tasmania, there were 71 with a total cost of $5.325 million. My apologies.

Mr VALENTINE - Can we see if we can get the breakup?

Dr SEIDEL - In Budget Paper No. 2, Volume 1, page 132, under Secondary Triage, it states that one secondary triage system is fully operational. It is estimated that 22 000 calls per annum will be assessed and potentially 60 000 patients will be diverted to alternative service providers. Can I ask you, minister, what are these alternative service providers?

Ms COURTNEY - The secondary triage initiative has been provided with $2.11 million in 2019-20 and $3.63 million was allocated in 2020-21. We have been doing work not only in terms of procurement, but also in terms of understanding models in different jurisdictions as

well because there are lots of learnings we can take from that. With regard to the model we are going to work through, I am happy to go to Mr Webster.

Mr WEBSTER - The model we will work to, as you would be aware, is secondary triage. Once operational, secondary triage around technical experience and secondary triage clinicians are trained to utilise both the clinical data system and the emergency services computer-aided dispatch. Secondary triage clinicians will comprise both paramedics and registered nurses, ensuring we have a 24-hour shift coverage.

As to the referral you talk about, we are working with the sector in terms of telling the person that the GP is the appropriate person the next day or depending on the category whether it is a referral to mental health or any other of the many practitioners in the field.

The second triage methodology is to find the appropriate area for the person to go to. It is not the case that all 16 000 will go to one spot, it will depend on the clinical need of the individual and then we will refer them for that clinical need. This will be rolled out over time, so it is not 16 000 in the first year. We obviously need to grow this over a period of time.

Ms MORGAN-WICKS - Extended care paramedics are also a referral pathway for suitable low-acuity patients requiring face-to-face assessment and management within the ECP scope of practice if they are unable to be referred to other providers.

Dr SEIDEL - Can I ask because you mentioned GPs, if you have spoken to any GP practices about secondary triage and whether they are willing to accept patients who call the ambulance service first? You mentioned it is a 24/7 service as well.

Mr EASTHAM - Ambulance Tasmania already has links with GP services whereby in-field referrals are made to GPs or a discussion at times is had in relation to the appropriate care for the patient at the time. The networks are reasonably well developed. There will be a formalisation of direct referral pathways and how the information is sent through to different areas. There is still some work to go in this space because referrals at the moment are done with the goodwill of the GP and the paramedic at the time and although it works very well, there will be some formalisation of that.

Dr SEIDEL - It is currently an informal network, isn't it, because there is no handover protocol and no standards as far as I am aware?

Mr EASTHAM - Secondary triage provides us with an opportunity to formalise all of that, particularly in relation to our data and sending appropriate referrals through a centralised system.

Ms COURTNEY - We are still working through that at the moment in terms of those pathways and we have a funding allocation of $440 000 for the development of the alternative referral pathway in this Budget, so that is the work that is being done.

MR SEIDEL - Do you anticipate providing funding to GPs who are taking on extra patients on short notice?

Ms COURTNEY - That is part of the consultation we are doing but not just GPs, community nursing as well, so there will be a range of models and it is fair to say that different

models will work in different communities depending on the service providers they have in those communities.

CHAIR - I might close this line item off now or we are never going to get to the end. It can be left open if there are any major burning issues.

Mr VALENTINE - Assaults on ambulance officers over the last 12-month period, but I'm happy to take that on notice,.

Ms COURTNEY - That is something we take very seriously which is why we have asked the department about managing people who assault frontline workers.

Output Group 90
COVID-19 Response and Recovery

90.2 Health Care and Front Line Workers Accommodation -

CHAIR - I have only one question in relation to health care and frontline workers' accommodation, and it was very much appreciated and necessary, is: was the whole $929 000 spent to accommodate workers and/or their families?

Ms MORGAN-WICKS - As a point of clarification, the $929 000 for health care and frontline workers' accommodation is for this year's Budget, 2020-21.

CHAIR - Brilliant, so going forward.

Ms COURTNEY - No, that was from the COVID NPA arrangements.

CHAIR - Okay. This is if we need it in future?

Ms COURTNEY - This is new. Let me have a look; I have a breakdown of the funding for 2019-20 that we provided to Public Accounts.

CHAIR - It is really a contingency fund if we need it?

Ms COURTNEY - Yes.

CHAIR - All right. We will move to the next one, 90.3.

Output Group 90
COVID-19 Response and Recovery

90.3 Health COVID-19 General Allocation -

Ms LOVELL - Most of my questions have really been answered but could you, minister, elaborate on some of the specifics that funding is for? It has a fairly general description.

Ms COURTNEY - With regard to the funding we have allocated, that covers a number of different areas. I will get some detail for you. The forecast cost to the Department of Health for the COVID-19 response in 2020-21 is $73.5 million. The difference is that is the actual cost. The components we have there is the state component because we have the NPA around some of the funding arrangements for various parts of our COVID-19 response.

Mr JEFFERY - The main items estimated for 2020-21 as COVID-19 are about $9 million, hospital and ambulance equipment; $25 million, PPE; $17 million, Public Health and operational response; $8 million, paramedic and ambulance services; $25 million, Primary Care and Community Health services; and about $11 million for additional non-clinical costs.

They are the main components. There is obviously a large component for quarantine hotels, which is the Department of Communities Tasmania.

Output Group 90
COVID-19 Response and Recovery

90.5 Cancer Council Tasmania -

Ms WEBB - This looks pretty straightforward, but I am interested to know what was provided. There was $500 000 provided to support the delivery of cancer-related services and programs during COVID-19 response and recovery. I would like to understand how that was arrived at. Was the need identified by Cancer Council, which came to request the assistance, and was that because of its fundraising limitations during this time?

Ms COURTNEY - Yes, that is effectively what it was. We had engagement from the Cancer Council. Its fundraising capacity this year was severely impacted by COVID-19. I commend the Cancer Council. It did an extraordinary job, it decreased a lot of their staff salary throughout the COVID-19 period and still retained a lot of the services it provides. Many of the people they served were in a vulnerable cohort so they worked quite creatively to continue servicing them.

The Cancer Council's fundraising was significantly impacted, as were some other organisations' fundraising. Considering how critical the Cancer Council is in delivery, that was an important mechanism to be able to support them through that period.

Ms WEBB - Were any parameters put in place around where that assistance provided is to be directed within their suite of services?

Ms COURTNEY - I think that will end up being part of the funding deed that will be determined. It was only been announced last week so will be worked through with the department to make sure that the funding deed is appropriate.

Ms WEBB - Is it anticipated that their needs this financial year will continue into years to come and that there will be a need for further additional assistance?

Ms COURTNEY - Tasmania is very good at supporting our charities. Last weekend they had the Cancer Council Ball in Launceston. It was very well attended. From a fundraising perspective, there was a significant amount of support from the community. It was pleasing to

see, looking back to previous years, how generous the people of greater Launceston are with fundraising.

The Cancer Council has been putting in lots of good steps in recent years, ensuring it has resilience and looking at how it can build up a future fund, for want of a better word, to build up the resilience of the organisation. They are doing a lot of work themselves. As with other important community stakeholders, we will continue to work closely with them and monitor other situations. I commend them. They have taken proactive steps in a difficult time to maintain their viability.

Ms WEBB - Are you anticipating that hopefully they will be back on a good footing and not require another top-up? Is that what I take from that answer?

Ms COURTNEY - I hope so. However, we will wait and see.

Ms WEBB - They no doubt receive funding from a range of sources, from fundraising they do themselves and from state government and federal government sources in particular programs. Do we have a way of determining that this additional state funding goes either to support programs that are state-funded or fundraising-funded and not federally funded? Therefore we are not offsetting -

Ms COURTNEY - We have a range of programs that we fund through organisations. The Cancer Council is one of those. Those programs are separate to this funding. We would want to make sure that the provision of funding we are providing is not to plug any gap from a lack of funding from another source. However, the Cancer Council is incredibly responsible with the way they spend their money. All their staff took a voluntary pay reduction throughout COVID-19 to try to protect their financial resource. I have an expectation that the money we provide will be used very prudently.

Output Group 90
COVID-19 Response and Recovery

90.6 Community Healthcare -

CHAIR - I have spoken to Bastian about 90.6, Community Healthcare, but it is self-explanatory and I am happy to move forward unless anyone else has a burning question.

Mr VALENTINE - Under the output, appropriation of $3.6 million has been provided for 2021-22, with $200 000 of this appropriation provided as the final payment to support the establishment of a newly formed Health Consumers Tasmania until 30 June 2021. Can the minister please outline what further initiatives the department will be pursuing to ensure strong and skilled consumer engagement can be maintained and funded beyond the end of June next year?

Ms COURTNEY - Consumer engagement is really important, as is the consumer voice. As part of the discussion paper we put out seeking feedback, which we have talked about earlier today, a big part of that is how we can strengthen the consumer voice within our system. Part of the feedback we are seeking from stakeholders in the community are specific questions on

how the consumer voice can be strengthened. Through that, I expect there will be ways we can look at how we can consider that in future budgets. They have an important role to play.

Mr VALENTINE - For Health Consumers Tasmania to continue?

Ms COURTNEY - We will consider that in future budgets.

Output Group 90
COVID-19 Response and Recovery

90.7 Elective Surgery -

Mr GAFFNEY - If you look at the explanation, and there are two parts to this, it says -

> The 2020-21 Budget provides additional funding of $45.5 million over two years to address elective surgery demand in response to the COVID-19 pandemic.

How is the figure of $45.5 million over two years arrived at as a solution to patient demand, or is that the figure we have got?

Ms COURTNEY - The figure was worked through as part of the Budget process. Obviously, we wanted to look at how we could make as positive impact as possible. We looked at some of the capability and capacity within our system to be able to deliver that. The clinical planning of that now is already underway, because we have the $15 million already brought forward from the federal government. Planning was already underway to how we boost that. We're expecting that to get out of the door as quickly as possible and in the most effective way.

Mr GAFFNEY - In light of that, we can assume it's likely to improve the situation, not just return to the status quo?

Ms COURTNEY - Yes, I'm hoping with this money, it won't just stabilise or just go back a little bit, that we will actually make some significant gains into our waiting lists and particularly for those that have been waiting the longest and over boundary patients.

Mr GAFFNEY - Thank you. The second part of that says -

> This consists of a State Government component of $5 million in 2020-21 and 2021-22 plus Australian Government activity-base funding of $4.1 in 2020-21 and $16.4 in 2020-21-22.

Now, correct me if I'm wrong here, but activity-based funding from the feds is not eligible for endoscopy and colonoscopy work? Is that correct?

Ms COURTNEY - We might get Ross Smith up to the table to discuss that. Before Ross goes to some of the funding mechanisms, we touched on it earlier because we still have funding we're rolling out. We are going to be delivering more endoscopies this year, a substantial increase than we have in previous years. There is additional - not in that line item - funding

that has been brought forward that we're going to be spending on endoscopies. I will get Ross to talk through the federal funding.

Mr SMITH - For endoscopy, there's a base level funded each year through the activity-based funding arrangements and the $5 million the minister mentioned earlier boosts that. That's why we are able to increase the number of endoscopies done this year from about 8000 to about 11 000.

Mr GAFFNEY - Yes, thank you. I looked at last year and that was concerning because last year the minister said endoscopy and colonoscopy do not qualify for an activity-based funding. I don't know whether I've read that incorrectly, but I asked the question because one is diagnostic and the other one is a procedure, not a treatment.

Ms COURTNEY - Often - and, Ross, correct me if I'm wrong - it's eligible if the endoscopic procedures are counted separately to the things we're attacking on the waiting lists. The $45 million waiting list is for other elective surgeries and there are the 11 000-odd endoscopies we're going to do with this financial year, the increase. We have an existing boost to funding we're bringing forward so that's separate to that other funding.

Mr GAFFNEY - Okay. Good. I just didn't want to see a position where there could have been a conflict between the funding from the -

Ms COURTNEY - And conflicting terms of - yes.

Mr GAFFNEY - That's fine. The last two. There has been considerable conjecture in our community and the media with respect to the Mersey, evidenced by a partial closure of the AED. For a while it was known as a centre of excellence for elective surgery. Could the minister please detail the Mersey's involvement in the state's elective surgery program and how the Mersey's continuity has assisted with the THS with elective surgery numbers? If you could provide those. I think you've saved them before, but it's good for people across Tasmania to hear about the role the Mersey plays in elective surgery provision.

The next question was touched on briefly before by the member for Hobart about no-shows - people who have booked in for procedures and just don't show up. Whether there's any information showing that, say, if you have a procedure in the Mersey but you might not live on the north-west coast, you might live somewhere else. Are there any statistics to show some people don't travel? We have always travelled from the north-west.

CHAIR -You are looking for information for the no-shows, are you?

Mr GAFFNEY - Yes, the no-shows, any information you can give us on how that impacts because that is one of the messages from last year - trying make certain people show up for their elected surgery and they just do not show.

Mr VALENTINE - My question is about the fact they show up, but they cannot get in.

Ms COURTNEY - In a moment I will ask Ross to answer with some of the detail you talked about earlier on the Mersey. As you have outlined, the Mersey is a very important part of our health system. This is why we have got a capital program there and indeed we have seen the recruitment of the specialists when it comes to the rehabilitation. We have the rehabilitation

beds and now a specialist, so that is not just good for the people near the Mersey Hospital, but also [inaudible] the care that can be found in the north-west is a higher level, which means people from the north-west do not have to travel.

There is also a significant capital investment being planned at the moment to ensure the wards are high quality. I will ask Ross Smith to provide some more detail on elective surgery.

Mr SMITH - You are correct, the Mersey is an integral part of the elective surgery program across the state. There is one stream leader that manages elective surgery on the north-west coast and looks at how they bear the balance of the allocation of elective surgery across there. There has also situations where some elective surgeries - for example, dental surgery from Hobart - have been allocated to the Mersey to be able to work on that. The day centre of excellence the minister has mentioned - that additional boost the minister mentioned before - the Mersey will also be involved in that.

Again, it is something we sit down from central office perspective with the local surgical service leaders and work out what the best mix is in their region - what do they need and what are the demands? - and then they allocate it. In the case of the north-west region, it will be the Mersey to make sure we get the best use of both those facilities.

Ms COURTNEY - With people not turning up or the no-shows, I don't know if we have the data; if we don't, we can provide that on notice.

Mr SMITH - Certainly, yes, there has been continual improvement in trying to be able to make sure we were reminding people, contacting them beforehand, but we can certainly get this data.

Mr GAFFNEY - The last question is to do with funding. Do you look at what is required over that period or do you say, 'We are going to put so much money into this procedure or into this procedure?'. Can you breakdown the funding going to different areas? Ruth might be able to ask that question better because she mentioned it to me.

CHAIR -You are talking about the bucket of money in TASCORP?

Mr GAFFNEY - No.

Ms COURTNEY - Is this with the extra $45 million?

Mr GAFFNEY - Yes.

Ms COURTNEY - We have a statewide critical team that will look at a range of factors. They will look at the demands, the waiting list and the capacities. and they will be across different regions of the state. They will look at even the actual clinicians we have, the capacity and capabilities. They will work through the best way to use that money that will have the best patient outcomes so it is not a central decision - that is a clinical decision will drive where that expenditure goes to, but it will be all around the state in a range of different areas. However, we will be making sure we are looking at some of those over-boundary people as a priority.

Mr GAFFNEY - The category 1s you want 100 per cent, and the category 2s down to 40 per cent clearance, and category 3s were 60 per cent or something.

Ms COURTNEY - We've the targets around the different categories and then - depending on the different type of elective surgery - there is a fair bit of prep across those. That's where the clinicians are better placed to deliver their expert judgment on how to extend that across such a wide spectrum of critical needs across the state.

CHAIR - It will include more complex surgery, not just a whole heap of cataracts and endoscopies and things like that?

Ms COURTNEY - And we have done that since we have been in government. That has been a key priority and, particularly for some of those people who have been over-boundary, making sure they are able to get their surgery.

Mr GAFFNEY - Thank you.

CHAIR - It is good to see some neurosurgery happening in that.

There are no other questions on that line. We will move to Capital Investment Program.

Capital Investment Program -

Ms COURTNEY - I mentioned earlier the governance restructure we had earlier in the year. One of the benefits of that was the creation of a deputy secretary role of capital, which Shane has taken over as part of the planning work we are going out for consultation on, which is looking at a long-term infrastructure plan across the state and getting feedback on that. That is one of the key priorities. As soon as Shane came on board, he was hit fair and square by COVID-19 but that's the work he is embarking on.

CHAIR - Are we looking at a long-term rolling infrastructure plan in Health?

Ms COURTNEY - I will get Shane to talk to this because what it's about is making sure that rather than lots of discrete projects, we've a cohesive plan of how we cannot just deliver things, but how we're planning for them in a reliable way. I will ask Shane to comment on what he is planning to achieve through that and through the consultation.

Mr GREGORY - We are looking to implement strategic asset management in accordance with ISO 55 000 International Asset Management Standard. That standard lays out the framework for management of any class of asset, so it's not particular to hospitals, it's hospitals, bridges, road, shopping centres, airports; it's agnostic -

CHAIR - Digital infrastructure or just hard infrastructure?

Mr GREGORY - It's more built infrastructure. Fundamentally what is does is it lays out a framework not only for how you maintain infrastructure but also how you plan it, how you link your planning back to levels of service, and what the end user is going to do with that asset.

It feeds off clinical services plans and the way we intend to deliver health services. From there we would develop investment plans over the long term. We would have short-, medium- and long-term maintenance strategies to ensure not only that we are building the right infrastructure in the right place at the right time, but also that we are maintaining the

serviceability and the value of that infrastructure so it can continue to do what it needs to do into the future and it's not just something that's built at a point in time for a point in time, and that we don't allow the infrastructure to deteriorate in value and we've got plans in terms of how we maintain it and also how we return it and when we're likely to renew it.

It's really drawing on long-term views of how health services will be delivered and then having a good understanding of what a forward program looks like over at least 20 years.

CHAIR - Minister, there are only a couple of new projects. One is the rollout of the human resources information system, HRIS, and the Regional Health and Ambulance Facilities Fund. The others are really just a continuation of funding in these. I am interested in when the North West Regional Hospital maternity services antenatal clinic is going to be completed. Is it going to be completed within the time suggested here? Will we see it this year?

Ms COURTNEY - I will hand to Shane to talk about some of the time frames with regard to those budget line items. One of the things you would expect is that many of these time lines have been significantly impacted by COVID-19. One of the things I hadn't appreciated until recently is that it wasn't just a clear delay, shifting something down the path. We had a lot of learnings from COVID-19 about how we should structure the physical set-up. So, it's not just a shift down the road, we're revisiting some of the work we had done before to ensure they are appropriate for COVID-19.

With regards to antenatal, I understand that the application is before the council at the moment?

Mr GREGORY - We are about to go to market for the works. We will be going to tender very shortly in the next couple of weeks to commence construction early in the new year.

CHAIR - Okay, so we expect a completion; barring another outbreak or something horrid, when do you expect to see it completed?

Mr GREGORY - We expect to see it completed and operational next calendar year.

CHAIR - Next calendar year, okay. I don't have any other specific questions. The rest look to me fairly self-explanatory.

Mr VALENTINE - The human resource information system - given the government wants to have a whole-of-government approach to things when it comes to ICT - did you work in with other components of government, other departments, to see whether that might suit their needs like mental health services?

Ms COURTNEY - Yes, a lot of thought has gone into this so I'll get the secretary to talk about that, particularly with regard to the other areas of government.

Ms MORGAN-WICKS - I'll try to constrain some of my excitement around the HRIS system, because -

CHAIR - It's a bit like the budget management system isn't it? I know how excited you used to get about that.

Ms MORGAN-WICKS - I know. I used to be very excited about BMS, but I am very excited about the HRIS system. It's one that we have had many conversations at a heads of agency level, around a whole-of-government approach and certainly the initiative for Health to take the first step, particularly given the age of our current payroll system and the lack of integration between our payroll, rostering and timesheets. We have nearly a double-entry system in terms of people having to complete rosters with information, then not integrated through to then completed time-sheeting, and with some 4000 adjustments of pay which we hope that the HRIS system will [inaudible].

I think I mentioned earlier the FTE that is involved - which is clinical FTE, because of the experience that's required in some of the rostering - a new HRIS system will actually look at the level of qualifications, accreditation and scope so that we can digitise that allocation and time-sheeting.

I'm hopeful that we will also know, particularly for things like the recommendations coming out of the North-West Outbreak Interim Report, about having an HRIS system that captures, for contact tracing, exactly the employees who are working in particular areas of a hospital. Hospitals are very large places, so showing where people are at any one time is certainly a goal for our HRIS system.

Mr VALENTINE - Very good. I'm pleased to hear that you've had those conversations. Thank you.

CHAIR - Any other questions on capital investment program? Thank you, minister and your team. I know that we are an hour over time and I appreciate your staff staying to assist with those questions. Thank you. We'll have a 10-minute break.

The Committee suspended from 4.08 p.m. to 4.18 p.m.

DIVISION 11
(Department of State Growth)

Output Group 5
Cultural and Tourism Development

5.4 Events and Hospitality -

CHAIR - We are now into the portfolio of the Minister for Small Business, Hospitality and Events and I ask the minister to introduce the members of her team at the table for the purposes of Hansard.

Ms COURTNEY - We have Kim Evans, Secretary of State Growth, and Brett Stewart, Acting General Manager, Business and Trade Tasmania at the table at the moment.

CHAIR - Do you wish to make an opening statement about this portfolio area?

Ms COURTNEY - Yes, and I will keep it relatively brief ,given the time we have this afternoon.

Tasmania was in a strong position at the beginning of 2020, businesses were on a high and confidence was strong. Obviously the COVID-19 pandemic hit us hard. We know that many Tasmanians have done it tough this year and this pandemic has been devastating for so many, but we know as Tasmanians our community comes together and meets these challenges.

While we are staring to rebuild our economy, for small business and, in particular, the hospitality and event sectors, many operators are still grappling with the challenge of Public Health restrictions, changed consumer spending habits and the new COVID-safe way of operating.

As a state government we have dedicated more than $1 billion to getting Tasmania through the hardest times of the pandemic. Of this, small business support offered and delivered through Business Tasmania amounts up to $80 million.

Looking at business conditions, according to the NAB October monthly business survey, in trend terms Tasmania maintains the strongest business connections in the nation. Two-thirds of Tasmanians who lost their jobs at the height of the pandemic have now returned to work. Many of the hospitality operators have adapted to new trading measures, with innovative ideas for service becoming the key to survival.

Events also took a major hit during the pandemic, with cancellation of all major winter events across the state and the industry generating less than half of its projected $86 million in direct economic returns. Through Events Tasmania we have worked closely with our event organisers to support them through this period of great uncertainty to ensure they are in a position to resume full operations as soon as they are able. Importantly, last month we released the framework for COVID-safe events and activities which will allow larger scale events to resume from 1 December.

The Budget is very exciting this year. It provides funding over four years to help establish Tasmanian NBL team, the JackJumpers, and work towards upgrading the Derwent Entertainment Centre is also progressing. We know that this investment will draw thousands of people to the revitalised DEC, which, when upgraded, will be a world-class sporting and entertainment venue.

We also believe our continued investment in the Collingwood Mapgies national netball team partnership will provide not only sporting entertainment at a national level but also broad development opportunities and access for coaching and official clinics in the state.

Overall across the small business and hospital and events sectors, this year has been extraordinarily difficult. We know that we are not through it yet, but we will continue to work with the sector to continue to support them as we work through our recovery.

Dr SEIDEL - Minister, are you able to provide the number of hospitality business in Tasmania in receipt of JobKeeper?

Ms COURTNEY - I am afraid we do not have the JobKeeper data. You will have to seek that from the federal government.

Dr SEIDEL - Okay. Are you concerned for the viability of hospitality businesses once JobKeeper ends?

Ms COURTNEY - We know that JobKeeper has been an enormous assistance to many businesses across Tasmania and I applaud the federal government for its initiative with JobKeeper. We have seen a number of hospitality businesses being able to either restructure or ensure their business is able to operate within a COVID-safe way as JobKeeper has started to unwind. Obviously those businesses who are still severely impacted are still able to access support through JobKeeper.

In terms of state government support, this is why we have provided such a broad suite of support. Obviously there has been cash support in terms of grants but we have also provided support through the THA as well as funding for people to access professional assistance such as accountants and lawyers and marketing to be able to look at how they structure their business. In this Budget we also have $10 million to support energy bills because feedback from the THA was that that was one of the biggest challenges because it is quite a large fixed cost embedded in many people's systems at a time when they do not have quite the surge of revenue they would usually have. As we move forward, we will continue to work closely with the sector. We are very engaged with the THA on monitoring this.

It has also become very apparent that across the hospitality sector there is quite a diversity in terms of the impact of COVID. While at the beginning it was pretty much across the board, some businesses have been able to rebound relatively quickly. There have been some hospitality businesses that indeed are operating at, or even in excess, of pre-COVID activity; however, the diversity is quite broad and there are still many that are quite severely impacted in terms of their business models around gatherings and those ones that also rely on interstate visitors. However, with the ease in border restrictions, we will see that happen. As we move forward through the recovery, we will continue to look at how we can work with businesses in that sector to support them.

Dr SEIDEL - Have you considered lobbying your federal colleagues to extend JobKeeper beyond March?

Ms COURTNEY - I have written this year to federal colleagues, both the Treasurer, Josh Frydenberg, as well as Michaelia Cash, the minister responsible for small and family businesses, around JobKeeper, particularly earlier in the year. I think the federal government, in the pathway it has since announced in terms of the de-escalation of JobKeeper, has taken into consideration the fact that a lot of businesses have a long tail with regards to it.

It is also important to note that there are number of businesses we provide assistance to but because of the timing when they started their business or because of the way they employ their staff, they were not eligible for a lot of JobKeeper. That is where we have also worked with some of our grants and also some of the energy support to be able to assist them. That has meant for some businesses, they were able to access to the full extent and other businesses were not.

Ms LOVELL - To follow up on the JobKeeper data, I understand that data is collected by the federal government, not the state Government, but have you requested that data at any stage? The number of businesses in receipt in of JobKeeper?

Ms COURTNEY - With regard to engagement with the federal government for that type of data, that would be done through the Treasurer. That question would need to be directed through the Treasurer.

Ms LOVELL - As Minister for Small Business, understanding fully the impact of the pandemic, the understanding the impact of JobKeeper, both those businesses that have been eligible, those that have not been eligible and then the impact when JobKeeper is withdrawn and cutback, would that not be helpful for you to have access to that data?

Ms COURTNEY - With the support we have provided so far, almost all our grant schemes and support mechanisms have been stood up, consulting with industry on how it works for them. Indeed, the one in this Budget around energy support was as a result of feedback from the hospitality sector about how we could best assist it.

With regard to eligibility for longer support, people come to us and we have a range of hardship measures we are able to bring forward. With regard to the eligibility or not, some businesses will be about whether they are eligible or not, and some businesses it will be whether even if eligible or not eligible, what their current operating conditions are.

With regard to data collected by the federal government, that would be something for the Treasurer to pursue.

Ms LOVELL - You don't think it would be helpful for you to understand the number of small businesses in Tasmania in receipt of JobKeeper?

Ms COURTNEY - Given the strong relationship we have with the sectors, and we are getting a lot of feedback through both the THA but more broadly across a whole lot of industry engagement around the impacts on them, as a government we have provided the biggest stimulus package and support packages per capita of our economy compared to any other jurisdiction. We have stumped up and there is obviously a significant amount in this Budget as well.

As we go forward, we will continue to work closely with the peak bodies, as well as businesses, and our small chambers of commerce, on how we can target our support as best as we can.

Ms WEBB - Mine are broad and related to the impact of COVID-19 in this space. The hospitality sector has been hit really hard by the pandemic in light of the fact that structurally it was already a somewhat vulnerable area, casual employment, contract, short-term, seasonal and all those sorts of things. We also know that the workforce composition had some vulnerabilities as well concerning women, students and new Tasmanians, so the pandemic came on top of that, compounding the impact on vulnerability.

Minister, what projections do you have about the hospitality industry and services, particularly the employment in that space post-pandemic, especially in employment among those more vulnerable groups in that industry who have been impacted as we move forward? What projections do have?

Alongside that, I am interested to know what input you are making into the PESRAC process, to see that those expectations about that sector and the employment in that sector are addressed quite meaningfully in their medium- to longer term recovery recommendations and suggestions?

I am particularly interested in things that are not only switched to construction, but also things that will keep them potentially in a similar space or an aligned space and secure employment into the future.

Ms COURTNEY - I will provide some opening remarks and then I might get the secretary to provide some further comments.

There are a few parts to your question. First, one of the things we did was providing support for temporary visa holders. We know that across our hospitality sector we have a strong and important core group of hospitality workers, particularly in some roles like chefs. We have had challenges to be able to resource these roles the past.

We work really closely with a number of organisations and it was done through Michael Ferguson's portfolio, the distribution of that to ensure that we could retain those skill sets. I know that was something business owners wanted to do.

A lot of business owners I have spoken to went into their own pockets to support their temporary visa holders to ensure they could support them to stay.

With regard to the projections for the future of the hospitality industry, we are very optimistic about the recovery in the future. That is why within the Budget we have the funding across two years of the RTO, both the THA and the TICT. This is an initiative they have brought to the Government, how we can complement some of the training that is already provided out there.

One of the things that I am really keen to see through that, and it is also through the work that Jeremy does in his school portfolio, and also in Education, is how we can transition young Tasmanians, but also other Tasmanians, into the very meaningful careers there are in the hospitality sector.

For some in Tasmania, it is seen as a stopgap job that you do for a point in time, whereas there are really meaningful pathways for employment in it.

With our regional dispersal of our tourism as well, it has meant that that has been an oar to stretch out to the regions. A lot of the funding we provided to help with things like great customer experience. It is how we not only increase the quality across our entire system, but also the level of training and how we can move to those career pathways.

I might ask the secretary if there is anything left over?

Ms WEBB - Potentially, you said there are nuanced ways you are looking to support particular cohorts in that sector that may be especially vulnerable.

Ms COURTNEY - One of the things I would probably talk about later in the other portfolios is some of those areas around the Women's portfolio as well as Strategic Growth, and how there is alignment across each of those. Indeed, some of the PESRAC recommendations I am dealing with in my other ministerial hats go to those outcomes. We have worked to deliver a lot the PESRAC recommendations assigned to this portfolio group through the grants we have already provided.

Mr EVANS - It's a good question that you ask ,and it is not an easy one to answer in a clear way, but if you look at various parts of our community that are the most vulnerable, you would have to go to the regions as one of the more heavily impacted areas.

We have been doing a number of things. Very early on we worked with the Tourism Industry Council and the THA on a recovery program for our visitor economy, our tourism industry. No doubt that, in some of those regional and more regional areas, getting the tourism industry back up and running quickly, and getting people moving around, was one of the most beneficial things we could do.

Whilst borders were closed, there was a big focus on intrastate marketing. The Government also initiated the voucher scheme, which has been very successful and interestingly we collected quite detailed information about the spend by Tasmanians as they moved around.

Of the vouchers that have redeemed to date, the participants indicated that they have spent something in excess of $5 million on food and beverages around the state as they travelled, in addition to accommodation and other spends on transport and the like.

That is a direct thing we have done in the regions to try to assist. The minister has talked about temporary visa holders, who are a very vulnerable group, and we have been able to work with businesses, and, in particular, individuals, to get critical support to enable them to get through the pandemic. We are heavily engaged with PESRAC and the processes they are working through. There were a number of specific recommendations in their interim report that we have already actioned. For example, continuing to provide business advice for recovery programs through our Business Continuity Grant Program and other supports.

Importantly, over this coming summer as things are now starting to rebuild, and access is starting to improve, but with events not operating, we are putting a lot of emphasis on to assisting the promotion of our hospitality, our cafes, restaurants and hotels in terms of encouraging Tasmanians and visitors to eat out locally. Those are the sorts of practical things we can do to try to assist those particular cohorts you speak of.

Ms WEBB - Minister, were you surprised, given the vulnerability of workers in these industries, that the PESRAC process didn't involve inviting relevant unions to be part of the workshops and formal processes of their planning for the second state?

Ms COURTNEY - With PESRAC, the detail around the pathway forward is probably a question for the Premier, considering it is his council, but they were looking at ways they could bring a range of different ideas and solutions forward. From the first interim report, the recommendations from the people on the recovery council show that there is a breadth, I would suggest, looking at the interim recommendations.

Ms WEBB - The question wasn't about the council itself. Were you surprised, given the vulnerability of workers in your spaces here in these portfolio areas, that unions hadn't been invited to be involved in the workshops and the formal processes in the second phase of consultations? That was the simplicity of the question.

Ms COURTNEY - PESRAC and the mechanisms going forward are obviously a question for the Premier. However, a lot of the support we provide throughout these portfolios

of Small Business, Hospitality and Events is looking at how we can ensure that the employees are supported, particularly with some of the mental health initiatives done specifically through this portfolio.

There are initiatives in there to help small business owners with their staff, because it came back that one of the big challenges they had was, not only was it incredibly stressful for the owner, but they didn't have the skills to deal the mental health challenges their staff were coming to work with.

A good example was at one of the roundtables I had. A very successful bookshop owner said, 'I am not trained to deal with staff having anxiety or other challenges.'. That is one of the things that was set up through the $1 million that I announced a few weeks ago, specifically for these small business owners, so they can either get the support they need, or get their staff the support they need, and have the skill sets.

Ms WEBB - A further question that follows on from that, in a way. Minister, as you would be well aware, as we are opening up the travel restrictions and things are re-normalising, we still have to do that, alongside adhering to all our social distancing and Public Health requirements. We have probably all heard concerns expressed about the pressure that is put on staff in venues and owners of businesses to ensure that those arrangements are functioning effectively in their spaces, and that can potentially create some quite difficult situations between patrons and staff and business owners. I am interested in the guidance and support that has been provided to the industry broadly, but to venues and to staff within venues, to make sure adequate training and support is there to manage that interface between providing their service and upholding public health requirements.

The level of confidence that you can have as minister in this space, and we can have more broadly in the community, that it is going to function effectively, going forward.

Ms COURTNEY - The first comment I will make is Tasmanians have responded very positively, and on the whole have been very compliant with the things we have asked of them. We have asked a lot, and Tasmanians have been very good. I think when we have seen complacency, it is more just about someone forgetting than actually trying to not comply.

We have worked really hard with the Public Information Unit and the THA to ensure that we are supporting them with their messaging. That is something we are continuing to do - to look at how we can further strengthen it because, particularly in a hospitality venue, there is a lot to ask of the staff. We are continuing to work with the THA and PIU on how we can support that even more.

We are also ensuring that a lot of government messaging we are doing through the PIU is keeping firm on the messaging of shared responsibilities. A venue has responsibility, staff have responsibility and, importantly, patrons have responsibility, and that comes to things such as responsible queuing outside a venue as well. There is a share that the venue will take care of, but patrons need to do that as well. We work really hard in our messaging to make sure that patrons are aware of that.

As we move towards implementation of the public health order that already exists around patron details being logged, one of the good benefits is it not only provides the data for contact tracing, but when you go to a venue it is a really good reminder at one of those locations. If

you walk in, for example, to the Whaler down at Salamanca, and you click your thing, it actually does change your behaviour. I find, for me, you will walk in and you will be aware. You will use the hand sanitiser, and you keep up the new habits rather than regressing to the old. I think some of those things we are implementing will have additional behavioural benefits, not just the contact tracing rationale.

Ms WEBB - Do we know broadly across the industry how the uptake of the more technology-based data collection arrangements are tracking compared to pen-and-paper collection?

Ms COURTNEY - We do not have data on it. We talk to the THA a lot, so what we are doing as a government is providing pathways for different types of mechanisms. The Government has produced and is launching an app based on an ACT Health one; we have worked in collaboration to effectively use their technology. That is a low-cost technology solution.

Through the Digital Ready website, through Business Tasmania, we also have a really good resource that outlines the different types of things you can use, based on both the types of clientele you have, and the level of sophistication of your IT system. I went onto it and managed to access a free web-based app with a QR code, which I have on my office door, and which I can use to log the people who come in and out. I actually set that up in half an hour. There are relatively accessible mechanisms.

There are also a lot of private operators in the market. There is one being endorsed by the THA that provides added functionality for businesses, so they can use it for bookings and managing patron numbers as things get busier into summer, because there are still restrictions on venues. There are ones that are more sophisticated with added functionality.

We have not wanted to be prescriptive about what app people use, because of the fact that first of all we have an older population. We know a lot of Tasmanians do not have access to a smart phone, so that precludes them from that technology. I also know, from speaking to regional chambers of commerce, that even if you wanted to use an app, a whole lot of communities couldn't because they do not have very good internet access. It would not be able to function.

We've tried to create the criteria of what you need to report, and then a whole suite of tools and ways, and then push out that information through the chambers of commerce so that people can work out what method works for their business and their clientele.

Ms WEBB - Given that we're not mandating a technological mechanism and we're expecting, from what I gather, that there will always be some element of paper-based, non-technological collection mechanisms, where do we look to ensure the responsibility for privacy and management of data for people?

My understanding would be - you might be able to confirm for me - if I leave my details on a piece of paper at a venue, it isn't covered by our Personal Information Protection Act, and it's not covered by, in many cases, the Commonwealth act because that only applies to businesses with turnovers of more than $3 million, which most of these businesses probably wouldn't have. A lot of them would be paper-based. So in providing personal details, there

isn't a legislative privacy protection in place. Perhaps you can confirm that or correct that for me. If there isn't, how do we have confidence about how privacy is being managed?

Ms COURTNEY - It was part of a legal direction signed by the Director of Public Health under the public health emergency. Embedded in that direction is clarity that this data is being collected for a public health reason and a specification that it can only be used for a public health reason. The privacy of the data collected is covered through the Public Health direction.

From a public health perspective, it's embedded in the legal direction. Directing people to do it contains within it the privacy mechanism that it can only be used for that purpose and it can only be provided to Public Health for that purpose. That's something that we will monitor. There are significant penalties if you break any order that's made by Dr Veitch under a public health emergency. I have not heard of misuse of data from it.

I know there are concerns if someone has a piece of paper that's out in the open. From what I've heard, you might have a table for a group of people who are agnostic and write all their names down and for people who are worried about writing their names down, if they speak to the operator and ask to write their name on a separate piece of paper and put it in a box or something like that so that they can retain their privacy.

Ms WEBB - It's interesting, the degree to which you provide venues with education about that but then also some insistence and compliance about that. Certainly lots of venues I go into don't have that option to do that immediately. For some people for whom this might be relevant, let's just imagine it might be a woman who is vulnerable and doesn't want to put her details in the public domain and doesn't want to sign something that's going to be visible there, to have to ask for a different mechanism is, I think, too high an expectation; the venue should be providing that.

Is further effort planned or in progress to ensure that venues provide that full suite around those options so that it isn't something that the patron - particularly a vulnerable patron - may have to request? You say you haven't heard reports of it. I've received promotional emails and things like that from venues where I've left my details. I didn't leave them for that purpose. There's one anecdote for you and there's plenty of others out there in the community that I've heard about too.

Regarding putting your name and a phone number in the public domain that's sitting on a bar, will it only be if something negatively happens as a result of that, that we then decide that wasn't an acceptable way to do it?

Ms COURTNEY - As I said, we haven't been prescriptive about the method the operator uses. The direction says -

> The information that is provided is retained by the owner or operator for the purposes of management detection, notification, treatment or prevention of the spread of disease or managing a threat to public health or a likely threat to public health as a result of disease, ensuring the compliance with or enforcing this act. It must be kept in writing for at least 28 days and must not be used or disclosed other than as authorised under the act.

That is the legal mechanism. If patrons have concerns about the mechanism with which a venue is collecting it, I suggest that the patron talk to that venue. If there are broader concerns, as you said, you have an example, I'd suggest if anyone thinks someone is contravening a public health act, they report that.

I imagine the best mechanism would be through WorkSafe, which is doing the compliance, or the Public Health orders because we don't want that. I appreciate your feedback as well, Ms Webb.

Ms WEBB - I'm certainly not going to go and report that business to WorkSafe and have them penalised. I know they had it raised with them by another person the week before, and clearly hadn't adapted what they were doing.

Ms COURTNEY - A visit from WorkSafe would be helpful. WorkSafe throughout this period has worked to be educative rather than being driven by penalties. They've only provided a limited number of penalties to businesses for repeat noncompliance. It's a good example of what further work we can do through the PIU.

Ms WEBB - Beyond what's described in that matter of how the data is used, what consideration was given in deciding that a piece of a paper on a public bench where people put their name and contact details isn't safe enough? There could be a different way it's done. For example, it could be held behind the counter, given out for filling in and put back behind the counter.

We could have chosen to say to businesses, when you collect this data on paper, if that's the way you're going to do it, you can't leave it lying where it's readily visible. We could have chosen to make it a requirement that it isn't an acceptable thing to do, to have it publicly visible in a ready way. We didn't. Was consideration given to that in terms of safety and appropriateness around privacy?

Ms COURTNEY - A lot of things were considered when forming the direction. The challenge we have with forming a direction is that we have such a non-homogeneous range of workplaces and hospitality venues around Tasmania. What can be efficient and effective for one might not be appropriate for another venue.

A lot of high-patronage venues are using electronic ones. In the past couple of weeks, considering that I basically spent most of my time in Hobart eating out every meal, I think almost every venue that I have seen has transitioned to an electronic one. My expectation is, particularly with the free app that the Government's providing, that almost all venues will transition to that from the pen and paper method due to its COVID-19 perspective because you're using a pen, the privacy, the record keeping and the time stamping.

The ones that won't will be the ones that can't because of either their type of clientele or for some venues and for some businesses it'll be different depending on who is visiting. A good example is there will be some venues where if you are going in to be a patron at a bar you will use the COVID app, but if you've got a room of 50 people coming in for a function at a set time, they tend to use a piece of paper, because the room is sort of known to each other. I expect businesses will evolve to do what is appropriate. I am happy to take away the comments you've made and provide those to Public Health around the order and also to WorkSafe for its

compliance with this, and particularly the privacy provisions embedded within the Public Health order.

Ms WEBB - Thank you for that. I agree with all those things you said - largely the technological solutions will take care of this - but there will be residual exceptions. It is not so much complying with the privacy matters, it is also a safety matter. There could still be flexibility if the requirement was simply that it can't be left in a readily visible location. Then each venue could decide how best to manage that. Maybe it is filling in an individual thing and putting it in a box. Maybe it is having a clipboard behind the bar, whatever. We haven't then put a really narrow constrictors on them other than don't leave it visible.

Ms COURTNEY - The counterargument to that is if your venue is - and I've seen it when attending a church service where a congregation of people who know each other well, the most efficient way for them to get a large group of people all arriving at the one time and going into a room, is actually everyone just writing down their names as they go in. Doing something that specifically precludes what works really well.

Ms WEBB - What I'm suggesting is exactly that, just they wouldn't write all their names on the same thing and leave it visibly lying around. They would write their name on something and put it into something.

Ms COURTNEY - I'm just looking from a venue operator perspective to have 300 bits of paper coming in an hour your staff then need to collate.

Ms WEBB - We've probably exhausted it. It's a safety matter and my point really is if we get to a point where something dreadful happens because of it and then we say, 'Gosh, maybe we should have been more careful', my original question was what consideration was given.

Ms COURTNEY - A lot of consideration.

Ms WEBB - And we've now given it more consideration and I thank you for taking that away as well.

Ms COURTNEY - And I will; I can understand where you're coming from, particularly with vulnerable people and vulnerable women, and is a really important point to make. What has been made clear is the work that goes on before we make a Public Health direction and often the one page that gets published does not show the amount of -

Ms WEBB - The iceberg beneath it.

Ms COURTNEY - work behind it and the fact you're making a direction that has to cover all these different things and you're trying to minimise as many unintended consequences as possible. We have in the past amended Public Health directions based on feedback, so happy to take that feedback on board.

Ms WEBB - Thank you.

Mr VALENTINE - A question in relation to that. How do you actually get the message out? How do you know you're getting to every business operating out there? Do you do it through their peak bodies or do you do it direct to them via emails, or what?

Ms COURTNEY - We do it in a range of ways. The core way we get out information around COVID-19 changes, restrictions and legal directions is obviously the coronavirus website for businesses. Business Tasmania has a large number of businesses on its database. It does weekly and sometimes even more regularly weekly updates to its businesses that provide information on either changes in rules or support that's available.

Mr VALENTINE - They've got to be registered with them anyway.

Ms COURTNEY - We do register for that, so we spend a lot of time encouraging businesses to come and register with Business Tas to be able to do that. We are able to gather that data and we send it out to all of the people we have data for. We also work very hard through the peak bodies. There are obviously other big peak bodies that come to mind like the THA and the TICT. We also work through the industry sectors, the Seafood Industry Council and all of those ones that represent building and construction, Housing Industry Association. We also have a strong network with our small chambers of commerce. I do regular roundtables with the small chambers of commerce around Tasmania to be able to provide updates with what's happening.

Earlier in the year we provided $100 000 in funding across those small chambers to help them as they communicate to their membership, knowing for a lot of people until COVID-19 hit, they were quite happy not to have a lot of engagement with government. It is building up those new networks, and we work hard on that. As I said in an earlier question, WorkSafe is doing a very good job.

Mr VALENTINE - Councils?

Ms COURTNEY - Yes, we have pushed out a lot of the information particularly with regard to events frameworks as well. I have written a number of times to mayors and general managers around the support available and restrictions. At the moment, through the Events team, we are looking at how we can go out and talk to councils particularly on that area because we know councils and particularly, their community development officers, play a big role in a lot of those smaller events that still happen, but tend not to be on our state Government Events Tasmania radar because they are not funded through us, and do a lot of those community events particularly over summer.

CHAIR - Minister, this area, as you mentioned earlier, includes events, and there seems to be a sector overlooked in support and I do not see any in the forward provisions. The ancillary services that support events like lighting, sound, staging, those people engaged in that have pretty significant capital investment in their equipment and everything so what support is there for them?

Ms COURTNEY - Yes. The ones that are Tasmanian businesses have been eligible to apply for the range of grants we have already had, so a number of them have applied for the range of hardship grants throughout the year.

We have recently closed two grants schemes. We had the Event Infrastructure and Critical Support Small Business Grant program - a mouthful but very good. This one was $2.5 million targeted at those businesses that have been absolutely critical to the events industry. Things like marquee hire companies, onsite waste management, the AV companies that have specialised equipment because not only are they in a very difficult situation from a business perspective, we expect our events industry to rebound and when it does they are critical for that to happen. We will need them there. We cannot do AgFest without them, for example, so that is where we stood this one up. It was also available to event promoters under a range of strict criteria to ensure - it was a specialty service - it was there at the end so they are being assessed at the moment. We had that broken down into a range depending on their turnover, with grants available up to $100 000 is my recollection.

Mr EVANS - Businesses with turnover of more than $1.5 million per annum were eligible for grants of $100 000. A turnover of less than $1.5 million, but more than $1 million, $50 000. Smaller businesses of less than $1 million but more than $250 000 were eligible for grants of $15 000 and then turnover of less than $250 000, but more than $50 000 were eligible for grants of $5000.

CHAIR - These ones have just been finalised now, did you say?

Mr EVANS - The applications have closed. They closed on 13 November and they are currently being assessed as we speak.

CHAIR - Okay. There is a cap on that fund though? If it is over-subscribed, is there any capacity to support those?

Ms COURTNEY -As with other grant rounds, we have worked hard to be responsive to what the demand has been. In grant rounds we have seen over-subscription, we have worked to understand what the need is and looked at further support. There have been rounds recently that have been under-subscribed and we have looked at how we can use that funding. We had a good take-up, but that is where we are at the moment and I do not have the numbers, although we have a sense of the number of people who have applied, I don't know what their breadth is in terms of turnover; however, if we need to continue looking at ways we can support them, I will speak to the Treasurer about that.

One thing I want to make clear with all these portfolio areas is that we very much recognise that for some there is still going to be a long recovery period so we've obviously got a number of initiatives within this Budget - a number that have rolled out and things like the $20 million package we are rolling out. There are still some unexpended funds within that from undersubscription, so we continue to circle back to industry regularly to work out the need and also how we can use public money effectively because that's a very important aspect as well.

As we move forward with events, I guess the critical thing is the hardship support so we'll continue to understand industry and work with them on that. Through the framework that we have stood up we're hoping that we're going to see more events and a bit more certainty about events going forward that will help them through their recovery. In terms of funding through Events Tasmania, we've worked hard with a lot of the events to look at how we can provide and have either rolled over funding or worked with them to ensure that events can retain their capacity when an event hasn't happened this year so an actual event can happen in future years.

In terms of future events, they're the things we will work through, particularly those we will look at in future budgets and how we can roll them into that recovery.

CHAIR - I quite like the possibility for a new training program for responsible queuing. There's another business opportunity there for someone.

Ms WEBB - I think the British have that in their genetic make-up; they're very good at queuing.

Ms COURTNEY - Some people are also good at looking, finding the queue and standing in it, not realising there's a shorter queue up the back - I'm good at that one.

CHAIR - It's a whole new business opportunity for someone to actually teach people responsible queuing. Are there any other questions on this line?

Mr VALENTINE - Not unless you've got stats on the number of events that have actually been cancelled or postponed.

Ms COURTNEY - Of the 66 events supported by Events Tasmania scheduled to take place in the 2019-20 financial year, 45 events took place before the beginning of April 2020 and the remainder of those either cancelled or postponed their 2019-20 event. The cancelled events that had been scheduled to take place are the Tassie Fighter Con V; the Hawthorn Games in Tasmania that were scheduled for 25 April and 23 May; East Coast Harvest Odyssey; Flinders Island Food and Crayfish Festival; Vintage in the Tamar; Australian Musical Theatre Festival; Breath of Fresh Air film festival; Dark MOFO; Australian Rally Championships; and the Tennis Tasmania Annual Championships

We worked with individual organisers to assist with funding as well, because a lot of events had already expended a lot of their money and then had no revenue stream, so the team at Events Tasmania has worked really closely with organisers. Some have just cancelled, some have looked at postponing and some have looked at doing smaller or bespoke events. One of the core things is how we can make sure they have a pathway to recovery because our events season is very vibrant and we also know that a lot of events have been built up over decades of hard work run by volunteers.

Mr VALENTINE - They are only the ones that Events Tasmania were involved with, not local government?

Ms COURTNEY - I've lists of ones that have been postponed as well in 2019-20 and I also have the financial year because it cuts off in the middle of June. I have lists of cancelled events for 2020-21, but the data we have is on ones funded through Events Tasmania.

Mr VALENTINE - You haven't contacted local government to find out how broad that is?

Ms COURTNEY - A range of events have spoken with us and some of the smaller events as well.

Output Group 90
COVID-19 Response and Recovery

90.6 Tourism and Hospitality Financial Counselling -

CHAIR - In 90.6, Tourism and Hospitality Financial Counselling, I noticed there is $100 000. I was wondering who will be delivering that? Do you have a preferred provider or do they get like a voucher sort of thing to get it?

Ms COURTNEY - That money has already been provided through a grant being expended through SBA Collins.

CHAIR - It has already been provided? Right.

Ms COURTNEY - Yes. SBA Collins was using that as a partnership and there was further funding involved in that. The one I was speaking about a few weeks ago - that was the $1 million where we partnered with Tasmanian Lifeline. With that one, we have stood up as a partner with Tasmanian Lifeline to produce a program developed specifically for Tasmanian businesses.

CHAIR - Has the whole of this $100 000 been expended?

Ms COURTNEY - It has been committed and is being provided through that partnership with SBA Collins, so it is within this financial year; however, it was committed earlier. The $1 million was a separate amount of money.

Output Group 90
COVID-19 Response and Recovery

90.22 Peak Body Support Fund -

Ms COURTNEY - I can speak broadly to that. That is continuing the partnerships that we will be doing with the peak bodies. One of the things that has become very apparent through COVID-19 is that the impact to different peak bodies' memberships has been quite varied We will be engaging with a range of peaks and will have more to say on that in the coming weeks and months.

Output Group 90
COVID-19 Response and Recovery

90.24 Small Business Sustainability and Recovery Assistance Package -

Ms WEBB - I recognise it is a matter of public record that the Government and the department have decided to break away from data transparency, accountability and good practice in releasing details of the recipients of these publicly funded grants. While I place on record that I disagree strongly with that break from established good practice and good governance, in recognition of that decision by the Government and the unlikeliness that it is

going to change, I am going to place my objection on the record on behalf of the taxpayer and move on to the questions I have.

Is the $20 000 assistance package allocated for this financial year? We know we are not out of the woods yet with the pandemic, so will the Government see fit to increase and extend the assistance package further or create a new but similar package that will take us further beyond this financial year? Will you now undertake to make clear to all potential applicants for any future same or similar fund that they will potentially have their names released or their business names released as part of a transparency and accountability measure around taxpayer-funded grants?

Ms COURTNEY - I will step through it. With regard to the $20 million line item, the sustainability recovery grant program, that is a program we have rolled out only in recent months, so that is separate from the $60 million you referred to in your preamble.

Several months ago we conducted a number of face-to-face roundtables around the table. We asked local chambers of commerce to bring a number of their local businesses to those and that was how we framed up the Small Business Sustainability and Recovery Grant program. The feedback from businesses directly fed into this grant program.

This grant program has had a number of different components. Underneath the $20 million we have the Small Business Sustainability and Recovery Grant program which was a $15 million parcel. We received a number of applications but all the funding wasn't expended. We are working to look at how money can be further redirected to support businesses. As part of that, we have also had effectively the rolling on of the Business Sustainability Grants, which are the $750 grants.

One thing that we have seen is that demand for some of these grants has abated throughout the year. We are taking that to mean that businesses have recovered, or there are a lot of businesses that have recovered. We've expanded that based on feedback so it's no longer just for accounting-style advice, it's also for business advice such as marketing and other things.

Within that funding envelope, we also have the $1 million that I mentioned where we've partnered with Tasmanian Lifeline, as well as the Mental Health Council. We are also partnering with a number of peak bodies to work directly with them and their members to ensure that we've got the right support for them.

I'm happy if there's any further detail, perhaps the secretary can go through that so that I've got some voice left for dealing with Strategic Growth.

Ms WEBB - I'm not so much interested in the detail. Back to the question though, which was, if you were to rollout a similar program, say, to the one - I understand it's not this one that I was referring to; it's the broader one that came earlier with the $60 million. If you were to rollout further programs of that nature, will you make a commitment now that that will have the standard normal governance and transparency accountability in terms of disclosure of recipients?

Ms COURTNEY - If we're rolling out a package like we rolled out at the beginning of the year, our economy would be in a dire position. I'm not going to pre-empt what that would be. I'm hopeful that we're never going to do a grant round where we had to get money out of

the door so quickly, where all our staff were working from home, where businesses were blindsided, shut overnight night and on their knees.

The circumstances where that grant round stood up are very different to even the grant round I just talked about in terms of the time that we had to be able to stand it up, the time we had to engage with a range of stakeholders, and the way we had to look at the training of staff who were all working from home to be able to assess quickly. To be frank, I really hope that we're never in that position again. For the state and for those businesses it was horrific.

While I think that there are plenty of learnings from early this year about a range of different areas from Government, including learnings from those grant rounds - I know the Auditor-General is doing work - I'm sure that there will be learnings for the Government. However, I can put my hand on my heart and say the Government and the team at Business Tas and the small business team did their very best to get an enormous amount of support to businesses very quickly when they were on their knees.

To be frank, Meg, I'm not trying to be tricky about it, but I don't want to say what we would do if we were in a situation like that again.

Ms WEBB - With respect, minister, and I know you're not trying to be tricky about it, but you did not really address the question. Of course, we would all absolutely agree with you and God forbid we are ever in that position again but potentially we could be. My question relates to that. If that were the case and we were rolling out a similar grant round and we'd actually alerted people to the fact that there would be accountability and transparency at the time that they applied, asking for a commitment that even given the extremity of the circumstance that that standard good governance, accountability, principles would apply, would you commit to ensuring that there is that visibility and accountability around the recipients of publicly-funded grants?

Ms COURTNEY - As we've seen when we've got other grants that have stood up in emergency situations such as bushfire type grants, those details aren't publicly released.

Ms WEBB - No. You probably didn't alert them to it at the time you gave it to them either.

Ms COURTNEY - We will always take advice from the department. Perhaps the secretary would like to comment.

Mr EVANS - In terms of alerting grant recipients, it is a standard practice that when we put out a grant program, as part of our grant documentation, we would make it known to grant applicants that their details might be released. It doesn't say that we will release but we reserve the right to release them.

Ms WEBB - And they have entered into that knowing that is the case?

Mr EVANS - That we may, yes. In the ordinary course of events, the normal grants program is usually about innovation, growth, very positive situations, we would make them public. We pride ourselves on being open and transparent. In this particular instance we were rolling out thousands of grants a day for $2500 to about 14 000 businesses to people who were not applying because they wanted to do something positive and create jobs, but they were in

absolute dire hardship. They were in an emergency so we made the judgment that it is not in the public interest to have all the details of all those individuals publicly released.

If you think about it, in terms of the number of businesses in the state, it is about one in three received some sort of grant.

Ms WEBB - Was consideration given, or perhaps I am not well enough informed about this. Given that decision was made, and we don't need to re-prosecute that any further, I understand that is the position that you have and the rationale for having it, whether I agree or not, where did you land deciding the appropriate level of achieving transparency and accountability working back from fully disclosing names and businesses? For example, can we find out in the public domain how these grants were distributed regionally by industry? Even for example by demographics, female-owned businesses, male-owned businesses, things like that? Can we see those levels of detail?

We don't jeopardise individuals or privacy matters or the rationale you put there but with the idea that the principle would be to the greatest extent possible we should be transparent and accountable. Where have you landed using that principle at what is the greatest extent possible of transparency and accountability in this instance?

Ms COURTNEY - I am happy to take that on board and see what we are able to provide. It is not something I have datasets for but we can look. The ones that might be challenging will be around things like gender in particular because often applications are in a business name, so that would be difficult, but I could look into what we do have.

Ms WEBB - To my mind, given the furore around this matter, being able to discuss it in terms of we are attempting to achieve transparency and accountability to the greatest extent possible within what our belief is around wellbeing and here is where we have landed, rather than just a shut door, that would have been a good faith gesture. I hope we can see something come out around this that shows where we have landed.

Ms COURTNEY - I am happy to take that on board and see what we can do.

CHAIR - On that point, as a member of the Public Accounts Committee, there has been information provided to the Public Accounts Committee.

Ms WEBB - But you are not allowed to release it.

CHAIR - No, I am just saying there has been information released to us and until we report on this some of it is not public, but some of it is.

Ms WEBB - Along the lines of what I was just discussing there?

CHAIR - Potentially. The minister has made a commitment to look at what can be provided. You will take that on notice. The problem is being able to report in time. We have been so snowed under with work. It has been tough for the Public Account Committee too, I might add.

The Committee suspended from 5.25 p.m. to 5.39 p.m.

DIVISION 9

Department of Premier and Cabinet

Output Group 7

Strategic Growth

7.1 Strategic Growth

CHAIR -Thank you, Minister for Strategic Growth, and I will get you to introduce the people on your team. If you want to make a brief opening statement about this, that would be fine, and we will move into questions.

Ms COURTNEY - Thank you. To my left I have Jenny Gale, secretary of the Department of Premier and Cabinet, and to my right is Alice Hollingwell-Jones, executive director of strategy and engagement.

The Tasmanian Government has a plan to rebuild a stronger Tasmania with the 2020-21 State Budget which is focused on bolstering confidence and creating jobs. Tasmania has experienced steady economic growth in recent years, even during the COVID-19 pandemic, but we acknowledge that the benefits and opportunities of our growing economy are not always felt equally across all our regions and communities.

The Government's vision is to ensure all Tasmanians - no matter where they live, no matter their background or circumstances - have opportunities to participate in and benefit from Tasmania's growing economy.

Strategic Growth is about unlocking the potential of it in our regions. It is about working with community groups, industry, local government - indeed all areas of our community - to plan for and enable opportunities for Tasmanian regions and Tasmanian people. The elevation of the Strategic Growth portfolio to a ministerial portfolio earlier this year is a reflection of the importance the work the Government is doing. It is a portfolio I am delighted to be leading as we continue on our task to deliver the positive future every Tasmanian deserves.

This Budget includes support for a range of strategic initiatives which invest in local communities to support resilience, and economic and employment growth as we continue to respond to and recover from the COVID-19 pandemic. We know Tasmanians in some regions face significant social health and wellbeing barriers to employment. We have committed funding of $1.3 million over two years for the Glenorchy Jobs Hub to assist local business owners to meet their workforce demands and to help Jobseekers into employment.

The Jobs Hub will provide significant opportunities for Glenorchy residents and businesses, and the potential to support positive change in the region through this project is very exciting. The budget includes continued funding for the Sorell Jobs Hub with $950 000 to extend the project for a further two years, ensuring the successful program can continue to deliver services assisting local Jobseekers into employment in southeast Tasmania.

We are investing $470 000 over two years to support the Hamlet Employability Program which provides practical work experience and job-readiness training in hospitality to

Tasmanians facing multiple barriers to accessing education, training and employment. We are committed to ensuring that Tasmanians have the right education, training, and training opportunities to meet the future skills of employers. This is why we have provided $420 000 over two years towards WorkSkills Inc's Troublesmith's Employment Program - a unique social enterprise work experience, coaching and job placement program focused on assisting Tasmanians between the age of 15 and 24 to long-term employment.

In 2020-21 a further $1.4 million is provided for Strategic Growth employment partnerships under the COVID-19 provision funding so we can provide support for locally-led solutions to employment challenges and regional disadvantage while supporting recovery.

I take confidence in the fact that the work we are already doing is in line with the recommendation and the Premier's Economic and Social Recovery Advisory Council's Interim Report and look forward to continuing our work with communities to drive our recovery. This is all in addition to the ongoing community-led projects underway in George Town in my electorate of Bass.

Strategic Growth portfolios like this are helping to create pathways to employment for more Tasmanians and this is a Budget that will help support that. I look forward to the committee's questions on this area.

CHAIR -Thanks minister. Your opening comments confirm the question I wanted to put to you. On page 241 it talks - as you have in your speech - about what this output group is about: contributing to the delivery of jobs hubs in Sorell and Glenorchy and social enterprises in Hobart. They are all very worthy programs. I don't have anything other than praise for those. You also talked about the focus of this and the reason it was established was to provide to our disadvantaged regional communities.

Four initiatives are in the south of the state and some of them in Hobart, which is fine, but there are significant challenges in our regions in employability, getting people into work, and providing business opportunities. The note says, 'This includes investing in local communities to support local resilience endeavouring to support economic and employment growth throughout Tasmania'. I would like you to explain how that is actually playing out in the north-west, the west coast, the east coast and down the Huon. These are areas that find it difficult sometimes at the best of times.

Ms COURTNEY - George Town was one of the ones I mentioned in that. I might get either the secretary or Alice in a moment to talk in a bit more detail about the George Town initiative.

With regard to the portfolio, given it was set up during last financial year, a lot of the initiatives that we have provided more funding for were initiatives that the Government had already provided support for. We had already provided support to Troublesmiths and to Hamlet, and based on that success and on budget submissions from those organisations, additional funding was provided through those portfolios. We have the new Glenorchy Jobs Hub but the other funding that had been provided had been extending already existing ones. As we move forward now that is what we are looking toward.

One of the challenges in the portfolio has been that we are in quite a different economic climate than we were at the beginning of the year. My predecessor, the former premier Will

Hodgman, under his portfolio responsibilities looked after these types of initiatives. When Peter Gutwein initiated it as a portfolio in itself, it was looking at - with the strength of the economy - how we ensured we were allowing more Tasmanians to benefit from it.

COVID-19 has had a huge impact in the economy in some of the areas of need, but also some of the opportunities. That is what this Budget has done. It has provided some of the funding initiatives for us to be able to look at these further partnerships. I will pass to the secretary for some further comments.

Ms GALE - The other thing that is really important is on the back of the previous jobs action plan - which was a forerunner to the Strategic Growth portfolio - it was decided that we would have an evaluation undertaken by the University of Tasmania so that we can look at what the best features were of the success of those programs and think about whether, or how, that could be replicated in other areas around the state. With the Budget, the thinking was that we would need to prioritise in those areas where the need was greatest. George Town was one of those areas that was prioritised as a result of that.

The previous jobs action package programs provided some good outcomes that we hope that the evaluation will give us a bit of a clue about how we can replicate those in other areas.

CHAIR -When do you expect that?

Ms GALE - That's a very good question. No, I do not have a date. Minister, through you, we will take that on notice and we will come back.

CHAIR - Will that be made public, the actual review document?

Ms GALE - It is a review of an internal program. We had that discussion earlier, so I can't say and I'm not exactly sure. I would have to go back and have a look at exactly what the nature of the evaluation was going to be. It was not a review as such, more of an evaluation of the projects that we had like the funding, to which the funding was allocated in that case.

Ms COURTNEY - And to help inform our future funding towards other programs as well.

CHAIR - The review is not of the programs that are funded under this, they were the other jobs?

Ms GALE - That is correct. It is an evaluation.

Ms COURTNEY - It is an evaluation of initiatives prior to this portfolio becoming a portfolio. The reason the secretary mentioned it is because it will be able to inform, particularly when we are looking at geography. One of the things that's important in this portfolio is we are exploring geography as one aspect that can drive barriers to access to these opportunities. There are other barriers that are not geographic, so how we look to identify those and how we prioritise that funding -

CHAIR - UTAS is looking at that? Or is that work that you are doing of the other barriers besides geographic?

Ms COURTNEY - That is the work that we are proceeding through with this portfolio and it is also looking -

With some of the investments made so far, the other aspect that is important is how we get the right level of community engagement. That is something easy to say, but sometimes takes a long time to work with a community to ensure we have the right structures and the governance right to be able to take this forward, because the issues we have had in George Town is a really good example.

The south-east is another good one and this is the work we have been doing in Glenorchy over the past few months, working with the community to understand what the capacity is, what the capacity within council is, and then how we get the right local governance and local partnerships truly led by the community and opportunities for employment.

That is one of the challenges of this portfolio as it is not a cookie cutter model where we can put one here and one here. It takes quite a substantial amount of on-the-ground work to ensure we can get a model that is sustainable and community led, because we want to be able to provide support and guidance. We don't want it to be led by bureaucrats in Hobart. We want it to be a community led one.

CHAIR - Fit for purpose for the community it is in.

Ms COURTNEY - Yes and that takes a substantial amount of work for us to help the community achieve but the successes are enormous. The work has been done by the Future Impact Group, and True Pack Leaders Table.

In George Town, they have done a broad range of community engagement to ensure their projects and what they are doing, looks quite different to some of the other initiatives. This is more on pathways to just employment, where the Collective Impact Group in George Town is looking at how they create more opportunities across more social, education, health and wellbeing communities to drive some more sustainable change in that community. There are slightly different outcomes.

CHAIR - It's not just employment.

Ms COURTNEY - No, it's also about how to engage with the community to ensure that as a step towards employment.

Employment is one outcome, but for a community like George Town, the initiatives identified in that region have been a launch pad, which is a central community space they are equipping with a commercial kitchen and other resources. They are staffing that to support socially inclusive environment with targeted skills development, so that is going to stimulate learning, innovation and business, co-production at that site. They have an urban renewal model to revitalise the main street with pop up shops, and created projects. Community groups, incubator hubs, and start ups at little cost. They also have a Digital Warrior's program, the community-run digital electricity program, which is part of a program to support participation in the digital economy and enable the community to learn and participate.

The members on that, as well as community members, the schools are the Beacon Foundation, an important partner and the council. Particularly with the work that the council

is doing through its mountain bike paths, they are setting up the hub in George Town by purchasing the old RSL building, to be able to use that as a platform for employment and training opportunities for young people through the jobs that will be created through the mountain biking in that area.

That is the pathway the community has determined will work for them to create opportunities for young people and that engagement piece in a community with a lot of young people at risk of disengagement.

Ms WEBB - To backtrack for a minute, because I am now a little less clear about what was evaluated by UTAS for you. They were things under the previous iteration before Strategic Growth was its own portfolio? Specifically, what were the projects or programs?

Ms GALE - The Jobs Action Package which was done in consultation with TasCOSS and the Tasmanian Chamber of Commerce and Industry and Government, through Department of Premier and cabinet and Department of State Growth.

We focused on four areas: Derwent Valley, the south-east or Sorell, the west coast and Break O'Day. There were four specific initiatives, once again led mostly by the community - and the focus on that -

Ms WEBB - It's okay. I know what they were. I just wanted to check. Those four different programs were evaluated through UTAS?

Ms GALE - No, the evaluation hasn't been finalised yet.

Ms WEBB - But that's the types -

Ms GALE - And process of evaluation - they're being evaluated.

Ms WEBB - That's what I'm just confirming, yes.

Ms GALE - They're being evaluated, yes.

Ms WEBB - So each of the four separately as part of that package.

Ms GALE - The evaluation is going to look at not only the individual components but also the regions. It will look at readiness. It will look at the difference between the outcomes and, I suspect, what the factors are that contribute to more successful outcomes for the regions. It hasn't been completed yet.

CHAIR - I think you've probably covered George Town?

Ms COURTNEY - Yes.

CHAIR - You don't need to add any more to that?

Ms COURTNEY - No. I have more detail on George Town that I'm happy to provide. They have the FIG, the Future Impact Group, and they have the Future Impact Leaders Table. They have the council, the Trade Training Centre, Beacon, the local shops, the Northern

Workforce Development Officer, the George Town Community Hub, the community house, the Chamber of Commerce as well as business leaders engaged in that.

CHAIR - Who is the lead in all of that?

Ms COURTNEY - I might get Alistair to explain. That is being led between the FIG and the FILT. Drawn from the FIG, which is what I just went through, is the Future Impact Leaders Table, which is a smaller group of volunteers who have met fortnightly since late 2019 delivering several pieces of work, including data collection, to develop an agreed base for measuring the outcomes. There has been a lot of support for this through the council. The funding for this has gone through the council to be able to support the FIG and the FILT with the initiatives they have developed. The FIG was formed in 2016 so it's been over a long period of time this has developed.

Ms GALE - It's a collective impact approach where the local community determines that there's a need and then through the various leadership - I understand that in George Town the work started through a consultancy that specialises in collective impact work who worked with the community to bring together the people that formed the Future Impact Group, the representatives from the community - they work together. As a result they formed the other group and they've been working on what they believe to be the appropriate programs for their community. It's very much a collective impact.

Ms WEBB - In a collective impact model you have a backbone organisation. Am I to understand that the council is acting in that role as the backbone organisation, that's the funded entity to do the coordinating function?

Ms GALE - I understand that the finances are being run through the council, which is obviously an incorporated body. We used that model in our previous jobs action package as well. For example, on the east coast, the Break O'Day Council, I think it was, auspiced the funding on behalf of the group that was working with that.

Ms WEBB - Councils are well-placed to do it because they're so local and grassroots and connected.

Ms COURTNEY - And Beacon Foundation has also played a substantial role in the George Town model. They have a very embedded model in George Town with schools and the Trade Training Centre. Beacon's been one of the key partners that has been there to help develop this.

CHAIR - Are there other groups in the early stages of setting up to do that sort of work that we've seen in George Town in other parts of the state?

Ms COURTNEY - They're the conversations that we're currently having with a range of different groups. Some of those are led by council and some of those are otherwise. It was pleasing to be able to get additional funding in the Budget to be able to cover Hamlet and Troublesmiths as well as some of those existing ones. Because of that, we are able to use some of the resources that we have in the portfolio now to direct some of those other initiatives. You can expect we will have more to say about other initiatives in the coming weeks and months. I'm up in the north-west visiting some tomorrow.

CHAIR - The funding allocation here and by appropriation is really just to run that section of the department? This doesn't include the funding that is available for these projects?

Ms COURTNEY - All the funding you see in the Budget that's allocated to this portfolio will be delivered through funding other organisations. The resourcing for this is supported by DPAC.

Ms GALE - DPAC provides the staffing.

Ms COURTNEY - There is no staffing embedded.

Ms GALE - All that funding goes directly to the organisations or the groups according to the projects they put forward, which are approved.

Ms WEBB - Could we get a breakdown of how that funding breaks across the different funded programs?

Ms COURTNEY - We were very pleased to be able to get additional funding for a range of initiatives in this year's Budget as well as the additional amount for the broader initiatives. There had been some expectation that we would have to use some of that core money for those. It gives us a bit more flexibility to look at some of these new initiatives. Also, there were some timing things that meant that expenditure came in this financial year even though we expected it to go out last financial year.

Ms GALE - For the 2019-20 year we rolled forward one of the projects under the previous Jobs Action Plan that hadn't been completed. I think that was in the Derwent Valley, from memory. We rolled forward $170 000 to support that program. Hamlet was provided with $110 000, Troublesmiths extension of grant funds $75 000, and Loaves and Fishes was supported to continue their existing service to the tune of $30 000.

In the 2020-21 year the funding committed was additional funding again for Hamlet of $70 000; Troublesmiths of $52 500; the Tasmanian Community Transport that supports the Sorell jobs extension, $30 000; Colony 47, $150 000, that is for the Sorell Employment Hub extension and the Glenorchy City Council, which will receive funding of $1.3 million over two years in 2021. That was $231 000 to a certain point in the grant deed.

Ms COURTNEY - There was an allocation. George Town was allocated in last financial year, but it will actually end up rolling out in this financial year. That was $1 million.

Ms LOVELL - Minister, was the money for the Glenorchy City Council for the Glenorchy Jobs Hub?

Ms COURTNEY - Yes, we're working through that. I can provide an update for where we're up to with that. They have recently had the expression of interest for their steering committee.

Ms WEBB - You mentioned the $1.3 million over two years to Glenorchy City Council when I was asking about line item 7.1 Strategic Growth and the breakdown of that figure. I think the $1.3 million to Glenorchy is over here in the COVID-19 measures, is that right? That

seems to add up to $1 3 million - $650 000 and $650 000. Now I'm a little bit confused as what was captured in that.

Ms COURTNEY - The Glenorchy money that we have committed is accounted for through the COVID provision, the $650 000 over those two years. That means we now have some additional capacity within that base level of funding to be able to look at other initiatives this financial year. That is the one on which work is currently under way on looking at the best mechanism to be able to achieve the outcomes with communities and also look at the PESRAC recommendations.

We had new funding for initiatives that I had initially anticipated would be used by the base level funding. It's given us more flexibility with that base level funding now through this financial year. That's the work that we are continuing on.

Ms WEBB - To clarify that a bit further, I am interested to understand under 7.1 Strategic Growth the $2.68 million that is in 2020-21 and exactly what the breakdown is of that amount. I presume from what you just said that the $650 000 in this financial year and the $650 000 in the next financial year for the Glenorchy Jobs Hub replaces the existing funding that they were receiving, which I acknowledge was a smaller amount. From what you have just said, you have now repurposed that.

Ms COURTNEY - No. The money that you see there, the funding for the Glenorchy Jobs Hub, was announced several months ago. So that is a new funding initiative. Money has not been provided yet. I understand that the grant deeds are being stood up at the moment. I will go to where we are up to. I will get Alice to do that because I am running out of voice.

Ms WEBB - We can talk about that when we get to that line item.

Ms COURTNEY - What I am saying - and Alice will correct me if I am wrong - is that because we have a provision for that now, it had initially been anticipated when we were looking at the Budget for this financial year that we would be covering the budget for Glenorchy through that. Now that we have a separate provision for that through the Budget as well as a separate provision for additional money for Hamlet and Troublesmiths it has given us more flexibility in that baseline number you are looking at there. That is not fully allocated yet, so that is why it does not add up.

It also includes an additional amount of money to respond to a PESRAC recommendation and because that money is new money it is not allocated yet so that is why I cannot give you a breakdown that adds up to that amount of money.

Ms WEBB - You probably can if you itemise those things as yet to be determined for this purpose. It sounds like the replacement came from the existing efforts that were being funded, Hamlet and Troublesmiths, which were part of the existing allocation which have now been replaced by the fresh increased allocation.

Ms COURTNEY - No, sorry for the confusion. I will get Alice to explain this in a moment. We have ongoing money for Troublesmiths and Hamlet which is in the base amount. We have provided them an additional amount of money on top of that, which are those two line items that are there. I will ask Alice to try to explain that. I am sorry if it is not easy, because particularly for Hamlet and Troublesmiths, they are in both buckets, to add to the confusion.

Ms WEBB - Presumably when you provide me with a number for the 2.68 this year, that will show that Troublesmiths and Hamlet sit there as well as over here in the COVID-19.

Ms COURTNEY - As well, yes, so those amounts that the secretary talked about are embedded up there in that base amount - sorry, that funding up there in that output group, 90.89, that is an additional funding amount provided to those organisations for that finite period of time. There is unallocated money in there for this current financial year.

Ms LOVELL - That was my question to clarify, so Troublesmiths, for example, got $52 500 in the 2020-21 Budget.

Ms COURTNEY - Yes.

Ms LOVELL - In addition to that they are getting the additional $220 000 and another $220 000 on top of that, but Glenorchy is not getting $1.3 million in this bucket and then another $1.3 million, that has just been transferred.

Ms COURTNEY - Correct. Sorry about the lack of clarity from us.

Ms LOVELL - No, that is fine. Thank you.

Ms COURTNEY - Do you want me to talk about Glenorchy and where we are up to? Alice has been working very closely with the council.

CHAIR - Are we moving on to that output?

Ms LOVELL - You keep saying Alice is going to speak and then she doesn't.

Ms HOLLINGWELL-JONES - As the minister has explained, we have $1.3 million committed to Glenorchy over two years and we have been working very closely with Glenorchy in the establishment of the first stage of their project. Stage 1 for the Glenorchy Employment Hub relates to three key foundational pieces for how the employment hub may look moving forward. The three key projects they are working through at the moment relate to the engagement of a workforce coordinator who will be helping to facilitate community engagement which, as the minister has expressed, is fundamental and core to these sorts of projects.

It is also looking to a consultant and they will be having a workforce plan developed. We'll build off the economic development plan that Glenorchy City Council has already worked on themselves. They will also be looking at the establishment of the governance committee that will sit over the job hubs. They're looking at both a steering committee for that high-level governance and decision-making as well as a reference group and they're seeking working members and people who are interested across their community right now. It closed on 15 November and we understand they had significant interest, which is great.

Ms WEBB - I presume we've moved onto 90.6.

CHAIR - I think we're doing them altogether.

Ms WEBB - It sounds like it's expected to be quite fruitful that the evaluation occurred at that early iteration of the programs.

Ms COURTNEY - Yes.

Ms WEBB - What are the plans for evaluation, capturing and monitoring outcomes for the ones that are currently now being funded?

Ms COURTNEY - Some of them have previously done their evaluation. I think Troublesmiths has engaged UTAS historically to evaluate their work and I understand that that was made public by that organisation. With each of the organisations, because we stand up a separate grant deed for each of them because they're quite different, those are the things that the department takes into consideration with the formulation of the grant deed. There's not a specific set of KPIs. That's where the department provides advice and embeds those within the grant deed. I'm sure that perhaps Alice or Jenny can speak further to that if they need to.

Ms HOLLINGWELL-JONES - They're embedded into the deed.

Ms WEBB - Performance information, I can see that on page 241, but there's not going to be an external evaluation in that similar mode?

Ms COURTNEY - We're not anticipating it. Depending on how this portfolio grows and evolves, that may be a consideration down the track but it's something we're looking at at the moment.

Ms WEBB - To clarify, can I ask a question about the Hamlet support? I'm a big fan of Hamlet and what they do. My understanding is that the work experience and support that's provided there doesn't necessarily result in a qualification or some formal training. Is that correct?

Ms COURTNEY - Alice might have the detail of that.

Ms HOLLINGWELL-JONES - Both the Hamlet and Troublesmiths programs are targeting specific cohorts and it's really around addressing specific barriers to employment for those cohorts, so it won't necessarily always lead directly into an employment outcome but it's certainly that training and experiential kind of opportunity that could then lead to those outcomes.

Ms WEBB - It wasn't employment outcomes I was asking about. I acknowledge it would be quite counterproductive for us to set an expectation about a particular level of employment outcome. We'd get what we see in employment agencies funded federally, where they just drive results for that instead of genuine outcomes for the individual. I was asking if they receive a formal training opportunity at Hamlet, potentially as part of their work experience there and support provided there?

Ms COURTNEY - I'd have to take that on notice in terms of what they do for each person who goes through the program. I know from speaking to them it's around looking at how you can get the right skill and the right support for the kids that come through. A lot of it is around pre-training skills so that they can embark on a formal training pathway, perhaps. It's almost the step before that.

Ms WEBB - Yes, that would be a wonderful outcome to capture too, not just employment outcomes, which I think sits at about 41 per cent which for that program is not too bad. It's quite impressive. Further training outcomes, as in transition to training, would be another positive measure to capture success.

Ms COURTNEY - I've just been provided some data. In terms of Hamlet's recent report, they've provided over 22 000 hours of work experience to 260 participants, 96 per cent participant attendance rate and 100 people have continued on to paid work. There's obviously merit in ensuring that these can continue into other training pathways. For Hamlet and Troublesmiths, their key focus is getting that level of engagement, and what the barriers are for people being able to make sure they are employable, and they can get the experience they need - and confidence, for a lot of these young people - before they take the next step.

A good example: today, one of my team went to get their lunch at Salamanca and noticed that one of the people we recently met at Troublesmiths is now working at a venue at Salamanca. For that participant, that has been a really good outcome, because that has been their objective. Having more formalised training pathways for them to go into - and as we talked about in hospitality, looking at how we can get more structured work into more career pathways there - is important too.

Ms WEBB - It would be great if you could provide information about whether there are some formal training outcomes that are captured within the Hamlet model, and also the Troublesmith model?

Ms COURTNEY - Correct me if I'm wrong, Alice. It wouldn't be a recognised training program that they run, but they work with the kids, effectively through a series of training modules. I think it's over a 12-week period, three months, and there's a mix of doing hands-on work, and different parts, in making the products and doing front of house. Within that, they also do peer-based learning - graduates from it come back and then teach the new participants coming through.

From speaking to many of the participants - and I'm probably using the wrong terminology - but it's almost that employability or that pre-employment pathway. For a lot of these kids it's simply building confidence to be able to do a training component. It wouldn't be a formalised one. However, particularly from what I've seen at Troublesmith, the way that they do it would lend itself, particularly for young people, to be able to transition in. Although it wouldn't be a recognised RTO-type training, within the organisation it is quite a structured training program. Effectively they have a training folder with modules that they work through over the period of time. Some of it they do at work, and some of it they do afterwards. From a pathway to be able to go into -

Ms WEBB - That's right, it prepares you for training.

Ms LOVELL - They work very closely with their participants, in getting them into formal training too, where they want to. As a comment, I was really pleased to see funding for Troublesmiths, because I know they had some real challenges when their federal funding was cut. It would have been a terrible shame to lose them, because they do some fantastic work.

Ms WEBB - Is it likely that the performance indicators that are put into those individualised contracts for those different things are goal-based - acknowledging that different

participants are going to have varied goals about where they might arrive? It might be employment, it might be further. It might have just been completed the effort.

In terms of measuring the program and how well it is doing, because they receive public money, do you put performance indicators in about those outcomes? So, it's not just raw employment or training, or whatever, but it's about how well they achieve the goals of the individual participants?

Ms COURTNEY - I might get Alice to talk to that.

Ms WEBB - The reason I'm asking is more from the perspective of, what if one day another organisation came and pitched to do a similar thing with a claim that they can achieve better outcomes? How would we know who might do better to get us value for money in that space?

Ms GALE - What we put as KPIs in the grant deeds varies. For example, Hamlet had already done, through the University of Tasmania, an evaluation on the social returns on investment. That evaluation indicated that they had a one-in-three return - three dollars for every one dollar spent - so in terms of value for money, and given the social benefits that provided, it is most likely that would have sufficed for Government. It does vary from program to program.

Ms WEBB - You can understand why I am asking the questions. It is not that I am questioning the programs, it is just good to know that we get effective as well as working programs.

Ms COURTNEY - With a portfolio like this we have an envelope of funding, and we have to make sure that you get the best outcomes. As with all parts of Government, I am also very conscious that every time we provide a grant it is taxpayer money, and so there is an obligation to ensure it is used prudently.

Ms GALE - The focus of the programs is so different. For example, in Hamlet and Troublesmith, it has been described as more about getting through some of the barriers that these young people have to accessing formal training or education. It might just be a matter of giving them confidence to access that, whereas others may have a direct pathway into jobs. On the continuum, it will be from that very early pre-job, or even pre-training preparation and removing the barriers to the end, which may be, as I said, into some jobs.

For example, in the Derwent Valley in the previous iteration we had some direct jobs as a result of identifying that transport is the key problem there, and so by putting in place regular transport to some places, people were able to pick up some casual and fixed-term work.

It is a very individualised, according to the program and the region in which the work is taking place.

CHAIR - Thank you, minister. We will let you do a changing of the guard and hope someone outside is well enough to come into the room to talk about women.

Committee suspended from 6.22 p.m. to 6.26 p.m.

DIVISION 2
Department of Communities Tasmania

Output Group 4
Disability Services and Community Development
4.5 Women's Policy

CHAIR -Thank you, minister. We are now onto the portfolio of Minister for Women. If you could introduce some new people at the table.

Ms COURTNEY - To my right we have Michael Pervan, Secretary of Communities; to my left Kate Kent Deputy Secretary, Community, Sport and Recreation; and to her left is Courtney Hurworth, the Acting Manager of Policy Programs within Communities, Sport and Recreation.

CHAIR -Did you want to make a fairly brief opening statement?

Ms COURTNEY - The Tasmanian Government is committed to creating a more inclusive Tasmania that empowers and enables women and girls to fully participate in our economic, social, political and community life.

I acknowledge the work of my predecessor, Jacquie Petrusma. In her six years of dedicated service for women she achieved a lot including the Tasmanian Women's Strategy, when that was developed, as well as the Women on Board Strategy 2015-2020. Over the five years of the Women on Board strategy, we have seen a significant increase in the number of women on government boards and committees. As at 30 June, the percentage of board positions held by women was 46.4 per cent, an increase of 12.6 percentage points on the number of board positions held by women since 2015. This is a remarkable achievement and our new Women on Board Strategy 2020-25 will continue this momentum and progress towards reaching a target of 50 per cent.

Working in hand with this strategy is the Women in Leadership scholarship program. The 2019-20 Budget allocated funding of $200 000 for this over four years. Today, I am delighted to open the next round of these scholarships, which is a joint initiative of the Tasmanian Government and the Australian Institute of Company Directors, to support Tasmanian women gain a greater understanding of the duties and responsibilities of being a board director.

With regard to this portfolio, I am advised by an outstanding group of Tasmanian women through the Tasmanian Women's Council. I thank immediate past Chair, Annette Rockliff, and current and former members in what has been a very challenging year. It is more important than ever that opportunities for women and girls are front and centre. To this end, we have refocused the Tasmanian Women's Council's broad purposes and functions to help advise government's strategic direction and leadership and workforce participation initiatives.

Workforce participation by women, where women can access the opportunities and rewards of our economy, is critical. Greater access to workforce participation supports small businesses, our regional and remote communities and will further support our state's recovery. Women are the backbone of our communities and this Government has continued to support the important role women play in community and civic life.

We recognise there is still more to do, however we have developed a momentum of progress and we are looking forward to more achievements over the coming years.

CHAIR -Thank you, minister. Tasmania can be proud of the number of women in our parliament. As elected members, we are leaders in that and also the significant progress made by women on boards. There are a few areas I want to ask about in relation to some of the comments you have made but also some of other areas that you have not touched on.

COVID-19 has had a particularly significant impact on women and girls regarding employment and other aspects. My question to you is, first, in relation to the Budget. When the Budget was being developed, as Minister for Women, did you actively look at the gender impact particularly in the terms of the impact on women of all the policy decisions that sit behind this Budget?

Ms COURTNEY - Regarding the broader impact of women through the Budget and policy development across Government we have the Cabinet process which has a number of women on it and also me as the Minister for Women. In the development of policies - whether that's part of policies that go into the Budget or policies that are developed outside the Budget process - all of those are looked at through a prism both from a policy perspective, where we have the PLP with lots of female participation and we have Cabinet where we look to how we can ensure that all sorts of areas of the community are represented through policies. Gender is definitely one of those and a very important one, however, it is not the only area.

CHAIR - I'm not suggesting it's the only one; but we're only talking about the Women's portfolio.

Ms COURTNEY - About women.

CHAIR - Yes.

Ms COURTNEY - Through me, Elise Archer and Jane Howlett being on Cabinet means we are able to ensure we have that oversight from senior women and it is an important way to look at how policies have an impact.

CHAIR - Do you measure in any way the gender impact? You talk about the high level of engagement around the table and it's important that there are women at that table. It would be good if the table was half women but you've still got a way to go in the party to achieve that.

I am interested in how you measure - if you do actively measure - the gender impact of these policy decisions.

Ms COURTNEY - We have three women's portfolios through the strategies that we have implemented and the actions that underpin those, and we are still in the process of developing our Leadership and Participation Action Plan. We're looking at how we can deliver outcomes and through those outcomes we can measure what is being achieved. Women on Boards is one type of leadership metric but we look at other metrics - in terms of participation of women within government and particularly through the initiatives that we have within this Budget. The funded initiatives of $400 000 plus $2.5 million allows us to partner with a lot more industry organisations to ensure the learnings we have from government, and indeed some of the community perceptions about women's participation in those industries, can be addressed.

CHAIR - I'm really pleased to see - and I am sure you supported it too - the Premier's support for the Supporting Industry Pipelines for Women - it's a pilot project that we started up in Burnie. Shannon Bates and I met in my office some time ago to talk about 'his brilliant idea' so that was really positive and it's followed all the way through.

Let's look at the decision by the Government in this Budget to focus particularly on spending on infrastructure - a lot of it's not new, but continuing the focus on roads and bridges and the like. It's a challenge because we know there's a very low level of women participating in those workforces in construction. Even with social housing and the focus there, we don't have a lot of women participating in that side of the construction industry either.

Did that raise any concerns for you that it was a really big focus of this Budget?

Ms COURTNEY - There are a couple of things that I want to mention. First of all, there are other areas of government that have had a significant increase in funding. We did Health this morning and a significant part of the Health workforce is women. Through structural increases in funding in other parts of our portfolio and particularly in the Health portfolio, the provision of a number of new full-time positions across that area will be beneficial to women. I also think the attention on some of the aged care areas as well - while our state government only provides funding for a small number of those, I expect the private sector and the federal government have an expectation that we are going to see increased employment there.

From a building and construction perspective and the investment the Government has put in, we know from experience, and this isn't just here in other places, in ways to help drive and stimulate our economy, investment in infrastructure and construction are very effective ways to do that.

As a Government that is looking at an economy that earlier in the year had for many areas virtually ground to a halt, we had to act decisively to ensure that the economy didn't go into a full recession. We needed to ensure that we acted swiftly to ensure that we could get money out of the door quickly and to do it in those areas that create those multiplier effects.

Building and construction and infrastructure are those. I accept that the direct employment from that at the moment, considering the participation of those industries, is more men participating in those industries. However, we know that the multiplier effect across other areas of the industry is beneficial more broadly in other areas of the economy and where women have higher participation.

One of the things I'm really pleased with in the Budget, we got the $400 000 for the supporting industry pipeline. What is not shown in these Budget Papers, but was highlighted in the Premier's speech on Budget Day was as part of the COVID-19 provision in Finance-General we also have $2.5 million to be able to work with industry on ensuring that we are providing the pathways for more women to participate in those industries.

It is something I feel really passionate about. I have been minister for some of those more primary style industries before and the building and construction industries. We've got strong relationships as a Government and I personally deal with a lot of these organisations and peak bodies. I have had extensive conversations over a long time with them about how we can partner with them, not only to look at some of the learnings we've had through Government and the extensive policies that I feel any one of my colleagues at the table here could talk about,

but it is also about how we can do those practical things on the ground to help ensure that we have those training pathways. We want to ensure we are breaking down those barriers and through the leadership initiatives that we are also doing it from a policy perspective and that we are encouraging more senior women into those industries so they have mentors.

To have $400 000 plus $2.5 million is a significant amount of money for this portfolio. I'm very confident from the conversations I've had with industry and the ideas we've been kicking around, and from what you've said, the experience that we have, we'll be able to use what is a time of stimulus in those building and construction style infrastructure industries, use that to be able to ensure we get a strong foothold -

CHAIR - Sorry to interrupt, but to try to get a couple of questions in this area. How do organisations, groups, people who have ideas about this actually access that funding to establish programs? I know there are companies that I've worked with and in Queensland there is a company there that has all women crews on road crews and things like that. How will that be achieved?

Ms COURTNEY - With the funding that's been provided, the $400 000 and that support we are looking at - it hasn't been finalised yet, but we're getting to the final stages of a project to be able to go out and start recruitment to have positions to be able to support that. That part of it is well progressed.

In terms of the $2.5 million from the COVID-19 provision, that was only announced last week - the Budget seems like a long time ago - sorry, two weeks ago. I've been looking at this Budget for a long time. We've had preliminary engagement regarding this funding, the $2.5 million. However, we've had quite a long-term engagement with them about what we can do. That is the work that will be happening in the coming weeks and months. That will be the roll out of that, considering that it's in this year's and next year's budget.

CHAIR -Through expressions of interest, or how will it be done?

Ms COURTNEY - That's what we're working through with industry at the moment. On the expectation that we will look at some of these different industries, because it's not just building and construction. It's around a lot of the service providers that go into that. We also know in the mining and minerals industry as well as agriculture and energy. So the pathways will be slightly different.

I also know from engagement with a lot of these peak bodies that each of the different sectors has got different levels and some are further along the journey than others at how they encourage more women to participate.

Some industries have very good programs in existence already that we can work with them and partner with them and bolster. Other ones perhaps do not quite have that yet so it is how we also look to those industries and help them take some of the more preliminary steps that have not been taken yet. We have some great Tasmanian companies. As you would know, we have many of the leaders within these organisations and these sectors. We do not have to change any mindsets there. There is a strong belief that this is not only the right thing to do socially, it is the smart thing to do economically. It is how we do that.

This will be framed up in coming weeks, but part of it is also how we break down some of the misconceptions within the community. From engagement with a lot of women who have entered some of these non-traditional areas, one of the biggest barriers for them were perceptions of their family and friends, not the perceptions of the employer. I have heard many, many stories of a young girl coming home from school and saying, this is the career path and dad saying 'over my dead body', perhaps remembering the culture of the workplace in a mine or on a work site or building site maybe 20 years ago. It is how we break down some of those perceptions.

CHAIR - Stereotypes.

Ms COURTNEY - Stereotypes. Also I know from talking to many employers and particularly some of the smaller employers, how we assist them to have the confidence to have girls and women on their sites because that can be a barrier for them. They have perceptions and they very much want to create opportunities themselves.

CHAIR - Maybe they could take them down Grange Resources, which has a lot of women driving trucks. They look after their trucks much better than the men.

Ms COURTNEY - They do a great job. I remember one of the ladies I met who was driving one of those trucks. One of the added benefits from these industries, and this goes to what we were talking about before, Ms Webb, was around a lot of these industries have good opportunities in permanent roles rather than casual ones. I know one of the ladies I spoke to -

CHAIR - And higher paid.

Ms COURTNEY - at Grange had worked in a different sector. She was working casually and was a single parent. In her former role she was not able to get loans and things like that, or have access to paid parental leave. This new role created that opportunity and she said that her view on that workplace as a woman was she was accepted and embraced whereas in her previous roles in other industries she wasn't. That, for her, was a light bulb moment that was completely against her perceptions as well. There are a lot of perceptions in different areas, but there are a lot of good opportunities.

CHAIR - There are other areas I want to go to. I have another line number but Meg might have a question on this particular matter. Then we will come back to other areas.

Ms WEBB - More back to where you started, if we can.

I am going to take you back to where Ruth started with her initial question to you, minister, which was around the concept of a gender lens on policy and a gender impact assessment on policy. To begin there, you would be well aware that it is standard practice in many jurisdictions, in fact it was standard practice in the federal government here until relatively recently, that a gender lens and a gender impact assessment was done, particularly on the budget. It is a very normal thing to do and it is important for effective policy development and effective accountability around policy decision-making.

That is what the member for Murchison was asking you about initially in terms of whether there is a presence of that in this. It is not about how many Cabinet members are

around the table who happen to be women or being able to provide a perspective. It is about tangible assessment at a policy development stage, decision-making stage and reporting stage.

We can take it as read that you are not currently staffed as the Minister for Women to have that provided to you and then through you to the broader Cabinet. You are not staff currently -

CHAIR - Is that a question or are you asking a question?

Ms WEBB - I am getting to a question. It would appear from your answer to Drew's question to have provided to you a gender lens statement about policy being considered by Cabinet and the decisions made there or a gender impact statement around the Budget later.

My question is, what resourcing would be required for you as Minister for Women to be provided with those two things? That information, a gender lens assessment of policy to take to Cabinet on all policy and a gender impact statement to be delivered associated with the Budget or further to that mid-year financial reports, but that accountability? I would like to hear from you a commitment to identifying what resourcing would be required to have that provided to you as Minister for Women and then a commitment to advocate for that. I think you would find the Premier receptive to that advocacy. I do not believe the resourcing that would be required would be unrealistically high and it would be a tangible way that you as minister could deliver on that? I am looking for a commitment.

CHAIR - Could the minister answer the question? There are a couple of questions there first and a request for a commitment.

Ms COURTNEY - Without having advice on the resourcing I can't make a commitment.

Ms WEBB - The first commitment was to identify the resourcing required.

Ms COURTNEY - I understand in the Premier's hearing he took on notice some questions around his commitment around this. I am conscious of the preparation of budget papers and preparation of the Budget is resourced through Treasury, not through Communities Tas. We put up a range of budget bids for initiatives. As the Minister for Women, my priority is within an envelope of funding. Noting the fact, we have always had finite resources within Government and scarce resources, because we want to use taxpayer money effectively, our focus has always been within the Communities' portfolio to utilise the funding we have to get the most action and the best outcomes we can in participation and engagement.

I would not want any of the resources I have in this portfolio not doing what they are doing now and that is why I am excited to have additional resourcing for the supporting industries pipeline for women and the additional recruitment will be under way soon to be able to support that.

With regards to a process around the preparation of Budget, my understanding is the Premier took that on notice. I do not want to go to an answer the Premier has already taken on notice to reply back to the Committee.

Ms WEBB - I don't believe he took that particular element I am asking of you on notice. As minister for Family Violence he took it on board to consider a gender impact statement and

the value of that in relation to the Budget. That is my understanding of what he took on notice yesterday. What I have asked for from you as the Minister for Women is a commitment to not re-spend or take away from what you are already doing - although in the context of $3 million-odd over the next little while it probably wouldn't take away a great deal of that - but a commitment to identify the resourcing that would be required, which I think you could do within current resourcing. Identify the resourcing required to do those two things - gender assessments of policy to feed into Cabinet and then a gender impact statement on the Budget; which isn't about forming the budget. It is about assessing the budget once it is formed and being able to make a statement about how it impacts in regards to gender.

It is not about budget formation. It is a piece of policy assessment work that is done separate to that. Will you commit to identifying the resourcing that would be required to provide that as a first step?

Ms COURTNEY - Yes, I will take that on notice.

Ms LOVELL - I had a question about women on boards and there has been some progress with some numbers released recently. My question is about paid board positions and I think this is not too bad. I am expecting what it will tell us is pretty good. My question is specifically in relation to the number of women compared to the number of men on boards. Comparing the number of paid positions held by women and men and then comparing the number of men on board. Comparing the number of paid positions held by women and men, and then comparing the level of remuneration for those positions.

Ms COURTNEY - Ninety-six boards and committees provided a remuneration to their members. Women held 49.4 percent of positions that are remunerated through annual sitting fees. Women received a total of $4 117 277.60 in annual fees at an average of $9 097.28 per member, while men received a total of $4 215 830.25. We like our decimals in this portfolio. And an average of $9 034.06 for consistency for per male member.

CHAIR - I was going to go to this area with the women on boards. On our Government boards, are you able to give us the total number of board positions there are, the number held by women, and men too, if you like. There are a number of men and women who sit on multiple boards and we talk about the number of boards that women are on, but it might be one woman on 10 boards. I am trying to get the break down to the number of women.

Mr VALENTINE - Trying to find how many bodies.

Ms COURTNEY - I've been told we have taken that on notice, so we have the data, so rather than reading through the list of names, we can provide that to the Committee.

Mr VALENTINE - The number of bodies really.

CHAIR - I am interested in whether women. If you have got say -

Ms COURTNEY - I don't have actually, so -

Ms WEBB - We don't need to know the men, if we are asking for the number of women.

Ms COURTNEY - I thought it was from a comparative perspective.

Ms KENT - As of 30 June 2020, there were 907 filled board positions which were held by 762 individual board members: 421 were women and 486 of those of men. Of those individual members, 46 women and 48 men held two or more board appointments.

Ms LOVELL - Sorry, of the 762 individuals who hold those board positions, how many are women and are men.

Ms KENT - There are 421 women, and 486 men. There are a number of women and a number of men who hold two or more board positions.

Ms LOVELL - If we could get the breakdown of the 762.

Ms COURTNEY - Okay.

Ms KENT - We have the names of all the women that held multiple positions

CHAIR - When you provide that answer, can you provide the number of boards they are on, because there is an issue with governance around here once you are on too many boards. There is some good governance principles around this. I would be interested in the men who are holding multiple board seats.

Ms COURTNEY - We can do that and it is also quite helpful having a list of what they are on because there is a range of committees that don't have many sittings during a year, and maybe called upon only occasionally. So the context of what they are, is important. Obviously the workload being on Hydro is very different to being on an advisory committee that might meet once a year.

Ms LOVELL - Further to the position of our boards, do you have a breakdown of the number of men and number of women holding volunteer positions or unpaid board positions?

Ms COURTNEY - I believe we do. If we don't have it here, we can provide it on notice. I don't seem to have it here.

Ms LOVELL - That's okay. I'm happy for you to take it on notice.

Ms COURTNEY - Yes, I might just take that on notice.

Ms LOVELL - Thank you.

Ms COURTNEY - This is the end of June, I'm assuming. The number of women on unpaid boards or committees is 137 and for men, unpaid, it's 206.

Mr VALENTINE - Do you have the number of women who are chairs of boards compared to the number of men who are chairs of boards?

Ms COURTNEY - Women held 33.3 per cent of all chair positions, and 53.8 per cent of all deputy chair positions.

CHAIR - That's on the paid boards?

Ms COURTNEY - That's on all but I don't have the breakdown of chair positions on paid boards though.

Mr VALENTINE - That might be interesting to get, if you have it.

CHAIR - Is that possible to provide with the other data you're providing or is it -

Ms COURTNEY - We should be able to. However, my only caveat is we have to get these done by the end of the week. We might have to go back to the source data and often we might have to go back to agencies to get that. We collate the data but it's produced by agencies. Yes, we can, but we might not have it readily available by your due date, but we're happy to provide it.

CHAIR - I think our due date here is Monday.

Ms COURTNEY - We will make our best endeavours. My only caveat is because we're reliant on other agencies for their information -

CHAIR - And we don't need everyone working all weekend.

Mr VALENTINE - No.

Ms COURTNEY - which is one of pulling this data together. We're relying on a lot of reporting.

CHAIR - Okay. Are there any other questions on women on boards? No. I was going to go onto another area, minister. It has been raised with your predecessor - access to low-cost termination of pregnancy in the state. We have legislation that provides the framework for this but we don't have a policy position that provides for it.

As the Minister for Women, what representations have you made on behalf of women, particularly from the outer reaches of Tassie, like the area I represent, to access low-cost termination of pregnancy?

Ms COURTNEY - Provision of low-cost termination of pregnancy is something that as both Minister for Health and Minister for Women I'm committed to ensuring that we can continue to achieve that. Obviously, given private service providers and the way the market has shifted and evolved over time, has put some challenges into that. It's something that I'm committed to so they are available.

There are circumstances where women need to travel and the Government provides PTAS for women to be able to do that. We also provide funding to a range of prescribed providers to assist women in terms of contraception, termination, and decision-making around this. It's an area that we're very focused. As the minister, I'm focused on looking at where opportunities can come in the future, particularly for regional areas.

I'm also working hard because another area of need is around education. When I say education, it's about the provision of information for people. One of the things that became apparent to me is that provision of information that's easily accessible, accurate, timely, is something we can do better in. We're working with some women's organisations on how we

can do that better and also how we can work also with GPs and our primary carers to ensure that they've got the information pathways as well.

CHAIR - Minister, wouldn't you agree that providing PTAS to a woman from Marrawah to go to a private facility in Hobart - when she's in a vulnerable position, may have other children that she needs to provide and arrange care for, has a partner who she may not want to know - that's hardly adequate and that it needs to be a service provider much closer to home, particularly when we are talking about surgical termination? Medical termination should be available in our regions, but in terms of surgical termination?

Ms COURTNEY - Perhaps when we had the Health people here because through one of the deputy secretaries in the department of Health, we've had a lot of engagement. We had Hampden Park that did not end up standing up. It's an area that we continue to actively look at to see what service providers might be available -

CHAIR - Will you actively negotiate with the North West Private Hospital, for example?

Ms COURTNEY - With regard to provision of private services, the Government will continue to look at what service providers are available. We have to look toward what providers are in the market, and there are varying providers. There are different degrees of willingness and I'm conscious of that. I would have to seek advice from the department of Health because I don't have the right officials here -

CHAIR - You're committed to making it accessible in every sense of the word, not just giving people money to enable them to travel, but to provide access closer to home for those for whom travel is problematic?

Ms COURTNEY - I accept that. It's something I will continue to look at, how we can find solutions for women. I believe that women should be able to have access to the full suite of reproductive services and not just the actual service, but the support around it that they need. When I came into these portfolios, it's something that I felt strongly about and something we will continue to focus on.

CHAIR - Including it in your next service level agreement with the THS would be a start.

Ms LOVELL - There are four pretty conveniently spaced public hospitals around the state.

CHAIR - That's correct. Putting it into the service level agreement would be one apparently foolproof way of doing it. Does anyone else want to follow-up on that, or any other matter? No other questions? There you go, minister. Thank you.

Ms COURTNEY - Thank you. I appreciate the committee's time. I have been remiss as I haven't thanked each department as they've stepped down from the table. I'll do an omnibus thanks to these extraordinary people who not only have helped with the budget papers, but the work of the department this year under extraordinary strain because of COVID-19 to be able to deliver business-as-usual activity has been extraordinarily difficult. Each of the departments has had significant resourcing being deployed to COVID-19 response. I'm very grateful for everyone's work.

Mr VALENTINE - I don't reckon they've seen too many weekends either, that they can call their own, put it that way.

Ms COURTNEY - There's still more to go. Thank you very much.

The Committee adjourned at 7.03 p.m.