Tuesday 7 June 2016 - Estimates Committee A (Ferguson)

LEGISLATIVE COUNCIL

ESTIMATES COMMITTEE A

Tuesday 7 June 2016

MEMBERS

Mr Farrell
Ms Forrest (Chair)
Mr Gaffney (Deputy Chair)
Mr Hall
Mrs Hiscutt
Mr Mulder

SUBSTITUTE MEMBER

Mrs Armitage

IN ATTENDANCE

Hon. Michael Ferguson MP, Minister Health, Minister for Information Technology and Innovation

Ministerial Staff

Peter Poggioli, Chief of Staff
Kyle Lowe, Adviser
Melanie Pastoor, Adviser

Department of Health and Human Services

Michael Pervan, Secretary
David Nicholson, Deputy Secretary, Corporate Policy and Regulation Services
Michael Reynolds, Chief Financial Officer
Pip Leedham, Acting Deputy Secretary, Purchasing, Planning and Performance
Mathew Healey, Director, Strategic Projects
Erin Wise, Manager, Budget Development and Advice, Budget and Finance
Dr Leonard Lambeth, Chief Psychiatrist
Narelle Butt, General Manager, Mental Health, Alcohol and Drug Directorate
Jodi Glading, Registrar in Medical Administration, Planning Purchasing and Performance
Paul Templar, Acting Chief Executive Officer, Ambulance Tasmania
Mark Veitch, Acting Director, Public Health Services
Peter Boyles, Chief Pharmacist

Ben Moloney, Project Director, Royal Hobart Hospital Redevelopment
Lisa Howes, Manager, Office of the Secretary

Tasmanian Health Service

John Ramsey, Chairperson Governing Council
Dr David Alcorn, Chief Executive Officer
Craig Watson, Acting Chief Operations Officer
Eleanor Paterson, Acting Chief Financial Officer
Dr Ruth Kearon, Project Director, Maternity Services - NW
Michelle Wickham, Acting Chief Financial Officer DHHS

Capital Investment Program

Ben Moloney, Project Director, Royal Hobart Hospital Redevelopment

Department of Premier and Cabinet

Rebekah Burton, Deputy Secretary
Ruth McArdle, Director, Office of eGovernment
John Willson, Assistant Director, Office of eGovernment
Piero Peroni, General Manager, TMD
Michael Mulley, Executive Manager, Finance and Business Development, TMD
Katie Ault, Commercial Strategy Manager, TMD
David Strong, Acting Chief Operating Officer, Corporate and Governance Division

Department of State Growth - ICT and Innovation

Bob Rutherford, Deputy Secretary Industry and Business Development
John Perry, Coordinator General
Matt McGee, General Manager Client Services
Catherine Forman, Liaison Officer

The committee met at 8.59 a.m.

CHAIR (Ms Forrest) - Good morning, minister, and welcome to Estimates in our fine Chamber. You know all the members across this side of the table. If you could introduce the staff on your side, for the benefit of Hansard?

Mr FERGUSON - Good morning to you, and members of the committee. Thank you for the welcome. I introduce Mr Michael Pervan, the secretary of the Department of Health and Human Services, and congratulate him on his appointment after previously having served as acting secretary and deputy secretary. I also introduce Mr David Nicholson, the deputy secretary, Corporate Policy and Regulation Services.

CHAIR - Thank you. I assume you would like to make an opening comment about the Health portfolio, to lead us off, and then we will have questions. An overview first generally, and then we will go down to the output groups.

Mr FERGUSON - Thank you, Chair. I have a brief overview of the Budget. I am very grateful to serve Tasmanians in this role as minister for Health. It has been now two years that I have been in this role, and I think it is well-known that since coming to office there have been a significant range of issues that have needed to be given attention and to be addressed. The health system generally, and the state in which it has been found by the Government, some significant integrity and governance challenges, and of course, the Royal Hobart Hospital redevelopment, which needed attention. My focus and that of this Government has been on addressing all of these in a systematic way, so that our work and our health system generally actually helps Tasmanians who need our care.

We are making progress, and the budget that we have brought down and which will be examined today shows that the Government is continuing a record investment in our health system. There is an additional $51 million incorporated in this budget as new resources from the state Government for frontline health services and it brings our total budget for this budget and the forward Estimates to $6.4 billion. We want the additional funding to demonstrate our commitment to building a better health service for Tasmanians. And that sits, of course, on top of last year's additional $100 million. Of those funds includes nearly $30 million for new and improved hospital services to deliver better outcomes for patients under our one health system reforms. Clinical services are being consolidated into sites which are capable and equipped to deliver services safely and efficiently.

Additional funding is also being provided to target obesity and smoking under our soon-to-be unveiled Healthy Tasmania strategic plan. It also provides additional support for patient-first initiatives, which are actions designed to ensure hospital emergency departments are treating people as quickly and safely as possible. And there is funding for mental health priorities, as identified in our Rethink Mental Health 10-year plan.

Importantly, the Government is continuing to roll out more than $180 million in existing health priorities, including our $76 million commitment to our elective surgery plan; $24 million for patient transport and accommodation services; nearly $17 million for the operational costs of the newly opened Northwest Cancer Centre; and our resources to tackle ice and other drugs.

Our commitment to Tasmanians to have state-of-the-art health facilities is why we are investing more than $515 million of state and Commonwealth funding into frontline health infrastructure that will benefit generations to come.

I welcome the Estimates process and thank you for the opportunity to be here and look forward to answering your questions.

CHAIR - Thanks, minister. In terms of the overall picture to start with, you talked about record investment of $51 million additional frontline health services. Can you expand on those and how that will actually be spent? What are we actually investing in? People, projects? What are they?

Mr FERGUSON - Chair, are you asking me about the new initiatives specifically?

CHAIR - You mentioned $51 million of additional, but I think it was $100 million you put in

last year, so are they human resources, where is this money going? I want to lead on to another question, but knowing what answer you give.

Mr FERGUSON - The funding from last year's Budget was a $25 million allocation across each of the years across the forward Estimates. That was about providing additional support to the THS for its services that it provides through all of its activities. And yes, by far the majority of those needs of the costs base of the THS is personnel, is people, health professionals. Much the same can be said about our additional $51 million, which has a breakdown in the papers and they are targeted - they are more targeted, this year, if you like - and they describe in broad terms, as I have just done in my opening statement, the improvements that we want to make through Patients First in our emergency departments, and the extra funding for the mental health priorities, which if you want to ask me questions about that, I can talk.

CHAIR - I am interested in the number of staff. How many additional nurses or other allied health workers or people that make up your salary cost, your employee expenses, are included in this amount?

Mr FERGUSON - Madam Chair, I am happy to. I want to provide you with the answers that you are looking for. I can describe the funding and how it has been targeted and for what outcomes it is designed to achieve, or I could talk to you about the actual employment that occurs across the organisation.

CHAIR - I am interested in numbers at the moment. We will get to services. Numbers of people, I am talking about.

Mr FERGUSON - So that is a different question, as to the employment numbers, which I am happy to provide. What would you like me to give you? I can give you FTEs.

CHAIR - Additional nurses, allied health professionals, I am interested in how many more you are employing and in what areas?

Mr FERGUSON - I need you to tell me, are you looking for year-to-date in the current financial year, or are you asking me to describe how the new funding and what numbers of extra staff it might employ. What are you asking me for?

CHAIR - Can we look at how many nurses are employed in the last financial year, and how many nurses are employed - I am looking at, are there increases in nurses in front of patients basically, and not just nurses, but allied health professionals and others relating to the frontline services that you mentioned at the beginning. I am not trying to be difficult here. I am trying to make sure we get the answer to how many people there are delivering services to Tasmanians.

Mr FERGUSON - I can do that. I want to be a help to the committee. I have a table here which I can describe and give it numbers on, for example nursing staff and what the trends are in employment numbers. The latest data that we have on this is for the pay period ending 26 March 2016, and year to date - well, sorry, at that point in time, the number of nurses, 3347.82 FTE. Total employment in the Tasmanian health service at the same time, same date, 8006.16. If you are interested in trend, that compares with two earlier financial years. I have end-of-financial year for each of the two previous financial years. So for nurses previously on last pay period, June 2015, that was 3267.64, and for the financial year prior to that, June 2014, last pay period, 3255.46. So you can see a trend to in fact employ additional nurses in THS.

For the whole organisation, I have already provided the figure for March, but the previous end of financial year, June 2015, was 7814.29, and the prior financial year to June 2014, 7955.5.

CHAIR - So there is a reduction and then an uplift again. Is that what you are saying?

Mr FERGUSON - There has been a consistent uplift in nursing numbers.

CHAIR - Overall, I am talking about?

Mr FERGUSON - Overall, there was a one-year reduction, and it is, the March 2016 number is the highest it has been.

CHAIR - Yes. So what number is that?

Mr FERGUSON - That is 8006.16.

CHAIR - The reason I am interested in these figures is Health has been a never-ending nightmare in trying to figure out where the money goes, how much we spend, what we spent it on, and where there are cuts, increases, whatever. So when we just look at the Statement of Cash Flows in the THS, going to there, but also when you look at it in budget paper 1, the General Government Income Statement, I raised it with the Treasurer yesterday, we have seen only increases of 0.9 per cent, 0.8 per cent, and 1.9 per cent over the forward Estimates in the total employee expenses. That is the general government sector.

In the THS, for example, I have not actually worked these out, because I brought 2015-16 down by mistake, the other one is up in my office; they look exactly the same from the front, except for the numbers. We should have different colours in each year - maybe a little tip.

Mr FERGUSON - We take that on board.

CHAIR - However, they are still not the increases. If you have a 10 per cent wages policy, you are increasing the numbers of nurses. You are allegedly increasing the number of staff right across here, after a bit of a decline last year. So how are we doing that? What is happening? Are we not paying people as much? Are there fewer people? How does it work?

Mr FERGUSON - I do not actually understand the question. The nurses in fact have been consistently trending up, although the organisation has fluctuated in FTE. Are you asking me how that is occurring?

CHAIR - Yes. Are there savings being made in other areas that equate to employee costs that it make it very difficult to understand how, or be confident in the accuracy of the numbers.

Mr FERGUSON - You have not asked me about the Department of Health and Human Services, which I could equally provide you with numbers on employment there which sees a reasonably significant decrease in employees in the department.

CHAIR - Yes, but the THS is not DHHS.

Mr FERGUSON - That is correct, yes. What I am saying though is that to get the bigger

picture, you see a significant reduction in the public service in the department. There has been a significant volume of work to streamline the Department of Health and Human Services. Together with that, you may remember from our first Budget two years ago, where there were significant savings initiatives that were Government policy, which have been, I think, successfully implemented at the department.

Then we have actually produced significant additional resources for frontline services, and predominant among those is the funding for elective surgery, the $76 million. We have responded to the demand pressures that we have had in the THOs and the now THS from the point of view that we have been continuing to meet the needs of the community.

What you are seeing there is that the organisation's employment policies to a great degree are a reflection of the resources that it has been provided by the department. That is, the department purchases services from the THS and the THS have used those resources to employ staff.

CHAIR - I am going to try to take a bit of a journey through these budget papers, all three of them, to get a full picture, if necessary.

So the THS is only the one output group in budget paper 2 in the DHHS section, and this year's Budget total is $1.368 billion. Normally I write these things down. Last year's Budget amount shows $1.355 billion. So it appears there is a small projected increase. The policy and parameters statement shows budget policy changes of $10 million and budget parameter changes of $20.9 million, making the total change for the estimated outcome for the Tasmanian Health Service Budget for 2015-16 $30.9 million. That is in the policy and parameters statement.

Does this mean that the estimated outcome for the Tasmanian Health Service this year is $1.386 billion, compared to last year's Budget of $1.368 billion, what appears to be a reduction in spending of $18 million? I am trying to follow the numbers.

Mr FERGUSON - Chair, I would like to introduce Michael Reynolds, the chief financial officer for the Department of Health and Human Services. I invite him to assist with the response and to characterise how the numbers have been laid out, what factors have contributed to the fluctuations, and also to describe how the state Government's additional funding actually provides an additional resource in that context to the THS.

Mr REYNOLDS - Thank you, minister. If I may, Chair, I will take you back to some of the comments made earlier in the reply to the Budget, looking at the UPF statements. You made comments about the 2015-16 estimated outcome and looking at the Health table was going to be $1.6 billion thereabouts, but next year it reduces to $1.591 million, a reduction of about $52 million in movement.

There are a couple of reasons for this. One is that 2015-16, we are actually having a spike, or increase, in what I describe as one-off-type expenditures. There was, for example, a carry forward of some $5 million in elective surgery from the previous financial year that will be spent this year. That will not be an ongoing issue, because it goes back to the $20 million allocated as part of the Budget and forward Estimates. So that is an amount that will not be reflected in 2016-17.

We also had a payment to the Commonwealth related to the aged care and disability cross-billing. This is related to the NDIS and is subject to ongoing discussions between the state and the Commonwealth for some time, and it actually relates to amounts dating back to 2013-14 and 2014-

15. We had an amount of $27 million, nearly $28 million, associated with that particular issue which will not be reflected in the 2016-17 Budget, and it drops off by the tune of $20 million because it is a one-off type of payment.

So between those two items, we have over $25 million in funds that will not be needed or required essentially in 2016-17.

The other issue that is well known, of course, is the relationship with NPAs and what is known in that space. We do have a number of NPAs expiring, both this year and next. This year's estimated outcome includes payments of around about $64 million in NPA funding. The 2016-17 budget, there is $29 million worth of NPA funding from the Commonwealth that we would expect to pay. So there is a reduction in $45 million.

So those three items alone total almost $58 million in expenditure and differences that will not be incurred in 2016-17 financial year. So whilst it looks like a reduction or movement in that sense, it is because of the nature of the particular payments being made in this financial year.

CHAIR - Going to policy and parameter statement page 60, budget paper 1, under the parameter adjustment over those forward Estimates, you have $15.1 million 2015-16; $12.2 million in 2016-17; $12.7 million in 2017-18, and $11.3 -

Mr REYNOLDS - So you are referring to the shared term for THS?

CHAIR - Yes.

Mr REYNOLDS - We have identified, particularly through the consolidation that has happened with the THOs and the review, more generally, that is going on with their own source revenue, that they have identified that there is opportunities to increase the revenue estimates by those particular amounts over the budget and forward Estimate years.

CHAIR - On what basis are they doing that?

Mr REYNOLDS - I know the CFO of the THS will be better placed to answer this question than I, but I know for example that they have been conducting reviews of the revenue estimates to identify opportunities to improve their revenue collection, for example, and also how they code various activities that gives them a great opportunity to recruit revenues from the Commonwealth.

CHAIR - On page 72 of the policy and parameters statement, or some of the commentary around agency revenue from the Tasmanian Health Service, it notes there that increase of the full Tasmanian Health Service reflects an upward revision of its own source revenue with the Private Patient Scheme of $2.3 million, it is a small part of it, obviously; Children's Dental Benefit Scheme, $5.8 million; and the Training More Specialists program of $2.2 million. Which is $10.3 million, which is a portion of it, obviously.

In terms of the Private Patient Scheme, there has been some criticism, I guess, that there is a desire - this is to you, minister - about our private patients being encouraged to have their surgery done in the public system, rather than using their private cover. I absolutely understand there are some patients who need to be treated in the public health system, even with private cover.

Is that a real issue at the moment? People are suggesting that if you have private cover, then

you should be using the private service and making room for those without in the public system. Is it a perception or a reality that privately insured patients who could be using other services are tying up public beds?

Mr FERGUSON - I will ask the secretary to assist me in a moment on that. The publicly funded and publicly available Tasmanian Health Service is available to everybody. There is no preferential treatment either way, particularly when it comes to services which are critical or of an emergency nature. Additionally, a person, their status as to whether they are a policy holder with private health insurance is not a consideration when it comes to whether a person should be given a service. Not only is that -

CHAIR - We do have universal access. I accept that.

Mr FERGUSON - Correct, but not only is that our policy, but it is also the rules that are imposed by the state by the Commonwealth legislation, I think it is the Medicare legislation. No doubt you are already aware of that, but that is the opening preamble on the way that we treat our patients. If the person is privately ensured, they also have the opportunity to elect to tell the THS that, and to allow us to claim against their policy as a health service provider. I do note that we are paid a significantly lower amount for that, but nonetheless, it is a source of revenue.

CHAIR - A lower amount than what?

Mr FERGUSON - It is a lower amount than a private hospital would be able to charge the same person for the same procedure in a private hospital, as a function, I suppose, of the Medicare funding that the state receives from the Commonwealth.

I am quite happy to invite the secretary to add to my answer, but I am not sure that there is a concern per se that I am aware of that we are certainly not discouraging or encouraging people to make any particular choices. I would happy to widen the conversation to include the secretary.

Mr PERVAN - Thank you, minister. I can only add a little to what the minister has already provided. The decision to admit is what comes first. So the patient has already been effectively admitted for treatment. Then we are required to give them the opportunity to elect to be public or private. It is part of the Health Insurance Act and the healthcare agreements between us and the Commonwealth that people be given the opportunity to elect to be treated as a public or private patient in a public hospital. There is no protocol or system or practice whereby that simple election gives you rights to a higher level of urgency or priority over a public patient.

CHAIR - You do get your choice of doctor though, don't you, if they are available and all that?

Mr PERVAN - You can if they are available. Of course, most patients when they come through would not be aware of who is on staff, who is on call. So it is a preference or a right of a private patient that is exercised pretty rarely. Similarly, we have challenges giving people what you would consider to be the full private experience you would get at Calvary or at Hobart Private in terms of a private room, and issues like that.

CHAIR - So your uptake rate - well, uptake is probably not the right word, but the decision for patients to elect to have their private health fund charged, which is effectively what it is, for their service is pretty low. That is what you are saying? I think you are saying, the commentary here would suggest that. I assume this is what this is suggesting, the Private Patient Scheme is actually

recouping a bit more. Is that what that means? I am trying to understand what this money actually refers to.

Mr PERVAN - The Private Patient Schemes, because there is more than one, are a private arrangement between doctors who have a Medicare provider number and the hospital itself.

CHAIR - This is separate to the patients that are electing to be private, or considered private patients in the public hospital, being paid for by the health fund, is it?

Mr PERVAN - It is interrelated. What happens is that the scheme acts on behalf of the doctors, collects the private insurance benefit, and then disburses it back to both doctors by way of a remuneration benefit and to the hospital to cover costs and undertake research, employ specific staff and a few other expenditures like that. As the minister pointed out, we get what is called the default benefit, which is about 30 per cent of what a private hospital would get. It is paid into a Private Patient Scheme.

CHAIR - Still looking at the bigger picture, minister, trying to reconcile the specific purpose payments on page 84 of volume 1, the health reform in 2016-17, you have $359.1 million. If you look at the output group for the THS, and source of revenue on page 116 that is in budget paper 2, where you have 'Activity-based funding and block funding' for 2016-17 being $351 million, there appears to be a discrepancy of $8 million and similar discrepancies for the rest of the forward Estimates. I am just wondering where the rest of the money is when you look at the activity-based funding and the block funding when you are trying to link these two documents together. THS, but I can ask later then.

Mr FERGUSON - Can I take that one on notice and respond to the committee as soon as we can bring forward that information?

CHAIR - That is all right, yes. I can ask it again under THS. They appear in budget paper 1 as well as here. It is hard to know where they actually fit at times. The flow of money into Health comes from so many different areas, it is hard to track. I am sure better people than me still have trouble as well.

Mr FERGUSON - I indicate to you, Chair, that in the interim, from my point of view, the information that is listed under the national health reform line item is numbers that I am more familiar with, and they often tend to be of that order of magnitude that we see in the federal budget papers as well. There is always, I understand -

CHAIR - Which line are you talking about, referring to, minister?

Mr FERGUSON - Under table 5.4, where you have referred to the funding under national health reform on page 84. So they are numbers that we are more familiar with under the activity-based funding model through our national health reform agreement with the Commonwealth, which goes back to about 2009, and they are the numbers that we are more familiar with, including the federal budget papers. They are usually the numbers that indicate what Commonwealth hospital funding looks like.

CHAIR - We are talking about the national health reform on page 84, that figure, yes. I was trying to link that to the activity-based funding. There is a footnote on page 87. It says, from 2017-18 to 2019-20, the Australian government has agreed to continue funding for public hospital

services using activity-based funding capped at 6.5 per cent annually. Then when we go to, in the THS - and I guess you might need another person at the table with this, but the activity-based funding does not line up here. There seems to be a difference of $8 million and I am wondering where that is. We can do it later. That is all right.

Mr FERGUSON - Your answer is being prepared as we speak.

CHAIR - Thank you. This may be along the same lines, the national partnership payments on page 85 in Health, excluding the $25 million in capex and national partnerships payment there, NMP, brought forward, to the bottom line - I assume this doesn't go through the Tasmanian Health Service, these funds, and the total for the NPP is $15.9 million. Again, output group 1, the revenue on page 116 says the NPP is at $25.5 million. That is in 2016-17. That is in the THS again, I accept. But maybe that is a question for when your other advice arrives, is it?

Mr FERGUSON - I have the answer to your first question.

Mr REYNOLDS - Thank you, minister. The amounts you are seeing coming through in budget paper 1, Chair, are payments coming to the department, and we have other responsibilities, obviously, for the Public Health portfolio as well.

CHAIR - Yes. Immunisation is one of the largest, I assume?

Mr REYNOLDS - I believe there is about $8 million associated with that, with those public health payments. So they come to the department, but they are obviously not paid through to the THS, because that is then the health activities going through the THS excluding -

CHAIR - That is the total of $8 million?

Mr REYNOLDS - Thereabouts, yes.

CHAIR - They are the ones that are not related to the THS, to public health and other areas?

Mr REYNOLDS - Correct, and other areas.

CHAIR - You can see why it is really hard to track all this.

Mr FERGUSON - Yes, and it is a fair point, because as everyone here knows, we have two agencies involved here, and when the Commonwealth is making payments in relation to Health to Tasmania, am I right, they all come through the department, all of them, and then it is the department that disperses them according to whether it is a hospital service, and so it should be directed virtually as a purchase through the THS or as a service that is provided by the department, including public health services.

CHAIR - Is there any way to make this simpler for people to look at the money? I remember Mr Nicholson was heavily involved in this, putting together a flow chart that would have stumped anybody when we established the original THO framework, I think, wasn't it, when I really wanted one at the end. Anyway, let the record reflect on that.

But here we are. You have federal money going in, state money going in, some federal money going to the state and then into the Health service. It was the most complicated arrangement, and I

am sure everyone agrees on the other side of the table, from the look of it.

How do we make it simpler to see where the money comes in, where it goes, so we know that the money is being not cut back? It is nearly impossible to see. I have people out there who are more experienced at looking at these numbers and in health economics than me, saying that they think there is money missing. So is there a way of making it easier to represent the true nature of where the money comes and goes?

Mr FERGUSON - I am happy to continue the discussion and to make our chief financial officer available to add further thoughts. But it is fair to say that the budget papers must reflect a true and accurate picture of the Budget and Treasury, which takes the lead on this, naturally adheres to these modern Australian accounting standards that they must do. So everything is recorded. There is no hiding, if you like, or there is no missing money.

I suppose that I would put to the committee that in our outputs, where we describe what our activities are going to consist of, that is perhaps one of the most transparent ways of being able to have a conversation about what we are going to do with the budget allocation that we are asking from parliament.

The secretary will add to my answer, and then the chief financial officer, will respond to the Chair's main question?

Mr PERVAN - In terms of the complexity of the funding model, and I think Mr Nicholson may have made a whisper of the spaghetti diagram that we spent a lot of time trying to develop. It has actually become slightly more complicated than -

CHAIR - You are joking.

Mr PERVAN - No. As a result of the Commonwealth funding model, we are subject to variations in activity throughout the year. The funding coming in from the Commonwealth is actually adjusted, and it can be. They also do what is called back-casting to verify previous data. One of our neighbour states has just had a very, very large adjustment where the Commonwealth drew back around $175 million of Commonwealth health funding as a result of corrections to data from two years ago.

So it is an iterative process, and the best we can provide for treasury and for parliament is the strongest data estimate we can, the best activity Estimates we can and to build a budget and planning for our budget around that.

Mr REYNOLDS - I completely concede, Chair, that these are complex numbers to follow through on budget papers. For the lay person to try to do it, it is perhaps difficult.

CHAIR - It is difficult, but anyway.

Mr REYNOLDS - It is difficult, and difficult for CFOs at times too, for that matter. As the minister says, there is nothing missing here. Everything that is required or allocated through Health or Human Services portfolio is fully accountable for, can be fully reconciled, down to the last dollar. There is never anything that has gone missing in that sort of sense; it is all fully allocated. In regards to how we could perhaps do this better, it is certainly an issue we can always discuss with Treasury. There is a balance, as you would appreciate, though, about how much information I can actually

put into the budget papers at any one time.

CHAIR - We have a very schmick expensive budget management system that is just about to come online soon, or anything could be possible.

Mr REYNOLDS - Indeed.

CHAIR - I encourage you to talk to the Treasurer.

Mr REYNOLDS - It had its genesis when I was even there.

CHAIR - I know. It has had a long gestation.

Mr REYNOLDS - Unfortunately, as the secretary has said, the nature of those things do make it difficult sometimes for it to easily flow through in almost summary-type tables information here. Perhaps there may be opportunities for discussions about how this could be actually presented.

CHAIR - That would be helpful. I want to go down the path, and I am going to read something that was provided by someone who looks at these things quite broadly, regarding the overall funding and how it all works, and whether you think you are on a good deal or not.

The new national partnership agreement and the public hospital funding signed at the recent meeting of the Council of Australian Governments, the Commonwealth agreed to fund state public hospitals on the basis of the number of patients being treated, rather than by block funding arrangements introduced in the 2014 Commonwealth budget, due to take effect on 1 July 2017. Well, we know all that. That is the history.

The previous agreement - there have been a few, I know; I have watched these over a number of years - limited Commonwealth funding of growth in hospital expenditure, the consumer price inflation, plus population growth. Tasmania's population is growing at about 4.4 per cent a year, and inflation is about 1.7 per cent. This would mean Tasmania would receive a nominal increase of 2.1 per cent a year in Commonwealth funding, regardless of the state Government's own contribution to hospital budgets and the numbers of patients that went up or down.

In contrast, under the new arrangements, the Commonwealth will fund 45 per cent of growth in the national efficient price and 45 per cent of increased patient numbers up to and overall annual limit of 6.5 per cent. Unless patient numbers were to fall, any state would get more under the new deal than under the other one.

But in a side deal, as I understand, struck at COAG, to give Tasmania and the ACT what the minister here has called a funding guarantee - formerly, this was called a national partnership on additional assistance for public hospitals - provisional Estimates in the federal budget show Tasmania receiving $1.9 million for 2018-19, and $4.1 million in 1920.

The budget papers note that the Commonwealth provides funding to Tasmania and the Australian Capital Territory for the national partnerships for additional assistance for public hospitals in the event that growth in national health reform funding is lower than growth in CPI and population in a given year. The arrangements will be settled down following further negotiations with Tasmania and the Australian Capital Territory.

A footnote in the budget paper says, 'Funding is indicative only and will depend on final entitlements to the national health funding in 2017-18 to 2019-20, leaving the option for Tasmania to receive more funding than estimated and beginning earlier in 2017-18, rather than a year later'.

Effectively, minister, the Tasmanian Government could do worse, will do worse under the new deal, if only growth in case load plus price inflation is less than 2.1 per cent.

That is the analysis of this situation. Basic health price inflation which tracks the costs increases from year to year of existing items, including wages, is likely to take up the whole of that 2.1 per cent. That means, effectively, there will be no money for new items such as new medications and all the more patients.

What do you say to that? I know it has been a moving feast of agreements and arrangements, and you think under one federal government you are going to have this arrangement, and then it changes and it is something new. Are we actually going to be worse off?

Mr FERGUSON - Chair, thank you for your thoughts. I would be interested in further considering that particular analysis, which you could perhaps de-identify and provide to me later at your option. I would like to say that we have been a very active participant in the national health reform agenda. We did achieve a significant outcome, which you have alluded to, which was achieved on 1 April when COAG leaders signed a heads of agreement for public hospital funding for 1 July 2017 onward. That does need to be compared with the potential funding arrangements, well, with the funding arrangements that were announced in the earlier 2014-15 federal budget.

The heads of agreement instead will see the Australian government providing an additional $2.9 billion nationally for public health services over three years. Our share has been estimated to be worth up to $54 million. That of course is a floating figure because, as we have agreed, it depends on activity.

Importantly, as you have alluded to, with that as the new environment to be working within the side deal is actually a very important one for the state. It actually means that Tasmania secured a guarantee from the Australian government that not all other states, in fact only one other jurisdiction, which was the ACT, got the same side deal. That ensures that the state would at least be better off than it would have been under the 2014-15 federal budget arrangements. I would be interested in the thoughts of your correspondent there.

While the heads of agreement is a welcome development, we need to continue our own work as a state and the work that we have been doing for example with our investments that we have been making in frontline health services. I know it is easy to focus on elective surgery. That is certainly should not be our sole focus, but using that as an example, our activity in that area has been substantially up, and it gets rewarded through activity-based funding through an ongoing balancing support from the Commonwealth.

I indicate to the committee that this Government will continue to seek the best possible outcome for the state, first by ensuring that the heads of agreement is appropriately enacted by an addendum to the national health reform agreement, then by seeking a long-term health funding agreement for beyond that expiration.

I add that the reference to population growth - it needs to be understood that that is not a jurisdictional population growth. It is in fact a reference to the national population growth.

CHAIR - So Tasmania's population growth or lack thereof does not factor into that?

Mr FERGUSON - Tasmania's population growth is not a factor. Tasmania's population, or an individual jurisdiction's own population growth or lack of growth is not a factor, but it is in fact a floating factor based only on national population growth.

CHAIR - So then the other states will start complaining about us again, will they?

Mr FERGUSON - Well, they might.

CHAIR - The secretary's nodding, so I expect they will.

Mr FERGUSON - But that will be their problem, not ours.

CHAIR - Yes. There are swings and roundabouts.

Mr FERGUSON - Yes. But that is what has been agreed, and that is satisfactory for our state.

CHAIR - Yes. In spite of the fact that you have a policy to grow the population.

Mr FERGUSON - Indeed.

CHAIR - I suppose other states have too.

Mr FERGUSON - What I would say, Chair, to you, is that taking out some of those uncertainties is a good thing. If it were an individual stat on Tasmania's year-by-year population growth, then that takes certainty out of the equation. It is better for us to have had the outcome that we achieved by getting jurisdictions to agree on a national population growth as the parameter that is used.

Mr FARRELL - I have a question arising from the secretary's comment about funds being back-casted, which is a fairly frightening thought. Is there any risk that that could happen to us in Tasmania, and what sort of impact that would have, if funds were back-cast?

Mr FERGUSON - I am happy for the secretary to answer that as well. Mr Farrell, it is part of the national health reform agreement that jurisdictions cannot overcharge, if you like, or under or over-calculate. It works both ways, of course, because in other circumstances we saw, where with more accurate or greater validation on past reporting of activity, there has to be a correction or a reconciliation take place, and it was Victoria that unfortunately found itself having to repay moneys, which essentially were overpaid from a previous financial year.

In Tasmania, touching wood, the only experience that we have had that I am aware of is where we have actually had additional Commonwealth funding paid to us as a result of a number of initiatives, including not in our hospital system, but with our Ambulance Tasmania. There have been some very hardworking people ensuring that back-records that are held by the department have been validated and ensured that we claimed maximum possible that is permissible through the Commonwealth agencies. I believe the Department of Veterans' Affairs is one of those.

One of the positive elements of some of the meeting of the community demands through our

public hospital system has been that we have actually exceeded budget on a number of financial years. That goes back many years, actually. In recent years, when that has occurred, although the state has had to provide additional funding, including as you saw in this year's revised Estimates report, it also means an additional claim on the Commonwealth.

Secretary, please add to that, but Mr Farrell was asking about risk.

Mr PERVAN - The risk comes largely from taking an overly ambitious projection towards activities that will be delivered, and we adopt a far more conservative approach. So in the activity that we are projecting, we always match that back to the state budget, and that is our limiting step. Other jurisdictions will actually do a more statistical approach, and in the case of Victoria, over-estimate the activity they will actually deliver. So that is where the risk comes from.

Tasmania has also been advantaged by the fact that we are learning and improving as we go, so if anything, as the minister just alluded to, as we get better at recording, measuring and qualifying our data, we are going to find activity that we missed, so we actually find ways to improve our position with Commonwealth revenue.

So we have had additional Commonwealth payments made to us while Victoria and some other states have had Commonwealth adjustments which are held back by the Commonwealth Funding Pool administrator, as opposed to the state having to come up with the money. Nonetheless, because of the conservative approach we have adopted, we are quite confident and quite safe that we will not suffer that.

CHAIR - About the activity that you have missed, what sort of activity was being missed?

Mr PERVAN - It tends to be activity that is reported or has occurred through outpatient departments - I will not take up an extraordinary amount of time, although it is very possible to do so. The Commonwealth payments are by way of a nationally-weighted activity unit. People always talk about the national efficient price, but the NWAU, the national weighted activity unit, is that national efficient price multiplied by 12 different adjustment factors.

CHAIR - Depending on what the activity is?

Mr PERVAN - Yes. There are two adjustments in every private patient and all sorts of things. So it is a very, very complex and convoluted funding mechanism. As we are improving the quality of our data, we are actually improving our financial position with that funding model. It does not necessarily mean that more activity has occurred, and if you want a really good indicator of raw activity that is coming through the health system, weighted separations are still the best indicator. The funding model does not actually equate to patients through the door.

Mr FERGUSON - Could you give the Chair a snappy answer on the role of coders to do that, then?

Mr PERVAN - Certainly. It is actually a partnership between clinical coders and the quality of the data that they are recording, particularly on patient complexity, and working in partnership with finance staff in terms of the funding sources and the way the national funding model actually works. That has been a strong collaboration between our finance section and within the department and the THS.

CHAIR - So in terms of iatrogenic complications, where these are things that people get in hospital, that creates an activity, I assume? So you are basically getting rewarded for an iatrogenic complication.

Mr PERVAN - At the moment, I would not say rewarded. You are funded because of this activity and it doesn't incur a cost, but it is actually a feature of the COAG heads of agreement that those sorts of things will come under consideration following work done by the Australian Commission of Safety and Quality in Healthcare, in collaboration with the independent Hospital Pricing Authority - two other gifts of the Rudd era - who have managed to secure the Commonwealth's support for funding adjustments based on so-called never events, things that should never happen in hospital, so unplanned readmissions, complications of the sort -

CHAIR - Yes. We will get to that probably under the THS. I am interested in some of the data around that. But we will get to that in the THS. It more suits there, generally, doesn't it?

Mr PERVAN - In terms of policy -

CHAIR - We can discuss the policy and the numbers. I would like to see the numbers, the performance. There is some performance information in the budget papers.

Do you have you a question, Leonie?

Mrs HISCUTT - I am interested in coders, but I do have a couple of other separate questions.

CHAIR - We will keep going with this for a minute. We will come back to you, if that is all right.

Mrs HISCUTT - Can I ask a question on coders?

CHAIR - Yes, sorry.

Mrs HISCUTT - With coders, do they normally only report one incident when they code, or you now encourage them to report three or four different incidences? How does the coding work?

Mr PERVAN - What would normally happen is, post discharge, the complete patient record will go to clinical coding and they will work through the entire episode of care, the entire admission. There might be multiple incidents. There could have been a stay in intensive care and all sorts of things. It is a very detailed record.

I should also put in a plug in for our coders and for the people in the department that work in the area. Tasmania is the only jurisdiction in Australia at the moment that does what is called 'full product costing'. We can actually tell the minister and anyone else who is interested, and certainly the Commonwealth, a granular level of detail as to the total experience of the patient and what that has cost and what has happened, the individual drugs that have been used, and in some cases even the nursing and clinical staff that have treated the patient.

Mrs HISCUTT - So a coder puts all that in?

Mr PERVAN - That is all in the record.

CHAIR - That is if they can read the nurses' handwriting.

Mr PERVAN - It is a live database. Health Central is a live database, so it is updating every 15 minutes. The biggest problem we have is, because we are wedded to that discipline, it takes some time to go through the patient records. A lot of it can be scanned in some ways quite quickly, but if it has been a complex episode, it takes quite some time and a very experienced coder to work through them.

Mrs HISCUTT - I have a new respect for coders, yes.

CHAIR - Just on that point, I am going to get on the minister's side of the table here for a second, these are the non-frontline people who are delivering patient care that often get criticised in our place and you cannot get the job without them. You do not get the money without them. So it is important. So I am on your side of the table at the moment. That is a huge thing. They often get criticised, the non-frontline service deliverers.

Mr FERGUSON - Well, our frontline staff who provide the public face of service do need the appropriate level of back office support, and we as a system certainly need that. I do not mind saying as well that through the reform of the Department of Health and Human Services that has occurred in the last two years, those services have been necessarily retained because it allows us to maximise our revenues.

CHAIR - Is there any other comment on policy you want to make around this whole area, minister?

Mr FERGUSON - I have a brief on re-admission if you like to discuss during 1.1.

CHAIR - We can do that now if you like, yes.

Mr FERGUSON - Can I ask you for some guidance, please, from your committee's point of view? Last year at Estimates, and the previous, we did the outputs for the Tasmanian Health Service in parallel with output 2.1.

CHAIR - We do the same.

Mr FERGUSON - You may care to do the same. That just helps us organise our day.

CHAIR - Sorry, I should have said that at the outset.

Mr FERGUSON - I have some information for you. I remember you raising this last year.

CHAIR - Yes. There was not much detail in the budget papers last year.

Mr FERGUSON - Unplanned readmission within 28 days following a surgical episode: the indicator shows unplanned, unexpected readmissions following selected surgical episodes of care. Same public hospital, according to the definition which is applied by the Australian Council on Healthcare Standards. The indicator addresses only patients readmitted to the same organisation, the same hospital.

Previous attempts to compile data have been collated inconsistently using different

methodologies which has resulted in data from across the different hospitals that was unable to be used for comparison purposes. The data that I can share today has been collated according to the definition applied by the Australian Council on Healthcare Standards, and which has been consistently applied across all data from all four hospitals, that is, all four major hospitals.

I add a note from the department that this information should be considered with caution. The readmission of a patient after surgery can be for a range of reasons. It cannot be specifically related to early discharge. Patients with progressive conditions, for example, advanced cancer and renal disease, through the nature of their disease may be expected to return to hospital at some stage even though the admission date was not planned.

So the year to date readmissions: 2015-16, 300 at the Royal Hobart Hospital; at the LGH, 201; at the north-west region, 47; at the Mersey Community Hospital, 35.

Unplanned hospital readmission refers to an unexpected admission for further treatment of the same primary condition for which the patient was previously hospitalised.

CHAIR - So it is the same condition? Yes.

Mr FERGUSON - There are three, actually. Unexpected admission for treatment of a condition related to the primary admission for which the patient was previously hospitalised, and third, unexpected admission for a complication of the primary condition for which the patient was previously hospitalised. But there are some exclusions. The indicators do not include hospital in the home patients and ED patients re-admitted to the ED only. They are not included. Statistical discharges, that is, patients who remain in hospital but change the type of care that they receive, and an example of that would be a surgical patient who becomes a rehabilitation patient, are not included.

For this year's Estimates, we have a higher quality of that information for you to be aware of, and the question we will always ask ourselves is, have we done everything we can to reduce the avoidable readmissions? That is an ongoing piece of work which is a focus for us and it was an area which the joint state federal commission into the delivery of health services in Tasmania gave Tasmania quite a scolding for.

CHAIR - Not having the data, or the rights?

Mr FERGUSON - No, because that was one of the criticisms that we faced as a new Government, that the health system had, for example, higher readmission rates than we should.

CHAIR - So this data is not comparable with previous years? That is what you are saying now?

Mr FERGUSON - I will ask.

Mr PERVAN - It is comparable but improved. So what we are seeing is a better quality data coming through, better monitoring, and a slight improvement in unplanned readmissions to theatre.

CHAIR - To hospital? Not to theatre? You said theatre.

Mr PERVAN - Sorry, under the unplanned readmission.

CHAIR - Yes. Okay.

Mr FERGUSON - We can provide - for example, we could indicate what the numbers were in previous years, but it could be argued that the data is of a different quality. I think we now have a stable platform.

CHAIR - Yes. I would be interested in trend, but looking forward, we can do it, but yes.

Mr FERGUSON - I think looking forward we have a stable platform to be able to report against.

CHAIR - Could you provide that data for the last couple of years, acknowledging that, and you can put a caveat on it, whatever you like, to indicate that? I understand the data is more robust now. There is always something you are not going to catch once you go to ED and then go home again.

Mr FERGUSON - Happy to, and would you like this now?

CHAIR - Soon, either on notice or during the day?

Mr FERGUSON - I can provide it now. I have it here.

CHAIR - You have it there? Yes, certainly, if you have it.

Mr FERGUSON - Chair, can I commence again, because I have given you year to date readmissions, which I do not want to compare with full-year readmissions. And for that reason, I will give you also the readmission rate, which obviously then can be compared.

CHAIR - Yes, okay.

Mr FERGUSON - So at the Royal, readmissions, 324 in 2013-14. That is a readmission rate of 5.1 per cent. In 2015-16, year to date, 300 readmissions and a readmission rate of 4.6 per cent. LGH, in 2013-14, 129, a rate of 2.7, and in 2015-16, 201, a readmission rate of 3.3. North-West Regional, 49, rate of 2.7, year to date, 47, readmission rate 2.7. Mersey, 26, rate of 1.2, year to date 35, and a rate of 1.7.

CHAIR - So for each hospital, they are reasonably consistent, I guess, but the Royal has a higher percentage anyway?

Mr FERGUSON - I would describe them as marginal improvements and decreases, but I am not convinced that we would be comparing the same body of data.

CHAIR - But it is a consistent data set for next year?

Mr FERGUSON - I believe we have a stable platform to report against in the future now that we - my advice is that this - and in part, this arises out of your questions from last year, by the way, Chair, so I think that is a more stable platform, that we take your constructive advice and listened to that and we have responded in this way. So in future, we should not necessarily focus on the readmission - because there are three elements to it, you cannot say the readmission rate is a bad

thing but where it is avoidable, it ought to be reduced.

CHAIR - Thanks, minister.

Mr FERGUSON - So we listen to the Legislative Council.

CHAIR - It is good to see that you do, and we will keep making valuable suggestions in light of that.

Mr FERGUSON - Indeed.

Mrs HISCUTT - I would like to go to a couple of queries in general overview. Most of the talk coming out of this department is about the Royal or the Launceston. Can you just give me an update on rural hospitals? We have Queenstown in our area on the north-west coast. In your area, there is St Helens that we hear a fair bit about. Do you have an update on any support that you have for rural hospitals that are going to help improve things? While you are at it, you might get the occupancy rates too.

Mr FERGUSON - Mrs Hiscutt, our Government has been very strong in our commitment to our rural sites, and we have been very clear that despite the broken health system that we inherited and a determination to work with the community and to be open and share the warts and all, as well as the good things that are happening in health, we embarked upon a consultation with the community which was designed to get people thinking about how can we change in a way that is positive and produces safer and more sustainable services. Everybody in this room knows exactly where we are at with those reforms. In some cases, challenging, but in hopefully all cases, focused on the needs of our patients.

One guarantee, however, that we have provided is that we will not be closing rural hospitals. That in itself was a way of providing a sense of security that people could come forward and be part of a positive process, knowing that it is not about budget or not about a desire to close.

I am pleased to say that there was a slight uplift in rural hospital separations in 2014-15, 4660, compared to 2013-14, 4568, a marginal improvement. We know that we can, however, do better to utilise our rural sites for the benefit of the whole community, and that is something that I referred to in our Patients First initiative, which has received some funding in this budget, where there is a clear action. It is a particular goal of mine that I want the Tasmanian Health Service to work on, to use our rural hospitals better, and I have asked the THS to progress that as a priority. Our work to use our northern rural hospitals better is further progressed than other areas of the state. And that is as a -

CHAIR - What sort of service are you talking about, when you say 'use them.

Mr FERGUSON - Utilise the service that they can offer. There is a view that our rural sites have a capability that could support our major hospitals better, particularly when we are looking at whole of hospital solutions for ED and bed block. So we don't want to be pushing patients out of the city hospitals into the rural hospitals just to free up beds. But we do want to if we can provide appropriate care to our patients in a rural setting, particularly if it is near to where they live. We should be doing that, and it has the additional advantage of freeing up beds in a city hospital. So that is the outcome that we are looking for.

A key element of that for success will be working with GPs in those rural communities. I recently met with GP representatives, there is an enthusiasm, I must say, and there has been a frustration. So the frustration is that the health system could be providing more support, and indeed trust, in primary care professionals in the community to care for patients in rural hospitals, because they are a key player on that. The opportunity, I think, sits with actually engaging with them more. Occupancy -

CHAIR - Do you have a table you can table, with the numbers in it, minister?

Mr FERGUSON - If I have a table I will table it. I do and I will, but I might just speak to it first. In 2014-15 rural hospitals occupancy rates varied significantly between 27 per cent and 94 per cent, the average is 53 per cent. I will table when I have an appropriate copy to table.

CHAIR - Do you have the separations in a table form as well?

Mr FERGUSON - Yes. I don't have it by hospital, but I have given the statewide separations.

CHAIR - Yes. I am interested in the separations from each hospital; can we get that, and the rural hospitals?

Mr FERGUSON - I will take advice on that, but I commit to providing you with average, with occupancy and trend, by hospital.

CHAIR - Yes. We will put on notice to get the separations.

Mr FERGUSON - So it sounds like that will be feasible.

CHAIR - Available today, potentially? Yes?

Mr FERGUSON - Sounds like the answer is yes. I like it.

CHAIR - I wouldn't have though it was that hard, to be honest.

Mr FERGUSON - I certainly don't have the brief on that.

CHAIR - That's all right.

Mr FERGUSON - Chair, I will table the occupancy today. It sounds like I will be able to, potentially in the same table, also have separations.

CHAIR - Later in the day is fine, yes.

Mrs HISCUTT - My colleague, the member for Apsley, will be keen to hear of anything that you might have on St Helens. Do you have anything on St Helens Rural Hospital?

CHAIR - They are spending money on it, eventually.

Mrs HISCUTT - She would be pleased to know.

CHAIR - Just ask that one while they are looking for that then, if you wouldn't mind, in the

interests of time.

Mrs HISCUTT - Are you happy, minister, to look for that?

Mr FERGUSON - Mrs Hiscutt, I presume you are asking that out of support for your friend, the member for Apsley?

Mrs HISCUTT - I certainly am. She would be very keen to hear of an update there, if there is one.

Mr FERGUSON - So thank you, and this has been something with a lot of community enthusiasm. Needless to say, the current and old St Helens Hospital decision has been made for it to be replaced on a greenfield, owing in part to the age of its infrastructure and the history of flooding. I am pleased the budget supports this rebuilding, the department has been working in cooperation with the Tasmanian Health Service and the Break O'Day Council on the St Helens Hospital redevelopment following purchase of land by council at Lot 2 Annie Street, St Helens. An MOU was signed between council, the department and THS for the parties to work together on resolving a suitable site for a new hospital.

My advice is that the feasibility study for the project, which is being conducted by Loop Architects, makes a number of key recommendations, which Break O'Day Council is currently working through. Understand, of course, that at this point in time Break O'Day Council own that land. The council has begun the process of engaging consultants to progress initial development and subdivision of the identified parcel of land. I am advised that the department and THS are maintaining regular conversations with council to discuss progress.

The project currently has $8.5 million allocated across the forward Estimates in the Budget. $250 000 is to be expended in 2016-17 for a consultancy on early design works. I am pleased to inform the committee that tenders for this design work have been issued to three local Tasmanian design firms, tenders are closing at the end of this month, and it is expected that the contract would be awarded by August or September. I am pleased that progress is being made on this important project, because we certainly want to support the needs of the community on the east coast.

Mrs HISCUTT - I am sure that she will be pleased to hear that. Moving back into my patch - helicopters. I remember going for a tour in the new cancer facilities up there with you on a day. We looked out a window at the end of the corridor and the project manager was telling us at the time that is where the helipad is going to be and that is where the skywalk is going to be. Do you have any update as to whether it is happening, when it will start, and are the funds allocated? You might even be able to address a proposed helipad at Mersey. I know some people have suggested the middle of the roundabout, but I am not sure that is a good idea.

Mr GAFFNEY - It's already there. It's the roundabout. The big roundabout is the pad.

Mrs HISCUTT - It is?

Mr GAFFNEY - Yes, it's big enough for it.

CHAIR - You stop the traffic, it's not that hard.

Mr GAFFNEY - No.

Mrs HISCUTT - I thought that was a joke.

CHAIR - No, no. It's right outside the front door. Why wouldn't you use it?

Mrs HISCUTT - Why wouldn't you use it? Yes. That's good, I will be interested to -

Mr MULDER - Land here when you can.

CHAIR - Yes.

Mr FERGUSON - Mrs Hiscutt, that has generated a fair bit of interest around the table in helipads. When I travelled around the state and we were sharing with the community the needs and goals of Tasmanian Health, particularly around the green paper stage, I was quite struck that the consistent theme that came from our audiences was about patient transport and the difficulties that people have faced with it.

Even though it is the case that we are asking the north-west community, your community, Mr Gaffney's community, to accept the largest amount of change, I strongly want to emphasise that it is a positive change, and we are always trying to reinforce that it is not about downgrading or removing. It is in fact about ensuring that services are safe in each of the sites where they are provided, but also that if there were to be services, and there are, for example at the Mersey, a range of services, for example, in-patient birthing, to be consolidated to another site, that is Burnie, that actually that opens up the way for Government to do new and more services at the Mersey.

That should mean, and does mean, particularly with the north-west cancer service now fully operational, that we are actually needing less patient transport. We are needing fewer occasions of patient transport. Nonetheless, I made a commitment that we would, for people around the state, work to do more to support an improved patient transport system.

You have mentioned in your question specifically the helicopter and helipads, there has been progress made on these initiatives -

CHAIR - I was wondering how that funding came into the whole output groups, the transport issue.

Mr FERGUSON - There is capital and recurrent funding in the funding that I have described; the $24 million, has capital and recurrent, of which $10 million was capital.

CHAIR - Something we can look at under the THS then, because it relates to service between major facilities as well as others.

Mr FERGUSON - What I can say right now, and happy to come back with more detail, there's $5.375 million for enhancing the Trauma, Neonate and Paediatric Retrieval and Referral Service, and that funding envelope includes the construction of helipads at both the North-West Regional Hospital and the Mersey Community Hospital. I understand, on advice, that the Bass Highway roundabout is the designated official helipad to service the Mersey at Latrobe. It is my further advice that it is very rarely used.

Mrs HISCUTT - I thought it was a joke, but it's not.

Mr FERGUSON - The planning fact is to build a new helipad, on site and not on the highway. That's the plan. There is design and work going into the very best way that that can be offered. The North-West Regional Hospital Project is further advanced. I understand it has already received local government approval. I might need to check that again. There is a plan right now for the helipad to be located in the car park, together with linkages to the main building.

Mrs HISCUTT - Is the linkage going to be a skywalk? Do you know? You might not know.

Mr FERGUSON - I understand it is to be linked to the new building, the new - yes.

Mrs HISCUTT - It sounded absolutely wonderful.

Mr FERGUSON - So they have done a great job in Burnie, and I hope that in the near future I can provide an update to the community specifically on what the model will be for the Latrobe Mersey Hospital.

Mrs HISCUTT - So you haven't got, particularly, start dates or anything, it's just -

Mr FERGUSON - The funding goes live on 1 July.

Mrs HISCUTT - So then you will be tendering?

Mr FERGUSON - I am just advised that the Burnie is now in the tender evaluation stage. The funding goes live on 1 July.

Mrs HISCUTT - Thank you. That's wonderful.

Mr FERGUSON - Just excuse me one moment, thank you.

If I may just very quickly, just to be helpful, the Mersey options review currently underway for Mersey Hospital helipad. Options are looking at the best construction methodology, and bearing in mind the onsite space, including coordinating with expanded ambulance facilities requirements on the same site.

Mr GAFFNEY - Following on from that, I imagine the helipad at the Mersey would mainly be for outgoing more so than incoming?

Mr FERGUSON - That is certainly our vision, yes.

Mr GAFFNEY - Yes. That section of the highway from the Raspberry Shed down through to Amber's is still federally-based and they haven't really decided what they're going to do with that section. So I can well imagine that with the ambulance services there at the Mersey too, it makes sense for the helipad - the access not have to cross a federal highway -

CHAIR - To stop all the traffic.

Mr GAFFNEY - Yes. It would be more to do with flying people from the Mersey to other hospitals, more so than in, wouldn't it?

Mr FERGUSON - Absolutely correct, Mr Gaffney. And also to let you know, it is my advice, because I have asked at different times, to me it seems strange that a roundabout in the middle of the state's second busiest highway would in fact be the designated helipad. Obviously it can be used for that, but I understand that the traffic has to be stopped, and I also understand that, on occasion where a helicopter has needed to land, in fact it has not used that site. The pilot has been able to land safely within the grounds.

My vision here is for a helipad which is designed and fit for purpose.

Mr GAFFNEY - There is a private helipad only two kilometres down the road, a helicopter service; they have pads there as well.

Mr FERGUSON - If I may offer, one of the reasons that helipads onsite, close to and indeed onsite with the hospital, is to avoid the need for an ambulance transfer, which in the case of the Royal here - and by the way, the Royal redevelopment helipad that the Government has put back in the project, the whole point of that helipad is not for principally the people who live in the area of Hobart, it is about people in the north-west, people in Launceston, in the north-east, because that's your parking spot for when you need to be quickly retrieved to the trauma service, for example. So that's the vision. Linking up our hospitals has been a key theme of our One Health System reforms. The helipads are an important demonstration that we are serious about a One Health System and ensuring that people get equal access to the better services that we are all aiming for.

CHAIR - These transfers also increase the risk of complication, out of a helicopter, into an ambulance, out of an ambulance.

Mr FERGUSON - Amazingly, landing a helicopter on the Domain, for example, and then transporting you by ambulance to the hospital equals a delay of at least 30 minutes, which can be critical to life.

CHAIR - And re-stabilisation. Rosemary, you are allowed to come and ask two questions.

Mrs ARMITAGE - Two questions per line item, so I will have two for this line item and two for the others.

CHAIR - And then we can have a cup of tea.

Mrs ARMITAGE - Minister, I have a question on the $76 million, the catch-up elective surgery. I assume that $76 million includes money for pre-operative tests for this surgery. You're not disputing that, so that's good. My question is, I am of the understanding that a lot of these pre-operative tests for the surgeries taken at the private hospitals, including the Epworth, are actually undertaken at our public system, at the Royal and at the LGH. So the cost for the tests is actually being borne by the public sector. Can you explain why that is happening, when my understanding was, and the understanding of a lot of the practitioners, that the $76 million should have covered all the pre-operative work and the money should be coming actually out of the money going to the Epworth and to the other private providers?

Can you explain to me why our public system is carrying that burden?

Mr FERGUSON - Of course, Mrs Armitage. The reason I did not answer your earlier pause was so that you were not deprived of a second question.

Mrs ARMITAGE - No, this is all the one issue.

Mr GAFFNEY - That was four.

CHAIR - That's one, I am counting.

Mrs ARMITAGE - No, this is just one issue. Two parts to the one issue.

Mr FERGUSON - I want to be helpful, so thank you for the question and thanks for acknowledging the $76 million. It is making an amazing difference in the lives of Tasmanians. Yesterday I had the pleasure of telling the other Estimates committee that in the 12 months to April 2016 our health system delivered more surgeries, more elective surgeries, than ever before. A new record. That has resulted in us changing lives, particularly for people on the non-urgent list, the category 3s who so rarely got a look in. We are talking about people who have waited six, seven, up to 10 years for their surgery. A year ago we had 120 people on that list who had waited more than three years. Now it's three people, and we have a plan to treat those three people in the coming months. So these are people who actually felt that they had been forgotten and would never get their surgery, and the stories that I occasionally receive are very moving.

Just on that, the over-boundary waiting list, that is the component of the overall waiting list which as at April was down to about 7400, those people who have waited longer than recommended, has now reached the lowest since records were commenced in 2005, a reduction of something like 1700 people. Our system has been showing that it is capable of delivering some great outcomes and it has been through a mature and prudent use of our funds, not just the $76 million but also the temporary money that we have, the special one-off funding that we secured from the Commonwealth in late 2014.

Mrs ARMITAGE - Is it fair that the public system is paying for the considerable pre-operative tests when the private sector is actually collecting the money for the surgery?

Mr FERGUSON - I will now come to the main part of your question. I wanted to say that, because it is important for me to say that.

Mrs ARMITAGE - That is all right.

Mr FERGUSON - We are talking about our public patients in all cases here.

Mrs ARMITAGE - Yes.

Mr FERGUSON - However their surgery is provided, and by whichever clinician and hospital, they are our public patients, and so we have a responsibility to provide for them the full continuum of care that they require. There is a need for tests, it will depend in some cases on how long the patient has been waiting. If tests are done, they need to be current, and if they haven't been done for a while, they might need to be renewed or refreshed, but they are shared with the medical record, otherwise the panel provider, that is the private provider, will pick up those costs.

I will ask the secretary to add to my answer so that I give you a complete picture. I would like to dispel any idea that we are favouring or putting out a disproportionate amount of the money into the private hospital system. Me personally, and our Government, we are not ideologically obsessed

about this one way or the other. I personally have ensured that our public hospitals have had first opportunity on our available funding. I just feel that is important to say.

Bearing in mind that the Commonwealth money was only available over a two year period, it would have been very foolish for us to have attempted to push all of that money through the public system. We would have seen a boom-bust. We would have had to employ large numbers of surgeons and nursing staff, only to let them go in two years. That is not a prudent use of resources. So we have used the private system as a balancing mechanism so that we can -

Mrs ARMITAGE - With respect, minister, that is not really my question.

Mr FERGUSON - No, I know. But I am providing context. I feel it is important context.

Mrs ARMITAGE - I do understand all that. But the $76 million - the concern that I have had raised with me by practitioners is that the public system is not picking up any of the surgery but is picking up all of the pre-operative tests and is funding them.

Mr FERGUSON - I assure you that the public system is running hot in surgery. We have opened additional theatres to provide the extra -

Mrs ARMITAGE - I am talking about the cost though to their budget.

CHAIR - You are talking about the cost of the pre-admission tests?

Mrs ARMITAGE - Yes. All the pre-admissions tests for places like the Epworth. They are having all their pre-admission tests, my understanding is, in the public sector, and the public sector is paying for it. They are going to the Epworth, having the surgery done, they are getting their full money, but they are not actually bearing the normal costs that a hospital would bear. Normally if you are getting the surgery, yes, you are picking up the money for the surgery, but you are also outlaying the money in the public sector for the costs. So you have the public sector here picking up the costs, not getting the surgery, so the cream basically is off to somebody else and they are getting the work. I do find that of concern.

It would probably be difficult for you to give me a figure, so I won't ask for it, but -

Mr FERGUSON - You are most welcome to ask, and I am happy to investigate and provide you with the answer. I would like to reiterate, I am not sure that I was clear enough, that if the tests have been already done by the public system for our public patient, then that information is shared with the medical records in the interests of the patient and that is of course provided to the private provider if it's a private provider that is caring for the patient on their day of surgery.

However, if those tests are not current and they require to be refreshed, they will be paid for or done by the private provider as part - I want to emphasise that -

Mrs ARMITAGE - I may need to check that, because that is not my understanding, minister. My understanding is that before these patients are actually going off for their surgery, the current tests are being undertaken in the public sector and not by the private provider. That is where my concern is.

Mr FERGUSON - I have taken advice, and that is my advice. If you wish, I would like to

make the secretary available to speak to this. I wanted to say one other thing about the process. So we went to a full and open and proper procurement process to secure the private providers, and that was a very rigorous one, it required -

Mrs ARMITAGE - I have seen the contract. I actually have a copy, yes.

Mr FERGUSON - Yes. It provided for a very robust way in which we can provide not just the surgery that people have been desperately waiting for, but also good value for the taxpayer. I just offer the secretary to further assist with the question.

Mr PERVAN - Thank you, minister. Beyond what the minister has already said, which is absolutely correct, it is useful to remember that the only person who can order a test of the nature that you are referring to is the treating surgeon. So the private providers cannot order those tests in the public hospital. So what is happening is that when the medical record is shared on referral, if those tests are current, and they might be recent, they might have been ordered by someone in an outpatient clinic, but those tests go with the medical record to the private provider. If they determine they need more tests or different tests, or that the ones that are on the file are too old to be clinically meaningful, they undertake new tests at their costs. That is implicit in the contract.

So we have not undertaken any testing for the private providers or those who have been referred out.

Mrs ARMITAGE - I may come back to you with that one on the floor of parliament, when I get my further information from the people who have brought the issue to me.

Mr FERGUSON - Of course. I just ask you to take that answer back to your informant.

Mrs ARMITAGE - It is more than one informant. I shall.

My second question is, how many patients that have had their surgery undertaken in the private sector, and I say including the Epworth, have actually been admitted to our state public system following that surgery with a complication or other matter relating to the original surgery?

Mr FERGUSON - I will take that on notice for the detailed answer, but can I offer the secretary, as our system manager, to provide an overview response?

Mrs ARMITAGE - Just to extend that slightly, how many patients have been admitted to the public sector, how long has their stay been, and probably the cost to the public sector?

CHAIR - You're talking about unexpected admissions?

Mrs ARMITAGE - Unexpected following the surgery in the private sector.

CHAIR - Yes. I am just clarifying, because some of them will be transferred back.

Mrs ARMITAGE - Yes.

Mr FERGUSON - This might include complications, for example?

Mrs ARMITAGE - Yes, I am looking for things like that, because my understanding was, in

the contract, and I do have a copy of the contract, that the private sector was responsible for any complications and the cost of any complications that may occur following the surgery.

Mr FERGUSON - We have this covered, but I invite the secretary to describe how we have written that into the contracts, and we may need to take it on notice.

Mrs ARMITAGE - I do have a copy of the contract. I have seen that it's in it, but I am wondering how many patients have come back, whether the contract is actually being fulfilled, whether the private sector is actually paying, and whether we have had many come back in that situation.

Mr PERVAN - Thank you, minister. Actually I anticipated that I might get this question today, and we are still waiting for verification. The minister has taken your question on notice. We have had no reports from any hospital of any of the patients going out to the private providers, presenting in an ED within 14 days of their surgery, as a result of complications arising from that surgery. So none so far.

Mrs ARMITAGE - Within 14 days. Some may take longer than 14 days, because some actually may be in - the contract is 14 days, is it?

Mr PERVAN - The contract specifies 14 days, and it would be very rare for a complication post-surgery to take longer than 14 days to present. But thus far, we have had none attend at all. But we will verify that with each of the sites through the THS.

Mrs ARMITAGE - That would be good, thank you. Chair, I will come back at the next one and I will give you -

CHAIR - A further two questions. Did you want to add something, minister?

Mr FERGUSON - No. We will take your question on notice and be happy to correspond with you on that.

Mrs ARMITAGE - That would be good.

Mr FERGUSON - Can we also acknowledge that even if there are issues - and unanswered questions that we could help with answers, that's great, but I think we need to keep our focus on the patients, including those ones who have been made to wait four years.

Mrs ARMITAGE - Absolutely. Thank you, I will come back for the next item.

Mr FERGUSON - So, Chair, I offer to table the total occupancy rates of rural hospital beds, and I am seeking further data on separations.

CHAIR - That is still coming. Thank you for the tabled document. So it being 10.30 a.m., we thought it's a good time to have a break. I will reconvene at about ten minutes to 11 a.m.

The committee suspended from 10.30 am to 10.48 a.m.

CHAIR - I believe we have basically covered everything. There are still some areas we will drill down into if there is something that the members think of that doesn't quite fit. I had trouble finding where rural hospitals, for example, really sits these days in an output group. It doesn't really fit under the THS, but maybe it does. Not clearly, though.

Output group 1.1
Health Services Systems Management

CHAIR - We will go to Output group 1.1, Health Services Systems Management.

I do this slightly tongue-in-cheek, you'll understand why when I get to the end of it, but I just wanted to compliment you on the performance information table 4.3. The tongue is in the cheek because if this is the performance information, just to get one THO agreement now, service agreement, what sort of performance do we really want to measure in this output group?

Performance indicators are just implemented in Government in the form of goals published, achieve them in the published time frame and then the service agreement. Of course, you're only going to get one because you've only got one THS. What are we hoping to achieve within this line item that perhaps could be better captured by more commentary around it?

Mr FERGUSON - Chair, it is not an unfair observation because of course, in the last 12 months we have moved from having three THOs for the system manager to manage, down to one THO, by the name of the Tasmanian Health Service. I take that onboard and observe that this is an area we are willing to review in the way that we report those performance measures. Because of the investment that the state makes in the department as a health service system manager, we need to have appropriate accountability there.

Chair, we are reviewing our performance output measures as well and I believe you will see that there will be a different arrangement in future.

CHAIR - It would be good to know a bit about what is actually happening within - because there is not insignificant money allocated to running this section. One of the criticisms with the previous government, and now your Government, continue with the Tasmanian Health Service on the THOs, the separation, that we are just going to double up with bureaucracy and that sort of thing and I think we need to see pretty clearly that is not the case, if that isn't the case.

Mr FERGUSON - I concur broadly with you in say that, that from a system manager point of view, it is difficult to come up with too many specific outputs of that work. The outputs that people will be particularly interested in will of course be by the provider.

CHAIR - I note that in the commentary around 1.1, it says that it is including service improvement and supporting the Tasmanian Health Service develop consistent collaborative models of care for chronic and complex conditions. That is obviously really important in reducing overall costs to the Tasmanian Health Service as much as for the department. I am really interested to know more about how that is going, what sort of models of care are being established.

I support your enthusiasm to try to streamline and coordinate services so more people have access to them in Tasmania and the collaborative models of care combine with that, so what is happening in that space? What progress is being made by the department to actually try to move these things up a bit more?

Mr FERGUSON - I will invite the secretary, as the head of agency and the system manager to add to my answer, but I volunteer an example of an area where we might be able to provide some extra value. It might be, for example, some objective way of reporting our performance on safety and quality because that is a key function that the system manager is looking at, not just in the public system, but across the public and private providers in Tasmania. Secretary?

Mr PERVAN - The clearest example coming from this Budget in an announcement recently by the minister of progress in this area would be the Community Rapid Response initiative in the north and an increasing collaboration between the DHAS, the THS and Primary Health Tasmania, aimed at the rapid response, in fact, of not only preventing admission but actually of drawing people out of EDs, where they can be managed better in the community.

In terms of the performance data, though, and your specific question, they are very complex relationships and complex clinical conditions we are talking about, so the three organisations are still collaborating on exactly what is meaningfully measurable. An interesting sentence, I know, but we could measure numbers of patients and all sorts of inputs.

CHAIR - I want outcomes, not outputs, so I went to the Auditor-General on this, a previous Auditor-General, I am sure the new -

Mr PERVAN - Indeed, and so do we, and certainly in their commissioning role, Primary Health Tas are funded by the Commonwealth to go through commissioning to outcome-based performance measurement. So we are trying to come up with metrics which actually measure the clinical outcomes which we can record the data from. So while the clinical interventions are nothing new or terribly innovative, there are some ideas and some principles we have known about for a long time. Coming up with the metrics to measure whether they are improving outcomes is actually quite challenging.

CHAIR - I accept that it is -

Mr PERVAN - But that is where we are heading. It is definitely where we are heading.

CHAIR - Minister, is this the area we can talk about the North Transport and Coordination Infrastructure, or is that somewhere else? You obviously read my speech, minister, or someone did on your behalf.

Mr FERGUSON - Yes.

CHAIR - This is not a nice little add-on. This is absolutely crucial and essential to making a one health service system work. There are a couple of different elements to it. You have the $10 million over four years for Health Transport Infrastructure projects and you have the additional $29.5 million over four years to support the wider Health system reforms. I assume that is part of that as well, with the consolidation of clinical services and things like that.

Mr FERGUSON - Yes, $14 million for services and $10 million for capital.

CHAIR - Can you give us a better indication of what is going to be provided under the capital, as well as the services?

Mr FERGUSON - So of the $24 million that was announced last year, that includes $10 million for major capital work to support the reforms. The capital funding will be extended over 2016-17 and 2017-18, so over those two years that we are about to enter and that is on initiatives which include a construction of helipads and transit lounges, plus potentially investment in additional patient accommodation. That is specifically what the funding is earmarked for, but we are taking advice and we have some work being conducted at the moment which I can speak to so that we ensure that it is appropriate and required.

Significant progress has been made against each of the initiatives, and with the exception of some relatively minor delays, the overall project remains on track with the scheduled dates in the white paper implementation plan. The current breakdown of costs allocated to projects is as follows, and this relates to both the recurrent and the capital components, so I will now break down the full $24 million.

CHAIR - Just before you go onto the breakdown of the capital and recurrent, you said the patient accommodation is potential or proposed, I forgot the words you said. I know helicopters are one thing, but the number of people that use a helicopter are far less than the number of people who need to drive from Circular Head through to Launceston or Hobart or even to Burnie and the West Coast and the East Coast, the same.

Mr FERGUSON - I used the word 'potential', and perhaps was the wrong place to use it. My point is that there is real money allocated for real capital in accommodation options, but we need to necessarily go through a prudent process of ensuring that before we allocate it to a specific project, that we know exactly what the needs are and that we will get good value. That was my only point that I wanted to make.

CHAIR - That is fine. It sounded to me that 'might have or might not'.

Mr FERGUSON - No, that is not -

CHAIR - There will be patient accommodation once it is determined where it needs to be and how much needs to be where.

Mr FERGUSON - Can I just break down the $24 million figure? That will add some clarity and assist. So the current breakdown of costs allocated to projects is as follows: $5.9 million for 12 additional paramedics based in Latrobe and servicing the Devonport and Latrobe areas, to deliver coverage in peak times. That is $5.9 million. That additional $1.4 million for extended care paramedics to treat people in their homes where possible and reduce the demand on the LGH ED. $5.375 million for enhancing the trauma, neonate and paediatric retrieval and referral service. It is within this envelope are funds that includes the construction of the helipads at North-West Regional and Mersey Community Hospitals. $875 000 to meet any additional demand for non-emergency patient transport, including extending out-of-hours support.

CHAIR - What was that last word?

Mr FERGUSON - Including extending out-of-hours support. Caution in dollar terms, but let me indicate that the allocation currently is $2.1 million to establish a low-cost bus service for patients and families between the LGH, the Mersey Community Hospital, and the North-West Regional Hospital, and to introduce or upgrade transit lounge facilities in these hospitals. I only say 'caution' because we are out in the market with a tender in relation to the North West linkages

between Latrobe and Burnie.

CHAIR - This is a bus for patients?

Mr FERGUSON - And families and the general community. I am happy to come back to that. State Roads is running that project in partnership with Health. $8.35 million to support patient accommodation and to reduce the need for patients to travel. Two components there. Up to $4.55 million has been set aside to help establish new accommodation options and/or upgrade existing accommodation services, and it is specifically in that area that I alluded to earlier that we are taking advice and going through a prudent process. The second component of that is at least $3.8 million to expand telehealth services and promote the use of those services more broadly across sites within the Health system.

There is a two-stage review of the Patient Transport Assistance Scheme. There is a review of the Patient Transport Assistance Scheme is also being conducted to ensure that the scheme is capable of supporting the white paper reforms. Stage 1 of that review - the Patient Travel Assistance Scheme, I should have said, stage 1 of the review is complete with changes already now made by ministerial policy on PTAS. This direction now provides eligibility to people travelling to the Mersey for elected surgery from anywhere.

CHAIR - So it helps people from Hobart to get up there?

Mr FERGUSON - It takes away a disincentive to take an opportunity to have surgery at the Mersey. So that is a first; that has not happened before. That is stage 1. Stage 2 is close to completion. There is extensive consultation that has occurred with key staff in the THS and a detailed review report has been drafted and circulated to key stakeholders for comment. The point there is that we committed, during that green and white paper stages of our One Health System consultations to reviewing PTAS to better align it with the needs of our patients. So we are seeking to improve the scheme and there is funding to support that.

Ms HISCUTT - Minister, you mentioned the bus. Is this what you are talking about, the bus for patients, say, coming from Hobart to the Mersey for an elective surgery, so I presume it is going to run them there in the night?

Mr FERGUSON - Yes. So the PTAS changes that the Government has made that I referred to as stage 1, shall we say, of that review, that is about supporting people's private travel arrangements to get to the Mersey, and so people will find their own way to hospitals for their various services, and PTAS is designed to support people being able to in fact afford to take up their options to get to the site. PTAS is a reasonably broad scheme.

CHAIR - As it is now, but changing so people can come to the Mersey from other parts?

Mr FERGUSON - So there are specific rules built into PTAS which ensure that the service, the funding, is used to the best possible outcomes and they are not easily abused. So it is designed to protect the scheme itself and if a service is available in your local area that you have been referred for, you can be supported. Where there is an eligibility to get to that service, then you are entitled to get it, but not necessarily to travel to the other end of the state if it is available more locally.

My point here is that the PTAS has now already changed to allow people to travel, to be supported in their private travel to get to the Mersey.

Ms HISCUTT - So that would possibly cover a night's accommodation after they are discharged from elective surgery, you would presume?

Mr FERGUSON - Yes, it does, Mrs Hiscutt.

CHAIR - Kim Miles in Burnie, who runs PTAS, is an amazing operator and he should be commended. He is brilliant. I have had lots of dealings with him and you couldn't get a more perfect person if you ever needed. That is all good.

Mr FERGUSON - There was a question earlier about the accommodation support and I would like to add to that answer. So the department has developed a brief paper analysing the availability and utilisation of affordable patient accommodation in each region. The paper will inform the development of the more detailed options paper which will be used to build the final strategy for the implementation of the funding. There is an RFQ which has been issued seeking a consultant to prepare the options paper.

CHAIR - An RFQ?

Mr FERGUSON - Request for Quotation. So that has been issued, seeking a consultant to prepare the options paper and the department is currently working with the preferred consultant to progress the development of the paper. Yes, it is expected that the options paper will be completed by the end of this month. I am not able to tell at this stage who the preferred consultant is at the moment, but I will in time. Yes, that is where that is at.

CHAIR - You mentioned $3.8 million in telehealth, it probably dovetails a bit with your other portfolio. What progress is being made there? There are so many circumstances where this could be used, but you hear that the connections aren't good enough to give people on the West Coast, in terms of the whole NBN debate down there, which is another issue.

Mr FERGUSON - You are quite right, Ms Forrest, this is very much in line with whole-of-government changes to our IT procurement, and telehealth should be a replacement technology for face-to-face consultations where it is appropriate and where it can be safely achieved, the same outcome. In fact, it could be argued in some cases it will provide better patient outcomes, for example, my often-cited example of the elderly gentleman in George Town who travelled at great expense to the taxpayer on non-emergency patient transport to Hobart for a post-op consultation that lasted five minutes, and then returned.

So using telehealth is not just a better use of our funds, but potentially holds the opportunity for better care of our patients, and indeed, reaching patients who might in fact avoid a visitation because they perhaps don't want to travel a long distance. We have a particular weakness on the north-west coast and the north endocrinology, so I will speak to that in just a moment, but we want to ensure that telehealth is seen as a solution, not as any particular Budget measure at all.

So the business case for the expansion of telehealth services was approved by the secretary in February. It outlines the department's proposed approach to the expansion of telehealth services. The process of establishing a special interest group has commenced, including consultation with our clinical advisory groups. The special interest group will support the key pieces of work required to establish and undertake the project. The special interest group will be established to align with the appointment of the clinical programme lead which is expected to be in place by 30 June 2016.

The process to establish project resources has commenced, including consultation with THS regarding the proposed organisational structure. The lead and the coordinators are expected to be in place this month. I am particularly pleased to inform the committee that endocrinology - so we have this issue with the department and the THS have predominantly relied upon polycom technology which is the video-conferencing technology which is used, but the whole-of-government telehealth architecture is moving to a different technology and it is branded Cisco. So Anittel has been engaged as our provider to provide advice on how we can better integrate those two different but potentially interoperable architectures. So we are working on that.

In endocrinology, and the endocrinology outpatients clinic trial is progressing well. We have placed Cisco units, the new system, has been deployed in both the north and the north-west. It is expected a southern unit will be deployed shortly and discussions are currently occurring with the clinical care teams regarding the location of the equipment. That is in fact intended to support that service gap that we have experienced due to an unsuccessful recruitment drive.

CHAIR - They still haven't been able to recruit an endocrinologist?

Mr FERGUSON - I think we are seeing temporary staff, but this is about bolstering the service and not an attempt to replace the service in its entirety. I have just been reminded that a key improvement of the Cisco system as opposed to polycom is that polycom is broadly described as a concierge system. It requires somebody else to actually join the two end-to-end connections or the multiple parties, so it is oversighted by somebody else, whereas the Cisco system is designed to work just like the telephones we are familiar with. You dial up the other party, and if you want to join additional parties, you dial them up as well. So it will be much more user-friendly, less reliant on a bookings system, needing to be in a particular place at a particular time. So if somebody is running late, it won't change the fact that -

CHAIR - You do not have to book the system.

Mr FERGUSON - You don't lose it because unfortunately you lost the booking.

CHAIR - In terms of other areas, particularly in the north - not the north so much - but certainly the north-west, pain specialists and with your move toward improved accessibility to medicinal cannabis, the need for specialists to provide care for those patients, I think it is still way too narrow, that is another debate for another day, can this be used?

Mr FERGUSON - It can be today and it doesn't need to be a debate because I would just like to reassure you that the parameters that we have put on that controlled access scheme are in fact very broad, so we have not limited to any particular illnesses.

CHAIR - No, it is the compound I am more concerned about, limited to the compounds, single compounds rather than the whole plant.

Mr FERGUSON - The pharmaceutical?

CHAIR - Yes, from a pharmaceutical point of view. We can chat about that another time.

Mr FERGUSON - Sure.

CHAIR - The broader question there is about specialists. Your media release and discussions that we had indicated that the patients who can be treated - and I welcome that introduction, I think we need to be careful we don't undermine it by not having the appropriate system, but that is another discussion - but if you need specialists, then are we potentially going to be limited in the number we can have in the state, as we are with all these sort of highly specialised practitioners?

Mr FERGUSON - Yes.

CHAIR - Is this going to be able to assist those people so that they can actually access the medication, wherever they are?

Mr FERGUSON - Are you speaking about cannabis specifically, or more broadly?

CHAIR - I'm speaking about cannabis and pain management, yes.

Mr FERGUSON - Secretary, I might ask if you could help me at the end of my part of the answer by describing the role of the CAGS and how they are actually assisting the CEO of THS. That is a little bit outside your area but it is relevant, and the role of the CAGS in establishing the statewide redesigned services and where telehealth come into that.

I take your point and I think that it is a blessing that we have ended the regional divide between the different parts of our state because that has been a barrier to - even though people would have always said, 'Oh, we consult and we collaborate', the reality was that you were working for different employers and with three different governance structures.

CHAIR - Some of us have not quite moved on, but they are not here in the room at the moment.

Mr FERGUSON - We are all on a journey and I have been persuaded by the merits. That is why we have amalgamated them. We have to break down the barriers and we need to work as a system for our patient, not for our region, not for our discipline, not for our hospital - for our patient. That means working in a different way. That change is occurring. There is more change required, but the clinical advisory groups are working in their various discipline areas and focused on developing the business cases that the THS will need to have to implement the white paper changes.

Secretary, can you add some value to that and drop in telehealth as well?

Mr PERVAN - In line with the implementation of one health system role delineation, what is required to give life to that is a series of clinical pathways or clinical streams. In some ways, that will build on the work that has been done under the Tasmanian Health System's package through former Tasmanian Medical Care Local, on their health pathways. What we do not have uniformly across the acute system are pathways that start where those ones finish.

So while they have done all their work, the challenge is now up to us to map out what is an optimal pathway for patients entering the hospital system and then discharging it and returning to primary care or self-care. The challenge for Tasmania comes in many ways, but in two particular ways with regard to this question. The use of things like telehealth will enable resources which are small in number and quite heavy in demand, such as specialists in neurology and neurosurgery to have greater direct reach with patients, so calling back to the minister's example of the gentleman in George Town, there are a lot of people that travel from across the state down to a neuro consult at the Royal. In many cases, they could be supplemented by frequent telehealth consults, but also

for the north-west where there are single clinicians or single discipline clinicians, it enables them to be part of a clinical network and to case-conference, especially in things like cardiology where they are, in the nature of their work, very technology-dependent. There is a lot of imagery and imaging that is used on screen. That can now be shared live and a case conference can occur through the use of the technology.

There has been some collaboration across the state for many, many years. What is happening now through the CAGS is that is being formalised. So the business cases which go to how each clinical stream will progress the one health system model will include those models of care and how the models will be developed, always within the horizon that we have through the Budget and forward Estimates, and I am sure Dr Elkhorn could add a great deal of detail to that under Output 2.

That is the work that we are expecting from them now, is the plan to deliver within the resources that they have, but using technology, using telehealth to actually supplement people on the ground and do it in a way which is collaborative and coordinated across the state.

Mr FARRELL - What is the cost of the Cisco system, to implement that?

Mr FERGUSON - The Cisco system is part of the whole-of-government telephony program which I could draw together a number for you. It is actually paid for by each individual agency through a TND on a managed service basis and virtually a cost recovery basis. So TND don't get paid any money by Government, but it meets its own costs by agency costs. I might need to just take that broadly on notice, or even have the answer ready for you when I get to IT Outputs.

I do not have to hand what the specific cost of this project would be. It would be minimal in the scheme of things because it is a small model that is being trialled with endocrinology. The units themselves, being a managed service, you do not actually buy the units, you pay for the managed cost and so you pay - it is a higher recurrent cost, if you like, because you have avoided the capital cost upfront. So I will take that on notice, if I may. Have I answered your question? Are you looking for the numbers on the endocrinology trial?

Mr FARRELL - Yes, just the one.

Mr FERGUSON - I am happy to provide that, yes. Even today, if we can.

CHAIR - Any other questions on this Output Group? We might move to the Tasmanian Health Service and we will do the Output Group 2, also the Tasmanian Health Service and work thought the Output Groups in the Tasmanian Health Service. Does that make sense?

Mr FERGUSON - Chair, I would invite -

CHAIR - As they come up, minister, would you introduce them for Hansard, please?

Mr FERGUSON - I am very happy to introduce the Tasmanian Health Service inaugural permanent Chief Executive Officer, Dr David Alcorn. I welcome Dr Alcorn and introduce you to the committee. Dr Alcorn commenced in this role in February of this year and has in fact taken up his appointed based in Launceston, servicing the whole community, the whole state, and has been a welcome addition to our leadership.

Also joining us will be the chair of Governing Council, Mr John Ramsay, who is on his way.

CHAIR - We can make a start. Did you want to make any opening comments about this, minister? Or we have done that already?

Mr FERGUSON - Happy to just take your lead.

Output Group 1.1
Admitted Services

CHAIR - We will start with Output Group 1.1, Admitted Services. We have talked a bit about some of these areas already so we are sort of crossing over a bit, but one of my favourite areas, the North-West Regional Hospital and the maternity contract. I understand for many years now, prior to your Government being in power and continuing, when we did have the three THOs, the North-West always went over budget. The main reason was the [inaudible] costs at Mersey and then the contract for obstetric services at the North-West Private Hospital.

Can we have an update on that? Also, my expectation was that we were going to start the integration of maternity services, particularly the birthing component. Where that has got to? I don't know if it has stalled or what is happening, but there seems to be a bit of uncertainty up there and when these changes have happened in the past, it has created a lot of dissent and discontent.

Mr FERGUSON - Chair, I am happy to explore this with you and to the greatest extent that I can. I will just put an overriding point that there are processes currently underway which involve negotiations. So that would be the only reason why, in some cases, I may not be able to provide you with a fuller answer than you might wish. I also invite to the table Dr Ruth Kearon who is project managing this area, the North-West Maternity Services project, engaged with us specifically on that project, so that will be of assistance.

I will give you an update. Maternity services on the north-west are currently provided by both the Mersey and the North-West Regional Hospital through a contract arrangement with North-West Private Hospital. As you have indicated, Chair, as part of the reforms, birthing and inpatient maternity services will cease at the Mersey and be consolidated to Burnie. Burnie was selected as the single site for inpatient services because it provides access to the higher dependency services and other necessary support services, including paediatrics.

Access to the birthing services for people from Circular Head and the West Coast was also a relevant consideration and this provides an opportunity for us, after many years of various reports and recommending change, the change that was avoided, the opportunity to deliver a high quality service for all women and their families in the north-west, by building an integrated north-west maternity service that provides accessible antenatal and postnatal care in all sites, including Burnie, Latrobe and a number of rural sites.

The north-west integrated maternity service will ensure an appropriate team of specialists can deliver high quality and safe birthing and inpatient maternity services for mothers and babies in the north-west. It is important to remember that this is all about ensuring the safety of mothers and babies. It is also necessary for us to sustainably attract and retain midwives, obstetricians and critical support staff, such as anaesthetists and paediatricians.

So to implement the integrated service, the THS Maternity Transition Project Team has been established. The team is planning the service model for maternity services that includes an

integrated birthing and inpatient maternity service in Burnie. And of course, Chair, you would be well-aware that there is a contract already in place with the North-West Private which is evergreen in nature, which does rather cover the way in which we, as a Government and the project team, need to conduct ourselves to get the best outcome for mothers and babies and for the state.

So subject to ongoing contract discussions, we expect to be able to announce the specific site location of the new service next month. That is the goal.

CHAIR - Of the birthing component?

Mr FERGUSON - Yes, of the inpatient service location. Yes. At least eight weeks' notice will be given between the location announcement and the formal transfer of services, in ceasing of birthing at the Mersey. So that was a deliberate decision of Government to ensure that people did not feel that there was an impending and sudden service change that would occur, and we envisage it may in fact be more than eight weeks, but it would be at least eight weeks' notice be given.

There will be no sudden changes, and neither should there be, to the delivery of maternity services in the north-west. Birthing and inpatient services will only be moved when everything is in place to ensure that it can be done safely. The Government will make sure that there is adequate time for staff and expectant mothers to make decisions about their future options. The Government will communicate with the community, in particular expectant mothers and their families, and our staff, to ensure that people are very clear about where they will access services once the inpatient service is moved.

So while there will quite clearly be changes to staff working arrangements to implement the new safer service model, as I said yesterday, there will be no need, nor a desire, for any forced redundancies. The THS will work to maximise opportunities for the midwifery team from the Mersey to be part of the new service. I would like to add to that as well, because I notice some comment overnight that I had dodged a question about people having to reapply for their jobs.

There will be no requirement for people to reapply for their jobs. I just want to close that gap. But there will be a change to the way that we provide services to our community. I know that all our staff, because they are so professional, will be naturally wondering and in some cases concerned about where this leaves them, 'What happens to me?' We make a commitment that we will continue to communicate at the earliest opportunity. Where there is news to be provided, we will share that with our staff.

We have plans in place to be continually listening to and sharing information with our staff and from my point of view as minister, I want to gently put out there that this is a change that has been called for, for many years, report after report and advice after advice. Today's Government has now made a decision. It is important now that we ensure that the decision is carried into - is implemented successfully with a definite and continued focus on the safety of our patients. That is exactly what I am aiming for.

Before going to other questions I emphasise another point in relation to the evergreen contract. So while it is an obvious choice to support the ongoing provision of inpatient maternity care through the North-West Private Hospital, I want to let the committee know that we are also actively exploring other options. In the event that we continue a relationship with the North-West Private, we would expect the North-West Private to resume providing a private maternity service to women on the north-west as part of any new agreement to support choice.

CHAIR - There is a lot in that, minister.

Mr FERGUSON - There is.

CHAIR - I could go a long way with some of that. The uncertainty is difficult. Maybe there is a time for questions later.

I haven't read the commentary around reapplying for jobs, I don't know what was said, but if midwives at the Mersey who currently could be engaged in the birthing aspect of the care of women and I am not sure, I haven't been there for a while, so the case models that certainly run in Burnie and to an extent they were at the Mersey, with midwives and keeping them across the continuum, if - and it is if because you have made all these opening sort of comments there that make it very hard to know where you are headed, if those midwives want to continue to operate across the continuum, particularly in the birthing aspect of a woman's experience, then they potentially, under the current arrangements, wouldn't be employed by the government, they would be employed by a private operator.

So in that case, employment - if they did need to apply for a job with a private operator, then potentially they would lose their years of service and all the other benefits they might have accrued that way. However, if, as I have said for some time now, it would be good to see a public birthing centre back in the public sector, then that may prevent that. So your comments, veiled as they were, were perhaps a little bit encouraging along that line. I won't put you in a position where you have to answer that directly.

Mr FERGUSON - Thank you, because you will appreciate that when a government is negotiating, as we are, with a private contract holder, it is important that all parties understand that bargaining should be genuine and real. That is where I want to keep that conversation - and that is about as much as I want to say. So we are actively exploring other options, but I have also said it is a reasonably obvious choice, given the nature of the existing relationship with the private.

I invite either or both of the CEO and Dr Kearon, Dr Alcorn and/or Dr Kearon, to bring some response to what you have said, Chair, bearing in mind we are not ready to indicate what the model of care will be at this point in time.

CHAIR - When are we expecting that?

Mr FERGUSON - That will be announced in tandem with a site location.

CHAIR - So what is the time frame for that?

Mr FERGUSON - We are aiming for next month - July. But if it took longer or shorter, in any event we have provided a buffer, a sense of comfort, that there will be no sudden changes. A buffer has been assured of eight weeks.

CHAIR - We would need buffers in that.

Mr FERGUSON - People need to be well aware of any proposed changes, well in time for them to make their own decisions and preparation for the important day. So I wonder, it is difficult for us to be opening speculating on the model, but I have said, and I say to this committee, to our

staff, our great and valued and respected midwifery team at the Mersey who are the group of people who perhaps feel most concerned, and that is understandable, I have said to them that we will ensure that any opportunities that we have for them to continue their skill will be maximised.

CHAIR - It is important for their professional registration and everything else.

Mr FERGUSON - That is right. So we are supporting that principle, but people do need to understand that we are doing everything that we can to get the best possible outcome based on a range of factors that are in play at the moment.

CHAIR - Just a couple of points I would like them to cover, perhaps, in their response is some of the important services that are provided currently on the north-west, including case load models of care, early discharge and the support around that, as well as the access to antenatal midwifery care, as well as obstetric care.

Dr ALCORN - I guess the first prefatory comment I would make is that we have been very involved with people on the ground, including the nurse unit manager of the unit at Mersey and also the director of obstetrics there and the staff, so there have been a number of consultations now and I am very confident that Dr Kearon and her team have secured cooperation for a dialogue and a meaningful dialogue about the models of care issue raised here.

There is no world in which we would not want someone who is involved in providing birthing services to be able to have that experience somewhere in our system, whatever the outcome of this process, and obviously we do have a number of birth suites outside of the north-west, but I will pass over to Dr Kearon at that point.

Dr KEARON - I am happy to address that. As you are aware, there are different models running in the north-west, both at Burnie and at the Mersey Hospital. At the moment, there is a case load model in Burnie, there is not a case load model at the Mersey Hospital at this point in time, but there is a very good antenatal service which is run by the midwives there who often are working in the birthing suite at different times. As part of this project, we are looking at the maternity services across the whole north-west region and what we are looking to do is to provide an integrated service which provides good access close to home for antenatal and postnatal care.

To that end, there is an assurance that there will continue to be antenatal and postnatal services run from the Latrobe site, as well at the Outreach site. Currently, the Mersey Hospital runs those Outreach clinics and we are continuing to negotiate with the funding streams that support that to ensure that we can continue the current level of service through that Outreach clinic.

They also provide, as does the Burnie end, some well-coordinated postnatal support. They have an early discharge program which is named up at the Burnie Hospital which provides outpatient support. We are looking to strengthen the antenatal and postnatal services across the coast as part of this project and we think that there is a really good opportunity through this service change to actually work across the services to improve the quality of the services at that end of the state, and by combining some of the volumes, we have a much better opportunity in terms of recruitment and retention of our medical staff which has been a very longstanding issue in the north-west.

CHAIR - Particularly in anaesthetics.

Dr KEARON - Yes, absolutely.

CHAIR - That has been a major problem.

Dr KEARON - Absolutely. So as the project team, we are spending significant amounts of time at the Mersey Hospital and in Burnie working with the staff on the ground. We are as inclusive as we are able to be with the maternity staff and we meet regularly on a four-weekly basis with the maternity unit staff in the Mersey, as well as in a much more detailed way with people across the coast, in terms of developing the service model.

Of course, as the minister said, we don't want to prejudice any of our discussions with the North-West Private Hospital, so it does limit some of what we can go forward with today.

Dr ALCORN - So clearly, models of care are inherent in any contractual negotiation, if one were to take place, so it really is not possible to go any further with that, at least from our perspective.

Mr FERGUSON - But the things that we have been able to say and wanting to say have been in an environment where a number of staff have felt that a decision to consolidate inpatient and birthing services at Burnie would mean that they lose their jobs, or that they are no longer needed. So we really value our team at the Mersey, and I have shared this with them personally, I understand how you feel, I would feel the same way if I were you. I feel that people have accepted broadly that the decision has been made and that we now need to make the most of it, and also understand and accept that people will continue to have hopes of the kind of service they will be part of.

So we have taken all of that onboard, we are not being cavalier about this at all and we are seeking to get the best outcome in broad. I do say that the chief outcome amongst all of the things that we want to achieve is an integrated and safer service, one that is reliable and secure into the future.

CHAIR - Mothers' and babies' choice.

Mr FERGUSON - Indeed.

CHAIR - And access to midwifery care. You see too much of it undermined in parts. I am saying across the world here.

Mr FERGUSON - Sure, indeed. In principle, I just agree with that, and that is where a lot of good people are doing good work to achieve that. I can assure you, chair and committee, it would have been a lot easier, if I can put it this way, politically to have left this alone for another minister another day. That is not the kind of Government that we are. We have been willing to take the advice, understanding that there are inherent risks going forward with just leaving things as they are, and doing what is right is - well, doing what you believe is right, in this case, for a safe service for mothers and babies, is exactly what we are targeting our work at, and within that, to the greatest extent possible, we will seek to maximise the opportunity for our valued staff, who at times haven't felt valued, to be part of the new service.

CHAIR - Some of that flows back to a former prime minister who interfered with the Tasmanian Health plan. We almost got to this point some time ago, so, and good on you for

following it through now, but we could have been so much further down the track if a certain person hadn't interfered in the way they did. That is a personal view shared by many.

Going back to this call for breastfeeding, that is a really important aspect of postnatal care, what is being done in that space?

Dr KEARON - Essentially, we are recognising that that is a really important part of maternity care and we would anticipate that across the coast we would strength the postnatal support that is available, especially in that initial two-week period.

CHAIR - So lactation consultants and that sort of thing are all part of this mix? You are engaging more with lactation consultants?

Dr KEARON - Yes, so we are certainly, in the service model, considering the needs of that postnatal period, including lactation consultants and other midwives who have skills in the lactation space.

Dr ALCORN - Yes, I would go out on a limb and venture lactation consultants will be part of the standard of care, and certainly with Launceston General Hospital probably getting its reaccreditation as a baby-friendly hospital. There is a very strong support for that.

CHAIR - So we don't have a performance information - we used to - about breastfeeding rates. While we are on that topic, do you have any performance information about breastfeeding rates across our hospitals?

Dr KEARON - I don't have to hand.

Mr FERGUSON - We will take that on advice.

CHAIR - Over the last two or three years would be good, to see what the trends are, and broken down to regions.

Mr FERGUSON - Just help me understand the specific question?

CHAIR - It is breastfeeding rates. They usually do it at six weeks and six months - I think that is still the case.

Mr FERGUSON - So it is a follow-up monitoring, is it?

CHAIR - Well, seeing how long women are breastfeeding. On discharge and then six weeks.

Mr FERGUSON - I am wondering if that is a CHAPS - the other minister's portfolio, Child Health and Parenting Service. That is perhaps why it is not in these. I am happy to come back and provide you with whatever I can.

Dr ALCORN - We may well have some data about breastfeeding at time of discharge.

CHAIR - At the time of discharge, but that is all collected in the discharge - in the prenatal mortality forms. Yes.

Mr FERGUSON - I might suggest, if I am slow in giving you that information, that if you haven't already met with the Minister for Human Services, that would be -

CHAIR - We don't scrutinise her. That is the other committee.

Mr FERGUSON - I will seek the advice and provide what I can to this committee.

CHAIR - Okay. Other questions on admitted services? Anyone else want to have a comment there? Did you want to talk about the Royal?

Mr FARRELL - Minister, just within relation to the Royal Hobart Hospital redevelopment and the problems that have been apparent of recent times, how will this affect your time frame moving forward for the hospital redevelopment?

Mr FERGUSON - Chair, I will follow your lead on this. I would have expected this in Capital Improvement Program, Infrastructure Program.

CHAIR - One of the other members wants to come back and ask a question, so we will deal with you while we waiting for that.

Mr FERGUSON - If you permit me to answer it, I will answer it now.

Mr Farrell, thank you for your interest in this project. Given the Chamber that I am in, I will moderate my remarks somewhat in that this has been a project which has been subject to significant governance, patient risk, financial and time frame failures when we came to office. In fact, as it happens, our chair of the Tasmanian Health Service also served the state as chairing the Royal Hobart Hospital Redevelopment Rescue Taskforce, Mr Ramsay.

The initial advice of the task force was that it was even questionable whether the project could have proceeded at all, such were the challenges that the overall project was facing and I have put the view forward that without a change of government perhaps we wouldn't have a project at all. So there is a range of changes that have been made to the project itself. Broadly, they include dealing with the governance issues and developing a stronger model for the way that decisions need to be made, having points of authority resolved and clear time lines and accountabilities for the project to be managed.

It also includes a change to scope. That includes on the basis of identified patient risk which was taken acutely unwell patients away from the hospital which is where they needed to be admitted - after all, they are hospital patients for a reason - so taking those patients offsite to another location in Hobart was identified as a key patient risk. That is why the project was modified to keep those acutely unwell patients onsite through the use of a temporary building which I am sure we will come back to in a moment, and as an interim way of keeping our patients onsite in safe, modern facilities while the building that they are coming out of, B Block, is demolished.

Second, for improved mental health facilities with more contemporary standards and outdoor space, the accelerated replacement of the hypobaric chamber at significant cost, but which amazingly was identified as a construction risk which was a massive issue, and of course, as I have alluded to earlier today, the addition of a helipad and it is breathtaking to think that a government could build a tower in a brand new building in a capital city hospital and not have a helipad, so we

have included that. So that is the new project which you didn't ask me about, but I just feel that is the context.

Since that time, the Government has also approved significant extra funding to meet the cost blowouts that had already occurred, bring it back within scope and set it on a proper time frame. Importantly, and as is public knowledge and which I have openly and honestly disclosed and talked about, the development of the temporary inpatient facility has been delayed. It is facing a number of challenges, in particular workmanship and the quality of the buildings not meeting what we had required in the tender.

The tender was not won by an interstate business. It was won by a Tasmanian business, Fairbrother, and as such, Fairbrother, including its principal, Mr Fairbrother, have given a commitment to me and to Government that they take responsibility for remediating the buildings, acknowledging that the mould that has resulted from water damage is a major concern that they are addressing and it will be addressed at no extra cost to the taxpayer.

I acknowledge that the Opposition want to point score on this and they have been doing so just about every week, but they never have solutions; they only ever have problems. I am solutions-oriented and I have made it clear that it is my expectation and the Government's expectation that the managing contractor will work diligently to meet the contractual obligations that it has, and because in your question, Mr Farrell, you asked me what is the time frame, so the managing contractor is under contract to complete K Block by the end of 2018 and I think everybody acknowledges that that is an ambitious time frame, but it is nonetheless their contracted obligation.

The Royal redevelopment will not accept possession of the new temporary inpatient facility until it is independently verified that it is safe for our patients and our staff and it is fit for purpose. As a major construction project, we need to acknowledge that the Royal redevelopment will face issues during its lifetime. This is one; no doubt there will be others. All issues will be responded to quickly and thoroughly to ensure the safety of patients, staff, and of course, people who are working on site.

I need to emphasise, and I do emphasise it for the committee, and we all need to understand that the Government does have legal rights in this matter, as you would expect us to. We have secured legal rights, but because many of the matters that will get invoked in questions of this kind are in fact commercial matters, I am not in a position, and I won't, potentially compromise the Government's legal rights under the contract through public speculation.

It is important to note that the project is continuing and last week I had the pleasure of visiting and seeing the new 9A in A Block which is now ready for our cancer patients to move into as part of the decamp plan. Thank you, Mr Farrell.

CHAIR - I was asking earlier on, minister, when you suggested that it might be better to have other people at the table, and this is the National Partnership Payments on page 117 of budget paper volume 2. The comment on the NPP there, and NPA funding, is that it is to be $16.1 million in improving health services in Tasmania, elective surgery, but the table on page 85 in volume 1 has a National Partnership Payment of $7.5 million, in reducing elective surgery lists.

I am not sure why there is a discrepancy. Which figure is right and how do you explain the difference in those two?

Mr FERGUSON - Just between us, I have not seen output 1, but it does not worry me. I will reintroduce Mr Reynolds.

CHAIR - In Output 1, you had it?

Mr REYNOLDS - Thank you, minister. Budget paper number 1 reflects the moneys the Treasury has received from the Commonwealth. Budget paper number 2 with the THS actually reflects when the THS has drawn the money down once the activity is done. So there will be a timing difference issue between the numbers, they will be different.

CHAIR - We have drawn down $16.1 million, but we have only received $7.5 million?

Mr REYNOLDS - There would have been moneys received prior, previous financial year. Prior financial years, from -

CHAIR - So $16.1 million is the total being spent, so we are not spending $16.1 million this year, we are spending $7.5 million this year?

Mr REYNOLDS - $7.5 million is in budget paper number 1.

CHAIR - Yes, that's right.

Mr REYNOLDS - So the money has already been received from the Commonwealth Treasury and is with Treasury, so they effectively bank it for us and then it is available to the THS when it has done the activity, and draw it down.

CHAIR - In terms of this, then, minister, you talked previously about the improvements to elective surgery waiting lists, particularly the high number of patients that were over boundary and the improvements you have made there. So how much of this money, the $16.1 million, has actually been spent and how much more do you have to spend? Obviously, it will run out.

Mr FERGUSON - Yes.

CHAIR - And then what?

Mr FERGUSON - If I need to get further specific data on how much is remaining, I will obtain that for you. Somebody may be able to bring that forward in the meantime. That is limited term funding and I understand that the money must be used by 31 May 2017. So we must use it by then, bearing in mind this was one-off funding from the Commonwealth. So that is the Commonwealth's elective surgery special additional funding which was supplemented, or grown to a larger number, in 2014.

When I was answering Mrs Armitage's earlier question, I talked about that because it has been important to balance the way in which the funds are used in this. That is why we have approached it in the way that we have, and under the project agreement that we signed with the Commonwealth, one thing that we were obliged to do was in fact establish the private panel, but we are not obsessing about that panel. It is really about ensuring that the funds are used prudently to get the best possible number and quality of outcomes for our patients while ensuring that the Tasmanian Health Service's own employment is sustainable into the future as well.

To that end, we have opened additional elective surgery theatres or surgical theatres at the LGH and the short-stay surgical unit has been opened as part of that work because a lot of people are working very hard and of course, the Mersey is a part of providing additional volumes and the Royal. I believe that we say the best way to describe the extra activity there is that we have opened the equivalent of another theatre in terms of case load.

CHAIR - Do you have a breakdown of the categories of surgery that have been undertaken in which facility under this program?

Mr FERGUSON - By facility? I couldn't commit to giving that data, but if I can, I will provide it. I could rapidly provide the committee with data or detail on the mix of patients and from which categories they have been selected. Would that be helpful?

CHAIR - That would be helpful too. The reason I am asking is because it is easy to do 10 000 cataracts and a lot harder to do 5000 hips.

Mr FERGUSON - My informal advice on this is that the complexity of the mix that we have been supporting has actually been on the higher side, but I would like -

CHAIR - That is what I am interested to hear, find out.

Mr FERGUSON - to have that verified before you take me as a quote. We are certainly doing cataracts and ophthalmology surgeries of course, but the informal advice that I can share with you now is that many of the long waiting, over boundary cases, particularly in the non-urgent, is that they are more complex than average. I would like to have independent advice. The secretary would be the best adviser on this, if you would? Either now or later?

Mr PERVAN - Yes, minister. I have just been trying to get some data for you.

Mr FERGUSON - To be very blunt about it, we have been very open now for three Budgets, I can remember. We have been very deliberate in our focus on the longest wait patients. Now, of course, if somebody is a category 1, it is urgent, ideally, within 30 days. That continues, but it is about getting the balance right here. We have tried, the Health system manager, that is the department, and the THS as a provider, the main provider, have been working to continue to meet our responsibility to care for patients that need it in a proper priority fashion. But while we have these additional funds available, we have had a deliberate strategy, not just of banging through large numbers, the strategy has been to target those people who have been waiting for years.

CHAIR - Paediatrics was another area, wasn't it, last year, you mentioned?

Mr FERGUSON - You are quite right. In our first Budget, the Government and the secretary made a policy decision to treat all over boundary children, which is exactly where we all want to be, but in the meantime, we continue to have large numbers of adults who were not just over boundary, but substantially over boundary, 120 of whom have been waiting more than three years.

CHAIR - So can we get that information?

Mr FERGUSON - Secretary, can we? By hospital?

Mr PERVAN - We can do. It will take us a while.

Mr FERGUSON - Yes. Please understand that may not be readily available, but we will make a commitment to provide you what we can.

CHAIR - Initially, in the first instance to get the categories of surgery that have been undertaken under this funding.

Mr FERGUSON - Under the Commonwealth funding?

CHAIR - Yes, the additional funding that you got for this purpose, under the National Partnership Agreement.

Mr FERGUSON - I will provide you what I can, but let's be clear, we have an elective surgery plan which is an amalgam of our state $76 million addition which we call reviewing health services funding, and the Commonwealth short-term available funding, and to the extent that I can break it down and itemise it, I will.

CHAIR - I am happy to have it all together. You obviously have a focus. I mean, the focus wouldn't be different with each category, are they? Or are they?

Mr PERVAN - I just need some clarification. When you say 'category', do you mean urgency category 1, 2, 3, or do you mean orthopaedic, ophthalmic and the type of surgery?

CHAIR - They type of surgery, yes. Someone is shaking their head behind you. Maybe it is not possible to get that.

Mr PERVAN - It will take us some time to extract it because the focus has been, as the minister said, on over boundaries regardless of where the surgery is.

CHAIR - If you can give me detail around the category in terms of whether urgent or not urgent, whatever it is, 1, 2 and 3. Yes.

Mr PERVAN - As per the minister's commitment, we will extract the data in whatever level of detail we can. With the minister's indulgence, there has also been some talk in various places about the panel arrangements and the contracting out being used to target the cheap and easies or there is cherry-picking going on. It is actually a conclusion of the commission on delivery of health services in Tasmania that our own public services were doing the cherry-picking and choosing to do the fast through-put, easy cases and that those that were going over boundary were the complex cases. They have been waiting the longest, so in many ways, this work with targeting the over boundaries has actually tackled those long wait cases and that is why the average waiting time has come down so dramatically because of those long waits.

CHAIR - So they are being conducted in the public system, though, or some are going to the private as well?

Mr PERVAN - Some are, some aren't. Some are going to the private.

CHAIR - So some of the more complex, over boundary cases are being done by private.

Mr PERVAN - They have. But equally -

CHAIR - So the state has been, or the public system has been picking out some of the quick and easy ones?

Mr PERVAN - That would be the assessment of the commission two years ago. Now, equally it is important to note that given the nature of clinical services in the private sector and particularly critical care backup, it is entirely appropriate that those more complex cases are done in the public sector where they have the highest propensity of wrap around care, intensive care and clinical support that you would need for those complex cases.

Our concern is the system manager was watching those complex patients waiting longer and longer and longer without a booking for surgery. One of the things that I wish I had said yesterday was it is important to note that of those cases that have gone to the panel contract, they were all over boundary, or would have been, by 30 June, but none of them had a booking for surgery. So some of the allegations that have been raised in public that these patients were booked and we have somehow snatched them and sent them to Melbourne and dramatic statements like that, we only selected patients on the advice of the CEO, and it was very good advice, who were not booked for surgery.

The fact that after they were given that opportunity, mysteriously were given an offer or a small number were given a date for surgery, that was a clerical or administrative error that we cleared up very quickly. But certainly we have been targeting people waiting.

CHAIR - So some of these were complex cases. I expect that some of them couldn't have been safely conducted in some of our private hospitals in Tasmania?

Mr PERVAN - I would agree.

CHAIR - The only way to get it safely conducted would be in a mainland private hospital where they have all the backups that we don't have because of our size. Particularly neuro and things like that.

Mr PERVAN - Interestingly, there are some procedures which are only done in Victoria, and of course, Tasmania has been transferring those patients -

CHAIR - Forever.

Mr PERVAN - to Victoria, Flinders in South Australia and New South Wales, yes, forever as you point out. But we have been working very closely with the THS and certainly the CEO has focused on the 20 longest waiting patients and I think they are all now booked or almost. We certainly have a very strong focus on those 20 complex, long wait patients, or even if they are not complex, they are for procedures that are very rarely done in Tasmania, so we may have to bring a specialist surgeon in to do them.

CHAIR - Which carries the same problems as sending them out, yes, or the same issues. I was just saying they are not really problems, but the same challenges as sending a patient out, not knowing the whole history and everything, as opposed to bringing in a surgeon in who doesn't know the whole history.

Mr FERGUSON - Yes. One thing I would add is that when a patient who has been on the

waiting list, whether it is long or short overdue, or within time, and has been contacted by the department, it has been an offer or it has been an opportunity to express a desire to take up the opportunity. It has never been, 'You have been selected to go to Calvary Hobart or Epworth'. It has been a question, 'Since you haven't been booked in Tasmania, would you like the opportunity to have your surgery elsewhere?' It has been entirely optional, and if the person says no, of course we will continue to keep them on our list and not disadvantage them in any other way.

CHAIR - Is that how you are going to deal with the Hobartians, trying to get them up to the Mersey? They won't be forced to go? It will be their choice?

Mr FERGUSON - I have missed something along the way there, sorry.

CHAIR - I just said is that the same practice, you are going to take Hobart residents, perhaps, who could have their endoscopies or whatever it is you are going to be doing at the Mersey an option or -

Mr FERGUSON - I have been given advice that there will be some procedures, for example, endoscopies that would be not a wise move to ask people to make the trip to Devonport, for those, but for others, we are -

CHAIR - Because of the pre-treatment. It is always unpleasant, but there you go.

Mr FERGUSON - But nonetheless, that is the vision for the Mersey, to be the only one of our hospitals that has a dedicated surgical focus on elective surgery that can't then be interrupted by overriding emergencies. You have seen what we have done with the PTAS scheme to enable patients to travel from outside, and I invite the CEO to describe the assessment process as well.

Dr ALCORN - I just wanted to give you some reassurance about the arrangements and the secretary could equally have said this. Where possible, we have attempted to have people who are going to be travelling interstate assessed within Tasmania to minimise those transports and with the patients' permission, have given those specialists access to the digital medical record so in terms of understanding their histories and so forth, we have done what we can to make those necessary facts available to them.

CHAIR - Some of these surgeons actually visit the state anyway, don't they?

Dr ALCORN - Some may, but these are panel providers that we are talking about.

CHAIR - Okay. Sorry, yes. Leonie, you had that question about how many have taken up the offer.

Ms HISCUTT - I did.

Mr FERGUSON - I know that there is a very high take-up, but the secretary would be best-placed to give guidance on that.

Mr PERVAN - This relates to the panel contract which the department, in collaboration with the THS, put in place. There have been other patients who have been transferred to other public and private providers directly by the THS, but in relation to the panel contract, we called or phoned 1500 patients and gave them the offer and the choice, and once we got to 414, which was a

performance target set by our minister, we arranged for those 414 acceptances to immediately go into the referral process.

We have then subsequently written to another 500 and made offers to them. So there is a very high take-up rate and it has been of immense benefit to people working in the department who are career public servants to have been having the experience of actually ringing patients and making them the offer and the positive feedback, the uniformly positive feedback, that we have had has been, in some cases, quite emotionally overwhelming for the staff.

So from our point of view, patients are being treated who have been waiting a very long time. They were very happy even to get the offer and to say, no, I'll stay with my surgeon, but just to have that direct contact, they have been incredibly positive and responsive.

Mr FERGUSON - To put the secretary's numbers into perspective as well, I was earlier able to indicate in the 12 months to April 2016, Tasmania achieved a record number of elective surgeries. The actual number is 17 590, so it is a significantly higher than usual number of patients being cared for. The point I am making here is that I want to moderate any view out in the community that might be promoted by a particular interest that we are just sending all of our patients to private. We are not. We are absolutely maximising opportunity through our public and using the public panel providers as a balancing service.

Mr GAFFNEY - One of the issues that has come up on a regular occasion is that people who fail to show up, present, and one, they don't contact, or two, they contact and say, 'Look, I haven't been able to fulfil what I need to before the actual surgery'. I am just wondering how the numbers go on that? Is there a better sense, or how do you measure that? Do you keep some stats that you could provide to us at a later date, saying from year to year this is the situation? That must be a nightmare trying to have an efficient system if people just don't meet the obligations.

Dr ALCORN - Yes. The critical issue is making sure that people are ready for care, and readiness for care, it is availability, willingness, as well as their physical health or changes in their physical health. So the secret to maintaining an up-to-date waiting list and to avoid people either receiving messages to come for surgery and then it being found that their other medical condition prevents that surgery from going ahead, or other reasons, is to keep that list up to date.

In terms of people failing to attend for treatment, that is probably more commonly seen in the outpatient setting. Usually we have very assiduous efforts to contact people before surgery and indeed, if people are listed at outpatients by their surgeon, we would also be giving reminder calls before the surgery.

Mr GAFFNEY - A follow-on quick question to that, alternately, sometimes if you are on the other side, that gets media coverage, so and so was booked in and someone wasn't available, there wasn't a room available, or the surgeon was ill or whatever. Do you keep measures of that? Do you keep stats on those?

Dr ALCORN - With some disciplines we do, particularly disciplines that are affected by cancellations significantly. An example of that is around emergency care versus elective care. So a typical example is if the intensive care unit is especially busy with trauma and other victims, it does make it difficult to schedule procedures that you know will post-operatively require intensive care. So they are the domains that we tend to focus on, where there is a single resource and it is shared by both the emergency flow and the elective flow.

Mr GAFFNEY - My last question is, therefore having a place like Mersey as a dedicated elective surgery means that you would have fewer interruptions to that sort of service performance for the whole state?

CHAIR - For the less complex.

Mr GAFFNEY - For the less complex ones, yes.

Dr ALCORN - That is a very important point to make. The cases that require an intensive care unit must be treated at those facilities and we do need to be very circumspect and make sure that people fit the profile of the facility that they are sent to.

Mr FERGUSON - I thank you, Mr Gaffney, for being in the hot seat in the Mersey area and I compliment you in particular for your impeccable responsible approach that you have taken and the Government appreciates it.

Mrs ARMITAGE - I am going to ask a question that has been on the notice paper since 7 April 2016. It has been there two months and I thought it is probably a good time to ask it again. The Government previously indicated there would be savings of between $21 million to $23 million from collapsing the three Health organisations into one. I have a few As and Bs to this question. Can the Government provide the detail of the current appropriation of $10 million in the consolidated fund appropriation, supplementary appropriation 2015-2016 bill? That is A

Mr FERGUSON - Mrs Armitage, I have two pieces of information to share with you. You have asked me about two different but related matters falling all in Finance, but two different matters. One is about the additional supplementary funding that was provided in the RER, the $10 million, yes? And you have also asked me about ongoing savings that have been realised as a result of amalgamating the three formerly regional THOs. I will address them in turn and if I can tie them together at the end, I will.

I would like to indicate that the Tasmanian Health Service and its [inaudible] organisations, the THOs, to varying degrees have had different financial results, to varying degrees have had different annual financial outcomes, where they have been supplemented for additional funding in some cases, in many cases. The amalgamating of the three now brings those, if you like, structural deficits, structural overspending factors together into one organisation.

In 2014-15, the outcome was a $32.3 million deficit, which included $6.8 million of WRIPs and TNBR costs. Adjusting for that, the outcome was $25.1 million which was met by Government and that was a combination of an additional request for additional funds, a small loan from Treasury and also the department, so a combination. In the new financial year, or in the current financial year, 2015-16, at the end of March the forecast was for an $8 million deficit which will be funded by the supplementary funding you referred to as per the RER of $10 million.

My latest advice is that to the end of April, the forecast was for an $11 million deficit, predominantly reflecting an increase in TNBR and WRIP costs, which again will be funded by the $10 million from the RER plus additional Australian government revenues. That is information that I provided yesterday to the other committee.

Mrs ARMITAGE - So the inefficiencies of some organisations, they are not going to be

masked by the efficiencies of others?

Mr FERGUSON - Well, you could characterise it, I suppose, however you want. The fact is we have one organisation. We have maintained the service profile broadly and we are now going into a new phase, supported by our $29.5 million budget allocation to support the new service profile which in different hospitals shows - is aimed at achieving the new clinical service profile which is about better care, better service.

Mrs ARMITAGE - I am looking for where the savings are going to come from eventually, the $21 million and $23 million, particularly if some areas are still going to be carrying deficits.

Mr FERGUSON - I am shortly going to come to that as well, but I want to say that there is nothing in it for the Government to try to mask -

Mrs ARMITAGE - No, I am just looking for the gains, that is all.

Mr FERGUSON - I appreciate that and I am just saying that bringing the three organisations together means also bringing together the three sets of books. That is the only point I am making. One must recognise that while I expect, and the Government expects our agencies to come in on budget, we always expect that and we always make it clear that that's the expectation, by the nature of the service that we provide it is historically the case that Government each year has to examine what support that the service requires. That is where we are at right now.

Let me come to the savings because there have been savings and I can give you some specific savings to date that have been able to be captured, bearing in mind that there will be efficiencies that we can't capture in a reporting sense.

So specific savings to date include the WRIPs and TNBRs that I referred to. So it is expected that those savings will capture a savings valued at $1.5 million in 2015-16 and ongoing savings of approximately $2.3 million from 2016-17 onwards. A quick calculation on my part suggests about a $6.1 million efficiency there, bearing in mind that earlier today when the Chair asked me some questions about FTE, I was able to show that we actually have more nurses, it is just a reshaping of the organisation.

Other savings achieved as a result of the consolidation include $4.1 million by shared services and a modest reduction, but a reduction in the cost of governing council fees of $62 000. So I make it there approximately $10 million of savings have been achieved directly as a result of the consolidation. Naturally, now that we are a new organisation, we look in the rear view mirror much less these days. We are much more interested in looking to the future, asking, is the budget that is provided for THS being used to make it the very best number and quality of safe outcomes for the community, and naturally, we look to our - well, we look to the THS to ask those questions and to act responsibly with the funds that it has been provided with.

Mrs ARMITAGE - On that, minister, is there a cap on how much additional funding will be expended to enable the THS to transition fully into a single statewide service?

Mr FERGUSON - My answer to that would be the same as my earlier one. We have, however, provided record funds in Health, much as our critics would say otherwise. It is record funding and people will, and quite rightly, say we can always spend more. We can always spend more, there is no doubt about that, but it is a very responsible Budget and even though it is the case that we have

had to make difficult decisions early on, we are now able to provide the benefits of those Budget repair initiatives so there is extra money now for Health, more than we had in the previous year. It is growing, but as always, we need to be responsible with those funds and we look to the THS to run in a businesslike fashion, and as you said, as we are now a single organisation, to always recognise that it is not our money, it is taxpayers' money.

Mrs ARMITAGE - That's right.

Mr FERGUSON - We need to get the very best value for it.

Mrs ARMITAGE - Having said that we are single statewide service, can you tell me - this is still part of the same question - how many staff have left the Launceston General Hospital as a result of the transition to a single statewide service?

CHAIR - As a result of it? That is a really -

Mrs ARMITAGE - The question is, as a result of the transition? And from what areas have those staff been lost?

Mr FERGUSON - What I can do here to assist is refer you to a significant reshaping that has occurred in one of my two agencies, the department of Health and Women's Services, a significant reduction in FTE.

Mrs ARMITAGE - I just need to know, as a result of the single statewide service, has staff been lost and where have they been lost from?

Mr FERGUSON - My point is that we have reshaped where we put our funding. We have seen savings measures in the THOs. I absolutely don't walk away from that or pretend that it hasn't happened and we have seen staff depart the organisation, particularly THO South when it existed and now THS as a statewide single entity. We have seen staff departures. I don't know if I can give you -

Mrs ARMITAGE - I am happy to take it on notice.

Mr FERGUSON - I would need to take it on notice.

Mrs ARMITAGE - It has been on notice since 7 April so another week or two is not going to matter.

Mr FERGUSON - I will take your question which is on the notice paper as the question on notice.

Mrs ARMITAGE - That is the question. How many staff have been left the Launceston General Hospital -

Mr FERGUSON - Happy to do it.

Mrs ARMITAGE - as a result of the transition to a single statewide service, and from what areas have these staff been lost.

Mr FERGUSON - Yes. The latter part of the question, I will do my best to answer, as I always do. I am not avoiding your question. I am putting clear context on it.

Mrs ARMITAGE - My understanding is they are a quite considerable number and it would be interesting to know.

Mr FERGUSON - Let's await the advice. I think you may be surprised.

Mrs ARMITAGE - Yes. I am happy to await the advice.

Mr FERGUSON - I would like to share with you, though, that the THS is a much larger organisation than the amalgam of the three THOs than when we came to office.

Mrs ARMITAGE - In terms of staff?

Mr FERGUSON - In terms of frontline staff, it is a larger organisation. Particularly where you look at -

Mrs ARMITAGE - And I am happy to see that you have more nurses and less admin.

Mr FERGUSON - We do. We do.

Mrs ARMITAGE - But it would be good to actually see that.

Mr FERGUSON - Yes. Just as an indication - and Chair, I will take the question on notice as it is provided in the Legislative Council notice paper - but nurses, 3255 as of June 2014 and today, it is 3347. In fact, on 26 March 2016, 3347.82. So the organisation overall is modestly larger than - well, by 60 than when we came to office. My point here is obvious; we are reshaping the organisation and in particular there has been a process, subject to lots of politics and lots of people wanting to say lots of things about others, about staff being sacked, not the case. What we have done is in late last year we opened an expression of interest process for staff. Anybody could express an interest in a voluntary and negotiated redundancy or a WRIP, a Workforce Renewal Incentive Payment, but we only accepted expressions of interest from staff where they weren't absolutely necessary.

Mrs ARMITAGE - I look forward to that answer. The last part of that question is, in the new THS, how many executive manager positions are there and where are they based?

Mr FERGUSON - I can answer. The CEO might give me the number of your executive that you are building.

Dr ALCORN - Seven at present.

Mrs ARMITAGE - And where are they based?

Mr FERGUSON - Just a second. Could you please tell me the number of the proposed new executive structure that you are recruiting to?

Dr ALCORN - Certainly.

Mr FERGUSON - But their positions, I am pleased to tell you, Mrs Armitage, as the member for Launceston, not that this is parochial -

Mrs ARMITAGE - Oh, never has been.

Mr FERGUSON - For me, and I will tell you why.

Mrs ARMITAGE - Nor me, minister. Nor me.

Mr FERGUSON - I will tell you why - the CEO and his lovely wife have taken up residence in Launceston, and not that it is any of our business, but they have bought a house in Launceston and they live in Launceston because the position is based in Launceston. The executive that the CEO is building, all of their positions, have a statewide responsibility, but are based in Launceston. The CEO can speak for himself in a moment, but that is the case and it shouldn't be parochial. I am the minister who has made a range of decisions -

Mrs ARMITAGE - Based in Launceston.

Mr FERGUSON - My electorate is Launceston and I have a love and a passion for health reform that delivers better outcomes for the state. We can prove that it is not parochial by demonstrating that the agency doesn't need to have its administrative base in Hobart. CEO? Your executive structure.

Dr ALCORN - The executive structure at the first level at the moment consists of a Corporate Executive, the Executive Director of Nursing, Midwifery and Allied Health, a Chief Operating Officer, Chief Financial Officer, an Executive Director of Corporate Systems, an Executive Director of the Medical Profession, Executive Director for Patient Safety and the Executive Director of the Human Resources and Organisational Design.

Beneath them, there are three group directors, so that's not of executive level, but one for North, North-West, one for South and one for Mental Health. Now, I should stress that we haven't appointed to all these positions. We do have an active recruitment process underway and we do have an offer in relation to some of these positions, so I would rather not go any further than that.

Mr FERGUSON - Chair, if I may at this point indicate, thank you for the questions, any that I haven't answered, in particular the one that you -

Mrs ARMITAGE - You haven't actually said where they were based, but I will wait for that.

Mr FERGUSON - I have.

CHAIR - Yes, he did.

Mrs ARMITAGE - He said that the actual office, but - all right. I will wait for the -

Mr FERGUSON - But let's be clear. They won't be stranded in Launceston. They have a statewide responsibility and they will be expected and they will support the CEO as part of a statewide organisation that is focused on every corner of our state.

Mrs ARMITAGE - Technically, does it matter where they're based, if they're a statewide

function?

Mr FERGUSON - This is my point. It doesn't. Their place of where they are based is not as important as the role that they have. The function is to support the THS across the state. It is a point that I have gently made to people outside of Launceston, is that in fact it demonstrates not only that it is a focus on the state, but also that it is a picture of the appropriate level of separation between the purchaser and the provider and it is a good decision in that it demonstrates to all that the THS is here for everyone.

Mrs ARMITAGE - My second question, and it is a much shorter question, and it is something that has been raised with me quite a lot of times. I am sure it has been raised with you as well, minister, is regarding online pathology and radiology results in the public health system, and the ability for people that are not panel providers in the private sector that may be seeing a patient, to access those results. I have been told that sometimes a patient will go to a private provider's rooms, perhaps to get a CT or need some preoperative test, it takes too long to write to try to get the results, that the public system can access the private system online, but private providers, in their rooms, if they are not on the panel of providers, cannot access the online system of the public hospitals, which means sometimes there are delays, or sometimes people actually have to have tests done again.

So can you advise me, is it possible - I have been told that it is possible - that the hospital has the technology, that it can do it, so will the public system look to provide these results to save over-servicing, and particularly for patients, I believe, that a CT scan is the equivalent of a great number of chest X-rays and no one wants to have unnecessary tests that they don't need. So is there a reason that the public sector doesn't provide this, or doesn't allow the private sector to access those results?

Mr FERGUSON - I will offer you an answer in a moment. Is this the same question also as is on the notice paper?

Mrs ARMITAGE - It is, but I thought, while you're here and I had two questions, I would ask it.

Mr FERGUSON - I have no problem with that, just to clarify. So, secretary?

Mr PERVAN - It is possible. There are two limiting steps. The first is that for the public system to provide that information to a private provider outside the panel contract, it requires the patient's written consent because it is actually the patient's information, not the hospital's information. The second point is one about technology and the capacity of the private provider's technology to speak to our technology, but they are the only two limitations on any arrangement for the provision of CT scans, medical imaging, pathology results, for a patient out to a private provider.

Mrs ARMITAGE - So I should be able to get back to the people that have concerns, who have spoken to me, and I believe it has been ongoing for some time with many practitioners that are involved, that they have had great difficulty and have been unable to access it, so if they simply can provide - because it was part of my question on the notice paper - that with the patient's consent. I think you find that many of the specialists, particularly in the city of Hobart and Launceston and the larger areas, would have technology that was composite with the public system.

Mr PERVAN - With the permission of the minister, it will require a discussion and it will require organisation, but there is no legal or financial impediment to the sharing of that information in the interests of the patient and that would be our focus.

Mrs ARMITAGE - Could I ask that question how the discussion can occur, so that this can happen? I am being told that, at the moment, patients are being disadvantaged because some are having unnecessary tests and unnecessary delays because of the lack of access.

Mr FERGUSON - We will respond.

Mrs ARMITAGE - You will respond?

Mr FERGUSON - If I answer the question to the committee, do you take it off the notice paper, or do I have to do it three times?

Mrs ARMITAGE - No, no, I am happy to remove it.

Mr FERGUSON - We have now attempted to answer it, we will provide extra information.

Mrs ARMITAGE - I am happy to remove it from the notice paper, that's fine.

Mr FERGUSON - And I could do it through which other process would you prefer, though?

Mrs ARMITAGE - No. The Estimates is fine.

Mr FERGUSON - It is your choice, yes.

Mrs ARMITAGE - No, quite happy just to have the answer. It doesn't matter where the answer comes from, it's just within the community and it is a statewide thing. This isn't parochial, but I believe it happens right across the state.

Mr FERGUSON - You are absolutely right.

Mrs ARMITAGE - I am aware that with radiology, perhaps at the Launceston General Hospital, that has been put out to tender so I imagine that if it goes to a private provider, that actually might be taken care of with a private provider, that might not be the issue, but we still have the other issue of pathology.

CHAIR - Thank you, minister. How do you intend to answer this question? Could you just clarify?

Mr FERGUSON - I will be taking it on notice for the committee.

CHAIR - Thank you.

Mrs ARMITAGE - That is fine. Thank you very much, and thank you, Chair.

CHAIR - I have a question about the cardiothoracic unit. I understand that there has been approval given to build a centre at Calvary. There is some concern by the specialist clinicians that this will undermine the cardiothoracic unit at the Royal and that basically the approval has been granted to build the facility and they will need a licence which if they submit a compliant application, it will be approved.

Mr FERGUSON - Yes.

CHAIR - So there is some concern, I understand, by the clinicians.

Mr FERGUSON - I have heard some concern, Mrs Forrest, yes.

CHAIR - Yes. I would like you to update us on that because there has been a bit of dissent in the ranks, I think.

Mr FERGUSON - I will.

CHAIR - Or concern, certainly.

Mr FERGUSON - There has been a concern raised, that I am aware of, and I will keep my remarks minimal for reasons that I will explain in a second. There has been a concern raised. The granting of licences to a health service establishment, i.e., private hospital, is actually something that I have no say over. It is a statutory process that is governed by an act of parliament, the Health Service Establishments Act, and it actually establishes the process of whether a licence can be granted for a service to the secretary of the department, and only the secretary, and also the secretary to take independent advice.

For that reason, I will shortly ask the secretary to answer any of your questions on process, and he will, as he did yesterday, I am sure give an indication of the ways in which he might be guided into making a decision.

I have heard the concern put. I would like to emphasise for the committee's benefit that the suggestion that was unfortunately made in public that I had issued a licence to Calvary to establish its service is not true, on two counts. One, I don't have the power, and two, there's been no licence granted. It is wrong on both counts.

CHAIR - My question more to you, minister, is the potential to undermine the existing cardiothoracic, being we are not a big state.

Mr FERGUSON - I can answer that part of your question before deferring to the secretary. So responding to that, this, I understand, is an initiative of clinicians in the southern Tasmanian area. In particular, it includes our head of department of cardiothoracic - so the Director of Surgical Services and the Head of Department of the Cardiothoracic Surgical Unit, Services Unit, at the Royal Hobart Hospital is Dr Ash Hardikar, so I believe that he is one of the proponents, if I may put it that way, or at least supporters, of the proposed new service. Government is not, but as a clinician, that gentleman is.

In fact, I will leave it now to the secretary to further respond, but I want to say that this has come from clinicians who want to provide a greater and broader service to the community and as such, it is not a THS-initiated matter. I nonetheless appreciate your question, but I have to now defer to the secretary.

CHAIR - You still have not answered the question about whether you think a second one could undermine the viability -

Mr FERGUSON - My advice from Ash Hardikar is this, and I am quoting him. He has written:

> I would like to emphasise that the whole idea of a private cardiothoracic unit was to bolster the Public Sector Service and at no point to compromise it at all. The way I look at it, this is that once the private sector opens up the total workload in Hobart will go up and enable us to have three surgeons and three perfusionists. This was the opinion of Mr Paul Bannon, our ANZSCTS Chairman, as well as a couple of other surgeons in Melbourne.

So the only advice that I have from a relevant clinician on this, at least someone who is in the cardiothoracic service in our THS, is one that endorses growing the service in the south of the state.

CHAIR - But he is still in that position?

Mr FERGUSON - Yes. I do really now want to bring the secretary in because it is a statutory process, it is arm's length from Government. This parliament decided that it should be that way.

Mr PERVAN - So the approach to me as the licensor came from two directions: one was a couple of private providers who applied for a licence to undertake cardiothoracic surgery, and those applications were made under the Health Service Establishments Act 2006, which as the minister correctly points out, some days I regret it, vests the decision-making authority with me. The act sets up a health service advisory committee which considers the applications independently and against very, very specific criteria.

An important point to make at this point is that because of the act that we are talking about, this is only about private hospitals, not about public hospitals or public patients. So when we refer to the committee having to give consideration to the impact on other services or a critical mass of patients, it is the effect on other private services and the effect on -

CHAIR - That is a bit of a failing in the act, then, is it?

Mr PERVAN - No, because the act was put through to licence private health establishments.

CHAIR - Yes, I hear what you are saying.

Mr FERGUSON - I could speculate that it is about managing a conflict of interest that a minister may have.

CHAIR - Yes, that could be it, but I am just thinking about, it seems to be a deficiency, that in a small state like Tasmania where there is a specialised field, it is a process to enable a private operator to initiate a service that will compete with a publicly-provided service that could be undermined by the sheer fact that we don't have the critical - I hear what Mr Hardikar said, in terms of it could increase the activity, but if it can't even be considered or isn't considered?

Mr PERVAN - It actually will work because I will flip you back to a previous question you asked, and remember the decision to admit the patient for cardiothoracic surgery at the Royal is based on the clinical need for them to have surgery. It is not on whether they are public or private. That happens after that decision.

CHAIR - Yes, yes.

Mr PERVAN - So those patients, that volume of patients, will still come through the Royal, including private patients because they elect to go private after the decision to admit has been made. So that volume of patients won't change.

CHAIR - Elect to go private, in a private hospital?

Mr PERVAN - No, in the public.

CHAIR - Within the public system, yes. Yes.

Mr PERVAN - Say at the Royal. Now, the business cases that were presented by both of the applicants refer to a number which they have come up with of up to 500 patients which are currently receiving cardiothoracic surgery in Victoria and in other mainland states. So these proposals are being predicated on repatriating those private patients back to Tasmania.

CHAIR - So, two proponents there are? You said there were two proponents?

Mr PERVAN - Yes, but the fact that in terms of the impact on the public, there should be none because those patients, those volumes, will continue to go through to Royal Hobart. These cases, the second component, these two applications that we are considering at the moment, are based on repatriating Tasmanian patients back to Tasmania.

CHAIR - So it is not just Calvary; there is another, then?

Mr PERVAN - There is another applicant, yes.

CHAIR - So approval has been granted, not necessarily through you, to build -

Mr PERVAN - Yes, through me.

CHAIR - As well? Okay.

Mr FERGUSON - If I can add, because I have been through this yesterday, there has been no licence issued.

CHAIR - No, I understand that. I am talking about the approval to build.

Mr FERGUSON - But there has been, I understand that one of the responsibilities of the secretary is whether to allow building works to occur.

CHAIR - So the other proponent, have they sought approval to build?

Mr PERVAN - Yes.

CHAIR - And has that been granted?

Mr PERVAN - Yes.

CHAIR - So they are both building?

Mr PERVAN - No, no, no. Sorry, no. We are still waiting for further information from the other applicant, but we have been waiting for, I think, over six months now and as a consequence, Calvary are moving in advance of the other applicant.

CHAIR - So they are starting to build?

Mr PERVAN - Yes. Or they have approval to build.

CHAIR - And they do that on a hope that they are going to get a licence?

Mr PERVAN - They do that on the very explicit understanding that they have very specific criteria they have to meet to undertake a purely private service after they have that building finished.

CHAIR - And if they meet it, they will be granted a licence?

Mr PERVAN - The act says that they can't actually provide the service until I give them a licence, but if they meet all of my requirements, then the licence will be issued. I don't have the discretion to say no because I don't like them.

CHAIR - That's right. So in your determination, there is no requirement anywhere to consider the potential impact on a public service, even though you're saying it won't have it because they are just repatriating these patients back from the mainland, but there is no provision there?

Mr PERVAN - In the process of considering - there is no process under the act, but the committee did write to the THS on numerous occasions - all right, yes. Another criteria, the current availability of services in the local area. So under that criteria, I would have to consider the service at the Royal which is for public patients predominantly.

CHAIR - So what process is that in?

Mr PERVAN - That's under the Health Service Establishments Advisory Committee process.

CHAIR - This is prior to granting a licence?

Mr PERVAN - Yes. So they can undertake the works, but included in my deliberations and those of the committee will have to be an assessment of the current availability of services in the local area and we have had advice from the most senior Crown lawyer that that relates to private services only.

CHAIR - So back to that bit?

Mr PERVAN - Yes.

CHAIR - So it does not actually look at what is provided in the public sector?

Mr PERVAN - Because the act is entirely directed at the licensing of private services.

UNIDENTIFIED SPEAKER - Following on from that, that means the second proponent who hasn't put the paperwork in, application, is going to have it much harder because if this one goes through, then there is already -

Mr PERVAN - Yes.

CHAIR - Might be why you haven't heard from them.

Mr FERGUSON - We would be speculating.

Mr PERVAN - But the first proponent has certainly done a great deal of work around identifying the patients that could be - private patients, that could be repatriated from Victoria and proving the viability of those. Now, it is probably also worth noting that in the numbers of patients required to maintain a safe and high quality service, we are using the Australian and New Zealand Society for Cardiothoracic Surgery Standard, which is in fact written by Mr Hardikar. So we can reasonably rely on his advice as part of the bid from Calvary that if a licence is granted, that it would be a sustainable and safe service for private patients.

CHAIR - Time will tell. Thank you.

Mr FERGUSON - It always does, Chair, and I am just seeking to be careful with how I engage in this because the act must be obeyed. I was being challenged on this yesterday by the very person who brought this act into the parliament, Lara Giddings, which was bizarre. I am simply making a point to this committee that I understand that there may well be different views out there in the Health community about the issues that you have raised. What we are seeking to do is to be helpful for the committee to understand what the obligations on this gentleman are and -

CHAIR - Why he is sweating at the moment. No, not really. It's all right.

Mr FERGUSON - He's actually not, but it would be understandable. And there is a bit of politicking being played on this. I want to say that we are committed to the cardiothoracic unit that we provide at the Royal as part of the Tasmanian Health Service, and whatever the decision might be on a licence application from a private hospital on this, we are committed to our service for the Tasmanian community, and we will take what steps we can and advice that we must to sustain it.

CHAIR - For the record, because we're stuck in here all day yesterday with the Treasurer, we have no idea what goes on in another place, so I wasn't aware that the former minister, whoever at the time, had brought it in. But I was here when that legislation came through the parliament.

Mr FERGUSON - I am sure there would be nobody here that wouldn't be encouraging the secretary to diligently adhere to what the law says.

CHAIR - I have a question here on the North Eastern Soldiers Memorial Hospital at Scottsdale. One of our colleagues is interested in understanding the medium to long-term plan for acute services and bed numbers for our rural hospitals. The NESM particularly. There was some information provided to the member that there is a further push to reduce the number of acute services, with no paediatric under-18 available and pretty much anyone who presents at the hospital door is directed to the LGH. That is the concern that is being expressed by people in that community, I understand, and that the focus is for aged care accommodation, as opposed to a more semi-acute service.

Mr FERGUSON - I have the two smartest minds in Health in Tasmania with me at the table, and very happy to inform the committee on the current and future prospects for our regional communities at Scottsdale, with the North East Soldiers Memorial Hospital and the New Norfolk

District Hospital, and any others that occur to the members. I assure the committee and the community that we are committed to all of our rural sites.

If anything, the Government, in my view, is that we need to be looking for opportunities to better utilise our rural sites. New Norfolk, in particular, holds that prospect very much before us. The question has perhaps come from a member concerned with Scottsdale, and I would like to say that at both Scottsdale and New Norfolk, there are no acute services. Am I right? There's no acute services provided. They subacute hospitals in the hospital care that they provide, and they do that in conjunction, of course, with the major hospitals as part of the THS. So they are part of the THS, yes, they are part of the overall - but I would be very happy to invite the Acting Chief Operating Officer of THS to the table as well and we can fill in any gaps that are necessary here because a picture of what is proposed for Scottsdale was the main part of the question.

CHAIR - The main focus of that, but also about staffing levels in these areas, in these hospitals.

Mr FERGUSON - Importantly, there are some proposed changes there which is all about securing the role of aged care in the community and it has been warmly received by the community, the specific steps that we have been taking, not just in supporting May Shaw at -

CHAIR - Swansea.

Mr FERGUSON - taking over it, but transfer of business of Aninya Hostel, but also the residential places that are currently with the NESM also to be transferred. Craig, could you bring an update on -

CHAIR - Please introduce him for Hansard.

Mr FERGUSON - Yes, of course. I introduce Craig Watson, Acting Chief Operating Officer for the Tasmanian Health Service.

Mr WATSON - We have quite a body of work being done around our rural hospitals and how we better utilise them. This is being informed both in the role they can play across the system in assisting our major acute hospitals with issues of their block or challenges for beds there, to make sure that we maximise the use of the beds available in those hospitals, but also to make sure that the services that they undertake are safe and appropriate for both the physical capabilities of hospitals and the skills and scope of practice of the people who work within them.

This obviously is varying pieces of work, depending on the facilities and the issues facing them. We have obviously had particular issues with aged care beds at Scottsdale in which a solution has been found in regards to the provider there and that is transitioning across. The minister has referred to the New Norfolk Hospital and would have referenced that because we are probably looking at making that a bit of an earlier adopter or exemplar of some of the works we are trying to do in relation to better utilising the facilities.

New Norfolk has advantages in terms of its proximity, if you like, to where the Royal is, the number of beds and the skills of the people we have there, the attractiveness of it as a facility. I don't know how many members have visited it, certainly one of you will be very familiar with it. So Mr Farrell is obviously very aware of it, and we have had already engagement underway with the GPs out there as what the opportunities are to better utilise it. So the lessons we will learn from there will roll out to the other facilities.

This will be addressing a combination of factors of having the right relationships with the GPs and their willingness to take patients under their care, as I said, making sure we have the appropriate staffing within the hospitals, the nursing staffing, but also the access to allied health services, to support patients who are transitioned from our acute setting from our major hospitals into that facility, as well as having the right information available to actually encourage patients to be willing and agreeable to do that.

Indeed, also having the right information and understanding with our clinicians within our major hospitals, for them to understand that it is safe for patients to move from their care to the rural facilities because sometimes there is even some tendency to hang on to a patient a bit long within the acute hospital because sometimes they are not as aware of the care that is available within the rural facility and that the patient can be ready to go.

So that is a variety of different pieces of work that we are undertaking and trialling different elements at different facilities, but we are looking at New Norfolk certainly as, as I said, an earlier adopter of that. As I said, the ability to market it to patients because it is an attractive facility, it has nice sized spaces within there, it has a nice outlook.

CHAIR - Scottsdale specifically? What are we doing with Scottsdale?

Mr WATSON - In regards to this work?

CHAIR - Yes, yes. What is the future for Scottsdale?

Mr WATSON - It will be exactly the same in looking at how we can better utilise it within our overall bed management and overall patient load, and particularly to enable the earlier transfer back of the patients from the LGH or the Royal, if they were transferred down here for care -

CHAIR - So maintain that subacute focus? You are not losing the subacute bed focus?

Mr WATSON - No, we have no plans to change that within the work we are doing. As I said, our focus is on actually using the beds better that we have and the Government and the minister have an ongoing commitment around the non-closure of these facilities.

Mr FERGUSON - I would like to just pick up where I think that the question has also come from because there was a question that I answered a year or two ago where a patient, a child, was not able to be cared for at Scottsdale and -

CHAIR - There was mention of paediatric.

Mr FERGUSON - Yes, you did, and I understand that the policy on that is that if you need to have access to a paediatrician, well of course Scottsdale doesn't have a paediatrician based there, but it is - and I'm not making a commitment on this right now, but it is plausible that a patient that is currently not able to or not allowed to receive care at a hospital like Scottsdale might in the future, provided we get the medical supervision right. That then would be a conversation at a different level to mine, with clinicians to ensure that every patient that is accommodated at a rural hospital has the proper level of medical oversight and that we are providing a safe and robust service.

CHAIR - This is the focus for all rural hospitals regardless of where they are in the state. So

what you are saying applies to all?

Mr FERGUSON - Yes.

Dr ALCORN - We have some hospitals operated by Ochre, which provide services for us, but yes.

CHAIR - Queenstown. Ochre is running that now, aren't they?

Dr ALCORN - They have the medical component.

Mr FERGUSON - THS runs the hospital, but the GP -

CHAIR - The medical support is run by Ochre.

Dr ALCORN - Yes, and so what the minister is saying is that the relationship of the GPs needs to be such that they feel confident, skilled up to do that sort of work and so we obviously need to make sure we can tick all those boxes with our local general practice community before we would go ahead in that. We would also need to get the consensus of our eventual statewide director of paediatrics as to their view about it as well.

Mr MULDER - I just wanted to ask how the Tasman fitted into that regime.

Dr ALCORN - Tasman isn't a rural hospital, but it is a facility in which we have -

Mr MULDER - You have actually answered my question. The next one obviously is, why? Why haven't we created a hospital, a rural hospital there when you have one at Oatlands and St Marys and Scottsdale next?

Mr FERGUSON - I am sure I don't need to tell you the history of this, Mr Mulder.

Mr MULDER - No, no, it's a simple question. Why hasn't the facility been declared a rural hospital, if you're prepared to do it for Oatlands?

Mr FERGUSON - We are dealing with the facts of what is currently provided there and we have a partner in this. We continue to support the facility through our purchasing and contractual relationship. You need to see it fully in context as to what it is, though, so it is a multipurpose service. It is currently run by the Hobart District Nurses Service and it has a contractual responsibility to deliver services to the community from the NPS on behalf, if you like, of the - well, under contract with the taxpayer. So including the provision of necessary medical services, there is your GP care, but that is for the aged care residents and the sub-acute admissions to the NPS which I think is two beds, is that right? To two beds.

Mr MULDER - You are absolutely right, minister, I am thoroughly aware of the history and the current arrangements. My question goes to - perhaps I will rephrase it. What are the criteria for establishing a regional hospital along the lines of those that you have in the other areas, including Oatlands, for example? And then the question is, are there criteria, if there are, how come Tasman doesn't qualify?

Mr FERGUSON - For a start - and I would look to the CEO in a moment to assist me with

this - but you would be very foolhardy to want to open a hospital in a community as small as Tasman because you would be putting patients at risk right, front and centre, because it is easy for a government to build infrastructure. That is the easy bit. But as the Mersey and other hospitals have taught us, providing a safe service is a different question. The fact is that our current service provision on Tasman is for two sub-acute beds at that multipurpose service. The main purpose there is of course providing aged care in the community and fortunately even with the recent somewhat troubled history, we have been able to secure the main service which is provided there, being aged care, and aged care residents need medical care. They need GP care, and so that's why it is important that Hobart District Nurses as the provider takes the necessary steps that they must take to ensure that there is GP coverage. So that's that.

I am not aware of any proposal, let alone a serious one, to establish a hospital on the Tasman Peninsula and I suggest that I'd be quite happy to invite the CEO to provide the committee with some idea of what criteria would be needed. No problem. But at first glance, that's not a proposal that I've ever heard before.

I invite the CEO to inform the committee what would be required to establish a hospital of the kind that we have at, for example, New Norfolk or Scottsdale.

Mr MULDER - So is Oatlands a similar -

Mr FERGUSON - Oatlands is also an NPS.

Dr ALCORN - Really, they all supply similar services. It comes down to the population there, what their needs are and the ability to service those needs on the basis of the geography and the population. So we've heard a lot about telehealth today and that will help a great deal in bringing in special services, but really, we must be cognisant of the population that's there and the more elder and fragile, they're probably going to need more often treatment to one of our major hospitals and the situation where we are providing elder care and an ambulatory facility is probably - to go the next step and establish a hospital really requires a layer more complexity that would need to be justified on a cost effectiveness basis because we have a lot of demands on our resources.

Mr MULDER - So the question is, it is not just population, it is also the demographics of that population? It is not just population, it is also the health profile of that population, and then there has to be a critical mass to justify -

Dr ALCORN - Yes, and obviously as the minister says, proximity to other major centres and ease of transport in and out as well. So our situation on the West Coast is that we don't have easy transport out by road.

CHAIR - Or by air at times.

Dr ALCORN - Yes, or by air at times, so we unfortunately have to have higher complexity of services on the ground there.

Mr FERGUSON - Mr Mulder, one of the benefits of the multipurpose service model is that it does enjoy the support of the Commonwealth taxpayer as well and it allows for a flexible approach to what the community needs are and so that ratio of, for example, aged residential care and sub-acute admissions can and is designed broadly to meet what the likely demand is. So if ever we can improve that, and I want to just add Tasman into this conversation about we can be using rural sites

better, although we don't operate the Tasman site, it's operated by HDNS, it equally falls within our wish to better utilise sub-acute beds in regional areas. Even though we don't run those beds, we obviously are part of the pathways for patients to be able to use them.

CHAIR - A quick question on one point before we break for lunch. This also includes cancer screening services. I am sure you probably saw in our Preventative Health Community Report, minister, about some of the inefficiencies in the cancer screening, particularly the bowel cancer screening, the kits provided by the Commonwealth. It is a lot of money spent and possibly most of them end up in the bin because people don't want to send poo in the mail. So are there any considerations being given to actually working with the Commonwealth and perhaps better utilising the money that's there to promote screening of bowel cancer particularly, but it does take into breast screening and the pap smear screening programs, things like that.

Mr FERGUSON - So your question is, specifically?

CHAIR - Are you likely to have any discussions with the Commonwealth about better streamlining cancer screening and the available funds to broaden the reach and the compliance, I guess.

Mr FERGUSON - I am not sure if the expert advice would recommend broadening the reach because I think the whole point of the way that the screening program is designed is based on - well, usually it's based on the NHMIC guidelines. Is it in this case?

Dr ALCORN - Yes, but can I add some points, minister? So in terms of bowel screening, the scope of that program has been progressively expanded, the recommendations of it. Obviously the ability of any system, public or private, to meet the expanded recommendations is limited. People, gastroenterologists, have previously provided me advice in another state that it really isn't possible to triage all that well people who are requiring colonoscopy, even aside from the positive faecal occult blood response. So they group them into people who are at familial risk of cancer because they have a family history, people who are positive or symptomatic with their faecal occult blood, or symptomatic for other reasons, and people who are turning up for their pure screening. So it is a considerable volume of people and finding ways to address that is a national problem. This is not unique to Tasmania. In every single state.

CHAIR - The uptake of the kits that are sent around, though, this is my point, I imagine it's quite expensive to produce all those, send them out and a lot of them end up in the rubbish bin.

Dr ALCORN - This is the cost-effectiveness argument around any screening and having read, not Australian studies but US studies, that it is still cheaper to have a community based faecal occult blood screening program than to submit every routine colonoscopy.

CHAIR - I am not suggesting we submit everyone to colonoscopy, no.

Dr ALCORN - I am just speaking with my doctor hat on here. What we probably need to do is be a bit more insistent with referrals from GPs to our hospitals for colonoscopies, in system with the GPs to carry out some faecal occult blood testing.

CHAIR - This is my point, that maybe there is a better way to actually ensure that those who should be screened are screened. Just sending it out in the mail probably a lot of people who are otherwise well don't go to a GP and think, 'I'll just toss that in the bin, I don't want to poo on that

bit of paper and put it in the mail'.

Mr FERGUSON - Let's promote it, shall we - I know that you are being constructive here. So the data that I have suggests that the screening program in 2015 in Tasmania was 40.8 per cent of the eligible population compared with the national average of 36.1. So we're satisfactorily ahead of the trend, but wouldn't it be good if the figure were higher?

CHAIR - Yes.

Mr FERGUSON - I don't usually like to speculate, but I suggest that the cost of the program would be more oriented around the actual testing regime as opposed to the test kit.

CHAIR - Yes.

Mr FERGUSON - The opportunity is here for all of us to encourage people to not be squeamish about this. If they've been sent a test kit in the mail, it's for a reason, they're in the eligible age group, they might not get another kit in the mail for another five years, there's 10 years between tests if they skip one. So we should encourage people to take that test and to not be squeamish about it. I recently had the pleasure of supporting Rotary with its own Rotary bowel scan initiative - kits can be purchased in a local pharmacy for around $10 and you don't have to send poo back in the mail. It is a really simple test, it involves a simple liquid from the toilet bowl onto blotting paper and it fits back into a flat envelope back to the analysis lab and so that's a great partnership between Rotary and the health system, that if people are ever wondering whether they should take the test, anybody of any age can do that.

Mr GAFFNEY - Being part of that same committee, we were presented with some information from the women's breast cancer group and they felt that they could have a better bang for the buck because they could get into the communities more because they were more well-recognised and they could actually help push that barrow to get better returns. I think that was the idea, that -

CHAIR - It is looking at other options.

Mr GAFFNEY - It was trying to say 'how could they do that?'. So effectively the federal government provides us money, but actually passed it over and gave more of a free rein, where you could get a greater return and get to the people. So it was more of 'how can you impact on that relationship?'.

Dr ALCORN - That has not escaped my attention. The breast screening service is effective and they get through a deal of population. They enjoy a very positive reputation and one of the ways to get men to get services is sometimes to get their partner to give them a push in the right direction, and if the partners are already engaged in screening, where there are opportunities there. So it has occurred to me. Traditionally, bowel - well, the bit after bowel screening, colonoscopies, occurred within the hospital sector, I guess on the assumption that colonoscopies are best done in hospitals. That's probably not true for most of Australia now where it's being done in private day centres and so forth, or even in a Mersey-type model.

So what would be opportunities to engage the people who run breast cancer around this program, so we are exploring and thinking about it, but there's no commitment as yet.

Mr FERGUSON - But we take your points on board, thank you.

Mr MULDER - When you talk about your 48 per cent return rates and your disappointment that they are so low, are you factoring in the fact that, as far as I'm aware, at least among my circle of friends who are in this cohort, that most of us actually don't return those screens because it's part of our regular annual check-ups with our GPs anyway. So maybe you shouldn't be quite as disappointed with the uptake as you appear to be.

Mr PERVAN - That issue was actually raised at a general discussion at Carrick Health Council last year, as was some of the potential to adapt and innovate in cancer screening and the commitment was taken by the Commonwealth to take the issue away, do some more work - I was going to say exploratory work, but that seemed inappropriate - on the ideas and to come back with more information and a proposal for -

CHAIR - The answer to my question is yes.

Mr PERVAN - To the minister's, to Carrick Health Council. I was just trying to give you a bit more detail.

CHAIR - That is very good. On that note we will break for lunch and come back at 2.10 p.m.

The committee suspended from 1.08 p.m. to 2.09 p.m.

DIVISION 25
Tasmanian Health Service

Minister for Health

Output group 1
Tasmanian health service

CHAIR - We were onto item 1.3 in the THS. Leonie might have had some opening questions there.

Mrs HISCUTT - Yes. It is Emergency Department Services. Minister, there always seems to be a certain amount of pressure on emergency departments. Do you have any plans underway to address that? I think I heard you mention 'rapid response' earlier in your overview. Does that apply to the emergency departments?

Mr FERGUSON - I can assist you with that, Mrs Hiscutt.

Mr FERGUSON - It is an important question because with all of the reforms that we're going through, and there are many, and we have always designed our health reform agenda around providing services that can be safely provided in the facility best equipped to do that, we have also accepted and recognised that we are seeing significant additional demand in our emergency departments. That is happening, I believe I can say, to the greatest degree. That extra demand is being experienced at the Launceston General Hospital and the Royal Hobart Hospital. No doubt there would be similar pressure in the north-west coast. But we have certainly see significant extra demand. We need to meet that demand and we need to manage it as well.

What we have are two things that I would like to offer to you and the committee today. In April, after some very unfortunate events in some of our EDs, I took advice from the CEO and from the secretary about what our response prudently could be. So since then and in April, the Government has published what we call Patients First. It is a 19 step plan. It is a combination of initiatives which are designed to care for our patients in a more timely way; to have escalation policies.

For many years problems in EDs have been blamed on EDs. The support often that they require cannot be found within the ED. They need whole-of-hospital solutions. So really, for the first time we are formalising opportunities for the ED to make a cry for help and we would call those 'escalation policies' and that is just one example. It has already been used since 1 May when those escalation policies commence that the whole hospital shares the responsibility for freeing up beds so that ED patients who require it can be admitted to wards. That is just one example. I refer the committee to the Patients First material, which I could provide if necessary to indicate the 19 actions.

Mrs HISCUTT - That would be good. I was going to ask you about that next too. It is good that you have touched on it now.

Mr FERGUSON - I have just described one of them. There are many others including red flag events that we are developing, things that should never be allowed to occur. You specifically referenced and asked me about the rapid response service. That has a little history. The history goes a little like this: in 2011 around about that time we had a program in the LGH called Hospital in the Home. The whole point of that was to care for people in their own home that would otherwise have needed care in a hospital setting. So a hospital avoidance program. It was scrapped by the previous government. Prior to the election we committed $3 million to replace it, which is exactly what we launched last week. It bears a new name because it is a somewhat updated model. It is the Community Rapid Response Service. It delivers on our commitment.

We have commenced this and the funding provides enough that allows us to operate this in the greater Launceston area. From the outset the service is now being piloted and it is involving three medical practices already being Newstead Medical, Summerdale Medical and Launceston Medical Hub. Over the course of the next 12 months it will continue to be rolled out to all practices, 33 of them in the greater Launceston area. What is important about this service is that it is close engagement between the hospital and the GP of the patient.

A GP referral will initiate the care within - we say 'rapid response' because the service will be of four hours of that referral giving the GP the confidence that the service will, in fact, avoid the need in many cases for a patient to be recommended to go to hospital. The service is designed for people with acute illness or injury, and also to people whose chronic or complex condition has deteriorated in a way that would have otherwise see them presented in ED. So this is about assisting the care for the patient. It is a closer engagement, which we all keep talking about but we very rarely see happen in practice, between the primary care sector GPs and the hospital system. Importantly, a key outcome of it, apart from the care of the patient or care that is more tailored to their needs, is in fact freeing up beds in our hospitals and taking some of the strain off that high demand that we are experiencing.

Mrs HISCUTT - So does it work as such that the GP will make that call to the hospital then they will send someone out? So not like an ambulance, just a care?

Mr FERGUSON - They will make a call to the Community Rapid Response Service, which is within the THS. The service will then send an appropriate health practitioner to that person's home, to their aged care facility, or to a community nursing clinic. Importantly though, I make it clear, if a patient really does require admission to hospital then that would continue as normal.

Mrs HISCUTT - How long before you envisage that being rolled out across the state?

Mr FERGUSON - The funding we have at this point in time allows us only to offer this service in the greater Launceston area. We will closely monitor it. There will be a proper evaluation of it and subject to a positive evaluation then the government will be in a position to rolling it out to more areas.

Mrs HISCUTT - Looking at the figures on page 108 the money has gone down and that reflects the completion of a program called Improving Health Service in Tasmania Schedule E Improving Patient Pathways through Clinical and System Redesign. Are you in a position to tell me how that redesigning went? You might be able to refer to, in particular, to the emergency departments.

Mr FERGUSON - I might need some advice on specifically how it has supported the emergency departments. I think we would be looking for Health Service Innovation.

Mrs HISCUTT - This might be part of your rapid response?

Mr FERGUSON - It is not, no. It is quite different. Thank you for the question. As you have referred the state has been in receipt of some Commonwealth funding and one of those that you referred to is around clinical redesign. There are a number of different schedules to the agreement that the state has had with the Commonwealth. Funding for a number of elements expires over the course of the next financial year. They do not run out of funding at midnight on 30 June. The THS has work to do both in assessing and considering exactly how to transition away from the Commonwealth funding into services that are sustainable by the THS by the budget and the additional funding that has been provided by the Tasmanian Government.

I invite the CEO to add to that specifically around emergency. Before he does, because I think it will reflect on the EMU in particular would be one area to touch on which has been funded under that, yes, and the Launceston Fast Track Clinic, both of which we might be able to touch on today. I would like to point to the additional $5.4 million which is in the budget. It is part of the $51 million of extra support, specifically for the $5.4 million that is designed to support our Patients First initiative, which I touched on in my earlier answer. That provides security for psychiatric emergency nurses because I provided an undertaking that they would be continued. We just had to wait for the budget to disclose exactly how that would look. Additionally, we are supporting clinical initiative nurses where they are not already in place at the LGH.

So that is additional support that is being provided. I would like to indicate for the committee that whatever the CEO is about to say, I have asked for the THS to ensure that in the process of determining how we transition across that we continue to care for our patients and manage the workload that we have.

Dr ALCORN - This HSI was put in place long before I commenced and it was run through the University of Tasmania which has been in various parts of the THS and been providing advice and working with clinicians. If we look at the Royal Hobart Hospital and their interventions there that have led to significant change, probably the most significant we can point to is the acute - the

assessment and planning unit which is run by the general physicians. They work with Dr Nicole Hancock and her team to reduce the overall length of stay of general medicine patients by in excess of half a day, and although half a day sounds a bit derisory it actually is not across a large number of patients. They are very pleased with that effect and they believe that with further rolling out of that model they could achieve that elsewhere.

The other thing that HSI can reasonably claim credit for at Royal Hobart Hospital in concert with our chief operating officer, Craig Watson, is the development of the nurse navigator roles which are essentially senior nurses who are clinically experienced but whose main focus is on patient flow. Because they are embedded in the emergency department and not sitting far away, they can assist the clinical nurses who are providing the care to actually connect them through the wards and get people off to the wards more quickly. That is probably one of the models we will look at Launceston because we know that the emergency department does get access block from time to time.

It would be fair to say that the impact on the emergency department, it is a bit difficult because when you look at emergency department numbers you have to look at them seasonally adjusted simply because of all the winter flu demands. It would be fair to say that they have had some impact in Launceston, but the current results still have a long way to go before I would be even happy to call them acceptable. The Royal Hobart has also reduced the timing to the most admitted patients part of the emergency area and probably carved off about four hours off that.

Mrs HISCUTT - Good.

Dr ALCORN - Probably the other significant innovation that the HSI people, were they sitting at the table here, would say was that they gathered senior clinicians across a variety of different hospitals so consistent with the theme of 1THS and started to explore with them what were their common values and assumptions and even set them to work on this question that you have raised which is, what are the factors that would best drive emergency flow? Some of those factors have been lifted up into the advice provided to the minister that led to Patients First.

Mrs HISCUTT - So there was a talk recently about the winter flu rush of people. How do you feel about that? Would you like to make a comment, minister, on how you think that will be handled?

Mr FERGUSON - I would be delighted to do that. There has been a lot of talk about winter illness strategies and the need for them. There has even been a little bit of chatter that the hospital system is not well equipped for a winter illness episode. Well, that is conjecture but we still take it very seriously. The experts in our health system will be able to tell you that winter illness is reasonably predictable in the sense that we know it will happen that there will be a greater number of people looking for care during winter. My advice is often that the flu season moves around a bit during the year, from year to year.

We need to have our systems in such order that we are able to flexibly meet that demand and also ensuring that the harmonious operations of the hospital in all of the other things that it does, including planned surgeries, can be managed around that. I will invite the CEO to touch on this as well. I would like to indicate that around the Patients First initiative some of those, in fact, will be extremely helpful for winter illness strategies. One of those is the escalation policy which is now in place at both the LGH and the Royal. It is a good thing when the escalation policy is used because when we have seen it used already since the beginning of May it has been working. I seem to recall

one evening there were some 22 patients in the Royal ED who were waiting to be admitted to a ward. The hospital was suffering access block. The escalation policy was used. So this is, remember what I said, that the ED was left off into its own -

CHAIR - Sort out your own problems.

Mr FERGUSON - Sort out your own problem. This is your problem, not mine. Well we made it a hospital's problem. So once the escalation policy had been triggered, the hospital owned the problem, texted the relevant senior clinicians to come in and discharge their patients who were safe to be discharged out of hospital rather than locking up the beds. So that freed up beds. By morning, I understand, or even within that period that the escalation took place, it was reduced to four patients waiting for a bed. So it had worked and it was a good thing, not a bad thing. So when we next hear the hospital has been escalated we should reflect on whether we want to make that a positive or a negative. I would say it means that we are actually seeing all of hospital solutions.

CHAIR - So how many escalations have you had?

Mr FERGUSON - I would love to tell you. I know it is at least a couple, up to three.

Dr ALCORN - I think two. I would have to check on the exact number and give you feedback.

Mr FERGUSON - So we will let you know.

Mrs HISCUTT - We are not talking a lot anyway.

Dr ALCORN - No, you should not use it a lot.

CHAIR - No, you should not.

Mr FERGUSON - It is not intended to be a routine thing. But it is a new measure that says to our ED staff, 'You are not on your own', for the first time.

If I can quickly touch on this. As part of the winter illness strategies, the hospitals and the THS are now empowered. We need them to be prudent about this and careful about it. But we are saying that it will be reasonable to consider purchasing flex beds whether it is opening flex beds within the THS environment itself or to even purchase beds for nearby non-government hospitals. So that is an option that will be supported.

Importantly, by establishing the opportunity for community pharmacists now to vaccinate for flu, we are sending - and we are wanting you to help us - send a strong message to the community, really there is even one less excuse to not get flu vac this year. Have your flu vac for less than - if you are eligible under the federal government's program, by all means go and get it done for free at your GP. But if you are a person who does not normally get a flu vaccine, consider paying the $12 or $13 at your community pharmacy and you often do not need an appointment, but go and have it done.

CHAIR - Not all pharmacies though.

Mr FERGUSON - That is right. But we have changed the legislation to allow it. The only requirement on a pharmacist is that they meet the necessary training requirement and many of them

have.

Mrs HISCUTT -Minister, this is the first year that I have ever had a flu shot. Do you have any idea of the uptake in Tasmania? Has it been up this year?

Mr FERGUSON - We could let you know during the output on Public Health.

Mrs HISCUTT - Yes.

Mr FERGUSON - We are happy to take that on board at that point.

Mrs HISCUTT - No, that would be good.

Mr MULDER - Just on that point, that if you qualify you can go to your GP, I found myself at a GP for the usual check-up and asked if they would throw the flu shot in.

Mr FERGUSON - Yes.

Mr MULDER - Was basically told, 'No, you will have to go away'. I said, 'Well, why? You are a doctor. There is a pharmacy next door. Why can't I have it here?' The answer was, 'The pharmacy next door does not have any and although I do I cannot give it to you because you do not qualify under the government's program'. So I am not saying we did not talk our way through this bureaucratic nonsense, but I am just wondering why you have those things still around that only the doctor can give it to patients who qualify.

Mr FERGUSON - I would be guessing and I would be speculating, I suspect it might be Commonwealth-funded vaccines in that case. I am getting nods around the table. So there is your answer.

Mr MULDER - If you are interested in uptakes, I suggest you might look at that.

Mr FERGUSON - Yes, I suspect -

CHAIR - It is a public health matter. If you want to discuss that do it in Public Health.

Mr FERGUSON - Yes, that would come up in public health.

Mrs HISCUTT - So one last question there, the care of the doctors and nurses that work in the emergency department. It is always the highest stress, busy, busy, pressure all the time. I do know of a couple of ED nurses who have had problems. Do you have something in place for the welfare care of these staff?

Mr FERGUSON - It is a terrific question and it is a question with a heart because we recognise that as a good employer, we want to be a good employer, and we have a duty of care. In fact, we all have a duty of care including the staff members themselves to think about their own health. But we do provide support. There are industrially arranged arrangements to allow for our people to take leave when it is required, whether it is illness or, where it occasionally happens, if a member of our staff has suffered an injury at work and that, potentially, can include -

CHAIR - Stress, let's name it up.

Mrs HISCUTT - Yes.

Mr FERGUSON - mental stress.

Mrs HISCUTT - Yes.

CHAIR - Yes, yes.

Mr FERGUSON - Let's name it up. Then those things are provided for. But we do not stop there. We also provide specific and arm's length from the employer support, which is called the Employee Assistance Program. So that is a way in which a member of our staff, if they feel that they are on their own, in fact, they are not on their own and they can get that additional social support.

Mrs HISCUTT - Is that monitored by a lead person within the department? Do you have a unit nurse or someone who -

Mr FERGUSON - We would get reporting data. But we would not get anything that relates to the individual.

Mrs HISCUTT - Okay.

Mr FERGUSON - It would be completely confidential and private.

Mrs HISCUTT - I was just looking to see if there was somebody who looks for that - to provide help. Yes, I can see the nods. Yes.

Mr FERGUSON - Well, yes, they certainly do because part of the role of a manager is to show the concern for the welfare of their team.

Mrs HISCUTT - Lovely job.

CHAIR - So on that point, have we figures on sick leave from DEMS and the hospital generally or not broken down that far?

Mr FERGUSON - Not broken down that far, but I can provide you with overview tracking data which would give us a guide.

CHAIR - Yes, that would be good.

Mr FERGUSON - Thank you. THS. Modelling THS.

CHAIR - Yes.

Mr FERGUSON - You are quicker than me. Thank you, Lisa. We certainly do.

CHAIR - It may be best to table it, do you think, minister?

Mr FERGUSON - Sure, I will table the table. I might just give you the headline and I am able

to provide you with a breakdown by award. So that gives a guide as to the work groups, the vocational work groups. So that is sick leave. But she wanted workers comp, I think.

CHAIR - Sick leave and - yes. Is workers comp included in that or is that separate?

Mr FERGUSON - No. We have separate data. I will not need to table that because I can read it out quite quickly. So I can give you sick leave, which I will table. I will table for the committee the sick leave data, and that is by award and it is year to date for the financial year to March. It also has the previous two full years.

CHAIR - Good. Thank you.

Mr FERGUSON - For workers compensation which is the subset group of stress-related across THS in 2013-14 there were 50 claims at a cost of $2.9 million. In 2014-15 there were 47 claims at a cost of $3.4 million and for year to date to March in 2015-16 there were 29 claims cost of $1.9 million.

CHAIR - Okay. That is just workers comp stress-related?

Mr FERGUSON - Workers comp and stress-related workers comp.

CHAIR - Okay.

Mrs HISCUTT - So that last figure was that a six month period?

Mr FERGUSON - Nine-month period. Were you to pro-rata that out, you cannot really guess, but over a year that would look like 39 claims.

CHAIR - That is right across the whole THS, yes.

Mr FERGUSON - Eight thousand employees, yes.

CHAIR - You might not be able to answer this, but anecdotally, is it higher in DEM for example or is it across the board pretty similar?

Mr FERGUSON - I would be offering an opinion. I do not think I can answer that.

CHAIR - Okay. You do not know.

Dr ALCORN - Workers comp claims can occur anywhere. Residential care or subacute regenerated due to issues around mobility and staff replacement. I would not make a specific prediction. Obviously we are all focused on critical incidents, but it is not always critical incidents that produce the stress. Sometimes it is other factors.

CHAIR - Like workload.

Dr ALCORN - In broad terms as you asked me, yes, managers have the responsibility to keep an eye on these things and manage their team. But also our individual staff members, like each of us around this table, also share the responsibility to monitor our own health and to prevent illness, and to protect themselves from injuries at work including stress.

Mrs HISCUTT - So, Chair, unless anyone else wants to ask anything on the line item, I am finished.

CHAIR - Anyone else on the emergency departments? No?

1.4 Community and Aged Care Services

CHAIR - The next one is 1.4 Community and Aged Care Services. Leonie, you have the lead there as well.

Mrs HISCUTT - I have. Community and Aged Care Services, minister, the money does go up and down over the forward Estimates and that is due to federal funding from time to time. But Community Palliative Care, this would include end-of-life care as well. Yes. I have always been of the opinion that it is best in the home and a lot of older people do like to be at home versus a hospital bed. Would you like to make comment on whether that is the way that the health services are heading, and do you deem it is a good thing to do to keep people in the home?

Mr FERGUSON - The CEO will add to what I offer to the committee. I like the way you have asked the question because it reflects the fact that we want people to be as well as they can be even when they are dying. We want the experience and the last days, weeks, even months, of palliative care to be a time where the maximum comfort is provided to the person and to the greatest possible allowing that person to choose the place where they wish to die. I did notice a recent piece of research on this which was reflected in a report that the Government recently commissioned which showed that by far the majority of people wish to, or express a wish to, that when their time comes that they would like to be at home.

Mrs HISCUTT - The aged that I have dealt with always find it very traumatic leaving home.

Mr FERGUSON - Yes. So for that reason our health services, which are lined up not just in government, I have to quickly add, but also by non-government providers, aged care would be one and non-government providers like the district nurses providing services. So we would like to be able to have a greatest empowerment possible for the person to choose. I would like to answer as well with some update on where the state is at.

As part of the better access to palliative care work, the department and the THS have been working to enhance our specialist palliative care services through the development and implementation of the Tasmanian palliative care policy framework.

The THS, in collaboration, with the department has now developed and implemented a workforce model and development strategy to enhance the capacity of our workforce. Some other key reforms include a statewide patient registration and information system. A Tasmanian palliative care community charter is being developed and will articulate the community voice on palliative care needs and expectations. The Tasmanian palliative care formulary has been updated and work is underway to improve its accessibility to health professionals using IT.

So we have taken advantage of these funds and the elements will have lasting benefits for the health system through better integration between community-based palliative care services and, of course, our existing specialist palliative care services, and our inpatient facilities throughout the state. Particularly, in the north we have quite a lot of rural sites which have as part of what they

offer, all of them have, and some have more than one, suite which is specifically designed and provided for to provide palliative care pretty close to the community where you live but it is in the hospital. So they are greatly valued in those communities. Many of them, in fact, have been supported and fitted out by local service clubs that have helped to make them happen. We also have other inpatient facilities notably the Whittle Ward in Hobart and we have a contract arrangement with Calvary in Launceston for four beds at the Melwood Unit.

Mrs Hiscutt, because you are based in the north-west I am sure you would like to know what we have in store for the north-west.

Mrs HISCUTT - That was my next question, so roll on.

Mr FERGUSON - Yes. I might jump to that question. So the white paper also proposes an increased roll for the Mersey in providing palliative care services to the north-west. What is proposed is a level 3 service which provides multi-disciplinary services to patients with complex and unstable palliative care needs, shared between the primary care provider and the palliative care service. Like so many of the changes in service that we are embarking upon now as we implement the white paper, the final configuration of that depends upon the work of the THS which is currently underway to develop statewide service delivery models and proper business cases to implement the white paper reforms all of which will be supported by the additional $29.5 million in this Budget. Because I am mentioning the Mersey it just stands for me to mention that where we have seen a service no longer continue at the Mersey, the Mersey, nonetheless will see a replacement additional service come in, so that the Mersey community, if you like from a commitment point of view or an effort point of view, continue to get the health services that we know that they need and deserve.

Mrs HISCUTT - So the palliative care will be ready to be rolled out on 1 July?

Mr FERGUSON - I would not say that, no. I will invite the CEO to describe the palliative care for the north-west. We would first of all say that it is part of the implementation of the white paper and we would not want to see it introduced on a particular date, notably one as soon as 1 July because we would not wish to introduce one until it is properly designed and safe and at the highest possible standard. There is a role here for people not just to see it as something that we plonk into the Mersey. It needs to be part of a statewide model and with the right commitment from the correct professionals right around the state to support it. So, CEO, I invite you to touch on that and give the picture.

Dr ALCORN - I probably do not have a great deal to add at the moment in terms of Mersey simply because the focus of our work, obviously is on the north/north-west surgery integrated service and the maternity, and we really need to be moving some facilities out of Mersey before we can be locating things in. There is a considerable piece of work with us with our not-for-profit partners. So we use our state-funded palliative care specialists but we do it in good cooperation with our not-for-profits and that probably requires some more exploration.

Mrs HISCUTT - The reason I ask is because of the demographics from the north-west as well in Tasmania on ageing community that when I fielded phone calls about what was happening with the Mersey I would say things like, 'We are having more rehabilitation and palliative care', which sat very well with that demography. So that is still coming?

Dr ALCORN - It is still coming.

Mrs HISCUTT - Okay.

Dr ALCORN - So to that end we have kept rehabilitation, for example, and in its expanded form, going in Burnie until we can make that transition of much of the service to Mersey and that depends on decanting out the free birthing services.

Mrs HISCUTT - Yes, because not everyone needs an operation.

CHAIR - There has been some concern about the community nurses - particularly in some areas in our regional areas, minister - that there is a revolving door of staff. Permanent staff numbers are low and there is a high turnover of a lot of casual staff and new referrals all the time are making the challenge difficult. What is the situation with community nursing in terms of staffing levels, the use of agency or other local nursing arrangements across the state, but particularly in our regions?

Mr FERGUSON - We might just take that on notice, thank you, if that's okay, Chair?

CHAIR - That is all right, yes.

Mr FERGUSON - I am not aware of any particular concern, I have to say, so I appreciate that it has been raised with you. It is not one that has been raised with me and I will be happy to take it on board and respond.

CHAIR - It might be helpful to have the amount of relief, like agencies, nursing staff, right across the whole THS. If you could provide that?

Mr FERGUSON - I would be happy to provide that. Of course.

CHAIR - And break it down to community nurses as well as acute -

Mr FERGUSON - If I can break it down further, I certainly will provide that. Can I just commit that I will certainly provide the nursing temporary agency data for you?

CHAIR - Yes. By region?

Mr FERGUSON - If I can break it down by that. Realising, of course, we are moving away from regions.

CHAIR - Yes.

Mr FERGUSON - So I will provide you with what I have access to on that point.

CHAIR - All those community nurses are based out of small centres, out of our rural hospitals and things like that. That is why it is more of a challenge, perhaps on the west coast, to get community nurses that are there permanently. I am sure it is the same on the east coast and other places.

Mr FERGUSON - I will take that on notice, today or at the soonest opportunity. Secretary, do you have -

CHAIR - Just following up with -

Mr FERGUSON - Yes, if I can. I know that it is not what you have asked me for, but while I am gathering for you the casual nurse reliance, just to let you know that we have a demonstrated commitment to maintaining community nursing, that the activity in 2014-15 was 173 000 - I am rounding. The 2015-16 target is for 176 500. The target for the coming year would be 180 000. So we certainly continue to support community nursing. It is a professional group that has been maturing over a lot of years and it provides a wonderful service that we rely on. I will obtain for the committee the data that you have asked for.

CHAIR - Okay. Apart from the Leonie's comments about the palliative care services, there has been a shortage of palliative care specialists. Obviously, this is something that can be managed through - remotely to a degree. What is the level of palliative care specialist staff at the moment around the whole state?

Mr FERGUSON - I am exploring that for you. It is a subset of our medical workforce, to state the obvious, which we have readily to hand. The secretary has an update.

Mr PERVAN - The latest report from Palliative Care Australia actually has Tasmania leading the nation with the number of palliative care specialist per population.

CHAIR - Per population. Yes. But does that mean they are in the right places?

Mr PERVAN - Well, it is a single Tasmanian Health Service as you all know.

CHAIR - Yes. Yes, that's what I am saying - it is about access.

Mr PERVAN - I am advised we have excellent distribution across the state with a palliative specialist in all major centres.

CHAIR - So it must have improved in recent time then, if that is the case, because it has been an issue with, particularly up the north-west, access to people who are dying.

Mr PERVAN - It has previously been an issue.

Mr FERGUSON - I would like to get you a wholesale answer. If you like I will take it on notice as well.

CHAIR - Yes. Okay.

Mr FERGUSON - Meanwhile, I can table for you the sick leave rate comparison for 2013-14, 2014-15, and year to date?

CHAIR - Thank you. Okay. So dental is the only one to -

Mrs HISCUTT - Dental.

CHAIR - Yes. Dentures in some people's cases.

Mrs HISCUTT - Minister, this line item also covers emergency in general oral care and

dentures in eligible adults and children under 18. Are you able to give me waiting lists of the under 18s? And those on the health care pension holders, how is it going?

Mr FERGUSON - Thanks for the question. I have no doubt that you know that oral health is fundamental to our overall health. A healthy mouth lets us eat, speak and ask questions at budget Estimates, seek employment and socialise without pain, discomfort or embarrassment which increases quality of life.

CHAIR - Was that in there, about Estimates, or did you just add that?

Mr FERGUSON - Very creative. But to be serious, dental disease although almost entirely preventable is a costly disease in our country and the economic impact is comparable with that of recognised common chronic disease including heart disease and diabetes. So I am pleased to inform the committee that we are continuing to see falling waiting lists for oral health in Tasmania. This was the cause for me to call upon our centre in Launceston and congratulate them for their work.

I can advise the committee that there has been a significant decrease in the number of adults waiting for general care to the year - in the year to March 2016. Mrs Hiscutt, the waiting list fell by more than 1600 people, which is a 20 per cent reduction in the adult waiting list. This follows significant decreases in the prior year and is the result, and I must give credit where it is due, of increased activity funded by the Australian government under the National Partnership Agreement on adult dental care. I would also like to add that the general care waiting list has been falling across the state and the north of the state has the shortest waiting list of the three regions.

CHAIR - We are not talking about regions any more though.

Mr FERGUSON - You have just picked me up quite properly there.

CHAIR - Yes.

Mr FERGUSON - In fact, an oral health service is a statewide service. We do not operate on a regional basis, but obviously the list has been reported in that way. I can also advise the committee that there were more than 11 000 occasions of general dental care provided to adults across Tasmania in the nine months ending March 2016. This is for general dental care, people who are not requiring urgent work. All urgent work is prioritised under a triage system and seen in a time frame reflecting the need of the person. This is not managed on a waiting list and sees some patients getting a same day appointment. Oral Health has quite a flexible approach on this and they do offer different ways that a person, if it is an urgent case, they will offer stand by opportunities.

Mrs HISCUTT - It can be pretty painful.

Mr FERGUSON - Yes, you are absolutely right. Over the period to March 2016, there were almost 24 000 such episodes of urgent adult care provided to people that were not referred via a waiting list. There were also almost 15 000 occasions of service for dentures or other prosthetic services. From March 2015 to March 2016 the statewide waiting list for prosthetic services, that is dentures, fell by 70 people, around 10 per cent. In addition to this, almost 50 000 dental appointments were provided to children in Tasmania in the first nine months of this financial year. So it is a good update and although you did not ask me about it, I would like to say I am pleased with what I have heard from the federal Health minister about the future of the new, and will be legislated, Child and Adult Dental Scheme, which is very positive. I understand on informal advice

that we would expect a similar level of service under that.

Mrs HISCUTT - So that is Child and?

Mr FERGUSON - Child and Adult.

Mrs HISCUTT - And that will cover emergencies or all sorts of -

Mr FERGUSON - All will continue, yes. We will be looking for further information and we also - I am just bringing that little update for the committee.

Mrs HISCUTT - I look forward to hearing a bit more about that.

Mr FERGUSON - I am broadly advised that we would see a continued level of commitment.

Mrs HISCUTT - Lovely. I am done.

Mr FERGUSON - There is no waiting list for children I should have said.

Mrs HISCUTT - That is school children to the age of grade 10?

Mr FERGUSON - There is no waiting list for children. The only occasion where a child would be waiting for care would be if their dental care actually requires a general anaesthetic in a hospital environment.

Mrs HISCUTT - Thank you.

CHAIR - So, minister, on that point, my favourite topic, dental care for pregnant women. We have had a number of discussions about that. What is the Government's plan with that? Are we looking at targeting women in their first trimester particularly?

Mr FERGUSON - That is a good question. This idea of yours, Ms Forrest, in fact got a special mention in our white paper.

CHAIR - Excellent.

Mr FERGUSON - Did you know that?

CHAIR - No, no. I am just letting you know that I am very passionate about it.

Mr FERGUSON - You are too modest to admit it.

CHAIR - Well they do listen to me even though you blokes -

Mr FERGUSON - We listen to all of our Legislative Council colleagues. But I would like to let you know that we have taken that on board and it is not immediately to hand.

CHAIR - If you can provide what you are proposing to roll out and where, and it is funded?

Mr FERGUSON - In fact, we have such a large number of initiatives in the implementation

plan, I readily offer up to you that it is a bold and comprehensive implementation plan and the funding that is in this Budget is designed specifically to be used toward implementing that in practice. Sorry, just excuse me. I am going to get some more qualitative advice on that.

CHAIR - Yes.

Mr FERGUSON - We have an implementation plan and the concept that you described just now, in fact, is referenced in the white paper.

CHAIR - Great. All right. Any other questions on - what is it?

Mrs HISCUTT - I have got one I could put forward.

CHAIR - 1.4, yes?

Mrs HISCUTT - On palliative care. Hospital in the Home, which is not hospital in the home any more, this still applies for palliative care for people in their home, staying in their home?

Mr FERGUSON - I think you are referring to hospice at home, and that is the hospice with the and symbol - the '@ home'. That is a federally funded program which does not come through the state.

Mrs HISCUTT - Okay. All right.

Mr FERGUSON - It is a good service and it is my advice that although the funding agreement is coming to an end date, I understand that the Commonwealth has approved the roll forward of funds that were unexpended, which means that the service continues.

Chair, I can let you know that in our white paper plan for oral health we have committed to conducting a trial across the north-west to improve mothers' oral health by providing priority access to oral health services for eligible pregnant women. Naturally, that requires some further development and that is what we -

CHAIR - So the eligibility aspect is still being worked on at the moment?

Mr FERGUSON - I would like to come back to you. I will not shoot from the hip.

CHAIR - Women who are well nourished and healthy often have reasonable dental health themselves, but it does not guarantee it.

Mr FERGUSON - The reference may be about a means tested eligibility, but I will commit to come back to you with that. Please understand that that is a statement of intent.

CHAIR - Yes.

Mr FERGUSON - There is, in fact, a clinical advisory group process to guide taking us through to an implementation phase. Just as I have described for any of the other projects, we require a prudent plan process to be engaged. We are not just going to say, 'Yes, go off and do this'.

CHAIR - No, no.

Mr FERGUSON - We want it to be coordinated.

CHAIR - There is plenty of evidence about the benefits of good oral health in pregnant women.

Mr FERGUSON - Sure, and we acknowledged that in the white paper. Absolutely.

CHAIR - It has been my baby since I got here, one of those. So just in Mike Gaffney's area, statewide and mental health services.

1.5 Statewide and mental health services

Mr GAFFNEY - Minister, just a bit of a preamble. You would be well aware of seven recommendations from the Joint Select Committee on Mental Health and that was quite a long and involved process. Three times mental health has been mentioned specifically from that - those recommendations and it is pleasing to see that it had tri-partisan support, improving mental health and wellbeing through protection of protective factors and mitigation of risk, recognising the connection between substance abuse and mental ill health, and drug and alcohol misuse, and the third one was government significantly increases investment in financial and human resources in the area of screening and early intervention to address emerging current health challenges.

I thought those recommendations were positive and a lot of work had been undertaken. I was therefore somewhat surprised when I saw the line item for this activity and there was only an extra $10 000. So I am sure that there is other funds somewhere addressing those. But just from a first up look I thought, hello, there is only $10 000 more than there has been, and it has been more recognised that we are under-funded and under stress in this area. Could you provide the committee with a bit more information about that?

Mr FERGUSON - Of course. I suspect that we might have an answer that addresses your question which starts to sound a lot like an accountant explaining how accounting standards might work. Just note that there is no other explanation provided there. So I might need to just come back to you, Mr Gaffney, with another answer. I would like to acknowledge the work of the Joint House Committee. I could spend some time describing, but I will not unless I am asked to, the process that the government is going through in developing the five-year strategic plan. We recognise that there are many health challenges facing our state and better mental health can be supported through, no doubt, measures of the kind you have described.

We have made it a policy decision that while we will not cast aside any of the other needs, we are going to focus, in our strategic plan, on the two areas where we believe we need to make the biggest difference and that is smoking and obesity. I have also given an undertaking that the Government will respond to the committee's report, and so I will just take the report and the goodwill in which it is produced and the Government will certainly respond to that. On the funding, I would like to point to the - do you want to answer or I am going to press on?

Mr NICHOLSON - Just having a look at the question that was raised by Mr Gaffney, what we are potentially looking at is a slight decrease in Commonwealth, ABF and block funding in the 2016, 2017, 2018 years. Primarily that is a result of overhead reallocations in the THS and it is not a reduction in funding to any services in those output groups. The amount that that is factoring in is about $1.7 million. So that is probably an accounting treatment that is masking other ups and downs in funding within that particular output group.

Mr GAFFNEY - So if it is not a reduction, but you are not saying there has been an increase in funding for mental health services either. I would be interested to see a breakdown of what was apportioned in last year's budget and what has been apportioned this year, other than the accounting procedures because there does not seem to be any increase at all.

Mr PERVAN - It is also important to consider Rethink Mental Health and the state's contribution against the Primary Health Tas or the commissioning intentions for mental health services. Most of the Commonwealth funding that has been coming to the states over the years is now being channelled through primary health networks, particularly in the preventative area and in primary care. So that funding that used to come to us for the Commonwealth preventative programs will now turn up in Tassie through Primary Health Tasmania, and they worked very, very closely with the very authors of Rethink, actually, on developing their own commissioning intentions for mental health. So there are a pigeon pair of service strategies and the bulk of the funding now comes into the state via the Primary Health network as opposed directly to us and then out into the community.

Mr GAFFNEY - Do we have a figure with that, so the bulk of the funding that comes in because -

Mr PERVAN - Through PHT?

Mr GAFFNEY - Yes.

Mr PERVAN - We can ask them for a figure.

Mr GAFFNEY - Okay.

Mr PERVAN - But it is generally not reported to us, no.

CHAIR - That is all federally funded, yes.

Mr PERVAN - Yes. That was an integral part.

CHAIR - Yes.

Mr PERVAN - There is also a two part answer to that one. That was the Commonwealth's response to the National Mental Health Commission's Report that led to that change in policy and funding direction. We are also engaged in a process of writing the Fifth National Mental Health Plan, which will come through later this year and will also attract some Commonwealth funding. That has a very strong focus on preventative measures. By that I do not mean -

CHAIR - Within the state service delivery?

Mr PERVAN - Within the national, so that Tasmania will get funding from that. But it is direct preventative programs not social marketing.

Mr FERGUSON - I have other willing volunteers of information, Deputy Secretary NCE.

Mr NICHOLSON - Sure. So just to close that point out for Mr Gaffney too, so I am saying

this output there is not any reduction to funding to services within that output. In fact, it is an accounting treatment. That is actually offset by increases in other outputs including 1.1 which was admitted services and 1.3 which is ED services. It is 1.1, I think, primarily where the mental health funding is actually captured.

CHAIR - For the acute mental health in patient services?

Mr NICHOLSON - In the department, that is where it is in the system.

CHAIR - Okay. Right.

Mr GAFFNEY - Did you want to say anything?

Dr ALCORN - Look, the only thing I would add is just to give some reassurance, the money questions aside, that we are meeting with Primary Health Tasmania as THS. We have also got the department and Rethink in the room and we are looking at where all the different funding sources overlap so that we actually can arrange and make sure we have a network of continuity of providers. So they are early days, those discussions, but they have been very positive.

Mr GAFFNEY - Following on from that, does the Commonwealth funding for psychiatric emergency nurses runs out in the middle of this year, how much was that funding, and how is it going to - why would - what is the government going to do in response to not having that service now that it is not being funded federally, I suppose, what is the response?

Mr FERGUSON - I can help you with that. I can indicate that the cost of this - we have recognised as a Government that that service needed to continue and continue beyond the limited time funding of the Commonwealth and it is provided for in this Budget. I think it, together with the clinical initiative nurses, is funding of the order of 1.4 -

UNIDENTIFIED SPEAKER - It was 1.6.

Mr FERGUSON - Just one moment.

Mr GAFFNEY - If you could do an FTE on what that funding was, how many nurses did we have as psychiatric emergency nurses, that would be helpful?

Mr NICHOLSON - There is an amount for that particular program for PEN nurse replacement of 706 000

Mr GAFFNEY - Okay. That equates to how many positions or -

CHAIR - Sorry, nurses you mean?

Mr GAFFNEY - Yes.

Mr NICHOLSON - Just under five FTE.

Mr GAFFNEY - They are located where?

Mr NICHOLSON - Actually in the emergency department at Royal Hobart.

Mr GAFFNEY -Just a comment regarding the state's Children and Adolescent Health Service. I know there has been some funding increases in the past, but it is still regarded as possibly one of the lower funding in the country per capita. So I am just wondering what other initiatives or ideas are in the pipeline to try and increase the funding in that area?

Mr FERGUSON - Mr Gaffney, from your previous question - it might be something you already know - but the budget provides additional funds for mental health, specifically as allowing the health system and the THS to take the next steps in mental health in the Rethink Plan, the 10-year plan. The plan is very ambitious. It has over 100 actions. It is very comprehensive and we worked that up very closely with all stakeholders including our clinicians, and consumers, carers, and their families. So we are taking the first steps in that now and we are supporting that with $3 million in this budget, $750 000 per annum. I would just like to let you know that we will be working with the Rethink Plan Implementation Steering Committee to consider in detail the allocation of that funding. It needs to be consistent, of course, with the plan.

Mr GAFFNEY - Is that the 10-year, was it?

Mr FERGUSON - Yes.

Mr GAFFNEY - Wasn't it the one that the Nurses Federation had felt that they had not been consulted on? Is that the same? There was some comment, I think, by the Nurses Federation -

Mr FERGUSON - I would not like to speak for the ANF on that. We undertook -

Mr GAFFNEY - In October 2015 the state secretary, Neroli Ellis, said that it was unfortunate they were not consulted on that. I am asking if they were involved in that consultation, or not?

Mr FERGUSON - Yes, we did an extensive and indeed a public consultation process on that so I am surprised to hear that.

Mr GAFFNEY - The Nursing Federation says it was not consulted on the plan. I am wondering if you had any further information.

Mr FERGUSON - Perhaps I was aware of that at the time. I was not until you have just reminded me of it, Mr Gaffney. But it has been widely welcomed by, particularly, stakeholders in the sector with a special interest in mental health. Of course, it is worth mentioning as well that the government partnered with the Mental Health Council in the Rethink project. It was, if you like, the governance of it was shared. So we used that partnership to gain the maximum possible value from the sector.

Until you just told me about that, I was not aware of that concern. But we consulted with the Tasmanian community.

Mr NICHOLSON - I am just reading your statement on the release of the plan and the only concerns they raised were potential issues -

Mr FERGUSON - And PENs.

Mr NICHOLSON - And PENs.

Mr FERGUSON - Maybe that's the way it was reported. But I just wanted to let you know that the funding gives the steering committee the confidence to now take the next steps in detail of how we can utilise that funding in a detailed way and the further detail on that, of course, in the budget papers. But you didn't ask me about that, you asked me about CAMHS.

Mr GAFFNEY - Yes.

Mr FERGUSON - This has been something quite close to mine and the Government's heart. We recognised that there has been a service gap in the Child and Adolescent Mental Health Services and, I am told prior to me becoming minister, it had been a reasonably longstanding service gap, particularly in the south. So we have addressed that with an extra $800 000 recurrent. To be transparent, that is an additional $600 000 per year in budget papers, in last year's budget recurrent, and $20 ,000 provided by the department, I believe it was.

So that was a very significant uplift for CAMHS. The funding will enable the creation of up to eight new positions within the service to enhance the overall service, including addressing the significant unmet need for young clients up to 12 who have severe and complex mental health problems. I am advised, pleasingly, that recruitment processes to fill the new positions have either been completed or are nearing completion. I understand that in some cases that has not always been easy, but that is a very positive progress. Additional staffing accommodation and clinical space to house the new staff has also been progressed, and I could describe those in more detail if that is helpful. But, yes, we just appreciate that service, we recognise the need and I am thankful to the key clinicians who have informed the government about the needs and have warmly welcomed the additional support.

Mr GAFFNEY - Interestingly the preamble says that the service also provides for the crisis assessment treatment, intensive support, community care, and rehabilitation services, primary health care services and correctional facilities, forensic mental health service. I am wondering on the middle two - primary health care services and correctional facilities - and forensic mental health services to people with mental illnesses who have come in contact with the criminal justice system, is that an allocation of funds, or as a case study? You are saying that you are supporting these people, which I take for certain that you are, but I am wondering do you provide so much money for there to be that support within the correctional facilities, or how does it operate so that we will understand how much of that finance, the $116 million, actually goes into the correctional facilities, into those services?

Mr FERGUSON - I need to get a breakdown for you in order to come close to addressing the specific support that is provided within correctional facilities. The CEO, or chief executive officer, I suspect would also need to gather that advice because it is a statewide service. While it has been described precisely as you have read it out from the budget papers, that is descriptive in that to try to paint a picture of the service that is provided around the state.

Mr GAFFNEY - Yes, thank you for that, and I will put that on notice. But it is important if we are claiming this is what we are doing then we should have a budget allocation for that to cover those services, the range of services, so people can say, well, it is a genuine attempt to do something. And if there is an area there that needs more funding, that is what we need to do.

Mr FERGUSON - Sure. Mr Gaffney, I would be pleased to come back to you and the committee with the detail on that.

Mr GAFFNEY - My last three questions are to do with the mental health bed pressures at the Royal Hobart.

The number of acute beds in 2014 was 43 and it has gone to 30 because of reallocation. And that is fine. I know that there has to be a rebuild. And it has been said that the decrease of allocated spaces has gone from 4400 square metres down to 2200 square metres. Even when completed it is going to be 1600 square metres less than what it was initially. And there is the point of view that people with those conditions need to actually have more space not less space to be able to be - so I do not know, it is not my area of expertise. I wonder how you can justify that, or how you say that it is our experience or whatever. Those concerns have been raised with me and I would like to hear some input back from those who are our hospital experts.

Mr FERGUSON - I am happy to help you with this with information that I have right now. If you would like I can also during now or during the capital outputs, whichever is best helpful to you, give you some very useful feedback in this area.

Bear in mind that the Rethink project and even the journey that the state has been on prior to Rethink has placed a renewed emphasis on the providing wherever possible care for a mental health consumer patient outside of hospital if that can be achieved safely.

We have actually seen a reduction in counted beds in the THOs and in the THS over a number of years. Which, you know, if you were looking at any part of the health system it could be described as a bad thing, closing beds, well it has actually been happening under previous governments and this one is a reduction in demand for inpatient mental health beds. I will shortly describe that pattern of the number of beds. That has been a good thing because it actually is testimony to success of providing more care in the community, which is exactly where we want to be. We need to reserve the opportunity for inpatient care, and we do that, but I think that we are progressively getting the balance better and better.

Integration between mental health inpatient units and community teams continues to improve with the number of consumers discharged from hospital being followed up in the community in seven days. That has increased significantly. And the number of community and residential clients in mental health services continues to increase, which you would like to see if the minister is telling you that it is a good thing that inpatient beds are reducing, that the community and residential demand is increasing and being met. There is strong demand overall for mental health services. There is a projected increase in the number of community and residential clients in 2015-16.

I can give you information now on impatient beds. Due to decreased demand for inpatient services which has resulted from a stronger focus on community treatment bed numbers have reduced at the Royal Department of Psychological Medicine from 34 - I am not sure if this lines up precisely with your dates and numbers but this is what I have to hand, from 34 beds in September 2013 to 27 beds in February 2015, and 25 beds in March 2016. Now this may not be a count of the actual number of beds or the physical room for beds but this is an indication of the bed availability.

The reduction in bed numbers has increased the efficiency of the ward because now occupancy rates in 2015-16 are coming close to the recommended 85 per cent. So I am very happy if it is of assistance to you in also discussing mental health provision in the new redevelopment but it is pleasing to be able to say that in the new redevelopment both in the temporary inpatient facility, which is the modular building, and that has maximum capacity of 33, and the future K Block tower

will also have 33, and they will be a much higher standard. There will be a large number of individual rooms as well. I hope that is helpful because I think that paints the broader picture of what has actually been happening with the reform of mental health, not just under this government but to its credit, the previous government. And that is a good thing.

So just to round out my answer, the temporary inpatient facility has been designed with the capacity for 32 inpatient beds because two large single bedrooms can be converted to two bed wards if necessary due to extreme demand and use of the de-escalation room to provide a total of 33 maximum beds is possible.

Mr GAFFNEY - The last question. I do not always agree that if every other state has one we need to have one as well, but the question might be put forward that we do not have a mental health commissioner and apparently we are the only state that does not have a mental health commissioner. I wonder how that role, those responsibilities, are provided for within our system? Is it something you have discussed about, you know, a better way of doing it, or are you comfortable with how it is operating at the moment?

Mr FERGUSON - Mr Gaffney, you have asked me a question that I have not considered. I am simply happy to question the rationale around it. I could point to the fact that we have a reasonably new Mental Health Act here in Tasmania. It is going to be subject to statutory review within its first, I think, five years.

CHAIR - Hopefully it will not take 16 this time.

Mr FERGUSON - Good point, thank you. I am sure that if improvements can be shown to be needed, you know, those things could be considered at that time. I would just point here as well though to the very positive role that the chief forensic psychiatrist and the chief civil psychiatrist as statutory officer roles are playing in this space. I have witnessed up close how the chief psychiatrist has been able to provide a genuine interface between the services that are provided and the needs and the demands of the Mental Health Act. I have seen how on an individual level mental health consumers, carers, and their families have occasionally been disappointed or upset with an episode of care or a treatment and, for better or for worse, whether they were in the right or in the wrong, or somewhere in the middle. I have witnessed how the chief psychiatrist has been able to play a very positive role in reconciling parties and also -

CHAIR - Who holds that position at the moment?

Mr FERGUSON - Professor Leonard Lambeth.

So I am just sharing with you, Mr Gaffney, I have witnessed how he has been able to be a real peacemaker in different situations. And in one particular instance where I was written to by a family with a concern I asked Professor Lambeth to provide me with independent advice about whether this person had been treated fairly and I have seen how that has actually been a good mediating role. He has specific other roles which are prescribed in the legislation but I have seen the value-add that he has brought to the position has been a good thing. I will just mention in passing as well the role that we already have with opportunities for formal grievances and complaints processes which maybe in other states is the domain of the commissioner, I do not know.

Mr GAFFNEY - We do have a health complaint commission, don't we?

Mr FERGUSON - We do, yes.

Mr GAFFNEY - The delineation here as in other states, they both have that service and a mental health's, because the people with mental health commission or commissioner probably need to be handled in a different way to just a normal health complaints commissioner. I will just leave that on the table.

Mr FERGUSON - It is the first time I have been asked about that question. I have not considered it before, Mr Gaffney, in all honesty. But Tasmania's first permanent CEO of the Tasmanian Health Service is an eminently qualified psychiatrist, and he sits to my left.

CHAIR - And he is here for all of us then.

Mr FERGUSON - I am not aware of the most senior executive public servant in Tasmania previously having a psychiatric background so I think that we have a pretty exciting opportunity to get leading edge thinking implemented in our health service. If I remember correctly Dr Alcorn is also a current or previous member of his college. So, I value Dr Alcorn's opinion and I am sure you would be interested in his opinion as well.

We are a very small state and I am not sure that we would warrant it, but I am not saying that it does not warrant thinking.

Mr GAFFNEY - I did preface my comment with saying I do not always agree. But I was wondering the reason for not having it and whether it needs -

Dr ALCORN - Sir, I guess mental health commissioners come in two forms in other jurisdictions. One is budget holding and they have a substantial role in structuring and planning services. And the other is more of a policy input. So you could argue that if you have a strong policy framework, as we do now with Rethink, that that probably obviates a short term need for such a person. The other thing I would add in is we are very busy developing a consumer health forum in Tasmania. We previously have not had one. I do believe that we need to go back to the sector once we have people who have had training to be fully participatory in collaborative service planning and ask them what they think. For now I think we can feel reassured through the Rethink policy and the existing health complaints mechanism.

I take what you say about health complaints commissioners but really people who find themselves at the doorsteps of complaint authorities usually are an extremist emotionally as well as whatever their physical complaint was so they do develop an expertise in dealing with people like that.

Mr GAFFNEY - Thank you.

Mrs HISCUTT - Just one quick question, it might not be appropriate. In light of what is going on around us, I know that DPIPWE often give extra funds to community groups like Rural Alive and Well -RAW - and I know that the Health Department does partner with a lot of other private care providers, do you partner with people like RAW at all or give funds to them?

Mr FERGUSON - The Government recognises that it is not the best and only provider all the time, and we certainly do partner with non-government organisations, and that has certainly included RAW. In our first budget as a new Government two years ago we provided $1 million to

RAW, which was of great assistance. I will shortly have more to say about our support for Rural Alive and Well. I know that you mention it as an example, it is a very good example, and they provide the kind of engagement with the local community that governments often dream about. They are a great organisation and the Government supports the work that they do. They are also supported by the Commonwealth and we would like to see that continue of course.

I wanted to mention as well that the government business enterprise, TasNetworks, has also recently partnered with Rural Alive and Well and that has been terrific to see because TasNetworks has recognised that most of its assets and personnel are in regional areas around Tasmania and have made for themselves a strategic funding lifeline to Rural Alive and Well.

The Government has in fact recently written to Rural Alive and Well making available to them an offer of additional funding.

Mrs HISCUTT - I did not know that.

Mr FERGUSON - This is not a planned announcement but you have asked me about it. They have been concerned about their future funding arrangements and the Government will be providing them with $569 000 to cover them for the next financial year. That will allow them to continue their operations.

Mrs HISCUTT - That is in addition to what TasNetworks are providing?

Mr FERGUSON - That is right.

Mr FARRELL - While we are on mental health services and taking on board that we have a well-qualified man in that field as our chief, I wonder if there are any plans or ideas around Millbrook Rise - that is in my area - whether the services there can be expanded or improved, or what the future might hold for that.

Mr FERGUSON - I would like to offer to write to you with an update on our vision there. This may come as news to you, Mr Farrell, but the Government recently purchased that property. Did you know that?

Mr FARRELL - Yes, I had heard.

Mr FERGUSON - Yes, so we came to terms with the previous owner. I think that demonstrates a continuing commitment there. Nothing is forever in terms of the model of care. Through all of what this Government has done, and indeed the previous government, in the area of mental health we need to demonstrate an ability to change and to provide models of care that are contemporary, particularly around the fact that many of these sites are where people live, it is their home. I would be pleased to write to you and offer you further briefing if you would like it, because I know it is in your patch in your seat of Derwent. But, yes, we have made that purchase on behalf of the Crown and we certainly are maintaining and indeed increasing our efforts to provide appropriate care and more options for people to continue to live happy lives away from hospital.

Mr FARRELL - Yes, thank you.

Mr FERGUSON - Or to use another term, in a step down or a step up in the community, which might be a half way arrangement of care.

Mr FARRELL - Yes, it has been one of those facilities that probably could have been better utilised and, yes, it is the same model that has been around for a long time so there might be some new thinking on that.

Mr FERGUSON - Yes.

1.6 Forensic medicine service

CHAIR - Thank you. We will move on to output group 1.6 Forensic Medicine Service. Craig, do you have anything on that?

Mr FARRELL - Yes, it is a fairly straightforward one. It is still a fairly small unit under Dr Lawrence's care, so I cannot see of any great changes. Certainly into the forward Estimates, it just looks like a modest increase to keep things running. There was some concern about the amount being cut back last time but it looks like that has all been reinstated and, yes, I would just - unless there is anything exciting to report in that area.

Mr FERGUSON - There are no untold secrets in that one. It is business as usual.

CHAIR - We will move on.

Mr FARRELL - I would be surprised if there are any exciting changes.

Output group 3
Statewide services

3.1 Ambulance services

CHAIR - That will complete our 2.1 Tasmanian Health Service, we will move on to 3.1 Ambulance Services.

Mr FERGUSON - I introduce to the table Mr Paul Templar, acting Chief Executive Officer Ambulance Tasmania.

CHAIR - An old friend of mine.

Mr FERGUSON - Indeed.

Mr GAFFNEY - I am also aware in this section last year there were quite a lot of questions from different members so I will do some and then pass over for others.

I am always interested that say there was $51 million that was set aside for the 2015-16 Budget and it is not quite the end of the financial year, how do you measure whether that line allocation is staying under budget? So how do you know whether you have come under the $51 million or you have broken that budget? I am just interested in how you do that, is that a monthly or a weekly, or at this stage now you know that by 30 June you would have spent $49 million or $53 million?

Mr NICHOLSON - Mr Gaffney, through a range of our governance committees which are

very close overseeing the financial position of the various business units of the department. The public can see that in real time through our finance branch and it is something that obviously I have carriage of in support of Paul and the secretary to make sure that we are not exceeding expenditure in particular line items and where we do they understand what the reasons and rationale for that might be and we make adjustments as an organisation to cover that.

Mr GAFFNEY - My next question would be how has the $51 million gone for this year's budget for 2015-16, has the ambulance input line services stayed within their budget? And minister, after we get that response, in your overview you have mentioned the ambulance service, but I am going to ask to perhaps provide a little bit about the extra allocation for this year's budget. You might take the opportunity then to mention a bit more about the ambulance, per se?

Mr NICHOLSON - Yes, of course. So, the year to date budget for Ambulance Tasmania is slightly over in terms of its line budget that has been managed within the department's internal resources. There are some reasons for that including meeting the short term costs for ambulance work value outcomes. That is primarily what the department is managing through other efficiencies and internal reserves for this financial year. Obviously the Government has funded their work value outcome through the budget. So going forth that improves the position of the Ambulance Tasmania in the future.

Mr GAFFNEY - Thank you. The footnote we have here is the increase in ambulance service output with respect to additional funding provided in the budget for ambulance work, value case, and patients first initiatives for extended care paramedics and the reallocation of patient transport to support one health funding to reflect that Ambulance Tasmania will undertake a number of elements under this initiative. So that would be a good chance for you, minister, to explain a little bit more about those initiatives and what those elements are.

Mr FERGUSON - Of course. So particularly I earlier today complimented you and it was entirely sincere because, frankly, with the history and the need for health reform on the northwest coast being absolutely established, particularly through the advice of senior clinicians, I just appreciate the role that you in particular as the local member for Mersey has played. The Mersey Community Hospital is in your electorate and you have also just been through an election. And I admire the way you conducted yourself on that matter. Not because you agreed with me but because I believe you took to your community what you believed was the right, the best thing for that electorate. You can speak for yourself of course.

Mr GAFFNEY - There are a couple of us who thought it was always going to be one THO.

Mr FERGUSON - While I am praising you I cannot not mention the Mayor of Latrobe, Peter Freshney, and his councillors, who have been tremendous to work with.

Arising out of that process and the changes in the white paper that do specifically have changes in the way that the emergency service provided at the Mersey, that is the emergency department will continue to be a 24/7 emergency department. There will be some change there but not for admitting to the hospital. We want to make sure that patients are stabilised and then sent to a higher level hospital so that we can be even more confident of the care that they receive.

So specifically to support that and to make it achievable and safe the government decided this time last year that we would recruit an additional 12 paramedics specifically for Latrobe/Devonport area. On advice from Ambulance Tasmania, we have made a decision that they should be located

at the Mersey Community Hospital at Latrobe onsite with the existing - that is nothing to do with any other reason other than the practicalities of where they are going to be best accommodated with physical spaces. Those additional 12 paramedics will play a role in the whole organisation which services the whole of the state. Naturally they are there as a resource for the demand that we have in that community. So I am pleased to tell you that the interview process for the recruitment has been conducted, offers made. The new paramedics are currently being inducted to allow the service to commence from 1 July.

Mr GAFFNEY - Good, I will jump a couple of questions again. Will we be able to cover most of those paramedics from within our own state and our own training that we do here, or do we have to go to the mainland? I am not averse to going elsewhere for expertise, I just wonder if we have enough education here to be able to successfully plan for future paramedics.

Mr FERGUSON - Before I answer that I just let you know that last year we announced as part of our health reforms an additional three extended care paramedics for Launceston. To come back to your latter question, the answer is that it is an open recruitment process; that process has now been completed. I met quite a number of the new recruits, didn't I, acting chief?

Mr TEMPLAR - You did, minister.

Mr FERGUSON - I will invite Mr Templar to speak to this himself, but my recollection is that there was a genuine combination of University of Tasmania first year out graduates, a number of experienced paramedics from other jurisdictions, and one or two returning Tasmanians.

Mr TEMPLAR - Yes, that is correct, minister, there were a mixture. There were a number of interns who are just out of university having completed a degree and will undertake an 18 month internship with Ambulance Tasmania before being given the right to practice independently, and also a number of qualified paramedics, primarily from Queensland interestingly enough who have come here to continue their career in Tasmania, mostly for lifestyle reasons.

Mr GAFFNEY - The good weather.

Mr TEMPLAR - Yes, indeed.

CHAIR - Until this week.

Mr GAFFNEY - Well thanks for that. I am interested to know in the ambulance service, in this line item, what staff and personnel are in this current line item, and there are obviously paramedics but there are other people, other groups, whether they are administration or whatever, within this. Would it be possible to receive a breakdown of the numbers that you had in those positions probably from May 2014, May 2015 and May 2016, from 1 May, just to give a date over that so I could see where different lines were?

Mr FERGUSON - What I will do if I get some nodding on my right, Mr Gaffney, is take it on notice, but I believe we will be able to provide precisely what you have asked for. A breakdown of, if you like, frontline resource, back office support, corporate staff, clerical, and that will be for the whole organisation, Ambulance Tasmania. Which is a part of the department.

Mr GAFFNEY - Yes, well that is what I see, there is a figure allocation there for ambulance services so I am assuming that is staff, and I want to know the different numbers of staff over that.

When I research some questions for a line item I go back to the last year's *Hansards* and have a look and then go to the website and have a look on ambulance services. I was interested to know that in reading *Hansard* from last year that the 20-year management of assets plan was stated last in the lower House to be signed off in this financial year, but when I go to the website there is no plan. Then when I go into the media I then come up with a media article saying there is no plan that has been advertised yet. I want to know where that is because that plan was to do with asset management plan, was to do with stations upgrades, stations closure, and those sort of things. Why has that not been released? In last year's *Hansards* from the lower House it said that it was expected to be signed off in this financial year once feedback had been received from the steering committee regarding the asset management plan. Why has there been a delay, and if there was a delay is it because of the feedback they got from the steering group, and if so when do you expect that plan to surface?

Mr FERGUSON - Mr Gaffney, let me help you with an explanation of that. That study has been conducted. I will take you through the process in a moment. Now I will briefly cut to the chase. It is actually a study which has been procured through the SIIRP process, the government structured investment review program, it is internally deliberative, it is not going to be released, it is a part of the budget process for consideration in the budget process from year to year. That is why I am sure if you went looking for it that you were not able to locate it.

I will go back to the beginning. The reform future government business budget decision making AT commissioned the AT asset management strategy to forecast the built facility requirements over the next 20 years and beyond. The objective was to ensure that AT can configure and deploy resources in line with projected demand and enable achievement of performance standards. The key driver for change is the projected increase in emergency ambulance demand over the 20-year period and that is a function of the population growth and the increase in proportion of elderly Tasmanians. The projected resource, infrastructure, locations and capacity can be planned through phased investment as an outcome of this strategy. The contract for the study was awarded to Operational Research in Health Limited, ORH. The cost of the report was $179 000 and this was funded by the government structured infrastructure investment review program.

The methodology for the study was based on analysis of future services needs for AT based on current ambulance usage rates, population projections and provided by the Department of Treasury and Finance. Other states have engaged previously ORH to undertake comparable modelling for the same purpose. So as I indicated earlier, like all studies that are commissioned through the SIIRP process they are internally deliberative, they are prepared exclusively for the purpose of informing the budget process, future government budget decision making. So the government will not be releasing the report.

Mr GAFFNEY - Fine.

Mr FERGUSON - But I mean just to be clear, it is not intended to be anything different to what would ordinarily be the case. The outcomes of the study are to be considered against all other SIIRP studies and considered alongside other government funding priorities in future budgets.

Mr GAFFNEY - I can understand that when it comes to service delivery. When it comes to asset management, it is like the state government setting aside so many million dollars for the TT-Line, because that is an asset, they need to replace it. It is like for schools when they have a maintenance program, that is the asset, they need to maintain it, or there is a greater growth area out at Port Sorell so they build a school there.

I am a bit confused as to why this is any different if it is to do with stations and assets and why the Government is not releasing that report so people are aware that whether it is this Government or the next one, or whatever, that in 2022 you are going to have to put another room or another station at Dover or somewhere because of an increased population.

Mr FERGUSON - I respect that point of view. I will answer it in a way that might give some perspective. We in this budget funded the redevelopment of the Royal Hobart Hospital Pharmacy. I do not have intelligence on the previous government's processes but I do know that that business case has been circulating for a fair while in government. So I think it is a case that this is a competitive process internally to government and proposals need to go through the various stages of the SIIRP process and prove themselves worthy of progressing to the next stage. It is designed to take, to the extent that governments can, the internal politics out of competitive opportunities for ways of spending money. This fits within that framework. It is not intended to withhold valuable information from the community but I suppose it protects the process. I am informally advised that the pharmacy case was approved seven years ago. So I think it shines a light on the nature of the process. It is highly competitive because every minister and every department and agency are obviously putting up their best proposals, and many proposals, and there is a process designed to make sure that they are robustly assessed through a very rational approach. So that would be my explanation and I hope that is helpful.

Mr GAFFNEY - Moving on, yes.

Mr FERGUSON - I take the opportunity, please, Mr Gaffney, to provide to the committee the Ambulance Tasmania pay groups. I have provided this by award, which is perhaps the best guide as to what vocational groups are involved in the organisation, and that has the three dates of March 2014, 2015, 2016.

Mr GAFFNEY - That is very good, thank you. That is really good because my next question is about would the minister like to comment on the TIC's decision regarding the Tasmanian Ambulance Service award about the extra $2.5 million which is going to made in the financial year increasing to, I think, $3 million in 2017-18, and within that - and I suggest that is part of the 2016-17, there is another line item back here further where that is countered, but I suppose my question would be, and thank you for providing the FTEs and the areas, that there is no suggestion that there would be a decrease in staffing services along those because of the additional cost of those staff, I suppose that would be a concern?

Mr FERGUSON - Sorry, would you repeat the concern or the question, that last part?

Mr GAFFNEY - The concern is that when we come back next year and we ask what are your staff figures for 1 May 2017 that it is not going to be less than what there is in 1 May 2016 because it is a growth area, I would think?

Mr FERGUSON - Well it has already been the case that we have employed additional staff in the organisation.

CHAIR - Paramedic staff?

Mr FERGUSON - Yes. It is already the case and we progressed, it would seem, more again. Of course you know why we would want to do that: it is about improving our capability so we can

improve our responsiveness to the community. You have not asked me about this yet, maybe it will come up, but we are experiencing increased demand as well. So we want to be able to respond to that in a timely fashion.

Importantly the Government has taken advice from its own Department of Health to ensure that the service is adequately provided for so it can actually meet the cost of the work value claim that was made and assessed by the TIC, challenged by the previous government, and to an extent our Government, but in the end leading to an agreement to deliver the 14.1 per cent over a more affordable time frame of three years. This was agreed by all parties and stamped at the TIC as a change to the award. So obviously what I am trying to say right now is that the Government took advice from the Department Health and Human Services. We believe it is a prudent allocation but it requires this deliberate additional funding for it to feasibly deliver on that increase. In the first year we were able to manage within existing resources, as we were able to with employing the extra two, just over two, FTE for the Southern Midlands branch station as well.

Mr GAFFNEY - Just three other minor - not minor but more succinct, I suppose. Eighteen months ago there was some concern regarding the changes to the ambulance rosters, the conditions, and there was a discussion about the hours and the length of people on the task. I was wondering has it changed and what has the feedback been 18 months down the track about those changes to the rosters from an ambulance.

Mr FERGUSON - Would this be the length of shift?

Mr GAFFNEY - Yes. I am interested to see, now that it has been in place for 18 months, what the feedback is?

Mr TEMPLAR - Ambulance Tasmania last year became involved in consultation with the staff union about possibly changing the current shift roster pattern for urban stations. So currently they work a 10-hour day shift and a 14-hour night shift. Ambulance Tasmania had quite genuine concerns that not only are they working 14 hours in the night but that could extend to 15 or 16 hours in some circumstances because clearly we cannot say, well, you have gone to this emergency now go home and just leave it half completed. So we entered a period of consultation with the staff, it would be fair to say that there was opposition from a good number of the staff and certainly from the union. More recently I have had discussions with the union about how we might progress this and they have some concerns which I think bear further investigation. So we have an agreement that over the next few months we will set up a working party and work collaboratively and involve appropriate places like workplace standards and so on to work out a solution to the problem if we can, or the concerns.

Mr GAFFNEY - If I can go through, just following on from that, also any anecdotal responses to the impacts of the laws, the new legislation laws protecting paramedics and any staff in 2014, I think it was to do with the safety, the impact of the laws introduced in 2014, protection of the safety of paramedics?

CHAIR - The laws have been proposed; they did not go through.

Mr FERGUSON - I might offer up an answer on this, Mr Gaffney. I think you may be referring to the mandatory minimum penalty provisions that were brought into law for police?

Mr GAFFNEY - Yes, and did not go through for paramedics.

Mr FERGUSON - Yes, but it has not been extended beyond that work group. If you were to ask my colleague, the Attorney-General, she would be able to give more detail on the future of that. I am happy to volunteer that the Government is committed to evaluate that change to the law, which was for serious assaults, and the potential is being considered as part of that evaluation to extend that to other frontline emergency service workers, potentially including paramedics.

However, the organisation has been proactively doing some excellent work equipping our staff with training and support particularly in de-escalation and working side by side with police in those training sessions. I understand it has been very positively received and has just provided a greater level of skill in our workforce to be able to get themselves out of dangerous situations or if they find themselves in one, how to protect themselves somewhat with de-escalation.

Mr GAFFNEY - Thank you. The current target times for average emergency response, are they on track and how do they compare to other jurisdictions of similar regional sizes in Tasmania. My question would be are they at an optimum level and how does it compare to other states?

Mr FERGUSON - How it compares to other states, I will take advice. It certainly was the case at a previous Estimates when I took advice that different jurisdictions at times start the clock at a different time in the call taking sequence. But that said, I can give you some data and performance information that is further to what is in the budget papers. In 2015-16 to year to date 31 March, there were 61 562 ambulance responses and there were approximately 50 per cent of emergency calls were responded to within 12.1 minutes. The most recent figures for 2014-15 demonstrate that 98 per cent of Ambulance Tasmania's patients were satisfied or very satisfied with the ambulance service. Response time targets for 2016 and 2017 are the same statewide and in all regions as the targets that were published in last year's budget papers. Of course to state the obvious, there has been, as you allude to, a small increase in the average statewide response time. We are mindful of that and Ambulance Tasmania and its leadership are mindful of that and we will always monitor it closely including looking for opportunities to do better.

To support the service the Government has made the decision to put increased resources into the system to meet and manage the demand for ambulance services. This includes what we have already discussed, the 12 new paramedics in the northwest, and the three extended care paramedics for Launceston. In last year's budget we provided for two new paramedics, two FTE paramedics, to cover the 24-hour round the clock shift at Southern Midlands at Oatlands. Just in recent months, and is funded in this budget, we have also recognised the need for three extended care paramedics in Hobart. This is part of our Patients First initiative. I failed to mention our three extended care paramedics for Launceston. So all of those positions except for the Oatlands ones, are funded to commence from 1 July. The Oatlands paramedics commenced during the last 12 months.

In the current financial year we also put in place a new paramedic service in Southern Midlands but the two paramedics that staff that service do so one at a time in partnership with local volunteers. So it is still a maintaining of that partnership between the community and AT. Importantly, I believe there is more that can be done to meet the demand in the community and maximise any response. To that end we have committed to reviewing our options for extended scope of practice for paramedics as well as that secondary triage as part of our Patients First plan. So we are currently considering options between the department and Ambulance Tasmania to progress that body of work.

Mr GAFFNEY - The estimated cost last year of the Oatlands service was somewhere at around

$500 000. Do we have clearer figure, or any figure, or was that the figure, or has it come under that?

Mr FERGUSON - I am sure I do not have to tell you that in last year's budget we said that it was an estimate but in fact we believed, and we have taken the decision that at that time it could be funded from within existing resources so didn't require a new allocation. But we certainly did follow through with what we said. The actual cost would be a specific question that I would have to have raised through AT, and it will not take long.

Mr GAFFNEY - Is that all right? Okay.

Mr FERGUSON - Relevant to that of course is that it has not even been for a full year yet so we might be guessing. We might need to come back - not guess, we might be needing to make for you an estimate. And may I just say that because we are only talking about two individuals plus their coverage, we might be getting to that level where I am actually telling you what individuals are being paid, which is just an interesting point, isn't it?

CHAIR - Especially if they are not being paid the same.

Mr FERGUSON - Mr Gaffney, it is a very reasonable question. We did provide an indicative estimate of half a million dollars to establish that new model and we will provide you with that response.

Mr GAFFNEY - I am not overly fussed by it, other than the fact that if you are going to put something in place, you need to know how much it is going to cost.

Mr FERGUSON - Of course. So that was, on advice, I think that is two FTE plus the cost of their leave.

Mr GAFFNEY - The last question is to do with the emergency services computer-aided dispatch system, and it says the Tasmanian Fire Service and Ambulance Tasmania with a combined emergency services computer-aided dispatch system. I can see in the Minister for Police, Fire and Emergency Management a line item that has the cost and their share of it. I could not see in the ambulance service where the line item was. Where is it in your - I could not see the figure. Or has it not been paid?

Mr FERGUSON - I am going to ask the secretary and/or acting chief executive to assist with this answer, but I can indicate - so the ESCAT, as it is known, that new product, which is to support across the services, that is being funded specifically through the Police, Fire and Emergency Services department. However, as an interim step, we have required an upgrade also, because the computer-aided dispatch system at the AT state operation centre being used to manage the end-to-end workflow of emergency incident and event management is considered to be at end of life. The Guardian product is at the end of its life. A contract is being negotiated with the supplier for ongoing support and maintenance of that system subject to a substantial upgrade being completed. The planned upgrade to the upgrade CAD is schedule for August 2016. The Government has invested in the whole-of-government CAD system which is due for reimplementation in late 2017. It is anticipated that this will deliver substantial benefits to public safety resilience.

So the transition to the upgraded CAD of our current system is Guardian Command. That is the newer version. It is expected to provide AT with increased CAD resilience and reliability in the interim, while the whole-of-government CAD is procured, planned and implemented.

Mr GAFFNEY - No, that is fine.

CHAIR - So does this lock in with the whole-of-government radio network as well? Is there some connections in all of this, or not?

Mr FERGUSON - That is a different project, which I will invite an answer in a moment. But can I just say that on Guardian Command, that is an interim measure and importantly, we needed to make that decision to shore up the systems that we do have and ensure that we do not see any service disruptions to the community. The whole-of-government radio project is again a different project.

Mr TEMPLAR - The government radio network is a project that Police and Emergency Management are running. It is to have all the emergency service operate on the one radio system. Currently, police operate on a radio system and then fire, SES and ambulance operate on a different radio system, so a different frequency band, so to speak.

Since the Dunalley fires, there were agreements made so that we can actually switch the radio systems so, for example, ambulance can talk to police and vice versa, which is a significant and important improvement. Obviously it would be preferable to all be on the same radio network, so it is easy to talk to each other in emergencies, and that is progressing well at this point in time.

Mr MULDER - I have a few questions in relation to your, or both, because I think they are interrelated. The coverage issues with the digital radio that so bedevilled the previous whole-of-government radio process, I am wondering whether ambulance has specific needs in that department that are being factored into the -

Mr TEMPLAR - Yes, I am well aware that there were concerns in the original police radio network of gaps in coverage. To be honest, no radio network has 100 per cent coverage, particularly in terrain like Tasmania has. There will always be black spots. But we are certainly working towards making sure that they are minimised in the new system.

Mr MULDER - So the problem with your current system which you have updated just as an interim solution, when you get a unified radio system and unified dispatch system, is there any need for three dispatch rooms to be located at different places? So we are going to maintain three separate dispatch rooms, even though they are all using the same systems?

Mr TEMPLAR - There may well be, because the way that they do business is very different. This has certainly been the experience in Queensland, Victoria and Western Australia, where there have been similar initiatives to amalgamate or co-locate the CAD operations of different services. In particular, fire and ambulance tend to be far less loquacious on the radio, whereas police tend to talk to their base in their command structures a lot more, so they spend a lot more time on the radio gathering data and intel than fire and ambulance, who once dispatched, they are relatively quiet. So because they do their business differently, there is no great benefit in co-locating them.

Having a shared hub, having the shared technology, gives you the advantage during a combined emergency. But most of the other time, having separate operations also gives you the advantage of resilience in case there is a critical equipment failure in one of them. You can temporarily co-locate.

So at the moment, there is no great plan to have a wall room with all emergency services

operating out of it.

Mr MULDER - So with CAD and with radio, what is the likelihood of you requiring data between base and the responding units? We all know that different systems are good at different things, and that the main problem with a digital network where there was coverage was the voice quality when you try to pump it through built-up areas or hilly terrain. I wonder if there are special - do you envisage a time where you to see a need for data transfer than voice transfer? Has that been factored into your business plan?

Mr TEMPLAR - Ambulance Tasmania is currently installing what is called an in-vehicle information system, and they are being installed in all our vehicles as we speak. So that will allow data transfer between our communication centre and our vehicles, so that they have the most up-to-date information as they are responding on where they are going, and real-time mapping and vehicle tracking. That is being facilitated by the 4G telephone network.

Mr MULDER - So we will have a whole greater network and when the data will be going through the -

Mr TEMPLAR - Well, that is what we are currently doing. I could not answer whether all government radio networks, what its capability of transferring that data is. I would have to take that on notice, minister, because I do not know.

Mr MULDER - That is fine. I can deal with that tomorrow with the agency that is leading the project. I was interested in your grasp with some of the issues, because I think the whole of government project fell over the last time principally because agencies walked away from it. And that gave less than the critical mass. I am probably getting some assurances from the minister that we are not going to go through that debacle again. That is based, of course on, if you are going to move to digital and you are going to do it over the whole-of-government radio project, then you need coverage and you also need the technology that will sort out the problems of trying to transmit data in built-up areas, which is where I think you do it.

Mr FERGUSON - Mr Mulder, that is a very constructive comment, actually. Of course I will give my commitment on behalf of the agency to the project today. But it is a worthwhile line of inquiry, if you like, and I would like to assure you that from our point of view, this is one of the agencies that is participating in the whole-of-government radio project.

What we would be doing is not seeking from our point of view to prescribe a particular technology solution or to try to dictate a particular model, handset or platform. We would be looking for a capability. We would be looking for an outcome. And so with police leading it, we are a stakeholder, or a shareholder in that process, and what we will be looking for is the resource that supports our operational requirements. I take your points on board. I quite like what you have had to say about data transfer, and I will be inquiring into that myself.

Mr MULDER - For example, with your platforms for dispatch, be it digital or whatever it might be, has Tasmanian Ambulance got some special requirements which means that the old off-the-shelf products widely available around the world are just not suitable and that we have to design our own?

Mr TEMPLAR - You mean our CAD system?

Mr MULDER - Yes. No, the dispatch system.

Mr TEMPLAR - No, not particularly. CAD systems obviously can specify features in designing a CAD system, or features that you want, such as real-time mapping, tracking. So the upgrade that is currently going on will provide some features that are an improvement on the current system, and they are around real-time mapping and usability and functionality.

Mr MULDER - I am not talking about the upgrade. I am not talking about your new platform. I am just trying to work out whether ambulance are putting some specs in there that would suggest an off-the-shelf product which does not contain features you need. I am just wondering whether you have looked at that perspective.

Mr TEMPLAR - No, we specified how we want this to work, the CAD system to work, and the vendor is delivering the requirements that we specified.

Mr MULDER - What I am saying is that an off-the-shelf system will be tested against whether it meets your requirements?

Mr TEMPLAR - Correct. The current upgrade is being tested against that, and it is meeting our requirements, and the ESCAD will also be tested against meeting our requirements.

Mr MULDER - So those requirements are based on uniquely Tasmanian requirements, or are they based on generally accepted international requirements? I would not have thought that there would be much difference between dispatching a paramedic anywhere in the world to dispatching one here.

Mr PERVAN - Probably not, but notwithstanding that, we have been at the table since the beginning of this, feeding in our specs.

Mr MULDER - Yes, I do say this. But as a critical stakeholder in this particular project, I will get on my hobby horse about saying that Tasmania is neither in the position nor can afford to keep building its own special design systems, because we simply cannot maintain them and keep them up to date, as you have discovered.

CHAIR - Is there a question, or -

Mr MULDER - No, that is what I am, I have asked the questions and I have the answers and no doubt they will take on board my concerns.

Mr TEMPLAR - We will, and the company that is providing the system is world-renowned for providing systems of this type and has a very good reputation internationally. Ambulance Tasmania has a person working for it who is heavily involved in both the CAD projects, who in fact was responsible for bringing in a similar project in South Australia, successfully. So we have suitable expertise to make sure that our requirements are met and will be met into the future.

Mr FERGUSON - Thanks for your comments. I will take those on board, Mr Mulder.

CHAIR - Just a couple of quick questions, and we will have a break before going to public health services. You mentioned there has been an increased number of incidents that ambulances have attended, but fewer ambulances going out. Regarding what you might term 'inappropriate' use

of ambulances, people calling for things that they really should not, do you have figures on that? Is it something that we have looked at before?

Mr FERGUSON - We would, but I do not have them with me.

Mr TEMPLAR - It is very difficult to determine that.

CHAIR - There was a publicity campaign a couple of years ago to inform the public about what was appropriate use of an ambulance and what was not.

Mr TEMPLAR - And there is a campaign at the moment. You may have seen the advertisements on the back of ambulances with the little stop sign at traffic lights?

CHAIR - No, I have not had to phone an ambulance for a while.

Mr TEMPLAR - So there are projects ongoing to inform people about what might be an appropriate level of healthcare to call for, other than dialling 000 for an ambulance.

CHAIR - Are you seeing anecdotally any trend downwards in what you could consider inappropriate use?

Mr TEMPLAR - I could not say.

CHAIR - The other challenge that has been identified in previous years was the issues of morbidly obese patients and the challenges that presents to ambulance officers attending private homes particularly, where patients may not be in the best location to assist them. Is that an ongoing challenge, and how is that being met?

Mr FERGUSON - I can just say that you are absolutely right, and we need to arrest that as a general population health measure.

CHAIR - Which will come around next line item, yes.

Mr FERGUSON - The acting CEO will be able to tell you about the equipment and the vehicles that support that, together with the training of staff they are provided with.

Mr TEMPLAR - So each region has what we call a special operations vehicle. So that is a vehicle that has, its primary function is to transport obese patients who is capable of transporting patients up to 500 kilograms. The heaviest patient, to my knowledge, in Tasmania so far has been 280-odd kilograms. So that vehicle has a powered stretcher that lifts up and down, it moves in with the powered system into the vehicle.

In fact, there is no lifting. It is equipped with what we might call a hovercraft-type mattress to move patients along the footpath, or down across the lawn, and also, a blow-up mattress so we can lift patients up or lower them down. And we have staff in each region trained to operate that vehicle, and specially trained to extricate people from homes.

So for example, one of the ways of getting them out is to take the window out and put the blow-up mattress either side of the window and hover mat them across the window frame, and if you cannot get them out of tight passageways. So that is part of their training. I implemented, did the

project work to bring those vehicles in and it has been very successful and there is a demand. And every now and then, we find patients that we did not know existed who need our services.

CHAIR - So how do you know, if I call 000 and say, 'My morbidly obese friend needs assistance', I would not normally think to say that. So is it something that can be called up as a back-up?

Mr TEMPLAR - So we do not always know. I certainly, because I did the training as part of the project too, they took a case where the arrival crew found the patient was morbidly obese and needed the vehicle, and I went and attended that. So we often do not know. But if there is any indication that, or any hint of that, we will ask.

And secondly, we do, when we know of particular patients that may need that service, we send one of our expert bariatric officers to assess the property and work out a plan about how we extricate them, and we also flag, provided the patient is happy with that, and there was certainly no other patient in Queenstown, who we went and did that assessment process, and then we flagged that address so if got called to Mr Smith at that address, we always roll the bariatric trap, because we knew we would need that to extricate her to take her to hospital.

CHAIR - The number of 'Did not transfers', do you keep a record of those? Attend a home or a sportsground or whatever it is and do not transport?

Mr TEMPLAR - Yes, we do.

CHAIR - So how is that trending? Up, down? What numbers are we looking at?

Mr TEMPLAR - They are remaining fairly stable at the moment.

CHAIR - So how many are we talking about on an annual basis?

Mr FERGUSON - We will take that on notice.

Mr MULDER - I have some questions about the helicopter and/or the MEDIVAC use of the helicopter.

CHAIR - We did ask some of those earlier, so if they have been asked, I will stop you, because it will be on the record.

Mr MULDER - I am trying to work out with the response times. You mentioned that your response times are coming down and they are in the matter of minutes. Just for clarification, the response time is what, the time it takes for the ambulance to leave the station, or the time to arrive at the scene?

Mr FERGUSON - Mr Mulder, the time in Tasmania works on the basis of the clock commences not when the truck leaves, not when the ambulance leaves the station, but in fact when the call-taker has had enough information provided as to dispatch an ambulance crew. And the clock stops when the ambulance arrives at the destination. That is a more conservative type of way of keeping the time. I understand other jurisdictions commence the clock when an ambulance is leaving the station. That might discount some time.

Mr MULDER - We can have a debate but we will not about the appropriateness of which measure.

Mr FERGUSON - I am not making that comment.

Mr MULDER - The other point is, the helicopters - that must blow out your response times considerably, given the fact that it takes a good 20 minutes for dispatch to get the thing in the air, let alone on the scene?

Mr FERGUSON - I will ask the CEO to respond to that, but I would imagine that it would be very often the case that the first responder might well be a road-based crew depending on what the nature of the call-take might be. But that obviously will, from an operational point of view, I welcome - if you would answer that question as well.

Mr TEMPLAR - Mr Mulder, there is a time that it takes for both the paramedic and for the police search and rescue officers to reach the airport, to start the helicopter, and that can vary for a variety of reasons. When we decide to dispatch the helicopter to a primary case, so that is a case in the field as opposed to perhaps a retrieval from a hospital facility or similar, we look at a number of factors that includes the distance and the time involved in doing that. It is not as simple as the sort of 20 minutes flying time with the helicopter, but there is also the time for it to land and load, to go to the Cenotaph and unload, and then drive to the Royal Hobart Hospital.

All those times are factored in. Then we look for, will there be a clinical advantage to that patient as well as a time advantage in tasking the helicopter? If the answer to those questions are 'Yes', then the helicopter is always tasked. Sometimes the first arriving clinician will ask for the helicopter based on clinical presentation. Again, those factors of time and clinical, I guess, advantage are weighed up.

Mr MULDER - So with the advent of the helipad, we then probably get a bit more dispatched, because of that time factor, not the packaging and unpackaging stuff that goes on now?

Mr FERGUSON - Are you asking if taking out some of the time delay means that there will be more usage of the helicopter?

Mr MULDER - More usage of the helipad when it arrives.

Mr FERGUSON - That would be a clinical judgment on a case by case.

Mr MULDER - I am thinking about the sorts of things that are factored in, and that leads on. There was specific mention made of the Domain of the time factor involved, I would imagine the answer would be, possibly see a bit more.

Mr TEMPLAR - Yes, time is a factor, and if there is a clinical advantage in that patient reaching the hospital and the 15-odd, 20 minutes or so it takes to do a road transfer for the Cenotaph was no longer there, then it may well result in some increased usage.

Mr MULDER - How much use is being made of the helicopter in recent times? At the same time, you might just, on this, the perennial problem about who pays and who manages the budget for it.

Mr FERGUSON - We pay a standing rate, Mr Mulder. We also pay hourly rates for usage.

Mr TEMPLAR - So last year, usage was around 107 hours. The latest figure that I am able to provide you, which was on 23 May this year, the helicopter had undertaken 109 hours of Ambulance Tasmania specific tasking.

Mr MULDER - To date?

Mr TEMPLAR - That was at 23 May.

Mr MULDER - 23 May?

Mr TEMPLAR - Yes, this year. So one would, and I am aware that there has been a NETS retrieval from the Burnie hospital since then by a helicopter, so it has increased since then.

CHAIR - No other questions on this output? Thank you. We will have a short break. We will come back at 20 minutes to 5 p.m.

The committee suspended from 4.26 pm to 4.44 p.m.

DIVISION 4
Department of Health and Human Services

Minister for Health

Output group 3
Statewide services

3.2 Public health services

CHAIR – Welcome back, minister.

Mr FERGUSON – We have moved into output 3.2 Public Health Service and you need to introduce someone else at your table.

CHAIR – Yes, I introduce Dr Mark Veitch, Senior Medical Adviser Public Health Services. He is also the Acting Director of Public Health.

CHAIR – Craig has the lead on this item, so I will let him kick off.

Mr FARRELL – Minister, I think we foreshadowed before our break that we were going to look at a couple of areas concerned with lifestyle issues. I am probably not the right one to lead that bit off, but I thought I might start with picking up our discussion last year which was very much around the ice epidemic and the issues that faced the state then. I would like you to update us on how that program has been going and the results of that program.

Mr FERGUSON – Of course, Mr Farrell. I am sure that you and your constituency in southern Tasmania are as aware of the challenge that the whole state faces everywhere on this. It is a shared challenge for our state and indeed for our country. I acknowledge the many people who have been

advocating for greater awareness and evidence-based interventions to support a community response.

The government plays a key role here as a leader in the community, but so does the general community and every one of us has a role to be mindful of opportunities to discourage people of all ages, including young people, to resist the temptation of trying a drug. Unfortunately, we have heard so often the stories of people who thought that an experimental episode with drugs would be something that they would be able to get away with without becoming addicted.

We have listened to the community. In 2014 there was a fair bit of public reportage, which I took notice of. I also had a number of meetings in my own office where I listened to the concerns of a number of people. Prior to it actually becoming a political focus, I commissioned the Alcohol and Drug Service to do a review of what was really going on, to the extent that they were able to assess drug use in the northwest specifically, and to have a good look at the use of ice based on what data was available. I got a review report back in November of that year and I publicly released that report. It made a number of recommendations on how to better respond to drug and alcohol issues.

I absolutely understand that by far the largest need that was identified was a service gap on the northwest coast, particularly around residential rehabilitation. So that is why we saw that when, in last year's budget at this time last year, when we discussed the government's additional commitment of $4.8 million of taxpayers' money over four years, the larger part of that was to allow the establishment of new residential rehabilitation clients based on the northwest coast. So we have been since then, and between then and now, through a proper tender recruitment process that was open to all. In the end the best opportunity that came forward was from the Salvation Army. All of the funding of $4.8 million is being used to implement all of the recommendations, one of which being the new Salvo's provided Resi Rehab. That is in Ulverstone. That is very spacious. It is formerly an aged care facility so it is quite ideal as a residential rehabilitation facility. It is not in a crowded neighbourhood. It is really well located in Ulverstone to help cover the whole of the northwest coast. It is also closer to other existing Alcohol and Drug Service providers including the State Alcohol and Drug Service. But it is also available for nearby services that its residents and participants naturally you need to be able to access, like medical care.

The operations commenced in March and I am happy to tell you that the Salvos have advised that the centre currently, to date, has had 14 participating residents and there were 10 residents engaged as at 1 June. It is a 12 bed space that we have commissioned. I am now speculating but potentially the Salvation Army may be able to provide opportunity and space for more than that, but we have funded 12.

Feedback from participants has been very positive. One young lady, in particular, that I would like to share with you, Mr Farrell, was one of the guest speakers or one of the – our MC at the opening. A young woman. She opened her speech by saying that she had been clean for over 100 days, which received rapturous applause. She was first referred to the program by the Spencer Clinic. Her pregnancy was considered very high risk. Kate had been told that Child Protection would take her baby as soon as it was born because an order had been made. Of course, as this had happened to this young lady with her previous pregnancy, she was very distressed and had a motivator for change.

CHAIR – Kate is not her real name, I assume.

Mr FERGUSON – That is correct. I should have said this a person who I will refer to as 'Kate'. It is not her real name. Thank you for that, Chair. She was very distressed. But a motivator for change needs also the opportunity and the support to make the change. This young lady was in an unhealthy relationship. She did not feel that she would be strong enough to get through rehab. She was not allowed to access her own children. She stated that she felt supported, safe, and enabled to complete the program. She was able to experience life without abuse and without substances in her life and really started to enjoy the benefits.

Child Protection Services and other agencies were able to witness these changes in Kate. She had proved to them that she deserved a chance to keep her baby and was allowed with her other children. Kate's pregnancy was no longer deemed high risk and her happy and healthy little girl was delivered without problems just recently. Kate is currently in transitional accommodation, supported by the Bridge Centre staff and this young lady and her reconciled family are very grateful for the service that has been provided and looking forward to a happy future together. I tell that story because it brings back the importance to me and to all of us about what we are really here for.

It is never just about the money. The money has been an enabler for the new service, loving people around people who need help and people who have made a decision and a commitment to change. There are a range of other initiatives that are supported through that because the government, in fact, accepted all of those 11 recommendations from that piece of work, all of which are at various stages of implementation, if you like, this one being chief among them.

Mr FARRELL – Based on that centre's success is there, well, firstly, a need or plan to establish other centres in other parts of the state?

Mr FERGUSON – We would not say 'yes' or 'no' at the moment. My advice is that our 12 bed funded centre at Ulverstone as at 1 June has 10 residents. We want to also do more to ensure that we are maximising the resources that we already have in the state. One of the pieces of work that my department is working on is encouraging greater collaboration between the different service providers. So Pathways and Transformations in the south, together with the Salvation Army Bridge Program, Missiondale through Launceston City Mission which also has Serenity House, and now the Bridge Program in Ulverstone.

These players can and do work together, but increased collaboration, I think, provides the opportunity for a more contemporary framework. One of the other key recommendations is to provide better access to the detox facility here in Hobart at Newtown and that has been – there might be an uptake on that today. That is again an opportunity for us to ensure that people who are ready to make a decision actually get the opportunity to have that therapeutic care when they make that decision and not let the moment pass.

CHAIR – Minister, was there a couple of things you wanted to table, you said in the break?

Mr FERGUSON – There are. Thank you for the reminder.

I table for the committee, the answer to Mrs Armitage's question on imaging and pathology information being available to other providers; agency nurse expenditure for March 2016 compared to the previous; and Rural Hospital separations for the three financial years 2013-14, 2014-15 and to March 2015-16?

CHAIR – Minister, I wanted to know if you have had a particular focus on obesity and

smoking. In my budget reply, I made the comment that I was disappointed not to see a greater focus on preventative health. I know it is -

Mr FERGUSON – In the budget?

CHAIR – Yes. I know it is sprinkled through. But now we know that the – and this is not the fault of this Government - but the preventative health NPA has ceased and has not been renewed in any way, as far as I can see at this stage. I think it is terribly remiss of the Commonwealth and I hope that is addressed. I would like to see it because it really is a known area that does need better investment and certainly from the Commonwealth. I am concerned about the pressures that puts on the state government to be able to provide comprehensive preventative health framework. I would like you to comment on that, but then particularly to talk about what your plans are to address the smoking issue and obesity generally.

Mr FERGUSON – This is perhaps a case where I can be descriptive of our process but necessarily mysterious about the actual content because our five-year strategic plan will be released by midyear. We are tracking to complete it in that time.

CHAIR – Midyear being 1 July.

Mr FERGUSON - Middle of the year. I would not like to put a particular date on it. I need to make sure it goes through its final processes.

CHAIR – But, yes, we are not that far away though.

Mr FERGUSON - I certainly endorse and recognise your view that preventive health is a very important component of a properly functioning health system. From a policy point of view, like I have said for so many of areas of government responsibility, it is an area of shared responsibility with the community and the community sector and all well-meaning people in the state. It is why we have the ambitious vision for Tasmania to be the healthiest population. I hear what you are saying. The Budget provides not just the additional $2.6 million to support our priorities which will be unveiled, it also recognises – in fact, what I am trying to say here is that the project that we are coming to a completion on, recognises that it needs to be a whole-of-government strategy not just a Health department strategy.

CHAIR – The health and all policies-type approach?

Mr FERGUSON – What I am trying to say here is that I am not announcing a particular model, but I am endorsing the view that Government across its different activities and agencies has many opportunities, and often well-funded opportunities, that relate to preventative health initiatives. So for the benefit of the committee it might be worth me saying if you take all of Government activity across the range of portfolios it is estimated that Government already spends around $70 million per year on preventive health-related initiatives.

I will give you a couple of examples. The Department of Police, Fire and Emergency Management operate the PCYCs. So that is something that I put in there as an illustration. The Swimming and Water Safety Program and School Nurses Program, both of which are provided by the Department of Education and of course Health. So the question that we are seeking to address as we progress towards the release of our five-year strategic plan is, how we can improve governance and a targeting of those initiatives that are funded and supported? How can we value

add them and how can we improve them into the future?

It is important that our $2.6 million new commitment, which I hope is welcomed and I think it is, sits also side by side with the existing expenditure and the Government's mandate here will be to demonstrate governance arrangements so that we can have a greater confidence that all of the money that we are spending across government is cost effective and maximised. You asked me about tobacco, so I do not mind just saying here that the government has not made a decision on the proposal that we have released for consultation. We are still interested in what people have to say and stakeholder groups. But plainly smoking and its prevalence in the community together with our overweight and obesity challenge are the two areas that will be targeted in our strategic plan.

CHAIR – Just another, the NPA that has been ceased as the essential vaccines NPA, what was that actually delivering and what impact will that have on potential vaccination rates? I assume we are just not talking about childhood vaccination. We are talking about adult vaccination on – and we did talk about the member for Montgomery having her flu vaccine.

Mrs HISCUTT – The first time.

CHAIR – First time? There was one year before you were here, I think, when it was offered in parliament so all members could have it.

Mr FERGUSON – I will ask the secretary to bring some information to the committee on the special NPA. As a still reasonably new Government, there has been a range of initiatives that we have put in place to support better disease prevention in the community. One I have already touched on today is a closer engagement with the community in ways of obtaining an influenza vaccine. So the law has been changed to allow for that for adults and generally well adults to have their annual flu vaccination by a community pharmacist. I did actually have a number on that because I was asked how many pharmacists have done the training and are now providing that service to the community, my local pharmacist being one of them, who provided me with my vaccine this year. At the end of May over 70 pharmacists are now authorised as part of 50 authorised pharmacy programs. Of course, that sits in addition to vaccination programs which are provided in pharmacy. So that is a good thing.

Also the Government has funded a new initiative – I did this quite early on in my time as minister – that we are now providing pertussis vaccine to pregnant women to provide protection against whooping cough for newborns. So we have funded that program and it is being now available through GPs, some council immunisation clinics and some anti-natal clinics.

Mrs HISCUTT – Your education program there is very good that goes to the pregnant mothers because being a new grandmother I was told I was not allowed near my grandchild until I have had that vaccination, so the message is getting across to them.

CHAIR – There might have been one than one reason.

Mrs HISCUTT - That will be enough from you.

Mr MULDER – That may not have been for medical reasons, of course.

Mr FERGUSON – I am sure it was. So since 2015 the department has arranged delivery of around 4700 doses of pertussis vaccine to Tasmanian immunisation providers which indicates a

pretty solid take up of the new program. So that is good.

Finally, mentioning hepatitis B, last year the Government provided hep B vaccine to populations in Tasmania that are more at risk of hepatitis B infection. Since 2015 over 684 doses of hep B vaccine have been distributed to providers to use in this initiative which demonstrates a solid commitment to preventive health on an evidence based approach.

CHAIR – That is for adults, I assume, minister?

Mr FERGUSON – Yes.

CHAIR – Because babies of the last, I do not know how many years, most of them have been vaccinated. Certainly my youngest one was. So that would be for 23, 24 years that babies have been vaccinated for hep B. So you are just talking about catch-ups for adults in hep B are we?

Dr VEITCH - Yes. It is a program that is specifically targeted at adults who are at higher risk of hepatitis B and who are also likely to have missed out on vaccination through their age, or how they came to Australia, or their circumstances.

CHAIR – Age, yes. Right.

Mr FERGUSON – Yes, so there are some lifestyle factors in there and migrant population as well.

CHAIR – Yes. So in terms of that the cessation of the essential vaccine NPA, what impact will that have? What was that providing?

Mr FERGUSON – So in Tasmania child, adolescent and targeted adult immunisations are provided through general practice, local government and hospitals. The department provides support for that and the National Partnership Agreement on Essential Vaccines had four key intended outcomes, one to minimise the incidents of major vaccine preventable disease to maintain, and where possible increase the immunisation coverage rates for vulnerable groups, that all eligible Australians are able to access high quality and free essential vaccines through the national immunisation program in a timely way, and to increase community understanding and support for the public health benefits immunisation. So the partnership agreement has been reviewed and an implementation working group comprising Australian and state officials is expected to negotiate a new agreement by the end of December this year.

CHAIR – So there will be a gap.

Mr PERVAN – There is funding in the federal budget ongoing for the next four years for – there is still funding in the federal budget.

CHAIR – It is. But is that funded though? Like I said, it has been ceased. Are you just expecting it will be stumped up again? I know it is in the forward Estimates there $2.9 million this year then – well, 2.9, 2.8 it is.

Mr PERVAN – Yes, the figures I am reading from are from the federal budget for Tasmania, so it is still actually listed in the federal budget that the funding is not being cut.

CHAIR – Even though they have ceased it?

Mr PERVAN – The agreement has ceased. We are renegotiating a new agreement. So as we have settled the new arrangement, the funding will flow. But it is guaranteed as much as anything in the Commonwealth Budget is.

Mr FERGUSON – So whenever we have an NPA of any kind, we actually have a process of agreeing to the actual document that is the substance of the agreement together with a project plan.

CHAIR – So in terms of our conscientious – if I can use that word – objectors, do we have a significant number of those in terms of parents generally of babies?

Mr FERGUSON - I have a sheet on that because it has been a rather topical.

CHAIR – The term is probably not the right term to use. I think we have a new term for it, haven't we now, as opposed to 'conscientious objectors'?

Mr FERGUSON – The advice that I have is that, yes, there is a range of thoughts on this and my advice, which I will welcome my officials to add to if necessary, around 1.4 per cent of children are under-vaccinated because their parents have refused to vaccinate. My advice is that most under-vaccinated children are not, in fact, in that category of belonging to parents who have just refused to vaccinate. So most under-vaccinated children are among more vulnerable children in Tasmania and may not have been fully vaccinated because of the social circumstances of their families. This is one of the reasons why there has been a lot of support for the Commonwealth government decision to change federal legislation to provide for No Jab No Pay. So it is believed, and I think it stands to reason given that we are looking at a refusal rate in that vicinity of 1.4 per cent, that catching the remainder of people who are under-vaccinated, but plausibly willing to be, will, in fact, be captured by the new process.

Now it is a powerful incentive for your family tax benefits to be - if they were threatened solely because you have not got around to vaccinating your child. I think we are looking at a changed landscape in the future where we should see our vaccination rates trending where we would like them to be. I am also advised that it is likely to be impossible to actually set a target of 100 per cent. But we do have a design to get a herd immunity by getting vaccination rates up to about 95 per cent.

CHAIR – Is that the level, 95? I was just going to clarify what that was.

Mr FERGUSON – There are different stats on that, but I invite Dr Veitch to further respond.

Dr VEITCH – Thank you, minister. The national aspirational target is 95 per cent and there is a good basis for that being an adequate level of vaccination to prevent the most infectious disease, which is measles, from spreading in communities. So measures that get the vaccination coverage up to that level are probably doing the most cost effective job for the community, and pushing the vaccination coverage beyond 95 per cent is probably going to be relatively more expensive for relatively less public health gains.

CHAIR – Little gain, yes. Okay. Anyone else on those? No? I do not think there is anything else on that one. It is important and we look forward to your preventative health strategy, minister.

Mr FERGUSON – Thank you, Chair, and thank you for the work that you have done as Chair of the Joint House Committee. As I indicated earlier, whatever the five-year strategic plan says I would like to indicate that the Government will absolutely respond also to the report and recommendations.

I table for you the data that I have been able to obtain on breastfeeding information and levels. You did not ask for this, but it does show a differential for rates of breastfeeding at maternal discharge in the two different sectors, public and private hospitals. I offer that there would be some social explanation for the difference but is still useful for the committee's benefit and -

CHAIR – Yes, for sure, but it shows where your resources need to be.

Mr FERGUSON – It does. Helpfully, it has been able to be provided for quite a number of years back to 2006.

CHAIR – Thank you, minister. There being no other questions, thank you and your team for today. We have only got one little bit more to keep you for. We appreciate the input and the opportunity to question you. If there is anything outstanding, which there will not be much, we will write to you.

Mr FERGUSON – You will write to me and I will reply.

CHAIR – Yes.

Mr FERGUSON – Very quickly.

CHAIR – I do not think there will be a lot because you have done most of it during the day.

Mr FERGUSON – Thank you to you, Chair, and your colleagues for the process. It is a good process and I have picked up a few extra tasks that will add value to the work that I do as well.

CHAIR – Thank you. Thanks.

The committee suspended from 5.11 p.m. to 5.15 p.m.

DIVISION 8
Premier and Cabinet

Minister for Information Technology and Innovation

Output group 3
Electronic services for government agencies and the community

3.1 Information and communications technology (ICT) policy development and implementation

CHAIR - Welcome back, minister. If you would like to introduce your people at the table that would be helpful, for Hansard.

Mr FERGUSON - Thank you, Chair and Committee. I introduce to my left, Ms Rebecca Burton, who serves as Deputy Secretary in the Department of Premier and Cabinet and, to my right, Mr Matt McGee, the General Manager Client Services in the Department of State Growth, understanding, of course, that my portfolio straddles and is supported by two departments, one for our outward industry facing output and the other for our whole-of-government and Office of eGovernment Solutions.

CHAIR - So you have two output groups?

Mr FERGUSON - That is right. Our outputs are pretty clear, are they not, for DPAC, 3.1 and 3.3 but also I am supported by the Department for Industry Support, in IT, and if you wish to discuss those matters that would relate to Mr Groom's output 1.2, in Department of State Growth. What I am offering to you is that I am happy to take questions on any of those subjects and I am supported today by both agencies.

CHAIR - Did you want to make any opening comment about this portfolio area and responsibility you have?

Mr FERGUSON - I am very happy to give a brief overview, Chair, and I would like to say that the government recognises the importance of the IT innovation portfolio to the Tasmanian economy. I am very thankful to have this as a portfolio responsibility.

As I have said, I am supported by both agencies as we go about this important work in the Department of State Growth, including coordinator general. Strategically pursues investment, facilitates major projects, supports business and industry growth and ensures that we are investing wisely in infrastructure. ICT is a vital industry to our state, strongly supported, and there have been a number of achievements in this portfolio in the last 12 months, together with some valuable new initiatives in the Budget.

Free WiFi, just quickly, this is from a previous commitment which we are now seeing rolling out, providing free WiFi to enhance the tourism experience in cities, towns and popular tourism destinations. The network is now a partnership with Telstra, who were successful in the tender process, and the network will include up to 175 access points at 47 sites across 26 locations and the rollout is well under way.

Support as well for the work that we are doing to investigate Tasmania's opportunity, potentially, for extra data connectivity across Bass Strait. In the Budget we have provided an additional $100 000, which is a specific allocation to continue our partnership with Code Club. This follows the great success of our partnership with Code Club in the past 12 months, which saw young Tasmanians given the opportunity to learn coding in primary school. This funding will see Tasmania become the first state to implement the online version of teacher training and also fund teacher training courses around the state. Our message, by the way, is that we do not mind what kind of teacher you are, if you are interested in this the training is all that you will need to get up to speed to support your children in your class.

There is also funding in this Budget for a new initiative where we are partnering with Tas ICT. It is a proposal that we have supported and we are running it as a pilot, Generations, and the allocation of $50 000 supports building capacity and growing innovation. Generations will comprise a guest lecture program to be held around the state, featuring ICT leaders speaking on

their career pathways and the importance of study of STEM and ICT.

In my area of responsibility with State Growth and supporting industry and innovation I just want to mention, as well, the entrepreneurship and innovation hubs. This is something that is very exciting for our state. In March we announced that the government was providing seed funding, in partner with a range of organisations, not the least of which include UTAS, TAS TAFE and a range of non-government partners. It has been facilitated by the Office of Coordinator General and will see the development of start up support hubs in the former Mercury Building, in Hobart and in Macquarie House, in Launceston.

In the portfolio of eGovernment and the support that TDMD provides to other government agencies, I am happy to take questions and further discuss the amazing initiatives that we are pursuing, including creating Network in Tasmania 3, otherwise known as the Tasmanian Cloud, which is about providing more contemporary and more secure services across government.

CHAIR - Thank you. Tony, I will let you lead off with questions.

Mr MULDER - Thank you very much. $1.2 million, how much of that is staff costs and are there any other costs associated with them and, if so, what are they?

Mr FERGUSON - Can just get an indication of what output we are in?

CHAIR - 3.9.

Mr MULDER - 3.9.

Mr FERGUSON - Okay, so Rebecca.

Mr MULDER - Just before you do that, there is 1.2, 1.26, 1.29 and 1.31 and 1.35.

Ms BURTON - 187, okay. So in terms of the Office of eGovernment, it is primarily wage costs. So we have almost 10 FTEs and they work across agencies, developing whole-of-government strategy, Mr Mulder.

Mr MULDER - You made reference to the fact that some of the stuff is with the Minister for State Growth, but you have the relevant advisors with it.

Mr FERGUSON - Sorry, Mr Mulder, if I can help and explain my point on that? So if we are in output 3.9, which we are, this is exclusively Department of Premier and Cabinet and not related to State Growth.

Mr MULDER - Yes, I was able to ask a question about the State Growth portfolio because your department - just let me ask the question. Industry and business development is going from $63 million to $90 million and note 12 in the Budget papers says, 'Funding of the IT strategies that are the responsibility of the Minister of IT&I and Innovation have been included in this output, which is within State Growth'. So how much of the $63 million this year and the $49 million next year are you spending and what are you doing with it?

Mr FERGUSON - Now you have jumped to the output related to State Growth, am I correct?

Mr MULDER - Yes.

Mr FERGUSON - So I will be happy to provide that advice and I can initially indicate that the number of staff in the Department of State Growth who specifically support ICT industry engagement and industry development is a very small number of people, but it is engaged at a number of levels. I will ask the department official to describe them in further detail. But it is a very small portion of the Department of State Growth.

Mr McGEE - So in my area there are three people who deal with the digital future, so what is known as the digital futures program, and another person who looks after the relationship with the ICT sector. So, in total, it is four people. I am not able to give you actual dollar numbers behind those costs but I can take that on notice.

Mr MULDER - So part of those budget figures that I have just brought out there in the explanatory note relates solely to IT staff support, not to actual programs or projects?

Mr FERGUSON - There is program budgets as well. I am not sure if that sits within that specific output though, it may. Does it?

Mr McGEE - Yes, is would.

Mr FERGUSON - It does? The specific budget that we have for IT, I could easily collate for you because it has largely been described in the budgets that we have brought down in the last three years.

Mr MULDER - So it is the costings, that is what I was after, just how much of that budget are you administering, according to the note, and then what are you spending it on. Do you need to take that on notice?

Mr FERGUSON - No, not particularly, because as you have heard, we are a small team. The Department of State Growth, through the client services division, that Matt represents, provides specific support through the programs that we offer, including the initiatives that are funded in the budget. Initiatives such as, for example, our free Wi-Fi program, our support for Tas ICT and its various programs, the work that we are doing through our co-funding black spots and including workforce development. These are all activities that I have a specific interest in, there are others. The Department of State Growth is the anchor agency that represents government on the Sense-T initiative as well. I could produce for you a list of the various programs and funded activities that the Department of State Growth is responsible for, specifically in new ICT space.

I would have to add though that Mr Groom, who has responsibility for the State Growth portfolio, and my work have a lot of overlaps. His work, for example, as minister with responsibilities for skills development means that across the agency there are a whole range of different people who maintain an interest in ICT, it is not a separate division, as such.

Would you like a list of our programs and funded activities? I would love to do that and take it on notice to provide it.

Mr MULDER - I was going to ask whether you were going to take it on notice. That is fine. Just a couple of the issues that we have discussed in the past, the VoIP roll out impediments. What are the impediments of that program and what are the costs and who is paying for them?

Ms BURTON - So I am going to 3.3, Mr Mulder?

Mr MULDER - Yes.

CHAIR - Could you introduce the rest of the table, please?

Mr FERGUSON - I would like to introduce Piero Peroni, the general manager of the TMD division of DPAC.

Ms BURTON - So your question was in relation to the VoIP roll out, Mr Mulder?

Mr MULDER - Yes.

Mr FERGUSON - We have a modern communications project, Mr Mulder. It is a significant piece of work that has been led through TMD, supporting - understand, of course, that it is supporting each other government agency to make the transition to the new modern communications program. TMD has completed an agency transition now of over 12 000 analogue telephone services from the old Spectrum service to the new Voice over IP service, which is provided by Anatel. I would be very happy for Mr Peroni to describe any current challenges.

Mr PERONI - We embarked on this program of works some three years ago, which was to replace a telephony system that was probably 25 years old and had reached end of life so it was really a project we had to undertake. TMD absorbs the cost of project managing and leading the project, initially from the procurement phase through to implementation and we work with the agencies who apply resources on their side to work with us and plan the transition, which is often quite complex particularly in environments like hospitals and police stations. The vast majority is now complete, with the balance of the roll out still to happen in the north-west coast, in the two hospitals, and some general technology that needs to be replaced, like old faxes and security systems right across the agencies but the vast majority is now complete.

Mr FERGUSON - Mr Mulder, I can also summarise the overall project as having met with a few minor technical challenges over that three year period, but my understanding is it has been considered quite a success and where a transition at a sensitive location, for example a hospital, has taken place it has been a very careful and quite conservative approach at making the switch over and I can confidently say that it is meeting expectations, it is providing an excellent service.

At an earlier conversation that we had during the day today, with this committee, in Health, I described the Telehealth initiative with the endocrinology clinic on the north and north-west linking with the south and I was talking about Polycom versus Cisco. Well this is the Cisco system, the new platform that we are actually discussing as part of this project. It means that the face-to-face videoconferencing technology, in fact, is part of the same platform as the new phone system, so it is all interoperable and it is designed to be, rather than the concierge service where you needed to book it, in fact treating your videoconference session just like a phone call.

Mr MULDER - Moving on to your digital ready program, which the member for Montgomery asked a lot of questions about last year, can you give us an update on the roll out of that program and whether the uptake is still as expected? Last year you reported it was a little disappointing so you were ramping it up.

Mr FERGUSON - I do not remember saying that, but it sounds like you have reviewed the *Hansard*.

Mr MULDER - I have been accused of verballing in the past, but I am not allowed to say it.

Mr FERGUSON - In fact, yesterday, at a more hostile budget Estimates committee I described this as one of the things that the previous government did.

Mr MULDER - It is not over yet.

CHAIR - It is not over yet.

Mr FERGUSON - This was actually something that the previous government commenced. It was a different program when you compare it to now but it was digital ready from retail at the time. I am sure Mr Farrell remembers it. In opposition and going into that election we said that we would support it, continue it, and in our first budget because it, in fact, was not funded beyond that period, the Government provided in our first budget $800 000 over four years to continue it. I had an early conversation with the Department of State Growth about a different vision for the program.

To keep the very best of what it was but to enhance it, because although I was aware of and supported the intensive coaching service that it provided to the retailer community, my feeling was that it could support a larger number of small businesses in the Tasmania community. So we made some substantial changes to the program, added online elements and online bookings, greater promotion through social media and we also took it to a wider business focus than just retail. So now it is available across the business community, hence that you are ready for business.

The changes have transformed the program from what was a niche market targeting to the kind of statewide education and training program for small business. The result has been that in last year alone the program assisted 950 businesses with sessions in Hobart, Launceston, Ulverstone and the west coast. This year the program has expanded again, running through to late November, with 96 events across the state in eight locations, now including the east and west coasts, Scottsdale and King and Flinders Islands.

I mentioned how the program has been transformed, just as a comparator, as an example, and I am not knocking the previous government because this is where it started, but just to compare, in the last three years of the program, prior to the election, it was supporting 600 businesses over three years. This year alone, with the program still with more than five months to run, it has engaged with 803 businesses across the state. It has done that by offering different entry levels for business to get the support. So round two of the five rounds this year has just been completed, round three will run during July, round four in September will be taking Hobart and Flinders. Round five, in November, will include Hobart, Launceston and Scottsdale. I have more detail here if you would like it. Suffice to say, we are encouraging - and I would invite you to encourage your local businesses to find out more about it and to register their interest. They will find, by going to the website of digitalready.tas.gov.au, that there are resources depending on level of interest, level of preparedness to engage in the digital economy and, for time-poor people or for people in a position to spend more intensive coaching, there are different entry points that will support them.

Mr MULDER - That was my question, not about the opportunity it was so much about what is the uptake like because last year, and I will just use your 'can't recall' statement, I looked at the digital ready program and reflected it was quite a quality product in terms of the hand holding and

coaching that it can provide. I felt that it needed greater penetration into the Tasmanian community with a wider net of influence to give more businesses the opportunity. My question is, has the uptake been what you expected or what you would like it to be?

Mr FERGUSON - Absolutely. As the answer I earlier gave outlined, I think the uptake has significantly improved, significantly, by about four-fold and if we can do better of course we would always like to. So the wider scope is no longer just retail; retail continues to be eligible but it is now wider. To provide a wider level of interest, but also the engagement is the big success story here. I acknowledge the wonderful staff who have been willing to adapt to my request and to change the program. The results speak for themselves.

Mr MULDER - Moving on to your iCloud, or Net NT3 or whatever you have christened it this year.

CHAIR - Tas Cloud.

Mr MULDER - Tas Cloud. If you could give us an update on that program and how it is going. Furthermore, I have some issues with - sometimes, and having come out of the environment, it is easy to criticise silos and sometimes there are some really good, often privacy or security or business confidentiality, reasons why we have silos and how we overcome those issues, if we move into a cloud-type platform.

Mr FERGUSON - Chair, I introduce Ms Katie Ault, a commercial strategy manager with TMD, who has been a leader in this area. I am very pleased to report that the government has already started moving whole-of-government data to the Tasmanian cloud. Inside the department we refer to it as NT3. If you like, it is the next evolution.

If I understand it correctly that you are looking for an update on how that is travelling? In November 2014 the Government released a pre-tender consultation paper. We wanted to ask industry, 'What are the things that you believe we need to be mindful of before we go to market?' They thanked us for that, we actually had a crowded room up at the Wrest Point, which was tremendous, and the feedback was very positive and it helped us to shape what we would later go back to industry for in our marketing.

In July 2015 the Government released a request for tender for NT3 data centre as a service. In October 2015 we released the broader Tasmanian Cloud policy, and in December last year we announced agreements had then been signed with TasmaNet, TasNetworks, TPG and Telstra to make up the connection services panel, under NT3. Further, TasmaNet and TasNetworks have been signed to provide the data centre as a service. So we are on track with the commitment and the creation of a Tasmanian Cloud.

Today various services, including government email, Tasmania Online, Service Tas Online, dental health systems, human resources and key agency finance systems have been transitioned to new outsourced data centre arrangements, established as part of the Tasmanian Cloud.

Under the Government's Tasmania Cloud policy new panel arrangements enable all agencies to easily access data centre as a service but we have another service on the say, a different model, another managed service, called Infrastructure as a Service. This provides some level of choice for agencies to procure different levels of managed service solution.

I want to just make the point here that we believe, and we have taken, as a government, an important policy decision that precedes all of this and that is we are, in the modern technology era that we are in, government is not best placed to build and manage these services. Industry is much better placed, provided that we run a procurement program that insists on quality and value. So that is where we have got to. In terms of Infrastructure as a Service, following a tender process negotiations are under way with preferred suppliers and we wish to be able to launch that service and make it available to government agencies early in 2017.

So that is our broader strategy, to move Government IT infrastructure and business applications away from our outdated, often, in-house agency based arrangements into commercial more secure of a higher standard contracted data service.

Mr MULDER - Just to get a little more specific, I made reference to the silos and I think last year you told us, 'At the moment ICT services are broken up into different silos by different agencies. We want to redesign the architecture within a single environment'. Then you give an example from Education, which is really great, but then, 'Child Services, like staff from Health, Education, Justice and Police need to be able to access each other's networks. At the moment that is either not possible or very difficult to do, even though they are working on the same case, maybe the same child or the same family'.

That was where my question about silos often exist for really good reasons, often privacy, sometimes security, and there may be business and commercial confidence reasons. I would just like to get some comfort about the throwaway line that they need to access each other's networks and wondering what you have got around that.

Mr FERGUSON - I will invite Ms Ault to assist in answering this. We are starting to get into some reasonably technical matters and I will rely on my officers to help explain. I would like to make the point that the network core services will be a key element of answering this question. This is a later procurement that is going to be negotiated. I will be very minimal about that, given that there is procurement issues potentially involved, but I want to say that in all cases when we are dealing with a client, a patient, a family on a matter, if it is the government it is the Crown. If it is a government agency it is the government. We want our frontline service providers to work from whatever agency they are in. We have given those examples as, if you like, problems that can be overcome with a more unified government IT architecture.

I think, as I hear in your question, the point, which I endorse, that is that you still need to manage the risk of protecting privacy and a commission's based approach would absolutely need to be and will be built into that future architecture.

Ms AULT - Thank you. So the intention with the Networking Tasmania 3 services is that the new services would support a different security model. So the existing security model, on which data networking occurs, relies on separation between different agencies and when agencies need to collaborate, for example, for emergency services, flood recovery or because, for example, police and child health services people are working together perhaps in a location which is away from the normal agency site, we need to, in effect, punch holes in firewalls in a way that it not absolutely optimal for security if you do a lot of it. So the design that the new core will be based on is one in which security is delivered more at the application layer. So the intention is that it will then be possible to give public servants and contractors and other people, who are authorised to do so, access to those services and information systems that they are authorised to see from wherever they are and at whatever time. Because, of course, these days we are 24/7 and public servants are not

always in their office.

Mr MULDER - So we have the applications appear on your desktop and if you do not have access permission you cannot use it.

Ms AULT - Yes.

Mr MULDER - So you only know that such a system exists and then you are in a position to say, 'We need this data', so this online issue. I know there has been an issue, for example, with the Integrity Commission and the Police department, in terms of the Integrity Commission want to access their files and the Police department saying, 'Well, I don't think that's appropriate'. So that is the sort of thing, that the police application would pop up on the desk and then what, you would click on it and make a request?

Ms AULT - The reality is that applications and permissions and all of that stuff will need to be managed by agencies who currently have the authority and ownership of that information but the data networking infrastructure that underpins - that enables all those agencies to talk to each other will be capable of delivering that information between agency boundaries, if agencies have developed their applications to enable that functionality.

So, in the short term, there will probably be a substantial amount of applications that are on Legacy infrastructure, which will be supported by the suppliers. So if agencies are not in a position to update their applications or feel it is insecure to do so, then we can maintain the existing capability.

Mr MULDER - The question is, it becomes a general access provision for particular agencies or does it become a case-by-case request?

Mr FERGUSON - I will try to be helpful in answering that by saying whatever the relevant Government agency policies are would be built into it. May I give you an example? Not that long ago all of our email was available to us on our computer and as we logged in the email was downloaded to our local hard disc on our computer. These days none of us access our email that way. Most of us, I suspect all of us in this room, can access our email from anywhere in the world, on any computer, or on any device because it is in the cloud and it is device neutral. The technology does not care what you are using, it cares that you are authenticating who you are when you log in.

So we have a couple of questions there. One is the policies to ensure that people only have access to the information that they need to, to perform the duties, that is an agency responsibility under the appropriate use of any government infrastructure and software. The second issue, plainly, is ensuring that it has the appropriate level of protection so that the person is authenticating that it really is them when they are logging in.

Mr MULDER - My last area is onto your project management services, some that I am reasonably familiar with as Ms Burton will no doubt confirm. In terms, particularly, of the mobile radio and the tri-service CAD system that is being developed, my questions are fairly straightforward. I will ask the managing agency the details of the programs but just in terms of the project management services that you get will you just confirm for me, or explain to me, that there is a project plan, as we all know, with these things, so I am assuming there is a project plan and that that project plan contains regular project reports relating to scope, scope creep, if any, of course there would not be any, and progress towards deliverables, so that sort of reporting structure is in

place.

Ms BURTON - Mr Mulder, you have a long background in this, as do I, the Department of Premier and Cabinet, two decades ago started off on a journey of project management improvement and we spent a lot of time, effort and energy in developing resources, the online toolkit and, to be quite honest, that has been overtaken by contemporary project management approaches, which we point people to these days. But in responding to your real question, I think that the reality is that the work we did in those early days, and which you are aware of, had a great impact on agencies. There has been significant take up of training in project management and the short answer to your question is, yes, every project that is funded centrally, in particular through the structured infrastructure investment review program, i.e. has to have a business case.

If you have a business case then you address many of the things that you have identified. It has to have a project plan, it has to have an output realisation plan, and it has to have that whole suite of documents that actually deliver to the steering committee the set of performance indicators about the project. I cannot guarantee that there will not ever be project scope creep again or that, indeed, ICT projects may well overrun. As you know, these things sometimes get away for reasons beyond anybody's control, like the exchange rate, purchase of software, et cetera.

Mr MULDER - We all know that is where the regular reports, which I am keen on, will pick up those sorts of issues.

Ms BURTON - I guess the short answer to your question is, I think that the foundations that were laid all that time ago have borne fruit, in that no project is undertaken, even small projects run to a project plan so you would often be surprised to see something that comes up and it might only be a small project, but there is a project plan, project deliverables, this is the scope. So very positive outcomes, not necessarily always delivering the perfect outcome but we are all people and it is a real world situation.

Mr MULDER - We look forward to the final project report, or the final stage of all good projects, which is reward for non-participants. That is all for me, thank you.

CHAIR - Thank you. Mr Ferguson, did you mean to give me that as well?

Mr FERGUSON - I did not. I should not give that to you.

CHAIR - No. I thought I might give it back because my question was about IT security.

Mr FERGUSON - That is advice to me on how we are adding to our security. So thank you. That is very honest of you and thank you. I was, in fact, wishing to provide you with an update, which you have, for the benefit of the committee on the Tasmanian Cloud and its implementations.

CHAIR - In all seriousness though, one of the concerns that is frequently raised is about the security of clouds, security of data, particularly sensitive data, and I am sure you are aware of the Auditor-General's report, probably a couple of years ago now, highlighting a number of concerns regarding security in the IT area. So are you confident that is being addressed adequately, particularly in relation to the cloud?

Mr FERGUSON - There is a very interesting discussion that could be had about whether to test the comment that you have just offered, about questions of cloud security. There is a very

interesting discussion that could be had about whether really outdated infrastructure, that government is not well-placed to build and maintain itself, is more or less secure that a cloud solution. Obviously there are going to be risks with any technology and it is important that we take professional advice always and identify, through a proper risk management approach. Certainly I am aware of the report of the Auditor-General, I think it was last year, in fact it may go back a little longer but it was tabled and presented in March 2015.

CHAIR - He did not release it immediately, he allowed the departments to actually undertake some work before he released it.

Mr FERGUSON - That is quite right. So the government does have an information security policy. It provides the focus and the context for how we manage IT security across whole-of-government. The most recent security policy manual was approved in 2011.

Reflecting on the report of the Auditor-General, the audit examined IT security of five agencies. Moving information security policies from a siloed approach to a more coordinated and strategic approach has been recognised by the Government's IT Policy Board, as an approach that will improve whole-of-government arrangements. A revised information security policy is intended to emphasise a top-down, business-driven but, importantly, a risk-based approach. This includes identifying critical information and ICT assets, assessing the security risks of critical assets and prioritising treatment of security risks, rather than treating all of your body of soft data of equal risk and requiring equal security protection. A risk-based approach, in fact, is being recommended to us as a better way of providing certainty that the level of risk is accorded a level of security and focus.

Updates to information security procedures and standards will include engagement with ICT service providers to ensure effective implementation of the Tasmania Cloud policy. The current whole-of-government data networks agreements, in NT2, provide information security services, including proactive intrusion detection and reporting of information and technology and security incidents. I do not want to talk down our current arrangements in any way, but I do not mind taking the opportunity to say that we do see opportunity for a number of our agencies in migrating from own provided arrangements to a more commercial model in fact provides for, in as much as anything, better physical security as well.

CHAIR - It is not just the physical security. You have to actually get into the stuff.

Another unrelated question to that, do you have a table that you could list that shows the locations to the free WiFi that you are rolling out around the state?

Mr FERGUSON - I do not have it here. I will investigate if I have that here. It is certainly something that I can provide. Just give me a moment and I will check that.

Mr MULDER - Can you do it like you do the budget, by electorate?

Mr FERGUSON - I have been asked a question, by interjection, and I do not mind answering it as well, that, in fact, we took an electorate blind approach for this and what I did, I wrote to each of our regional tourism organisations and asked them to identify their top 10 sites. We had a little bit of trouble with that because most of the RTOs were not able to easily bring it down to 10, or whatever the number was I asked them to. So when we got to that point, really what we then took to market, indicatively, was that list. So I am going to provide the list of sites to the committee.

So I am just going to need to be a little bit cautious here. I have a list, I would like to explain one thing. We have actually come to a commercial relationship with Telstra, after having gone through an open procurement process. The offer was to build and own and operate and maintain a free WiFi network for this. Telstra won it and, in part, Telstra are using their existing site locations to provide this service. Under the agreement they will be deploying TasGov free WiFi to 175 access points throughout the state at 47 sites. So at this point in time, I am just going to ask if I can have some time to just check that if, in any way, the specific site locations are, in any way, commercial-in-confidence and if they are not I will table those or provide them to the committee, but there is a complete other list, which is available, which indicates where people can go and that is at freewifi.tas.gov.au, and I am going to ask if I can have that advice before we finish tonight.

CHAIR - I think we are nearly finished.

Mr FERGUSON - Yes, and I want to provide it to you, I just need to check that it is not - because I can indicate that my experience has been that Telstra, as the owner of this network and as our partner in this project, I have found that it is available in more spaces than they are contractually obliged to provide.

CHAIR - And dealing with some our blackspots and other spots then perhaps.

Any other questions, members, on these output groups?

Thank you, minister. It is very nearly 6 o'clock. You have had a long day, so thank you to you and your staff and the information provided and we will finish proceedings.

Mr FERGUSON - Thank you to the committee and thank you to our departmental staff and our long-serving Tasmanian public servant.

Ms BURTON - My last ever Estimates. I have been to every Estimates since they started.

CHAIR - That should be noted, minister, on the record, before Hansard concludes

Mr FERGUSON - I will take your leave on that, Chair, and I am sure that everybody at this table has had plenty of opportunities to participate in these kinds of process with people such as Rebecca. Rebecca has been a long-serving public servant, supported a lot of governments, supported a lot of ministers and premiers, and the best tribute I can say is to say thank you on behalf of the Government and all our members of parliament because your career of service has actually been in the service to the people of our state. Thank you very much for all you have done and we do wish you all the best for your retirement.

Ms BURTON - Thank you, minister. First premier, Robin Gray, I know I do not look that old, but I feel it sometimes.

CHAIR - All the best for your retirement.

Ms BURTON - Thank you.

CHAIR - Thank you, minister, enjoy the day off tomorrow.

The committee adjourned at 5.59 pm