**Tuesday 26 June 2018 - Estimates Committee A (Ferguson)**

LEGISLATIVE COUNCIL

ESTIMATES COMMITTEE A

Tuesday 26 June 2018

MEMBERS

Mr Finch

Ms Forrest (Chair)

Mr Gaffney

Ms Lovell

Mr Valentine

Mr Willie

IN ATTENDANCE

**Hon. Michael Ferguson MP**,Minister for Police, Fire and Emergency Management; Minister for Health; Minister for Science and Technology

**Ministerial Staff**

**Kyle Lowe**, Chief of Staff

**Daniel Gillie,** Adviser

**Emma Fitzpatrick**, Adviser

**Chris Edwards**, Adviser

**James Ritchie**, Adviser

**Ben Gourlay**, Adviser

**Department of Police, Fire and Emergency Management**

**Darren Hine**, Secretary DPEM and Commissioner of Police

**Scott Tilyard,** Deputy Commissioner of Police

**Chris Arnol,** Chief Officer, TFS

**Jeff Harper,** Acting Deputy Chief Officer, TFS

**Robert Bonde,** Acting Assistant Commissioner of Police

**Richard Cowling**, Assistant Commissioner of Police

**Donna Adams,** Deputy Secretary, Business and Executive Services, DPFEM

**Todd Crawford,** Director Business Services

**Marijke Harris,** Manager, Finance and Payroll Services, Business and Executive Services

**Lisa Stingel,** Manager, Media and Communications

**Andrew Lea**, Director, SES

**Sandy Whight**, Manager, Fuel Reduction Unit

**Department of Health and Human Services**

**Michael Pervan**, Secretary, Department of Health and Human Services

**Michael Reynolds**, Acting Deputy Secretary, Corporate Policy and Regulatory Services

**Ross Smith**, Deputy Secretary, Purchasing, Planning and Performance

**Eleanor Patterson**, Chief Financial Officer, CPRS - Corporate, Policy and Regulatory Services

**Nicola Dymond**, Chief Operating Officer, THS

**Craig Watson**, Chief Financial Officer, THS

**Neil Kirby**, Chief Executive Officer, Ambulance Tasmania

**Scott Mckeown**, Deputy Director of Public Health, DHHS

**Sam Halliday**, Deputy Chief Pharmacist, DHHS

**Ben Moloney**, Project Director, Royal Hobart Hospital Redevelopment

**Dr Aaron Groves**, Chief Psychiatrist, Mental Health, Alcohol and Drug Directorate

**Department of Premier and Cabinet**

**Ruth McArdle**, Deputy Secretary, DPAC

**Glenn Lewis**, Chief Information Officer

**The committee met at 8.57 a.m.**

**CHAIR** (Ms Forrest) - Minister, welcome and thank you for your time today.

**Mr FERGUSON** - Good morning, Chair, and committee members. It is a pleasure to be here.

**CHAIR** - As you have some significant portfolios, the schedule has us finishing earlier in the day but we think we may need to go beyond those times. There is a chance we may need to extend after lunch, which will push Police out. We will reassess closer to the lunchbreak. We wanted to give you timely notice so your staff are aware they may be needed. To avoid pushing on too late, we on this side of the table must ensure our questions are succinct and to the point. We hope you can do the same with answers. We will have a short period focusing on the overview of Health. That will be based on the opportunity for you to provide some opening comments, but not a re-run of the second reading budget speech similar to what we received from the Treasurer yesterday.

**DIVISION 4**

Department of Health and Human Services

**Mr FERGUSON** - I do not need to give an overview statement and I am happy to go straight to your questions.

**CHAIR** - That is fine, thank you. You may recall last year I requested the estimated outcomes for the line items in Health and we looked at the changing of the Tasmanian Health Service - THS - from its own separate entity back into the department. Can you provide the estimated outcomes, which will make it much easier for comparisons as we move through today?

**Mr FERGUSON** - Were you looking for the estimate of outcomes for the whole of Health?

**CHAIR** - Particularly the THS. The others would be helpful, but the THS and Statewide Services. I assume they would not be too difficult to find. This is in the expenditure summary.

**Mr FERGUSON** - Chair, I have acting deputy secretary, Mr Reynolds, with me, and he might assist in providing some commentary around this. The output expense for THS estimated outcome for 2017-18 is $1.563 807 billion.

**CHAIR** - That is the total. I am looking at admitted and not admitted services, the breakdown, so you will come to that?

**Mr FERGUSON** - I can give you the breakdown. If we go back, the figures I give you now will add up to that total figure.

Output group 1: Admitted Services is $909.481 million; Non-admitted Services, $204.656 million; Emergency Department Services, $122.034 million; Community and Aged Care Services, $205.695 million; Statewide and Mental Health Services, $120.401 million; and Forensic Medical Services, $1.540 million. That adds up to $1.563 807 billion.

**CHAIR** - Do you have Ambulance Services and Public Health?

**Mr FERGUSON** - Output 3.1, Ambulance Services, estimated outcome for 2017-18 is $79.903 million; and output 3.2, Public Health Services for 2017-18, estimated outcome is $29.316 million.

**CHAIR** - Do you have output 1.1, Health Service Management Systems? That completes the picture and should come to what is in budget paper 1 on page 165, which is the estimated outcome for Health.

**Mr FERGUSON** - Output 1.1 2017‑18, estimated outcome is $167 991 000. I am going to ask the acting deputy security, Mr Reynolds, to explain how those numbers meet up with budget paper 1, which is for reference as well. Are you looking for the complete picture of estimated outcome for total outputs in Health?

**CHAIR** - It is hard to compare the THS because of the way it was reported last year and there was no appropriation last year.

**Mr FERGUSON** - We have a unified chapter this year. It collapses down some of the ways the numbers have been disaggregated previously. What if you were to give some commentary on this as the financial guru?

**Mr REYNOLDS** - I have one sitting next to me as well. I will ask Eleanor to enhance my explanation, if needed. The numbers we provided to you were unconsolidated numbers, so for each of the outputs within both the department and THS now included in output 2. Where the numbers are put together for the purposes of budget paper 1, they are looked at from a state perspective, a whole-of-government perspective. Through that process there are consolidation issues. If there are transactions between the entities, between the department and the THS, they will be eliminated for the purposes of a consolidated set of accounts. That avoids double counting those numbers. That's why there will be a difference if you were to simply add the numbers we gave you compared to those presented in budget paper 1. The difference there will be through the consolidation process Treasury has undertaken.

**Mr FERGUSON** - What are the implications for next year's budget papers in respect of that history there?

**Mr REYNOLDS -** We have done a comparative set of numbers in this year's budget papers for the purposes of comparing this year's Budget - 2018‑19 - with 2017‑18 so they are comparable. Similarly, for next year's budget we will do the same in the sense of having comparable sets of numbers, so that we can make a judgement on how movements have occurred between outputs.

**CHAIR** - Next year's budget papers: I'm hoping the new budget management system - the schmicko system which I understand is working well - will include the estimated outcomes in the expenses summary of these output groups.

**Mr REYNOLDS** - That is an issue for Treasury and the Treasurer to decide. They determine the form and the structure for budget papers. If it's determined that's what they would like to present, that is what will be presented in the budget papers. I understand you have indicated the system is capable of doing that.

**CHAIR** - Thank you for that. It is helpful in forming our discussion when we get into those particular line items. I appreciate that. It was a bit like pulling hens' teeth last year.

Without having a calculator to add those up, from what the budget was in each of the output areas, which we will get to individually as we go through, there has been significant overspend in each of them from the Budget to the estimated outcome. The estimated outcome must be relatively accurate in terms of being very close to the end of the financial year due to the lateness of our budget Estimates this year.

What we see overall - I'm referring to budget paper 1 which includes the consolidated accounts as your staff have explained, minister - is that the budget for Health in 2017‑18 was $1.723 million and the estimated outcome is $1.81 million. Then in 2019, we are seeing a drop away. We are not spending more in Health, we are seeing less budget next year than was spent in the current year. I find the claim that we are spending more for Health consistently difficult to accept when we see that we had a supplementary appropriation just recently.

Can you explain to me how you can claim so much more is being spent in Health?

**Mr FERGUSON** - Because it's true. The Budget confirms all the commitments we made at the election. It was a six-year Health commitment of around $757 million. We are at four years, which the Budget and forward Estimates years cover in every year with increased funding. I understand the reasons for your questions and what may first appear when you compare estimated outcomes with future budgets. These have explanations, but I recognise that every year at Estimates there is this commentary around Health budget management and perhaps even management of other portfolios.

Every year we have these conversations, and we do our best to assure you that budget initiatives are additional spending measures. The estimated outcome shown in the Budget reflects unexpected spending to meet demand. This has been something of an unusual year in terms of unexpected demand. That is reflected in the estimated outcome and increased funding the Government provided for elective surgery in the Revised Estimates Report, which was an additional creation.

Funding to meet the additional pressures caused by a record flu season: the Government has always chosen to put extra recourses to meet unexpected demand. Hopefully, that will be welcomed, because it is exactly what has happened here.

You referred to table A1.16 in budget paper 1. It shows that every year funding increases throughout the forward Estimates. We are focused on delivering and showing transparently in the budget papers, the Government's commitments listed as deliverables in budget paper 2. This means more money to actually build those facilities, staff them and provide increased and better services.

**CHAIR** - I do not think anyone is arguing you need to invest in extraordinary events such as the flu season. The claim being made is that the state is putting a lot more money. The forward estimated outcome and the forward Estimates suggest this is really not the case. Considerable money comes from the Commonwealth. The information is available in the Policy and Parameter Statement shows the National Partnership Payments related to health and National Health Reform payments will total $53 million in 2019, so there is only $1 million in extra state money in the 2018- 19 year.

**Mr FERGUSON** - We can quickly dispense with that argument. Expenditure statements reflect federal revenues. The money provided in this Budget to stand up these new services is a massive investment from the state Government. I know there was additional information. I will ask the deputy secretary, and the acting chief financial officers to speak on that, because the funding the state provides come out of Consolidated Fund, which is significantly higher.

**Ms PATTERSON** - Page 171 of budget paper 1 shows Consolidated Fund expenditure. Health has an increase in expenditure of $62 million, which predominately reflects the election commitment funding put in by this Government.

**Mr FERGUSON** - That is the state contribution to the Health budget, which does not account for federal funding reported in the expense papers.

**Mr VALENTINE** - For clarity, the whole of the table?

**Ms PATTERSON**- Health is on line four.

**Mr FERGUSON** - Mr Valentine is asking whether all state funding is on that page. I appreciate where you are coming from, but we are quite open to saying that more money has been spent in the financial year than last year because the Government has been quite content, especially given the pressures in the system during a very bad flu season last year as one major contribution, with the extra $14 million provided in January for elective surgery as worthy investments and a good thing. As you can see, delivering on key deliverables is also provided for. We are quite comfortable saying that because we have been able to get the Budget to such a stronger position, we are in a position to be able to fund the extra costs that occurred during the year. I am happy to take further questions on that.

**CHAIR** - I assume that all the federal funding is on page 63 of budget paper 1 in the Policy and Parameter Statement. It is a parameter adjustment in Health. In 2018-19, it is $49.3 million - this is, additional funds above what the Commonwealth had already committed to in its parameter adjustment - $40 million in 2019‑20 and $35 million in 2020-21.

**Mr FERGUSON** - Chair, my adviser suggests it would be better to look at table 5.4 in budget paper 1, page 79, which deals more with the Commonwealth payments and adjustments that have been made, including different system budgets with estimated outcomes on page 79. The page you referenced - page 63, table 4.5 - is more or less internal to the state Government as to shifting figures and adjusting last year's budget, which may also take account of federal funding included in it, but is not just federal funding on its own.

**CHAIR** - Okay.

**Mr VALENTINE** - Is it just line one on page 79?

**CHAIR** - No, there is the National Partnership Payments further down.

**Mr FERGUSON** - There is a range of payments halfway down that page. I am sure everyone here would be aware that the federal government contributes to a range of health projects and initiatives in our state. We had a question in the other Estimates committee yesterday about differences, for example, between federal budget papers and state budget papers, which were explained by the fact that the federal government released its budget papers before ours. It wasn't aware of our budget in preparing its papers, but that catches up later on when there are activity updates. What do we call those? Estimates of future activity. There is a particular term and the numbers can appear different. People may be concerned, but they end up catching up with each other more or less because the state, when it is planning its health services, can confidently know how much activity-based funding we would qualify for.

**Ms LOVELL** - On that line, minister, I have a question and I would appreciate an explanation. I am curious - and there could be nothing in this, it is maybe just a peculiarity - but I looked at the previous three budgets, both Commonwealth and state, for 2017‑18, 2016‑17 and 2015‑16. When you compare those two line items in our state budget and the Commonwealth budget, every year over the forward Estimates in every one of those budgets, the figures in our state budget for National Health Reform funding have been significantly lower than the figures allocated for Tasmania in the Commonwealth budget. Why is it that in this Budget they are significantly higher for each of those years?

**Mr FERGUSON** - Ms Lovell, was your question on federal budget papers or state budget papers?

**Ms LOVELL** - Well, there is a link between the two.

**Mr FERGUSON** - Which one are you saying is consistently higher?

**Ms LOVELL** - The federal budget papers are consistently higher over the last three budgets until this year, when they are lower.

**Mr FERGUSON** - I am going to ask Ms Patterson to respond. I will ask the secretary to give a broader context on how the national administrator awards funding back to the state based on activity. We also need to touch on how the two governments let each other know about future activity estimates.

**Ms LOVELL** - Thank you.

**Ms PATTERSON** - When we are developing the budget we have an estimate of the activity provided by the THS. That activity can change depending on things like election commitments and additional funding. That then changes the amount of National Health Reform funding coming from the Commonwealth Government because it pays 45 per cent of the activity cost. We also a re-negotiation of the National Health Reform Agreement, which has impacted on the level of funding we receive. There is now a guaranteed amount and that is based on the 2017-18 forecast. As the activity increases in our hospitals that will change the numbers every year.

There is also activity and you have National Efficient Price - NEP. The price of the activity also changes every year. Even if you had the same amount of activity, with price increases that will also impact on the amount of funding we receive. There are also changes to the way the different activity is funded. In some instances, we have block funding for particular areas, in others there is activity-based funding, and sometimes there are movements between the two which then changes the amount of revenue we receive.

**Mr VALENTINE** - When you are doing the estimates, who does that? Is it the Commonwealth estimating or the state, and it is proved up in some way?

**Ms PATTERSON** - The state estimates the amount of activity. We advise the Commonwealth and based on that advice, at a point in time, the Commonwealth then develops its budget papers. There are different assumptions in some of these numbers. For example, in the forward Estimates the Commonwealth is assuming a 3.5 per cent indexation while we assume a 4.1 per cent increase, which is based on population growth and 2.5 per cent indexation. There are slight changes in the assumptions we make about the amount of revenue we are putting in.

**Mr VALENTINE** - Do you take into account ageing population as well, because we have a higher aged -

**Ms PATTERSON** - I do not think we take into account the ageing population. We take into account the type of activity we need to deliver to the population.

**Mr PERVAN** - I am sorry but I am going to add a little confusion to that explanation. Everything Eleanor said was absolutely correct, but it is the difference between estimated activity and actual. There is a reconciliation process through the National Health Funding Pool administrator. We submit our actual data as the services are delivered. They will go through an audit, review the data and then there is a national reconciliation process. The Commonwealth will provide its share of that additional cost if you have delivered more than you estimated. If you have delivered less than you estimated, it will take money back. That process can take anything up to a year. In 2015-16 it took three years before the Commonwealth finally paid out to the state something close to $1 billion in activity that had already been delivered, but it had not paid the money out.

After a rather ruthless data audit 18 months ago, Victoria had to pay back - you might have read a bit about it in the papers - a couple of hundred million dollars to the funds pool administrator for activity they estimated they were going to deliver but didn't. This is an iterative process that goes on constantly throughout the year.

**Mr VALENTINE** - It is their way of keeping us honest.

**Mr PERVAN** - It is. The other issue going on at the moment is due to the very strong interest of the Commonwealth minister. We are getting in-year adjustments to the funding policy. The one that is under the hottest debate at the moment is home ventilation for people who cannot breathe for themselves basically and under direction of the Commonwealth minister the Independent Hospital Pricing Authority - IHPA - has reduced the value of that payment from the Commonwealth's perspective. We are getting the Commonwealth changing the price of specific items in a financial year now.

**CHAIR** - To clarify, minister, they are reducing the price they are paying for that service. Does that mean people will not be able to access the equipment they need?

**Mr PERVAN** - No, it means the state picks up the bill.

**CHAIR** - We pick up the gap.

**Mr FERGUSON** - We qualify for less funding for a service we have already delivered. That can happen.

**CHAIR** - After you have delivered it?

**Mr PERVAN** - Yes.

**Mr FERGUSON** - It is unusual but it has happened.

**Mr PERVAN** - Last year, under the direction of the Commonwealth minister, the Independent Hospital Pricing Authority undertook three audits, I think, and the national funding pool administrator undertook two, going back to the 2015-16 year, on the assumption that the states had been gaming. Without wanting to oversimplify the system, if you build, as former prime minister Rudd did, a system where all the funding is activity-based, oddly enough the system delivers a lot of activity.

**Mr FINCH** - What is the quantum of what has been picked up by the state in respect of the issue referenced?

**Mr FERGUSON** - It's your fault for bringing it up, secretary, so you have to come up with the figures. It's a fairly granular question. The acting deputy secretary has the figure.

**Mr REYNOLDS** - I am advised that it is approximately $3 million.

**Mr FINCH** - It is $3 million? Can we get something more specific, please?

**Mr FERGUSON** - Sure.

**CHAIR** - There is obviously no issue with retrospectivity from the Commonwealth's point of view.

**Mr FERGUSON** - It also means that where we have done more activity than was planned, we get a revenue bump, which has also happened in recent years.

**CHAIR** - A revenue bump meaning?

**Mr FERGUSON** - Uplift - more money. It works both ways.

**Mr PERVAN** - To a cap. Once we go over the cap, the Commonwealth's contribution stops.

**CHAIR** - Is the funding of the 45 per cent of activity growth keeping up with demand? This is one of the risks identified in budget paper 1. I will take you to that because it is relevant to this discussion. It talks about the risks of the activity exceeding the payment. It is probably more likely to be a certainty because we have an ageing population and increasing demand on our health services. One bad flu season does not necessarily mean that is the only one we are ever going to have. Are you concerned about that? The Government's rule, if you like, that it will only meet 45 per cent of the activity-based growth? I can't find it now. You know what I am asking though, don't you?

**Mr FERGUSON** - I do. The state Government plans its services. It goes through the financial management process with Health and Treasury; it publishes the figures in the budget papers we are examining. The state works extremely hard to make sure that the documentation we provide to the Commonwealth proves the activity we performed and ensures that we obtain every dollar we are qualified to receive. There are occasions, for example, when we have done extra elective surgery; we have been able to do so knowing we would be able to budget for extra revenue as well. That has been quite enabling in that respect, but it is a case of the two governments working together and knowing there are the parameters for how revenue comes to the state for extra services.

**Mr VALENTINE** - With respect to issues with accreditation, we have had problems with the LGH, RHH and the North West Regional: Do those payments change in any way? Is there any risk?

**Mr FERGUSON** - No, there is not. They are training accreditations.

**Mr VALENTINE** - Do we receive extra to assist us to come up to scratch?

**Mr FERGUSON** - State governments are expected to run their public hospitals. Under the activity-based model, you would be entitled to Commonwealth funding towards it after having performed a certain number of activity units.

Training accreditation, which you are referring to, is not implicated in activity-based funding but it is still desirable. We want training accreditation for our key disciplines. We have 77 separate training accreditations in the state. Where training accreditation has been revoked or withdrawn in two cases, the eye is drawn to those two, but we have a lot of others. We regard those training accreditations as worthwhile because they mean Tasmania is helping to contribute to the next generation of medical specialists. Where there have been problems with those two and any others and where issues are raised between review periods, they need to be addressed so Tasmania can continue to perform its role as a trainer of advanced trainees. It does not affect the actual service nor does it affect Commonwealth funding.

**Ms LOVELL -** Thank you, minister. I do not have any further questions. I appreciate those explanations. I understand that already. I found it peculiar that there seemed to be a pattern of doing things over a number of years and the sudden shift from that drew my attention.

**Mr FERGUSON** - I think most states would have the same experience. The numbers would rarely align exactly with each other between their budget papers. It is a point well made.

**CHAIR** - Minister, regarding the amount of money spent in Health, you, or the glossy brochure, said we are spending $757 million over six years. It makes it hard to track when forward Estimates do not extend that far. How much of the $757 million boost, which I assume is all state money, includes additional grants?

**Mr FERGUSON** - The $757 million is a major commitment. It is the biggest uplift in Health spending in the state's history and it is a policy we are proud of. We worked hard on it and it's a policy we committed to over six years. By way of commentary, so did the Labor Party. It made a commitment on health over six years. We saw benefit in being able to paint a clear picture for Tasmanians of a health system upgrade that would go beyond the usual electoral cycles.

**CHAIR** - I am asking about the funding. Is it state funding?

**Mr FERGUSON** - It is expenditure. We have planned how we could build new services. I know you referenced, Chair, the difference between a six-year plan and how it models into a four‑year budget document. We are aware of that. If you look at our policy documents on what we committed to do, we have, without exception, provided time lines for our new services and our new building upgrades. You will see in every case they have been delivered in the four-year period, as committed.

**CHAIR** - I am talking about where the funding is. Is it state funding or are you relying on Commonwealth grants and additional funds?

M**r FERGUSON** - I am getting there, but that was the first part of your question on six versus four. The $757 million is all state expenditure, but also recognises that for performing that state expenditure, we will qualify for Commonwealth revenue.

**CHAIR** - You don't have -

**Mr FERGUSON** - It is not a $757 million-cost to the Consolidated Fund.

**CHAIR** - That is the question.

**Mr FERGUSON** - It's $757 million of state spending about which we have just had a long discussion. We will budget for receiving Commonwealth revenues toward those. I understand a lot of politics has been played around this, but any major party worth its salt would, in preparing its budget statements prior to an election, be able to say what the costs of its policy would be and what the net impact on the budget papers would be. That is exactly what we did.

We have delivered exactly what we said we would - building upgrades and new services included. Over the past four years we have increased our frontline staffing in the THS by 630 full-time equivalent staff members. We have done that predominantly around our commitments we have already honoured in full, including the $100 million in more funding for elective surgery.

I am sure you and the committee will be happy to know that this 630 includes more than 370 FTE nurses, almost 90 FTE doctors, 65 allied health professionals, 95 frontline operational staff ‑ including cleaners and ward clerks - and seven radiation therapists. That is a very large number - 630 more staff - compared to when we came to office. It is worth noting at the same time that no frontline FTE staffing levels have remained unchanged. This demonstrates that all the extra funds the Liberals have put into the Health system are providing more frontline care. That means better care and more services for patients. We know there is still a lot more to do, which is why we are here today. I thought that would be useful for the committee.

**CHAIR** - I looked at the Budget overruns Health has experienced over the last four years. The cost overruns for Health operating expenses averaged $82 million per annum over the last four years. This year - 2017‑18 - it was $87 million, which is close to the average.

I appreciate the comments about the flu season; that obviously had an impact last year. Have you been able to put your finger on why the budgets are so consistently underdone, an average of $84 million per annum? Can you identify where the overruns are occurring?

**Mr FERGUSON** - With respect, you say 'overruns', but I say we have provided extra funding which recognises the system demands it.

**CHAIR** - If every year for four years is basically the same, surely if you'd budgeted more at the outset, you wouldn't have to allocate extra funding to deal with it? We wouldn't have a supplementary appropriation bill; we wouldn't have RAFs, or whatever is necessary to meet this. One year? I can accept that. In flu season? I accept that, but when I look back at the last four years, it has averaged $82 million.

**Mr FERGUSON** - Obviously there is a budget management task for every head of agency. They and the Government are mindful of taxpayers' funds being used for the best possible results. In my time as Health minister I have been thankful I have been part of a government that, whenever these extra demands are being visited, has addressed them and provided the extra funding. It is not particularly new. I'm not sure when you would be able to go back and find the health system came in exactly on budget.

**CHAIR** - It is a long time, if ever. I am just talking about the last four years.

**Mr FERGUSON** - I appreciate your point. I am not walking away from it. In this business we make choices - for example, we made a specific choice that of that $87 million figure you mentioned, $14 million is for elective surgery. That is an area the Government didn't have to agree to do because it was -

**CHAIR** - That $14 million is not a small portion of $87 million, though.

**Mr FERGUSON** - It is about choices.

**CHAIR** - I accept that, but if there -

**Mr FERGUSON** - We have a great Treasurer who supports what I am doing. As a Government we care about people getting the services they need.

**CHAIR** - We have talked about how the need for elective surgery is not going away in any great hurry. Even when looking at the estimated outcomes you have provided earlier in the output groups in THS, for example, the estimated outcome - and admitted services is where elective surgery occurs - is still $909.481 million, but the budget for 2018‑19 is $879 million. These are big numbers; there is a lot of money being put into Health. The DEM is experiencing enormous challenges, which we will get to later; I am just making this point in the overview. The estimated outcome for DEM for this year is $122 million and the budget is $120 million. The pressure on our DEM is not easing. This is the point.

**Mr FERGUSON** - What is the point there?

**CHAIR** - The point is that we've spent more in these areas in the current 2017‑18 year.

**Mr FERGUSON** - The Government has provided extra funding.

**CHAIR** - That's right, and budgeted less. Every year for the last four years, an average of $82 million extra money was needed.

**Mr FERGUSON** - I hear where you are coming from with this. Every year we've provided increased funding. Every single budget there has been more money coming in to spend in the Health system; even in our first year when we had to do budget repairs. There was even still more money every year going into Health.

**CHAIR** - If we're going to put $757 million in over six years, why don't we front-load it a bit? You may find we are not having the additional needs for expenditure in Health. You may see that actually flatten. It just seems you are undercooking it and having to top it up all the time - and for good reason: Tasmanian people need it. Why don't you front-load it?

**Mr FERGUSON** - We are putting in significant extra resources and the Budget reflects that. Ministers work closely with heads of agency and there are conversations on a weekly basis about how we are travelling in areas where the agency is looking to government for guidance about choices, and we have made those choices. We are consistently in favour of meeting extra demand.

I hear your point and my conduct in this will continue. We will always do our best to meet the budget as provided for, but where there is a need for extra funds, I will have that discussion.

**CHAIR** - Maybe we need to have a chat with your friendly Treasurer.

**Mr FERGUSON** - That is exactly what I do - have a chat with my friendly Treasurer. The Treasurer has been a friend to me and to the Health system, and I am very grateful for that.

**CHAIR** - Next time, ask him about front-loading it a bit more.

**Mr FERGUSON** - You were with him yesterday, did you ask him?

**CHAIR** - We went a long time with the Treasurer.

Do members have any other questions? I have a couple, minister, in overview.

I draw your attention to page 138 of budget paper 2, which has a statement of comprehensive income for Health. Halfway down it says the 2018 net operating balance for Health is $190 million. That is what the Treasurer would call a surplus because it doesn't have brackets around it. Do you agree this is a surplus? If we are running a surplus, shouldn't we be spending more? This is my point. Isn't there capacity to front-load it to the tune of $190 million if there is a surplus, according to the Treasurer's definition? Or is the surplus because of capital grants which were included in revenue but not counted when they are spent?

**Mr FERGUSON** - Watch as I quickly pivot to the financial experts. I haven't told you that the acting deputy secretary's substantive role is as chief financial officer, in whose role Eleanor is currently acting. We have two great minds here on the financial reporting and accounting treatments. In Health we don't talk about surplus and deficit; in our initiatives we tend to find that -

**CHAIR** - It is a shame when you come across someone who is interested across the other side of the table.

**Mr FERGUSON** - It is not a shame at all. The Treasury set out the formats each chapter has to comply with.

**CHAIR** - I will be interested to hear what your finance people say on this.

**Mr REYNOLDS** - It would not be surpluses as we might define them under a normal profit‑loss scenario where we are making $190 million. That is certainly not the case in Health.

**CHAIR** - Does the Treasurer agree with this view? I asked the Treasurer about this yesterday.

**Mr REYNOLDS** - It is an accounting perspective of the financial position.

**CHAIR** - Correct.

**Mr REYNOLDS** - When you look at what our position is, I am one who always falls back to a cash situation.

**CHAIR** - Great. A man after my own heart, minister.

**Mr REYNOLDS** - That may be sacrilegious for someone who helped introduce accrual accounting in the budget papers, but I think it provides a more understandable explanation of where an entity may be, particularly in the department sense. While it has complied with all accounting standards in the preparation of this statement and demonstrates a $190 million-surplus on paper, it is not a situation where the department - for example, the DHHS - has that surplus sitting in a bank account unexpended, as we have been explaining.

**CHAIR** - Exactly.

**Mr REYNOLDS** - We noted the requirements and the Government's willingness, through our friendly Treasurer, to provide additional resources when required.

**CHAIR** - I might send the *Hansard* of your explanation to the Treasurer.

**Mr REYNOLDS** - I will never be able to set foot in Treasury again. That is how I would try to explain the number.

**CHAIR** - Thank you for that explanation because it makes a lot of sense to me.

**Mr REYNOLDS** - I am glad it does to someone.

**Mr FERGUSON -** I am not an accounting expert, but I know accrual accounting is designed to stop people from being able to hide treatments and transactions in a way that might mislead as to the true state of the books.

**CHAIR** - I am not disputing that, but my point is -

**Mr FERGUSON** - That is the Australian Accounting Standard.

**Mr REYNOLDS** - We have fully complied with those standards.

**CHAIR** - I accept that. Does this positive figure include the capital revenue we are talking about?

**Mr REYNOLDS** - I believe it does. Coming back to the concept the Treasurer uses, that net underline balance, when you take those sorts of things out, it is an accrual figure which is distinct from cash. It does have those vagaries in that we need to consider it.

**CHAIR** - To clarify, it is not $190 million sitting in a bank account somewhere that could be put into operational services for Health? Is it spare?

**Mr REYNOLDS** - No. Through our statement of financial position we show exactly what cash we have available. That is consolidated back into the state position. They are the various reserves and cash reserves we have which can be held against trust accounts - for example, donations and other things - but that is the balance of cash available to us.

**CHAIR** - Thank you very much, minister, and your staff for that explanation. I have a question. This is the profit and loss. It is good to have a neat and tidy profit loss for Health with the THS back in. That is fabulous, minister, and makes it much easier. The main expenses are wages, which are 65 per cent, supplies and consumables and grants, but there is another outlay that is 'Other', which runs at $27 million, which is not an insignificant amount. Can you tell the committee what that includes? In budget paper 1, in the General Government Income Statement on page 135, there is, 'Other'. It does constitute, if it encompasses the same thing, a significant portion of that.

**Mr FERGUSON** - We have a breakdown I can provide to you. The amount of $27.8 million comprises $14.9 million for Tasmanian Risk Management Fund premiums.

**CHAIR** - That is the medical liability, is it?

**Mr REYNOLDS** - That is our insurance premium. That includes medical negligence, but it also includes our premium costs associated with all our insurance claims, as you are aware.

**CHAIR** - Such as fires, floods and hospitals, and things like that?

**Mr REYNOLDS** - Property damage and the like. As you are aware, the government is a self-insurer. This is our departmental contribution to the state self-insurance scheme, which is the Tasmanian Risk Management Fund managed by Treasury.

**Mr FERGUSON** - The second figure is $12.8 million for workers compensation premiums. There is a smaller amount of $363 000, which is generally down in the sundry items and doesn't have any further breakdown.

**CHAIR** - The workers compensation premiums are in addition to the Tasmanian Risk Management Fund?

**Mr FERGUSON** - Yes.

**CHAIR** - It is basically about insurance, isn't it?

**Mr FERGUSON** - For this agency, that is the case.

**CHAIR** - This footnote to grants and subsidies on the same table, footnote 10 on page 139, states -

The movements in Grants and subsidies primarily reflect the allocation of funds for election commitments including for the Drug and Alcohol Rehabilitation Beds in Ulverstone; time limited funding for Rural Alive and Well initiatives; Epilepsy Tasmania and the Stroke Foundation; and the Tasmanian Community Health Fund.

Why are these not broken up further? The breakup of the health systems management has been a bit of a mystery. Can you provide a breakdown of all those grants, or are all of them listed in that footnote? It says 'grants and subsidies'; it doesn't give us amounts in that.

**Mr FERGUSON** - That talks about the movements being primarily reflected by the following factors.

**CHAIR** - Yes, do you have a list of all the grants?

**Mr FERGUSON** - There would be - no, we don't.

**CHAIR** - I assume there are more than those; that is the point.

**Mr FERGUSON** - Yes, of course. The footnote is an explanation for the variance in the figures between the years, not an attempt to summarise it. I am going to ask the deputy secretary to provide you with the context of this.

**CHAIR** - Are you able to provide a table with all the grants? There doesn't appear to be anywhere I can find them.

**Mr FERGUSON** - I am quite comfortable with tabling that page. With all due respect, I don't think you will find it very useful but it does provide some further breakdown. To me, it is more of a way of categorising grants than anything else. Very few of them are actually listed individually. When you get this, you will see how most of the grants are distributed across government.

**CHAIR** - We don't know for what purpose - is that what you are saying?

**Mr FERGUSON** - There are some here. I will give you a couple of examples. There are grants to population health programs, grants to planning purchasing and performance - part of the department. There are grants to corporate policy and performance - again, part of the department. There are grants in respect of Commonwealth funding. There are grants to the SCIFF - Special Capital Investment Fund - capital investment program and grants specific to the THS. There are grants specific to the THS and for cash reserves.

**CHAIR** - Do we have a list of all these grants? That is, where they are going rather than what they are for.

**Mr FERGUSON** - For the purpose of this financial accounting treatment, I have a breakdown I am happy to table for you.

**CHAIR** - I am asking a separate question now. Do we have a breakdown of all those grants? You might have to table it later, minister.

**Mr FERGUSON** - Maybe. I suspect we have grants and grants with two different understandings of what they are. These grants in respect of the accounting treatment required for these detailed budget statements. I have a breakdown for you that talks about refugee clinics, tobacco cessation projects, Rethink Mental Health, the Home and Community Care, Suicide Prevention Strategy, mental health policy, ice and other drugs, younger persons, and various THS grants. These are the grants specific to the THS so there is a little bit more.

**CHAIR** - Minster, in the budget papers there is no grant in the subsidy section. In other departments, there are grants and subsidies sections that detail those grants. We have the information, but there is nothing about all the grants you talk about in Health. I am asking you to provide a list of the grants, not right here, right now if you can't, but certainly provide a list.

**Mr FERGUSON** - I am happy to take that on notice and provide you with what I can, bearing in mind you are asking me a question and I am giving you the answer. I am happy to table the breakdown.

**CHAIR** - You have answered the question. I will go on to another one. In the budget papers no page in Health outlines grants, as it does in other areas. Obviously a significant amount of money goes into grants.

**Mr FERGUSON** - I will take that on notice.

**CHAIR** - The glossy brochure you referred to earlier informs us a massive $757 million is to be spent over six years. The same brochure also informs us that an extra 478 extra full-time staff hospital staff are included. However, on page 115 of budget paper 2, volume 1, in Health, we are told that approximately 946 full-time staff will be recruited for the opening of the new K Block at the Royal Hobart Hospital in 2021. Clearly this is in the six-year window: can you explain the discrepancy of 468 full-time employees?

**Mr FERGUSON** - The figure on the fact sheet on page 115 talks about 478 estimated extra FTEs, over the budgeted four-year period. It is a reference to the overall project of opening extra beds at the Royal Hobart Hospital with 250 beds very clearly in the election policy in the six-year plan. It includes additional funding to refit and renovate areas of the hospital to be vacated and moved to the new K Block.

**CHAIR** - On page 115, it says, '946 full-time equivalent staff will be recruited'. That means new staff. You said that according to the fact sheet, there will be approximately 478. Even with a bit of approximation and rounding up, it doesn't give you 946 FTEs.

**Mr FERGUSON** - Nobody is suggesting it is over the same time span. The 250 extra beds for the Royal Hobart Hospital is the longer term project, because it is not just about K Block. Once areas move into K Block -

**CHAIR** - That is not what the people think; they think it's going to be 250 new beds when K Block opens.

**Mr FERGUSON** - There will be 250 more beds available and they will moved into. For example, currently the women's ward in A Block is one of the services that would move into the new K Block tower. This will then create space in vacated A Block. You wouldn't put patients back into the dated facilities and so this is part of our commitment to the longer term master plan of the Royal Hobart Hospital. There is capital funding provided in our $757 million to cover required refurbishment of areas on site.

**Mr VALENTINE** - There is $28.1 million for ward upgrades.

**Mr FERGUSON** - That refers to the longer piece of work we are committing to as part of our six-year plan to open 250 beds.

**CHAIR** - You understand the confusion when you say the beds are going to be opened up. It does say 'progressive rollout from 2021', still well within the six-year time frame. The way it reads, staff are going to be recruited. Maybe it needs to say over a 10-year period or whatever it is, for clarity.

When people who are desperately waiting for the opening of additional beds at the Royal see that, they will think, 'Where are they going to come from, for starters?' It just doesn't add up. Over a period of how many years do we expect the 946 extra FTE?

**Mr FERGUSON** - That is a six-year figure, and a six-year estimate.

**CHAIR** - Six years from when?

**Mr FERGUSON** - From the financial year we are entering - 2018‑19.

**CHAIR** - Your fact sheet said approximately 478 extra FTE over a six-year period. You are saying that this -

**Mr FERGUSON** - No, over four. This Budget.

**CHAIR** - I did not read the small print, sorry.

**Mr FERGUSON** - It is not small print. It is the same size as the rest. With respect, we might be coming to a point of agreement. The fact sheet deals with this Budget, which is the financial year and the forward Estimates - an extra 478 extra FTE.

**Output Group 1**

**Health services system management**

**1.1 Health services system management -**

**Ms LOVELL** - Minister, you touched on accreditation earlier. I understand there are a number of training accreditations. I have a question about the hospital accreditations. The general hospital accreditation against national health standards: can you tell the committee when each of our hospitals is due for review of accreditation, or reaccreditation, against those standards?

**Mr FERGUSON** - I have two and while I am giving you these dates I ask the secretary to draw together the north-west dates. Launceston General Hospital has current accreditation to September 2018. As you may be aware, it has already started the survey process. The LGH, as I think I told the other committee yesterday, has received ticks on 199 of the 209 standards and there are 10 core areas where further work is required. There will be a reassessment opportunity to allow the hospital to address the issues that have been identified. To answer your question specifically, September 2018.

The Royal Hobart Hospital: I don't have the date of its current accreditation, but I can tell you it will be having its periodic review in August this year.

The North West Regional Hospital is accredited until May 2020. The North West Regional Hospital underwent its period review in October last year. The Mersey is the same.

**Mr VALENTINE** - That is general accreditation rather than specific?

**Mr FERGUSON** - Yes. The Royal's accreditation is until March 2020.

**Ms LOVELL** - The 10 core areas that were identified - you said Launceston had an opportunity to work on those areas before the review in September. What happens if at that review the hospital has not been able to address those areas of concern?

**Mr FERGUSON** - I am not going to go into that hypothetical with you at all. We would expect that we will go through that process in a meaningful and constructive way. That is how the accreditation process is intended to work. It is constructive to support the hospital to use what can be several months for improvement. It is not a disciplinary process; it is an improvement model.

**Ms LOVELL** - I am not suggesting it is disciplinary.

**Mr FERGUSON** - I will not countenance any suggestion that it will not be reaccredited. I would invite you to do the same because we expect to be satisfactorily reaccredited. I hope our staff will feel they are able to move on with that task confident in the knowledge we are all supporting them. Accreditation is important for every hospital in this country. I am aware other hospitals in other states have major failings that have been identified. One of them has more than 50 areas of unmet core required standards, yet they still get through, and it is important this will be the same.

**Ms LOVELL** - Are you confident they have 50 areas of requirements they have not met and they still have their accreditation? Are you confident that, even if in September the 10 areas identified are not resolved and the standards not met, the hospital will retain its accreditation?

**Mr FERGUSON** - No. That is not what I am saying at all. The process is helpful and constructive, and the hospital did well. I am not going to tell you what it is because it is not intended to be publicly scrutinised. It has had positive feedback as well, which I am aware of. Until the final report is done later in the year, it would not be prudent for me to brag about some of the key areas for which they received good commendation. It is a positive picture but there are some areas of concern. I am not being glib about that either. They need to be addressed and they will be. That is the expectation the secretary and the THS executive are working under, together with LGH management.

Ms Lovell, I believe I can be sincere in saying that you can look forward to the final report when it is issued because some very positive outcomes will emerge. However, some areas of improvement are required. Everybody, from me down, is committed to supporting the LGH in having all its 209 standards supported and evidence of those areas being met being provided. I was not suggesting we would be reaccredited not having met those standards.

**Ms LOVELL** - Thank you. You have answered the question in a roundabout way.

**Mr GAFFNEY** - A further question on that. We had concerns about some accreditation issues in different areas over the last 18 months. You said 199 have been ticked off, which is terrific, and there are 10 to go. Of the 10 remaining, are any of those reliant on funding to be satisfied? We want to know that if any of those 10 - it is very important - are reliant on funding, will the Government be giving enough money and is there enough time to make sure all of those 10 are ticked off?

**Mr FERGUSON** - Thank you, Mr Gaffney. I can assure you it is not related to budget. To answer your question, it would not be that an adjustment of more finances, for example, would be the missing link. It is more around best practice, process and governance matters. It is things within the culture of how a clinician might be using best practice techniques and documenting that, so it can be established that is current practice, which the assessors would always be looking for. I am trying to answer your question as directly as I can without breaching the confidence of the accreditation. It is not a case of having 10 more staff to ensure those boxes are ticked.

**Mr GAFFNEY** - It is important to put that on record because there have been some other accreditation concerns about attracting suitable staff to fill those positions. That is why we have lost some of that accreditation. If that is not the case with this one, I am comfortable with the answer being worked through.

**Mr FERGUSON** - I have been minister during previous accreditations where we have not had as much interest in how they were going. Areas of identified improvement were also encouraged and that has been done and they have been duly achieved and accredited. The LGH has not previously been accredited in my time as minister, which is five years ago. My advice is that when it was accredited five years ago, it was quite a similar set of arrangements. An initial survey report highlighted some areas of improvement, a certain period of time was provided, and in six months they achieved it and received accreditation.

**Mr GAFFNEY** - Is it a timeline situation? You said it needs to be accredited by September this year. You have given feedback saying there are 10 more areas. At what stage in the process do you tick all off or are alerted that we are not going to get it, because of what has not been ticked off. A timeline for the community to feel comforted the LGH still has accreditation?

**Mr FERGUSON** - I appreciate the question. When the Mersey and the North West Regional Hospital were reaccredited last year, we did not announce it. There is an expectation they are continually accredited. I appreciate there might be more interest here, but I am trying to be transparent for you and other members of the committee on this issue. We do not want to create a situation where unwarranted increased scrutiny or suspicion falls on the LGH. It is a very good hospital with excellent staff, leadership and frontline staff absolutely committed to the highest standards of patient care. This is what accreditation is ultimately about. I am supporting the LGH. I have given very clear direction, as I have in previous occasions, that it is our job to support the LGH. When the final report is completed in the latter part of this year, there will be some very flattering feedback for our hardworking staff.

**Mr VALENTINE** - My question is on the specific loss of accreditation over the last 12 months: have the issues been addressed?

**Mr FERGUSON** - I will ask the secretary to assist with this. I have been working closely with him on this, not only in supporting THS and the relevant departments.

**Mr VALENTINE** - I am not only talking about LGH, but all of them.

**Mr FERGUSON** - I appreciate that. The Launceston General Hospital Emergency Department Training Accreditation and the Royal Hobart Hospital Department of Psychiatry Training Accreditation -

**CHAIR** - North West Regional? They have restriction on the anaesthetics and extra supervision.

**Mr FERGUSON** - I am happy to go into others, but these are the two accredited.

**CHAIR** - It is accredited. They have a number of supervision requirements, imposed when it was threatened to be removed.

**Mr FERGUSON** - You were asking for progress?

**Mr VALENTINE** - I was asking what the situation is now with those previously lost accreditations.

**Mr FERGUSON** - Considerable work is being done and is a supportive model to empower local group of clinicians to be able to achieve accreditation so training programs can continue.

I do not mind emphasising there is not an impact on patients, if the service is not affected. Some might arguably say it would be a higher, even better service, if it was accredited. That is a fair point and the service continues uninterrupted. We want the accreditation. Those training programs are important status symbols for our training hospitals. We have been working closely with the psychiatry training accreditation, and I will ask the Secretary to provide an update on that. There has been closer than ever engagement between the department, the Tasmanian Health Service and the branch training council of the college for psychiatry at the Royal Hobart Hospital. The engagement has been very collaborative and understanding of all the history - the shortcomings where the service needed to step up and provide a stronger training experience for the trainees. No trainee has had their own training program interrupted, because the THS was able to provide trainees with accredited training in the community, which allowed them to complete their training programs.

**Mr PERVAN** - Thank you, minister, for letting me put it on record. With the minister's support and some strong collaboration between the department, THS and the local college branch training council, we were advised yesterday that the two registrar positions have been provisionally accredited. Registrars will be coming back into the acute stream from August. We have managed to turn that one around quite quickly.

**CHAIR** - That is good news.

**Mr FERGUSON** - It has been a lot of hard work and we have a lot of people to be grateful to. We could have just let it go - it's not an absolute essential for the health system to have this ‑ but we see it as an important element of enhancing the Royal's status as a tertiary training hospital. There are lessons learned here, including strong leadership and strong engagement with the college branch training councils.

**Mr VALENTINE** - I did not get the North West Regional Hospital update and the LGH.

**Mr FERGUSON** - We should also acknowledge the chief psychiatrist, Dr Aaron Groves, who is in the room. He has been a wonderful addition to our state.

**Mr PERVAN** - The LGH ED is a little more complex, in that there are issues around not only having the correct number of specialists in the ED but also the training programs that need to be provided to ensure a quality training placement for the registrars coming through. A great deal of effort has gone into recruitment of Fellows of the Australasian College for Emergency Medicine, or FACEMs as they are called in the trade. We are confident, as far as we can be, that we will be applying to the College for Emergency Medicine for an accreditation visit in early 2019 after the successful recruitment of a number of FACEMs and some fantastic leadership by the current director of the LGH ED, who got the training programs back to the quality required to satisfy the college.

**Mr FERGUSON** - Did you tell the committee how many extra staff you have recruited there? I don't know if you have it in front of you, but there have been a number of successful recruitments of FACEMs at the LGH, which has been very positive. More have been committed to but haven't commenced yet. That has been quite a positive piece of work.

**CHAIR** - Do you have an expected time frame to have the accreditation reinstated here? As soon as possible, I guess, but do you have any idea how long it will be?

**Mr PERVAN -** We are working to early 2019. It really depends on when the new staff land and the training programs can gear up. That's LGH.

**Mr FERGUSON** - Noting that current trainees are able to complete their training project and have it recognised. But the view is to plan for a positive reaccreditation rather than try to rush it. So it is to make sure we have the staff in place first. Bed pressures on the LGH is cited as one of the reasons for the LGH ED as well, so we must continue to improve bed management and patient flow, noting we have now opened up every ward area of the LGH. Everybody is working very hard. My last advice on this was quite positive as to our future gaining that training accreditation. We have spent a lot of time talking about two out of the 77 that the state does have - all of them are important.

**CHAIR** - What's your completion time for 4K? That was soon, wasn't it?

**Mr FERGUSON** - Ward 4K is due for physical completion by the end of 2019. That includes eight extra bed spaces for adolescents. Adolescent mental health will be a first for Launceston, indeed for the state.

**CHAIR** - Long overdue.

**Mr FERGUSON** - People have talked about it for many years, but we are now building those facilities.

**Mr VALENTINE** - You brought that out during the acute health services inquiry; you might recall the findings there.

**Mr FERGUSON** - Additionally, we touched on the extra beds at the Royal Hobart Hospital. Until this Budget, no actual extra beds were budgeted to be opened, so now we are in a position to talk about not just building the asset but how we occupy and backfill bed spaces, having renovated them, that have been vacated.

**Mr VALENTINE** - The North West Regional is the last one.

**Mr FERGUSON** - Training?

**CHAIR** - That is, of anaesthetists.

**Mr PERVAN** - I will read this straight off the page because there is some very positive feedback in it -

The North West Regional Hospital and Mersey Community Hospital were jointly granted provisional accreditation by the Australian and New Zealand College of Anaesthetists for the 2018 hospital employment year after a notification of intent to withdraw was rescinded in December 2017. The college has praised the enthusiasm and diligence in which the THS has approached the significant challenges faced, stating that they are thoroughly pleased with the progress that has been made and a follow-up site visit is expected to take place in June 2018.

I have not had an update, and the fact I have not had an update is very positive. I think there had been a negative response to the site visit, we would have heard immediately.

**Mr VALENTINE** - Thank you.

**CHAIR** - On that, it is only until the end of this calendar year if I understand what you read?

**Mr PERVAN** -Yes. It is not unusual for training programs to only have 12‑month accreditation, but the most you tend to get is two years. I will just check with the chief medical officer. The amount of time you would be accredited for would be based on the training program and any concerns with the previous accreditation. One or two years is not uncommon for training programs to be accredited for.

**CHAIR** - So you would expect, following this update and site visit, it must have just happened or is happening as we speak. After that, if it is positive, might we see an accreditation for one to two years from there?

**Mr PERVAN -** Yes. Given the amount of attention we have been putting into the training accreditations over the last six months in particular, I hope we would be well aware of any risks. None has been brought to our attention so I am confident we will get a good result.

**Mr WILLIE** - My question is about recruitment. When these accreditation issues are resolved across the hospitals, do you expect an uplift in recruitment? I would have thought quality of training and a high standard of service would be attractive to new staff, which is absolutely critical to recruiting new staff.

**Mr FERGUSON** - I agree with you, Mr Willie. Part of that, perhaps the smaller part, is the registrars themselves. If you are not accredited, obviously you cannot have accredited training places and then you would have access to fewer registrars. That is perhaps a smaller contribution, but registrars provide hands-on health care only with supervision. I have talked often about status of tertiary training hospitals. Where you have training accreditation programs, it adds to the sense of vibrancy and quality of a place to work and practise medicine. I agree with you that it will only support recruitment efforts.

**Mr WILLIE** - While they are not resolved in these specific areas, it is having an impact on recruitment. Is that what you are saying?

**Mr FERGUSON** - The opposite is true in the case of the LGH, where one of the key issues identified by the College of Emergency Medicine was over-reliance on locums. In fact while that training program has not been accredited, we have been recruiting quite successfully. It just means the effort has been there and the leadership has been very strong. As the secretary said, we have an excellent emergency department director in place there. She is doing a very good job and building her team. It is a constructive effort and people are working effectively together.

**Mr WILLIE** - That is at the LGH, what about the Royal? Are there issues with recruitment there?

**Mr FERGUSON** - The secretary has advised the committee it has been provisionally registered again. I am not aware of any particular recruitment challenge in that department.

**Mr WILLIE** - So the provisional registration doesn't have an impact?

**Mr FERGUSON** - No.

**CHAIR** - They wouldn't have registered if there weren't enough psychiatrists, is that what you are saying?

**Mr FERGUSON** - It would only be registered if it were considered a safe service and, if I can use the phrase, 'a quality training experience for the trainees'. That tends to be the kind of language the colleges use. Is the training experience up to 'our' standard? That can be a broad criterion. That is the kind of language we tend to hear, then you start to see particular issues being identified as I have described for the LGH.

**Mr GAFFNEY** - I have heard that sometimes when recruiting staff you have to offer a financial inducement for them to come to Tasmania. That makes sense. I have heard that sometimes once that has occurred and we have them here, we may not follow through with that inducement. Can you help me with that? I told the person told me that, that I wouldn't have thought it was correct. It was about offering higher than base wages to some of our specialists to induce them to stay in Tasmania. Has there been any issue regarding recruitment in some of the areas where we have lost accreditation? Has it been a significant factor in the finances?

**Mr FERGUSON** - I might speak broadly and give you one anecdote I am aware of. The broad answer is no. When the THS and, from 1 July, the department, including THS, make offers of employment, we stick by it. Usually - and I don't like to say this on the record at all - it can work the other way. Somebody might attempt to build themselves the best possible package after having already secured an offer. I am aware of a particular case that occurred before my time as minister, which I was pretty disappointed about. I am aware of one staff specialist who was invited to come to one of our hospitals before the Liberal Government was elected. When they arrived and moved their family here, the hospital concerned reneged on the offer and the person was not able to take up that position. I am not aware of that happening in my time.

**Mr GAFFNEY** - In the time of the current Government, there have been no instances where somebody has been recruited and been offered a package, only for it not to be upheld the following year?

**Mr FERGUSON** - Not that we are aware of. In the interest of transparency, the answer is no. We have had to provide an extra incentive to attract staff in certain disciplines, which was really what you referenced in your earlier preamble. That has been a market-based mechanism to ensure we are an attractive place to recruit to. We try to do that prudently and ensure the taxpayer is receiving a good deal as well. It has been necessary to do that in some disciplines. In a couple of them we have done that as a structural adjustment to the package, which would apply to the individual and all their colleagues in that same discipline. This ensures we attract and also retain.

**Mr VALENTINE** - Regarding accreditation, during our inquiry into acute health services we received a submission from Dr Bryan Walpole. Has any more consideration been given to that type of approach to accreditation, in which you have health professionals, academic teachers and researchers brought together under an academic medical centre? That is how Dr Walpole paints the picture and how that could assist in staffing more isolated areas because it has three components to it. It is not just employing somebody to do the professional side of the work on the ground, but there are also academic research and teaching aspects. Has any more consideration been given to that?

**Mr FERGUSON** - I don't have an awful lot to contribute on that subject at the moment. I am aware of the submission and I have certainly read it. The secretary might be able to provide some meaningful advice on the feasibility or the desirability of it. Dr Walpole is a fine man and a good thinker.

**Mr VALENTINE** - It is one approach and I was wondering whether there was anything -

**Mr FERGUSON** - I am not rubbishing his idea either, but I am not aware of any others who are supporting or encouraging that particular model. Secretary, can you speak to the committee on this?

**Mr PERVAN** - Discussions around an academic medical centre or academic health science centre in Tasmania go back to 2010. It was a feature project of the Tasmanian Health Assistance Package. At the end of the day it isn't so much about brick and mortar and signage, but about the relationship between the university and health service and professionals who work within it.

We are in the midst of discussions - always with UTAS, a committee of somewhere around 30 people - looking into a bid to the Commonwealth to fund basically an alliance which will get you to the same outcome without going through registration as an academic medical centre. It really is about relationship and collaboration more than just the plate that goes up on the street.

**Mr FINCH** - Minister, I have some questions about nursing graduates. I am led to believe there are 180 nursing graduates. How many will be taken up in the health system in Tasmania? Will they be deployed, what roles will they fill and where in Tasmania?

**Mr FERGUSON** - I am going to ask the secretary to talk more specifically about how an individual nurse going through their training right now might expect to be employed in the future. I will speak generally. We certainly are keen to encourage people to look at nursing as a very fulfilling and rewarding career, especially given our history in employing extra nurses. We have been able to take up and change some of the old dynamics where, not that many years ago, people trained as nurses were not able to get a job in this state, particularly when there were cuts.

We have been able to put on a lot more nurses. We are working closely with the University of Tasmania in particular so there can be a stronger contact between our health system managers and academics and we can shape expectations. There is a very large recruitment challenge ahead in our state, which is why we have commenced the new workforce unit in the Department of Health and Human Services - so we can attract and retain staff to open these extra beds.

Specifically around graduates, there are 180 more nurse graduate positions. We are funding an extra 30 each year so that builds on the existing 150. That was already an enlarged number from when we came to office. That is for nurses to go into what is called 'transition to practice' places, a special model I am sure a number of people here would be aware of, with extra support and mentoring for a graduate nurse coming in, but you do not have to go through that model, do you? No. Other graduate nurses might come in and not go through the transition to practice graduate position. My message to anybody considering studying nursing is to positively consider that because there are going to be jobs available. It will be the opposite of what was the case in the past. We will be actively looking for nurses. While we do not ever provide a guarantee, it is so much more job security than we have seen in the past. There is funding in this Budget for 180 nursing graduates, 30 each year over six years, over and above what we are doing at the moment.

**Mr FINCH** - Would there be a circumstance in which a nursing graduate might have to look outside of the state for employment at the moment?

**Mr FERGUSON** - I am sure there might be individual instances, but given we have vacant nursing positions that are being actively recruited for and the number of extra nurses we have employed since we came to office, it would be unexpected to find a nurse today who cannot find work. It would be unexpected

**CHAIR** - On that point, you cannot put a nursing graduate into the operating theatre or the ICU straightaway, but you may be able to in the DEM with proper supervision. There are many nursing areas where you cannot put them straightaway - you cannot put them on the maternity ward. Just having a graduate, that is good. I am not critical of the policy to engage them but the real challenge is in the specialist nursing areas, isn't it?

**Mr FERGUSON** - I agree with you, it is. We recognise that and we live it every day. That is why we have gone to some extraordinary lengths, including sending our chief nurse to the UK to encourage people to consider migrating to Australia, living in Tasmania and working for us, to deal with some of those workforce shortage issues. As you have said, a nurse is not simply a nurse; there are different specialisations.

**CHAIR** - Where are the particular areas of shortage in nursing?

**Mr FERGUSON** - Mental health, ICU and theatres.

**Mr PERVAN** - It comes and goes, but on a more or less continual basis there are always shortages of nurses in intensive care and critical care medicine, and of specialists in operating theatres. I remember it took us a year to recruit a specialist neurosurgical surgical nurse to support Mr Hunn. Although not paid anywhere near Mr Hunn, the effort to recruit them -

**CHAIR** - Which is part of the problem.

**Mr PERVAN** - The effort to recruit was substantially difficult because they are in short supply Australia-wide. In mental health also, and that is also a national challenge because mental health has great difficulty attracting nurses. We are going through a generational change of the younger nurses coming through. They have a slightly different skill set to the older, more senior nurses. We are seeing that challenge with the models of care, needing to move to reflect a population that has a higher burden of chronic disease, which will require a different skill set. The only thing I would add to the minister's comments is that we are reaching out to recruit from overseas and speaking to my colleagues in other states. The NHS has just been through trying to recruit our nurses; recognised, as they are, for being a very high quality workforce.

**CHAIR** - Some of them become politicians and you lose them.

**Mr PERVAN** - Only one or two.

**Mr FERGUSON** - Like science teachers.

**Mr FINCH** - On the subject of a dedicated full-time CEO for the LGH, could you apprise the committee of the current circumstance of management of the LGH, and is there somebody specifically there as the CEO?

**Mr FERGUSON** - A lot of work is underway. Since December, when I announced the Government's new direction on statewide governance, the secretary has been doing a power of work and that has involved a lot of close engagement with the individuals concerned, as well as the medical staff associations and the industrial bodies, such as the AMA, the ANMF. Everybody has been consulted, I can confidently say. By the end of this week we will be meeting our commitment around operational charts for each of our hospitals; no-one can be in any doubt as to who is in charge.

**Mr FINCH** - The go-to person.

**Mr FERGUSON** - The go-to person. Even with that said, there is leadership at the LGH but not with the title of CEO. I will ask the secretary to supplement my answer, but we will be having more to say about that later this week. It directly arises from the bill that was, thankfully, supported by every member of both Chambers, the THS bill that commences on 1 July. Consistent with that, we still have strong statewide planning, strong statewide governance, and a statewide executive and clearer visibility on how local decision-making is achieved at the hospital level. It has been an acceptance by the Government that we did not have the balance right on that, and there is the willingness to make sure we provide for that.

**Mr PERVAN -** Thank you, minister. What we will be providing to the minister in the next couple of days will be organisational charts that make it abundantly clear who at the LGH is in charge - this is in the whole hospital and the clinical divisions - who is the most senior clinician in surgery, the most senior nurse in surgery and so on. They have been deliberately designed so we can fit them on an A4 page and they can be pinned up on notice boards all around the hospital. There will not be any doubt as to who the 'go-to person' is on any campus, and where the escalation points are if people need to raise a particular issue, whether it be administrative or clinical. Those drafts went out last week for one final round of consultation. We are in the process of a final polish before we present them to the minister.

**Mr FINCH** - Minister, will there be a designated position of CEO?

**Mr FERGUSON** - No, there won't be. I am comfortable in ensuring you will be provided with a copy when it is finalised by the end of the week. That title would not exist in a future model.

**Mr FINCH** - It sounds as though there is going to be a few figures who will take a role in the management of the hospital. So, it will not be the one person who might oversee the management of the issues and what is occurring at the hospital? Somebody who can be that designated leader for the hospital?

**Mr FERGUSON** - The secretary is my subject expert on this. The Government, through the bill we have seen pass through parliament, is about stronger and clearer local decision-making for operational decisions under the one roof of the hospital. We are delivering on that and my advice is clear. The consultation has been productive and supportive of the draft issued and feedback received. There will be multiple people, for example, at the LGH, in charge of various departments. There will be clear leadership, which is understood to be someone who is in charge at the local level.

**Mr PERVAN -** I should have been a little clearer. The organisational charts going up will be traditional, but they will not use the title of CEO. There will be one person at the top. People will report up, through that person to the Chief Operating Officer of the THS, who will report directly to me.

**Mr FINCH** - Is this a new style of management for the hospital? Is it traditional, tried and true? Is it something that is going to be tested?

**Mr FERGUSON -** One of the things we are not walking away from is the real reason four years ago the Government announced a new direction, which was to bring our system together under one health system and ensure we have strong statewide planning: we were aware of risks in our health system. Services were being conducted in certain locations that were not considered appropriate and/or safe. We also saw duplications of some services in which it would have been better to have a new model. The white paper, which defines what services should be built up to what level in each hospital, remains unchanged. The underpinning philosophy of the One State, One Health System, Better Outcomes remains and one of the strongest supporters of that has been the AMA. It has insisted there should be no walk-away from the one health system. What we want, and the bill achieved, is stronger operational decision-making at the local level, which has been supported.

It is not really back to the future because we have the best of one health system. We have our hospitals working together as colleagues in the one system. We are building clearer lines of accountability for me. From 1 July 2018, I will no longer have two people reporting to me. I will have one and he is sitting to my left. It will be clear who is responsible for delivering outcomes ‑ for example, accreditation and employing graduate nurses. Previously those things have had grey areas or had seen duplication. At the local level, we want every clinician and support staff member to know exactly who they answer to. If there is a problem at the local level, we want there to be no doubt about where they can go to have that resolved.

For example, patient flow issues at the LGH. It does happen. If the hospital needs to be escalated because there is overcrowding in the emergency department, or there has been some other incident that affects the hospital, we want people to have the operational decision-making to deal with that under the one roof. There have been times when people have felt they needed to go outside that hospital to find a solution. We want to eliminate that situation to the greatest extent possible. Does that help?

**Mr FINCH** - Yes.

**Mr VALENTINE** - You are reducing fragmentation. We are not going to see duplications of software systems to support individual hospitals? Is that all going under the one umbrella?

**Mr FERGUSON** - Absolutely, Mr Valentine. We had three separate statutory organisations previously. That is why -

**CHAIR** - Which I argued against a long time ago.

**Mr FERGUSON** - History has proven you right.

**CHAIR** - Yes.

**Mr FERGUSON** - We are not going backward. In certain respects there was competition between over which would have the patient.

**Mr VALENTINE** - Having worked in the system for 20 years in the ICT environment, I can understand -

**Mr FERGUSON** - We saw different procurement between what were previously called Tasmanian health organisations. None of that is coming back. We are ensuring local people can be reassured they know that operational decision-making is being empowered at the local level.

**Mr VALENTINE** - That is fair. No fiefdoms, excellent.

**CHAIR** - Under a different output group, which talks about provision of support for policy planning, funding and service improvement across health services, I note that Australia is a signatory to the International Covenant on Economic, Social and Cultural Rights, which provides in Article 12 that everyone has a right, 'to the enjoyment of the highest attainable standard of physical and mental health.' I am sure you are aware of that. The Government's failure to ensure terminations are able to be carried out in Tasmania is a failure to allow women the enjoyment of the highest attainable standard of physical and mental health because they are forced to travel to Melbourne or further for a procedure. How many women have been required to travel to Melbourne for an abortion since the closure of the Macquarie Street premises in 2018?

**Mr FERGUSON** - Thank you for your question, Chair. I will answer the question as to numbers, which I think is what you are looking for. The Government is not requiring people to travel interstate. We have recognised this is a very difficult circumstance in every case in which a women is considering her options. The Government has worked to deal with this sensitively and respectfully. In respect of travel interstate, surgical termination services are provided in the private system in Tasmania. They are much more expensive than was previously the case. In recognition of that, the Government does not force anybody to travel interstate and has provided a way for women to access those services, should they travel interstate. That is why we specifically changed the Patient Travel Assistance Scheme - PTAS ‑ to provide an interim arrangement during the period of time when that service was closed in December. We are not forcing anybody to do anything, and I say that with the greatest respect. In terms of the actual numbers, I -

**CHAIR** - If you just answer that question -

**Mr FERGUSON** - I am not quite finished. I am quite happy to provide advice to the committee either now or on notice as to the number of women who are travelling interstate and using our Patient Travel Assistance Scheme.

**CHAIR** - That is the question I asked first. I have a series of questions around this, so if you could answer that initially.

**Mr FERGUSON** - I am advised that the number is four.

**CHAIR** - Four women who have travelled have been provided with PTAS support? Are there others who have travelled to Melbourne and who haven't applied?

**Mr PERVAN** - We would have to write to Victoria and ask them whether they could advise us. They probably wouldn't be able to advise us about people who travelled this financial year until their data has been verified in the next financial year.

**Mr FERGUSON** - Secretary, would a private provider - for example, in Melbourne - be in a position to tell us that?

**Mr PERVAN** - A private provider wouldn't but the Victorian department would keep activity-based records of activity in the public and private sector.

**CHAIR** - That information may be available at the end of the financial year, minister?

**Mr FERGUSON** - Following the end of the financial year.

**CHAIR** - To date, have any hospitals or clinics in Victoria where women from Tasmania have accessed termination passed on their costs for the service back to Tasmania? I understand that if the service is provided to a Tasmanian, they can pass the cost back. Has that occurred?

**Mr PERVAN** - Under the National Health Reform Agreement, any public health patient from Tasmania who receives service in any other state or territory, that information is passed on to the national funding pool administrator. They extract the National Efficient Price from us for those services provided. The Commonwealth pays that state directly.

**CHAIR** - I understand that. Have any of the women gone to a public service as a public patient in Victoria and made that claim as yet?

**Mr PERVAN** - We would not know that until later - as I said, the 2014‑15 reconciliation took three years. It would be one year, two years. The minister and his colleagues are seeking to increase the speed with which those reconciliations are done with the Commonwealth. The Commonwealth is resisting.

**CHAIR** - How much in total has the Tasmanian Government paid to enable women to access abortions in Melbourne, including covering the cost of their flights, accommodation, incidental costs or other costs?

**Mr FERGUSON** - What I can get for you is the dollar amount provided for patients who have travelled interstate.

**Mr VALENTINE** - Does that include accommodation?

**Mr FERGUSON** - Yes. I don't believe I am breaching any privacy here, but I am advised previously that four women travelled interstate to use a private facility.

**CHAIR** - Which is most likely. The public one is unlikely. How do we track this, because it is impossible? Minister, you said you weren't requiring anyone to travel, but if women want to access -

**Mr FERGUSON** - 'Forcing' was the word you used.

**CHAIR** - No, 'requiring' was the word I used and *Hansard* will reflect that. You said 'requiring' again in responding to me. You said you are not requiring women to travel to the mainland to have a termination, but if it's not available to them because of financial issues, as you said yourself, in the private sector that is much more expensive. For women from Circular Head, from the east coast, from the west coast and places outside of Hobart where the private provider is, it is not just the cost of the procedure that is well outside their capacity to pay, in the majority of cases it is also well outside their capacity sometimes to put fuel in the car to travel to Hobart. You are saying you are not requiring them to travel and that they can choose to travel. Well, they are not choosing - they have no other option. The only way they can afford it is using PTAS support and it is their choice to use PTAS support.

Minister, how can you say you are not disadvantaging women or allowing them to enjoy the highest attainable standard of physical and mental health while not providing it through our public hospital system when you say there are four women who have gone to the mainland? It is not going to put a huge burden on the health system, as it was alluded to in a debate in another place. I expect there are probably more but if it is only a small number, how can you say you are not disadvantaging women and that you are meeting your requirements under the convention?

**Mr FERGUSON** - You are obviously aware of my comments in the other place so you would also be aware of the narrative I provided to the other House about the circumstances in which surgical terminations are provided in public hospitals. That has been a longstanding government policy over successive governments; nothing there has changed. There are two things that have changed. The first is that there has been a private provider that you might call a low-cost or lower cost provider that ceased providing a service last year. The other change is that the Government expanded the criteria for the Patient Travel Assistance Scheme to allow for costs to be met in respect of women who are travelling to Victoria for what might be considered a low‑cost service in Victoria. They are the two things that have changed.

You would also be aware that the government policy on that is the same. While surgical terminations are available in the private sector in Tasmania, the closure of the local provider has resulted in a gap for low-cost surgical terminations of pregnancy in that private sector. You would also be aware that an interstate provider has expressed interest in establishing a local service, and the department is working with that provider through the licensing and regulatory process - as it would with any potential private health service provider. I am also aware that commercial negotiations are underway for suitable premises.

In respect of our public hospitals, you would also be aware that our public hospitals continue to provide termination in cases of high need, such as to save the life of the mother or where there is a severe foetal illness or damage. That has been the longstanding policy - it is our policy. There has been no change to that policy and since you have referenced my comments from Wednesday a fortnight ago, you were aware of the context of my contribution on those issues. We have expanded, as an interim measure, the Patient Travel Assistance Scheme. We have provided transparency around the numbers of women accessing that scheme to support their travel. We anticipate that the provider, in discussions with the department as to licensing and regulation and its own commercial negotiations, is likely to make an announcement on this proposed service in the near future.

**CHAIR** - Minister, would you consider subsidising a service to enable a low-cost surgical termination service to be available in Tasmania?

**Mr FERGUSON** - As I have said, there is a private provider that is working through -

**CHAIR** - I understand that. Would you subsidise such a provider?

**Mr FERGUSON** - That is not being proposed, but the Government is allowing the department to do its work. By the way, it is at arm's length from the Health minister. As it happens, it is for the secretary to make the decision on licensing a service provider in the private sector.

**CHAIR** - The secretary could also include it in the service delivery plan under the new act.

**Mr FERGUSON** - I have discussed that matter and the secretary, under the Health Service Establishments Act, is the decision-maker for granting of a licence to a private facility. That is not for scrutiny here today nor my actions in it because there isn't a role for me in the licensing process.

**CHAIR** - No, but in the determination of a service delivery plan for the THS, the secretary could include that as part of the service delivery in each of our three major hospitals.

**Mr FERGUSON** - The Government's policy is the same as it has been for many years. That is what our public hospitals are there for. I again bring to your attention that there is a private provider that is looking to provide a service here in Tasmania.

**CHAIR** - Minister, do you acknowledge the international research that shows where legislative frameworks, which we have got right, and policy frameworks that do not enable access to safe termination in an equitable manner have a negative impact on maternal morbidity/mortality?

**Mr FERGUSON** - I am not expert in that, but in my role as minister I am concerned for everybody's health and safety and welfare. The Government is acting responsibly, in a compassionate way and mindful of what has changed since last year. I stand by my earlier answers.

**Ms LOVELL** - To clarify, there is no intention for the Government to provide any public funding or support to a private provider to carry out this procedure in Tasmania - is that correct?

**Mr FERGUSON** - It is a matter for the secretary to determine licensing and other conditions to meet the necessary local regulation of that service. Negotiations are underway on a commercial basis with another service provider, which I won't speculate on today, and that is as much as I willing to say now.

**Ms LOVELL** - So it is a possibility that public funds will be used to support that provider?

**Mr FERGUSON** - I am not speculating on that, but, no, the Government does not fund abortions in the private sector.

**Mr GAFFNEY** - You mentioned the Patient Travel Assistance Scheme has been expanded. I imagine that some ladies would be more than comfortable travelling by themselves to the mainland for their termination, but there would be some others who would need the support of their partner or a family member. Is that other person covered under the Patient Travel Assistance Scheme?

**Mr FERGUSON** - I am advised that, yes, if a companion's travel is required, that is also supported.

**Mr GAFFNEY** - Of the four cases we have had, how many of those had -

**Mr FERGUSON** - When we obtain advice as to the money that has been spent, I think we will be able to answer that question.

**Mr GAFFNEY** - Thank you because I think it is important for people to realise.

**The committee suspended from 11.03 a.m. to 11.22 a.m.**

[11.22 a.m.]

**CHAIR** - We will make a start again. We have finished group 1.1. Kerry, do you have one more question on that?

**Mr FINCH** - Has staffing at the Launceston General Hospital Accident and Emergency Department increased or decreased since the 2016- 17 fiscal year, and if so, by how many?

**CHAIR** - We can ask under DEM; it fits under 2.3, Emergency Department Services.

**Mr FINCH** - I can leave it until that. I have another question.

**CHAIR** - We will leave it until DEM.

**Output Group 2**

**Tasmanian Health Service**

**2.1 Admitted Services**

**Ms LOVELL** - Minister, with line item 2.1, how much of this funding is being allocated to the John L Grove Centre and over what period? I understand the state is taking over funding for the continued operation.

**Mr FERGUSON** - I will have some number information on this. It was funded in last year's budget at $5 million per year. That has been confirmed for me. With the forward Estimates, there would be some indexation, with the increasing cost of labour.

**Ms LOVELL** - Minister, you mentioned escalation levels at the hospitals earlier - I appreciate you may need to take this on notice and I am happy for you to do that - but can you provide the committee with the number of occasions over the last 12 months, preferably with a breakdown by month, of the number of occasions the Royal Hobart Hospital was escalated to level 4 and also the number of days the Royal Hobart Hospital was operating at level 3 of its escalation plan over the same period?

**Mr FERGUSON** - I will make some comments on that and let you know what I am happy to take one notice. The escalation policy is something of a newer innovation in the Health system. It has been specifically designed to support staff and patients, and not always during times of very high demand in our hospital system. Escalation levels is not a performance measure and it should not be represented or misrepresented as a measure of performance. That would frustrate staff in terms of why they have been calling for, for quite a number of years, evidence-based escalation policies. The escalation protocols have been updated. They have updated in response to a report the Government commissioned. Ms Lovell, I am sorry to tell you that the previous government had a document called the Monaghan report, which was hidden, and also called for evidence‑based escalation protocols that were never implemented.

This is about supporting staff and hospitals so they can have the tools they need to support patient flow. Where I have seen parliamentarians expressing interest in escalation levels and posing questions of the nature you are asking me to respond to, it is almost always used as a flashpoint for crisis calls in the health system. That's quite destructive and corrosive to staff morale, people who operate magnificently during times of peak demand. They deserve our thanks.

I am not trying to be testy about the question. I am happy to take the question on notice but I don't undertake to provide it in the format you have requested. I will do my best to provide the number of instances, for example. I hope that when you receive the answer, you will use that information to support staff. If we start seeing hospitals criticised for escalating to any level, we are cutting across clinical judgements. Maybe you think I am being unfair to you about this, but that is my experience in dealing with colleague parliamentarians who ask me about escalation levels. I will take that question on notice.

**Ms LOVELL** - Thank you, minister. I appreciate the commentary and I believe you may be reading quite a bit more into my question. It was a fairly straightforward question.

**Mr FERGUSON** - I have been doing this for four-and-a-quarter years.

**Ms LOVELL -** There was no intimation. It was a straightforward question and requires a straightforward answer. Having said that, are you also happy to take on notice as well the same information for the Launceston General Hospital: How many occasions did they escalate to level 3? On how many days were they operating at level 2 of their escalation plan over the last 12 months?

**Mr FERGUSON** - In accepting the question on notice, I don't undertake to give it to you in that format. I undertake to send you what I can, noting that escalation levels are not a performance measure. That is not data collected as a measure of how the system is travelling. We measure performance -

**CHAIR** - Minister, I don't think the member was suggesting they were.

**Ms LOVELL -** I am not suggesting they are. I am sure you have the data.

**Mr FERGUSON** - I am qualifying my answer by letting you know I am not sure we collect the data in that form. I will undertake to provide you with the number of occasions the hospitals have been escalated - in what period of time?

**Ms LOVELL** - Over the last 12 months. Minister, on your commitment to the $20 million for elective surgery: how will this money be directed, which surgeries or categories of surgery will be the focus, and how will those decisions be made on where that money is invested?

**Mr FERGUSON** - Those decisions have already been made. The gentleman to my left, the secretary, has already drafted a service plan for THS. I advised the secretary of the Cabinet's decision on budget at an early stage, that there would be an additional $20 million of unexpected elective surgery funding for the health system that wasn't committed before the election. We have chosen to do that and it is a good thing. We have a draft which has also been shared with senior clinicians. We can speak about the volumes but I might ask you to do that. We are holding our activity up over 17 500 elective surgeries, which is about 2000 more than the base rate before we came to office. We are trying to build on the success of the last four years. I recognise the waiting list experiences fluctuations around increased numbers of additions to the list. The state Government has been doing a great job in partnering with our clinicians to see record numbers of people receiving surgeries. It has brought down the waiting list from about 9500 to about where it is now, just over 7000. The best picture in this, Ms Lovell and committee members, is the size of the waiting list and the number of people having their surgery conducted within the recommended time.

The answer to the question is: $20 million extra funding in 2018-19. The department had factored that into the service planning and clinicians are able to go ahead knowing how to shape their volumes over the next 12-months.

**Ms LOVELL** - Minister, are you aware of any plans for a private provider to commence oncology, radiation or haematology services in the state? If so, what discussions have taken place and with whom, between the department and the private provider?

**Mr FERGUSON** - There is a new one in Hobart. I know that because I opened it last year. I am not sure if that is the one you are thinking of.

**Ms LOVELL** - No, in the future.

**Mr FERGUSON** - I would need to take advice on that, but we welcome private providers to our health system and it is to be encouraged, broadly. However, we have a Health Services Establishments Act, which the secretary administers. I administer it, but the secretary is the authority involved in issuing licences.

**CHAIR** - He does all the work.

**Mr FERGUSON** - Yes, he does all the work, and a range of considerations have to be taken into account before a licence is granted. A service provider doing exactly what you have listed in your question has been recently established, yes.

**Ms LOVELL** - I am aware of that. Minister, your department committed to a review into the provision of maternity services on the north-west coast. Midwives and nurses were advised it would be released, or there would at least be some feedback from that review, in April this year. Where is that review? What is happening with it? When can nurses and midwives expect to see the outcomes of that review?

**Mr FERGUSON** - Thank you, Ms Lovell. Before you joined us in this parliament we spent a lot of energy in this area. Chair spent a lot of energy in this area as well. We undertook some service review through the white paper process between December 2014 and May 2015, which looked closely at how we were travelling with maternity on the north-west coast. We made the difficult decision, one of the most difficult decisions this Government has taken, to put an end to the avoidance of this issue as had been the case in the past. Birthing and inpatient maternity services at Mersey Community Hospital were consolidated to the North West Private Hospital in Burnie, as integrated maternity services of the north-west. That was not without disruption in Burnie either, because we have taken the role of outpatient services back into the public sector as well. There has been change on both sides, at both ends of the coast, on this.

The establishment of that integrated model was based on best clinical advice from specialists. It was all about, and nothing other than, putting the safety of north-west mothers and babies first. I was advised in making and supporting that decision that it would save lives. I have already had what I can only categorise as strong anecdotal feedback that this has already happened, which should be very satisfying to everybody here.

To give you an update, as at 31 March 2018 - I am sure you will be keen to know - there have been 1196 births in the 17 months since that new integrated service was stood up. You, Chair, will be particularly keen to know that 19 per cent of those were conducted through Midwifery Group Practice, which is strongly supported. I am getting rave reviews -

**CHAIR** - Did you say 19 per cent?

**Mr FERGUSON** - Yes, 19.4 per cent of the births. Not wanting to run away from the question, I will keep coming back to the point. Australia's midwife of the year, Carol Nicholas, is a coastal midwife and we recently celebrated with her. She is involved in Midwifery Group Practice as well. Back to Ms Lovell's question: after the 12 months of operation, as promised, a review was commissioned. The review involves participation by medics, midwives, consumer advisors and consumers, who are seeking the best outcomes. The review report, I am advised, is currently in the process of being finalised. However, the Government has taken its own views into consideration here. We have taken a good look at the physical spaces, an issue raised with me by a number of midwives. The Government has taken the investment decision of providing $2 million for an upgraded outpatient maternity clinic.

**CHAIR** - The time frame for that one?

**Mr FERGUSON** - We have committed $2 million for a purpose-built antenatal clinic at North West Regional Hospital. I have had a good look at the current facilities being used. They are not up to our standard. While I know people have gone to their best endeavours on this, you only have to spend a short time in there to recognise it is not to our standard. We are going to be building something appropriate, of high quality, which shows a respect for mums and babies and our clinicians there as well.

**CHAIR** - Built on site?

**Mr FERGUSON** - Yes. The intention is for that to be on site. It has a completion date of 2020. We are just coming now through this process. Early works are underway in terms of analysing options and considering the best model, but on site, yes. In the meantime we have just completed the new antenatal clinics at the Mersey Community Hospital, which I have visited. The staff there are doing a great job. Back to the point, the review report is in the process of being finalised. In the meantime we will not wait for that final report to budget for the $2 million for a purpose-built antenatal clinic at Burnie.

**Ms LOVELL** - Are you able to give a time frame of when that review can be expected? The outcomes? It was committed for April.

**Mr FERGUSON** - I am hearing it will be in the near future.

**CHAIR** - I have a couple of questions on that and I will come back you. When is the current contract with the private provider for maternity services due to expire? I commend you on getting rid of the evergreen contract, after a number of attempts.

**Mr FERGUSON** - We have an eight-year contract, which comprises a five-year with a three-year option, which commenced on 1 November 2016.

**CHAIR** - So eight years with a three-year - ?

**Mr FERGUSON** - The current contract would conclude, subject to people checking what I am saying here, in 2024.

**CHAIR** - This is beyond the term of this Government obviously. It is always good to think about things ahead and have a long-term plan. Will consideration be given to resuming a public birthing service in the public system at the end of that contract period?

**Mr FERGUSON** - I will answer that question by saying that it is public birthing, but it's obviously conducted by a private facility for public patients - mums and babies. It's been quite a breakthrough, as you have acknowledged in your question, that we have taken what was a never‑ending contract - an evergreen contract - down to something that not only has professional time-bound periods around it, but also has a different quality assurance philosophy sitting within it, so there can be performance management of that contract. We are, as a health system, aware of incidents that might require remediation and there can be a shared understanding of how it can be continuously improved.

Consideration has not been given to ending that after the eight years. It is certainly not a space we are in. In answering the question directly, my first priority would be around the quality of the service itself.

**CHAIR** - My question is around the cost. If it's more cost-effective to provide in the public system, acknowledging you would have to refurbish a part of the public hospital - at the moment there is no space.

**Mr FERGUSON** - We would have to build.

**CHAIR** - There are other areas that need rebuilding, including the Spencer Clinic - a separate topic. In terms of long-term thinking, if it's possible to be repositioned within the public health service and funded within rather than paying another provider, would that be considered if it is cost-effective?

**Mr FERGUSON** - We would always keep an eye on cost-effectiveness. That was one of the core tenets of the negotiation to get to the new contract. Who negotiated the contract? Was it THS or a department?

It was THS, in renegotiating the contract. The North West Private Hospital didn't have to agree to the new contract, but did so, and that also included a renegotiation of the unit price. We are happy to participate in that; it has been quite a breakthrough. Consideration isn't being given to ceasing that at the end of its contract. We would always assess and evaluate the effectiveness of the arrangements with a somewhat open mind. One couldn't help but be aware of the fact that that the service in Burnie was built on the basis of that contract. One would have to be mindful of the other unintended consequences of rushing to any suggestion of withdrawing it.

**CHAIR** - The unit price did reduce?

**Mr FERGUSON** - We are paying less per unit than we were before. Part of the renegotiation was in recognition that we are looking a higher number of births being provided through that service, through the integration. We were able to negotiate a lower unit price as part of that. Even better was a more contemporary contract. The previous contract was from the 1990s.

**CHAIR** - It was very old.

**Mr FERGUSON** - An even better performance relationship between the department - the Crown - and the private hospital to ensure we have a high-quality experience for mothers and babies with a strong medical model and lots of midwifery and expertise.

**CHAIR** - It bothers me when you say 'a strong medical model', minister, for what is a normal life event.

**Mr FERGUSON** - Let me tell you, it is a stronger medical model because the service on the north‑west coast was predominantly run by locums for the medical clinicians.

**CHAIR** - I am talking about the overall model. We are talking about difference things.

**Mr FERGUSON** - I probably didn't mean to express it like that. We have now been able to see a turnaround. I told you this last year; I am repeating myself. We went from having about one permanent and four or five locums to the other way around. It has been a breakthrough and with the success of the model, whatever else the review comes out with, none of us should lose sight of the fact that it has been a very important reform. We asked much of the coastal community to accept that change but already, I am advised, of at least one life it is likely to have saved.

**Ms LOVELL** - I have a question about the new beds at the Royal, specifically the adolescent beds, which we spoke about briefly earlier. There are 16 adolescent beds at the Royal Hobart Hospital and eight at the Launceston General Hospital that you have set up for specialist mental health care and to deliver better psychiatric services to young patients and their families.

How will that specialist mental health care be delivered and specifically how will it be staffed? I understand there won't be a demand for mental health care at all times in those beds. How are you going to ensure, when that care is required, that the appropriate staff are on board? When I talk about appropriate staff, it would be good to hear what consideration there has been towards staff specialising in eating disorders, alcohol and other drugs and, of course, psychiatric and mental health trained staff.

The second question is: when are you expecting those adolescent beds to be fully operational in both locations?

**Mr FERGUSON** - Those are important questions. The secretary will speak to these as well. There is a commitment for all those beds, 16 as part of the new Royal redevelopment as well as eight at 4K. I like the way you asked the question, because they are not just mental health for adolescents; they are adolescent beds within the paediatric zone. From dealing with local clinicians, particularly in Launceston, the model developed is based on mental health and other adolescent health issues. The beautiful thing is it is an adolescent unit, so they will have their own eight-bed zone there and 16 at the Royal. The 4K redevelopment is due for completion in middle to late next year, more like middle of 2019, with commissioning and staffing in the second half of the 2019- 20 financial year.

The project is due for practical completion at the Royal by August 2019. There will be a commissioning phase and a full allocation by the 2020- 21 financial year. All the work is underway for the largest number of new beds the health system, has ever opened, particularly the 250 at the Royal. It is supported by the work of the Clinical Planning Taskforce. To ensure full engagement with clinicians, the Government is supporting strong leadership and providing feedback into the process. The points you were asking will provide a model of care and stand us in good stead.

**Mr PERVAN -** The Clinical Planning Taskforce is powered by the department. It is chaired by the Chief Medical Officer, Professor Tony Lawler, and the core within the department has the planning expertise. It involves a cross-section of clinicians from within the Royal and the community, representatives of Primary Health Tasmania and others, so we can develop a robust and contemporary model of care for the new beds. That output goes to the health recruitment retention and workforce planning unit, so we can target the recruitment to areas we are going to need. This time, instead of approaching these things as a building project, it is very much are a service development project. Just as important as the bricks and mortar and the FTE is the service plan we are developing and the models of care that go alongside that, so we can provide a contemporary approach to adolescent care.

**Ms LOVELL** - Minister, are you able to guarantee that around-the-clock specialist mental health care will be available to be delivered on those adolescent wards? I appreciate you said it is a mix, it is not a mental health ward, but -

**Mr FERGUSON** - The teenagers will be there around the clock, so of course the care will be as well.

**Ms LOVELL** - The specialist mental health care specifically?

**Mr FERGUSON** - I am not a clinician but we always ensure that the model of care designed around these things meets best practice. We are not going to be admitting patients and sending them home every night at 5 o'clock. Definitely around-the-clock care to the highest expected standard. I am looking to see if people are nodding at me and everybody is. That places me on firm foundations. You can bank on that.

We are very committed to this. We are sorry it has taken Tasmania a couple of hundred years to get to this point, but we are getting there now. It has not been possible without built infrastructure. Up until about two years ago it was not even proposed for Launceston. The Government has seen the need for that. My good friend the Treasurer, as a fellow member for the Bass electorate, strongly supports this because there is also a wonderful outreach in this service for the whole of the north of the state.

The two should work in very well together - north and south - in building those models of care and for the first time providing specialist adolescent inpatient care. This is going to be a game changer for a lot of families, including those today that probably do not even realise that they are going to need it. It is going to be there for them. Everybody around this table should feel very proud of themselves that they have supported this wonderful and important development.

**Mr VALENTINE** - On the provision of mother and baby units in the public system, it seems there is only one unit in the state, which is in St Helens hospital. Four beds, I think. That seems very much under-resourced, especially if you have to travel from Burnie to Hobart to access it in that state.

**Mr FERGUSON** - I will take that as a constructive comment. I know that the state Government pays -

**Mr VALENTINE** - Is there any provision going forward? Are you looking at developing it?

**Mr FERGUSON** - That is a partnership between government, or THS and Healthscope -

**CHAIR** - At the Hobart Private?

**Mr VALENTINE** - St Helens.

**Mr FERGUSON** - There are no current plans to expand that arrangement but we will always keep our eyes open to that. The Government is always keen to do what it needs to do to support patient care, particularly in areas that are successful and where a case could be made.

I have just received advice that backs up what I am saying. We are happy to consider the opportunities. We have not made any firm commitments at this point in time. The secretary has touched on the important role of the Clinical Planning Taskforce and we have made statements to support this could be considered as part of that work.

**Mr VALENTINE** - It is a very stressful situation that mothers and children can find themselves in.

**Mr FERGUSON** - The postnatal period can be very taxing not just on the mother but on the whole family unit and, of course, the baby. We are satisfied this should be considered through the work of the Clinical Planning Taskforce. There may be a role for that as we plan for those 250 extra beds.

**Mr VALENTINE** - Especially in the north of the state where t no service is available.

**CHAIR** - Let me assure you that, as a midwife, having to admit a woman and her baby to the Spencer Clinic in Burnie was anything but ideal. That was in the immediate postnatal period. There is a need, thankfully not that frequent, but that case was pretty awful.

Of the extra 946 FTEs for the refurbished Royal, do you have a breakdown of the areas those staff will be recruited into?

**Mr FERGUSON** - Those estimates are indicative of what we would expect when the Government has made a financial commitment to what it would cost to staff and open 250 additional beds. I have to be non-specific in terms of how one might discuss this. I cannot answer your question because that work is not done. That is part of the work for the Clinical Planning Taskforce we promised in the election.

**CHAIR** - I wanted to ask some questions about acute inpatient mental health services. I note it is not part of this output, but it doesn't appear to be part of 2.5. Where would you like me to ask those questions?

**Mr FERGUSON** - I thought it was.

**CHAIR** - It says on page 125 that it 'excludes designated mental health wards in major public hospitals', but when you go to Statewide and Mental Health Services, it does not include acute inpatient mental health services. I am not sure where they sit.

**Mr FERGUSON** - I will clarify that for you before we proceed. We have dealt with it in 2.5 in past years.

**CHAIR** - I thought so. I am happy to do it.

**Mr FERGUSON** - I would like to establish the fact and you can decide when to deal with it.

**CHAIR** - I was disappointed it is not. They are inpatient beds in a public hospital.

**Mr FERGUSON** - I suggest we do it whenever you want to. It is in 2.5, because 2.1 excludes designated mental health wards.

**CHAIR** - It is not listed in 2.5. I am happy to do it there but that is alright.

**Mr FERGUSON** - We have always done it in 2.5 and my advice, based on -

**CHAIR** - Maybe the good Treasurer needs to review his words in this book and ensure it is included somewhere. It is such an important area, but it does not seem to fit anywhere, even though there is no allocation for it in the Budget.

**Mr FERGUSON** - We have crisis assessment and treatment, intensive support, community care.

**CHAIR** - Community care and rehabilitation service.

**Mr FERGUSON** - I think that covers the field. I propose it is 2.5, especially given your comment.

**CHAIR** - We will leave it until then.

**Mr FERGUSON** - It is not an admitted service under 2.1, but it is classified under 2.5.

**CHAIR** - I want to go to the performance information on page 126 with regard to admitted services. I am still looking forward to the day we see some outcomes-based performance information. I know the secretary may laugh to himself, but there we go. In terms of the 'Elective surgery patients - average overdue wait time for those waiting beyond the recommended time', in Category 1 - and I know there are some footnotes associated with this - the actual in 2016-17 was 29 days, and the target in 2017-18 is listed as 11. Is that is a realistic expectation? Coming close to the end of the year, we like to reach that target. Category 2, which is a longer time for people who can wait, the actual in 2016-17 was 10.07 days and the target for this year was 40, and the same again in the out-year. Can you explain why there is such an increase in the target and what it is likely to be?

**Mr FERGUSON** - Thank you, Chair. I do not have the benefit of having last year's budget papers with me. You may. We had an interesting discussion about targets in the other committee yesterday and the way -

**CHAIR** - I am not interested in how you establish the target as much as whether we are likely to achieve an improvement in this.

**Mr FERGUSON** - We have seen significant improvement in over-boundary performance. It has been pleasing. How the budget papers set out our targets is one thing, but we don't want to see anybody over-boundary. If you are clinically qualified to be on the elective surgery waiting list, regardless of the category, we would like to see you treated on time and in turn, under clinical best practice. We have set out a target for ourselves, having achieved some significant improvements in elective surgery waiting lists in the last four years, of 90 per cent treated on time.

**CHAIR** - That is okay. I want to understand where we are at the current year's end.

**Mr FERGUSON** - We will have some numbers on that. Are you asking for those?

**CHAIR** - Yes, I thought we would be given them.

**Mr FERGUSON** - I have some numbers for you that are not for the full financial year but are to March 2018: Category 1, 41; Category 2, 77; and Category 3, 53.

**CHAIR** - We have a much longer wait than the target and a significant jump from last year's actuals.

**Mr FERGUSON** - This is in the same financial year in which we have had extra pressure on the hospitals, especially around the flu season. That is the data I have as at that date.

**CHAIR** - This takes us to our beginning this morning, the need to front-load some of this to deal with those big challenges, such as the flu season, which may or may not occur again. I am sure we will, at some stage. This is what happens. Elective surgery wait times increase when there is no redundancy in the system. Is that a fair comment, minister?

**Mr FERGUSON** - I do not know if I agree with that. We put an extra $14 million into elective surgery this financial year.

**CHAIR** - The wait times have increased.

**Mr FERGUSON** - The average overdue days have increased. There are so many ways you can present this data and this is one of them. At the same date in previous years and for all categories, five years ago, it was 304 days. It is now down to 70. I accept your point there are different ways to present this.

**CHAIR** - Elective surgery admissions: do you have the actual to the end of March, whatever the time was?

**Mr FERGUSON** - The number of admissions has historically hovered around the 14 000 to 15 000 mark; to the end of March 2018, that nine-month period, there were 13 445 admissions.

**CHAIR** - Are you confident you will reach, at least, your target of 17 500?

**Mr FERGUSON** - It is a requirement and an expectation, even with the significant extra demand experienced in the latter half of the last calendar year.

**CHAIR** - These will be published in the annual financial report, I imagine?

**Mr FERGUSON** - Yes, there is always full transparency. For the next six days or so we are still operating under the Tasmanian Health Organisations Act and the service agreement, which is between them, the minister and the chair of the governing council. We have contracted 17 500 surgeries, which we have upheld by putting in the extra $20 million for the future year.

**CHAIR** - Wouldn't you contract for more, if you are putting in an extra $20 million?

**Mr FERGUSON** - The whole issue is that over the last four years we have been implementing our Rebuilding Health Services fund, the $76 million we put in our first budget. Over the first four years the amount was $16 million and then three lots of $20 million, and then that all timed out. All that $76 million funding was intended to bring down the long waitlists, to try to get the waiting list down to something that looks more like an equilibrium trying to approximate the number of additions with the number of removals. As a government, we took the extra decision that not only would we put in the extra $14 million in January but also an extra $20 million in this Budget. We are extending this by one year, to further drive down long waits.

**CHAIR** - I understand that, but wouldn't you then have a target of higher than 17 500 admissions?

**Mr FERGUSON** - Last year's volume was 17 500, including the final year of $20 million, so we have maintained the volume. What's the normal baseline without the boost fund? Is it in the fourteens or fifteens? The baseline funding for elective surgery in our health system sits at about 14 000. The extra funding has held up record levels of surgery over the last four years. We've never had figures of 19 000 done before, but we did in two consecutive years. You might be wondering why it's more than 17 500 - it's because we had extra federal funding.

**CHAIR** - I knew that.

**Mr FERGUSON** -The 17 500 stands for the full financial year and I would expect the THS has been cracking on delivering those. Patients admitted within time is a key measure. This is further knowledge for you to understand where we started and where we are looking at overdue wait time. The actual patients admitted within time has gone up from 59 per cent. It is now 74 per cent as at 31 March this year. That's positive, but we want to get it up to 90 per cent.

**Mr VALENTINE** - One of the findings of our acute health services inquiry last year was the submitting of costs associated with overtime and the engagement of locums continuing to put pressure on the state Health budget. Quite clearly, that impacts on nursing staff and the like. Can you give us an understanding of how staff overtime is in comparison to last year and the engagement of locums? What is the current situation?

**Mr FERGUSON** - The figures are not by hospital, but by award. I can break that down. Let me start with the global figure. Overtime is represented as FTE - does that make sense? Maybe, we have done it previously; I can't recall. Would you like that by award?

**Mr VALENTINE** - You could table it.

**Mr FERGUSON** - The average overtime FTE per pay period for the year ending March 2018 is 176. That is broken down into allied health professional, 5.21; Health and Human Services award bands 1 to 9, 9.76; Health and Human Services award HSO health services officer, 15.87; nurses, 76.95; radiation therapist, 0.07; salaried medical practitioners, 68.17; and visiting medical practitioners, 0.16, adds up to that total. That figure is also expressed as a percentage of the average paid FTEs. So a percentage of the overall work force.

**Mr VALENTINE** - Breaking that down into something that most can understand, you are saying that 176 FTEs are involved in overtime?

**Mr FERGUSON** - No, 176 is the expressed amount overtime, if you express it as if they were FTEs. It's 176.19, which is 2.08 per cent of our workforce.

**CHAIR** - Do we have a breakdown by region where the overtime is occurring?

**Mr FERGUSON** - I have it by award, not by region

**CHAIR** - You don't have a regional breakdown? If it is a really complex table, it would be preferable to have it tabled.

**Mr FERGUSON** - They are the same design. At Launceston General Hospital it is 62.45, expressed also as 3.02 per cent; at Mersey, it is 8.40, expressed also as 2.24 per cent; North West Regional, 22.99, also expressed as 3.66 per cent; and at Royal, it is 63.38, also expressed as 2.06 per cent of the workforce.

**Mr VALENTINE** - Can we have that tabled?

**Mr FERGUSON** - I'll take it on notice.

**Mr VALENTINE** - The other part of the question was about locums. How is that issue travelling compared to last year?

**CHAIR** - If I can just add to that question - particularly by region and speciality, because they have challenges for the north-west.

**Mr FERGUSON** - I have it by region.

**Mr VALENTINE** - And by speciality?

**Mr FERGUSON** - No, we have never done that. We have always done it by region. I have that here. To 31 March 2018, the total cost of medical locums is $29.93 million broken down by region represented as follows: north, $12.65 million; north-west, $13.57 million; and south, $3.71 million.

**CHAIR** - Minister, can we have on notice a breakdown of specialty areas? We are seeing the north-west still leading the pack. You talked about the recruitment of obstetricians and gynaecologists - that has been one of big areas locum costs. I am interested in what speciality areas are creating this increased spend in locums, particularly in the north-west.

**Mr FERGUSON** - Can I take that question on notice?

**CHAIR** - Yes. Can we have the same detail for agency nurses to complete the picture?

**Mr FERGUSON** - Yes, we have that. I am going to make sure it is up to the standard.

**CHAIR** - If you don't have it available now, minister, we could ask you to table it perhaps later this afternoon.

**Mr FERGUSON** - That's another idea. We do collect it, but I don't have it with me.

**CHAIR** - Either later today or we will put it on notice.

**2.2 Non-admitted Services**

**CHAIR** - Minister, as I have often raised in this area, rural hospitals are an underutilised resource in many respects, and there are a number of reasons for that. Your occupancy rate still sits fairly low in the target for this year - 'target' is an unhelpful word in this in many respects.

**Mr FERGUSON** - It is actually.

**CHAIR** - Yes. The number you expected it to be for 2017‑18 was 55 per cent; do we have an updated figure on that?

**Mr FERGUSON** - Yes, I do. I shared this with the other committee yesterday and I can tell you -

**CHAIR** - We don't listen to what the other committee does.

**Mr FERGUSON** - You would have been too busy with my friend, the Treasurer.

**CHAIR** - That's correct, and sleeping in between.

**Mr FERGUSON** - I am sure you won't want to write all of these down but if you are satisfied that *Hansard* can capture it, I can give you current rates of occupancy across all our 15 rural sites. I think I gave them to you last year as well. I was advised yesterday that the figure in the budget papers of 4700 was an error from last year's budget. Because of the way Treasury requires these to be set out, that error sits in this year's paper as well. I just wanted to note that.

**CHAIR** - The separations were not expected to be that high - is that what you are saying?

**Mr FERGUSON** - Correct.

**CHAIR** - There is always one mistake in the budget papers.

**Mr FERGUSON** - No-one picked it up last year. Jen Butler in the other place picked it up this year and I gave her a gold star.

The figures are as follows: to the end of March 2018, average occupancy through the period ‑ not at that point, through the period nine months to the end of March - was: New Norfolk District Hospital, 82 per cent; Midlands Multi-Purpose Health Centre, 58 per cent; Beaconsfield, 66 per cent; Campbell Town, 73 per cent; Deloraine, 61 per cent; Flinders Island, 30 per cent; George Town, 64 per cent; North East Soldiers Memorial Hospital, 49 per cent; St Helens Hospital, 40 per cent; St Marys Hospital, 47 per cent; Queenstown, 56 per cent; King Island Hospital and Health Centre, 37 per cent; and Smithton District Hospital, 35 per cent.

**CHAIR** - I tried to capture most of those. It is hard to write them down.

**Mr FERGUSON** - Separations to that nine-month period were, 3112.

**CHAIR** - What is the likely number of separation, given that 4700 was off the mark?

**Mr FERGUSON** - Given that it is three-quarters at 3000, you would expect around 4000 with four-quarters, or 4400.

**CHAIR** - Which is similar to the actual of the last year.

**Mr FERGUSON** - Yes.

**CHAIR** - There are some here. New Norfolk seems to have a fairly high occupancy rate, but there are others. King Island and Flinders Island are a bit unique in that you only have a certain number of people over there, but Smithton, St Marys and St Helens are all in the low 30s or mid‑30s to 40s. Is there any way to enhance the capacity of using these to take the pressure off the acute section in admitted patient services?

**Mr FERGUSON** - It is an important question and I am clarifying some advice. Clearly, in a number of locations there is what you might describe as quite low occupancy, but that is not necessarily a slight on the hospital.

**CHAIR** - I am not suggesting that for a second.

**Mr FERGUSON** - I know but obviously there is a wider audience. I wouldn't want people to be fearful - 'Gosh, only 30 per cent, what does the future look like?' They are staffed according to expected occupancy but in a number of cases like Flinders Island, the jewel of Bass Strait -

**CHAIR** - That's King Island.

**Mr FERGUSON** - There is a lot of unoccupied space, which should not be seen as a particular problem.

**CHAIR** - That is why I separated those out, minister, but ones like Smithton, St Marys, St Helens, even Scottsdale NESM.

**Mr PERVAN -** Smithton is a case in point. It comes up often in conversations with the Commonwealth. The figures the minister has just provided reflect state-funded activity. There are other beds at Smithton which are purely Commonwealth-funded or are part of the palliative program. We have been at Smithton when our data shows it has only been 30 per cent occupied and every bed has been full. That is a reflection of the different funding models that go to make up the beds. That is just another complicating factor in some of those facilities.

**CHAIR** - Is it possible to get more accurate figures of occupancy, even though some are funded by the Commonwealth? Obviously the palliative beds are flexible at Smithton, so they might only have one palliative patient, or they might have five.

**Mr PERVAN** - We would have to look into that because they are different datasets.

**CHAIR** - It would be interesting to know how well utilised they are, particularly if there is a backlog in the North West Regional Hospital in Burnie, for example. For people living in Smithton particularly, they could be cared for there.

**Mr FERGUSON** - I certainly agree with that. If it is clinically appropriate, we definitely encourage that. I know our staff do. We try always to encourage families and the patient to see the merit in considering a stay in Smithton, even if they don't live in Smithton. Sometimes -

**CHAIR** - Particularly for some of the medical patients. What was that, sorry?

**Mr FERGUSON** - Sometimes they are nicer for the patient - a more sedate environment with nice gardens to walk in. The best example of that was George Town. It is a beautiful little hospital. I visited there and had a conversation with a lady who lives in Lilydale. At first she was not sure about the idea of going to George Town, freeing up a bed at the LGH. She wished she had gone there much sooner, once she arrived there and realised how nice it was and how good the food is.

**CHAIR** - Maybe we need a bit of a PR campaign, minister, within rural hospitals?

**Mr FERGUSON** - We are doing that. We have even developed new materials to show families the gardens and nice rooms that are available. People are not always aware that some of our rural hospitals are very classy, good-looking, clean and safe, and have a nice outlook.

**CHAIR** - Some of them have had a lot of money spent on them and are continuing to.

**Mr FERGUSON** - George Town is a very good example of that.

**CHAIR** - Also St Marys and St Helens. Smithton has had a fair bit.

**Mr FERGUSON** - Yes.

**CHAIR** - King Island is getting more.

**Mr FERGUSON** - Yes.

**CHAIR** - Do you have the expected outpatient attendance numbers? Do you have the expected number rather than a target number - 2017‑18 is quite a bit above 2016‑17? Do you have a more up-to-date figure on that?

**Mr FERGUSON** - On attendances?

**CHAIR** - Yes.

**Mr FERGUSON** - We can certainly get the information. I don't recall seeing that in my preparation for today. I will provide on notice to you outpatient attendances for 2017-18 to 31 March. I will just need to ensure it is available. I am sure it is.

**CHAIR** - The other one is cancer screening, particularly for eligible women screening for breast cancer. I am interested in how that is tracking. You were hoping to get 90 per cent of women assessed within 28 days of screening -

**Mr FERGUSON** - Could I suggest -

**CHAIR** - Is that public health? It is under screening.

**Mr FERGUSON** - Yes, it is a THS service. It is not to the end of March so I do not need to take this on notice. The advice that I have says that the THS is expected to deliver 564 475 outpatient attendances, which is the same figure in the target. This indicates that the target is based on an awareness of what the expected amount will be. I am sorry, but I do not have a number to March.

**CHAIR** - That is all right. That is the full year you are talking about?

**Mr FERGUSON** - Yes.

**CHAIR** - No-one else can turn up in the next few days to muck up your figures.

**Mr FERGUSON** - I don't mind if they do. What I mind is if they cancel it.

**CHAIR** - What is the rate of cancellation on that? Not so much cancellations, but the do‑not‑shows that are more of a pain.

**Mr FERGUSON** - I don't have that with me but I will get it for you after lunch. You were asking about cancer screenings?

**CHAIR** - Yes. They are a pain though, the do-not-shows.

**Mr FERGUSON** - They are, doctors and nurses complain to me about those.

**CHAIR** - Or if they come in for surgery and they have had a big breakfast on the way. They are the other ones you want to send -

**Mr VALENTINE** - Or if they come and it's been cancelled.

**Mr FERGUSON** - Where would you like to start on cancer screening?

**CHAIR** - I am just interested in how many women have been screened for breast cancer - I am not sure where your figures are up to - and a follow-up.

**Mr FERGUSON** - I have this by calendar year. It is a little bit different to our other stats. This is possibly better actually because you are getting them for the full year, not nine months. In 2017, the number of eligible women screened was 32 420, which compares favourably to the previous year, with 31 292. More than 1000 extra eligible women have been screened in that time. Casting back, that is the highest figure in the last five years.

**CHAIR** - It is interesting these are on financial years, which makes it a bit hard to compare.

**Mr FERGUSON** - I am pleased to share this information with you. It stands to reason given we now have two buses on the road. The Government has funded one new one and renovated the older one.

**CHAIR** - I saw the older one arrive on King Island the other day.

**Mr FERGUSON** - Fantastic, that's very positive.

**CHAIR** - Are the women who require follow up assessed within 28 days of screening?

**Mr FERGUSON** - That is pretty much a high-water mark; that's up to 91.7 per cent for calendar year 2017.

**Mr VALENTINE** - With respect to cancelled appointments, a few years back, sitting in the clinic area, people were coming up and being told, 'Sorry, that's been cancelled today, you will have to come back or we have to reschedule'. Do we have any figures on those sorts of events, how many times patients have turned up for a service and it has been cancelled because of some situation in the hospital such as either the surgeon not being available or a bed not being available?

**Mr FERGUSON** - We actually report this, Mr Valentine; it is something this Government has done as a measure of transparency. We have put a lot of these stats online. The data are updated not just quarterly but monthly. The jargon for this is 'hospital-initiated postponements' and they are demonstrated on the www.healthstats.dhhs.tas.gov.au website, which demonstrates the numbers by the month.

**Mr VALENTINE** - Do you have percentages?

**Mr FERGUSON** - They are not percentages; they are in absolute numbers and they range over the last 12 months from as high as 275 to as low as 169 in December last year.

**Mr VALENTINE** - Out of a total of how many?

**Mr FERGUSON** - There were 17 500 surgeries, weren't there? This is elective surgery hospital-initiated postponements.

**Mr VALENTINE** - That is for elective surgery only?

**Mr FERGUSON** - Yes. That is in a calendar year and it just happens that our volumes over those two years varied between 19 205 and 17 500, so it's a number in between if you would like to compare.

**Mr VALENTINE** - So you don't have it for general clinical presentations?

**Mr FERGUSON -** I know we have it, but I don't have it here. I am happy to take outpatient postponements and no-shows.

**Mr VALENTINE** - That shows both sides of the story.

**CHAIR** - We will come back with Health after lunch.

Some members have questions on 1.3, Emergency Department Services. Estimated outcomes show little increase from what we have spent this year. It is probably a decrease. What was spent and what is happening now? There is continued pressure on our emergency departments. Do you believe you can manage the demand without significant increase funding?

**Mr FERGUSON -** It is a great credit to our staff. The pressure on our emergency departments can be proven with numbers. There is no question demand is up and that is represented in two ways: presentation, either ambulatory or by ambulance, has increased.

Not only has the number of presentations increased but also the number of presentations that require admission has increased. It has climbed from about 25 per cent to approximately 30 per cent. Even with all of this and last year's record flu season, our performance in relation to the four‑year target had deteriorated, but not by much.

It is testimony to our staff, how magnificently they manage and support patient care. The other broad point is you wouldn't expect to see many changes in the Emergency Department Services funding because they are and always will be fully staffed. The problem shows up in the emergency departments, but is a whole-of-hospital patient-flow issue. The problem manifests itself in the ED. You wouldn't expect to see particular changes there for those reasons.

**CHAIR** - You are spending $2 million less in the Budget this coming year than was actually spent last year. According to the information, $122.034 million was spent in this current year, and in this Budget it will be $120.214 million, so it is $2 million less.

**Mr FERGUSON** - There is certainly no cuts there, but our financial people will speak on this. It is not a cut; it might look like one or could be suggested that it is, but it isn't because to make a cut you would have to let people go. There would be questions about overtime, double shifts and extra staff being called in during periods of peak demand. An example is issues with locums, which at the LGH added to last financial year costs.

**CHAIR** - That information about speciality areas will be handy and help inform this.

**Mr FERGUSON** - I will come to that. Replacing locums with permanent staff results in spending less on the staffing, but you still have a full roster. The opportunity is in response to where the problem of the need for more acute care beds, which we are funding in admitted services. I think Mr Finch might have been asking about LGH recruitment.

**CHAIR** - Mr Finch was asking about that.

**Mr FERGUSON** - At the beginning of April this year, 4.76 FTEs emergency medicine specialist positions were filled. Approval was received for market allowance payment to attract and retain. It also applies to other staff, for retention purposes. Since this approval, three full-time FACEM positions have been filled: Doctor 1 - I am not going to mention the doctors' names - is due to commence in August this year. Doctors 2 and 3 are due to commence in February 2019. Contract negotiations have been initiated with two further FACEMs who have previously worked at the Launceston General Hospital, both seeking part-time appointments.

**CHAIR** - How many acute psychiatric patients have been in the Emergency Department awaiting beds for more than four hours, total stay, from the time they arrive, and how long were they there, over the last 12 months?

**Mr FERGUSON** - I do not have that information. I was asked the same question yesterday. I took that on notice and I don't have that advice. I am happy to take it on notice here if you would like me to.

**CHAIR** - Yes.

**Ms LOVELL** - While you are taking that on notice, can you include the longest period of time any mental health patient has waited in the Emergency Department at any of the hospitals in the state?

**Mr FERGUSON** - I am taking it on notice. I will see what I can do. The issue I had yesterday is that data wasn't presented to me broken down by DRG or anything like that. It was emergency departments in general, which I spoke to a moment ago.

**CHAIR** - If you can't do it today, we will write to you.

**Mr FINCH** - I am curious about the percentage of patients with private health insurance who have used the Launceston General Hospital accident and emergency department.

**Mr FERGUSON** - I do not know the answer to that.

**Mr FINCH** - As well, what percentage of patients with private health insurance have used the rest of the LGH? I am happy to take it on notice.

**CHAIR** - Rather than the LGH, across all hospitals?

**Mr FINCH** - We can ask for that, if you like. I am concerned with the LGH, but it could be across all hospitals.

**Mr FERGUSON** - Yes, we will send that to you and the committee. The secretary made an important comment. The information may have a limit on its usefulness. If you are privately insured, live in Launceston and present at the LGH ED, you may be well aware you are under no obligation to declare your private insurance status and it might not be full data. We will be able to give you some indication of those who are electing to use their insurance in the hope they have access to a TV and a newspaper. I am happy to provide the statistics.

**CHAIR** - There are a number who don't declare, I assume?

**Mr FINCH** - I think that is going to change. I have a sense people are going to be opting out of private health insurance to a certain extent because of that, the changing dynamics of costs and so on.

**CHAIR** - If they built a nice new private hospital right next door, they might not.

**Mr FERGUSON** - I am happy to say here, as I have done in other places, that there is a value proposition for the privately insured to consider, given that in Launceston there isn't access to the range of the private services people in Burnie and Hobart have access to, as privately insured. There are shortcomings there. Now it is on the record, Calvary is seeking to develop a new hospital in Launceston and, not that I am trying to bring up that subject matter now, there is opportunity for new models of care to be considered. If done well, it could add to the value proposition for private insurance.

**Ms LOVELL** - Minister, how many emergency department staff, across all hospitals and all roles, have submitted a claim for workers compensation in the last 12 months? Specifically, how many of those were for stress and mental health-related conditions or injuries?

**Mr FERGUSON** - I do not have that information and nor am I taking it on notice. I can give you workers compensation and stress-related across the workforce.

**Ms LOVELL** - So not specific to emergency departments?

**Mr FERGUSON** - No.

**CHAIR** - You will give that to us now?

**Mr FERGUSON** - If you want it now, I will give it to you now.

**Ms LOVELL** - Sure.

**CHAIR** - Maybe we could come back to that when Mr Reynolds finds it. Do you want to move on to your questions?

**Ms LOVELL** - Yes. Minister, I am aware there was discussion about this yesterday and I wanted to explore it with you a little further. There was a commitment to introduce a psychiatric emergency nurse in the Launceston General Hospital Emergency Department. My advice is that during the discussion yesterday a firm commitment was not apparent. Is it no longer the case that the role will be trialled at the Launceston General Hospital?

**Mr FERGUSON** - I don't mind reflecting on yesterday's conversation because your Leader was trying to force me into a corner and make me say things, even though I was trying to be helpful and constructive in the process. It was a disappointing exercise where I offered up what I was aware of and somebody tried to walk me into a firmer position, which I didn't have at the time.

The Government has been very open-minded on this. In fact we saved the PEN nurses at the Royal Hobart Hospital when their temporary federal funding ran out and the previous government had not provided for their future employment. We did. We stepped in and we protected that. It is now a structural part of our budget. The same model has been actively considered at Launceston. That is what I said yesterday. I didn't rule it in or out, one way or the other.

However, I have taken further advice, and I am advised that the THS has agreed to a pilot of the PEN nurse model in Launceston, which is a good thing. It will be trialled as a pilot and no doubt evaluated for its effectiveness. It is my hope and expectation that it will provide better care and more support, particularly to psychiatric cases that present at the LGH ED.

**Ms LOVELL** - Can you give us a time frame on when that trial will be implemented?

**Mr FERGUSON** - My advice is that it is out to recruitment at the moment.

Regarding the question on workers compensation claims and the stress‑related subset of that - this is for THS; to be helpful, I am also going to give you last year's equivalents: for the year to 31 March 2018, all claims for workers compensation across the whole organisation was 325; the previous full year was 430. These are new claims. That doesn't mean there weren't other claims that ran over other financial years. As a subset of that, across the organisation there were 49 stress-related claims in the nine months to March 2018 -

**CHAIR** - New claims?

**Mr FERGUSON** - Yes. New stress-related claims. That compared with 53 for 2016‑17. I have some notes here; I don't know how useful this is. Claims described as new claims received in the period due to organisational changes figures have been remapped for comparison purposes. I suppose that means the comparison is genuine.

**Ms LOVELL** - My question was about emergency department staff and you said you are not going to give that. Is that because you don't have that breakdown or because you are not willing to share that?

**Mr FERGUSON** - Because it is not available.

**CHAIR** - One more for me in this area going back to performance information on page 127. You have ED patients who are admitted, referred for treatment or discharged within four hours, which is the national benchmark. Do we have an updated figure on what we expect the percentage to be in 2017‑18?

While you are looking for that, minister, do you collect data on how many of those returned with an exacerbation or development in the condition they presented for and were at home - the ones who were discharged, not the ones who were admitted because they would be in hospital?

**Mr FERGUSON** - I'm quite happy to take the latter part of the question on notice and report back because I know we have the readmission rate. You have always been interested in that. I don't believe we will be able to commit to doing that for people who had a pathway through the ED. I don't believe we collect that. That is a fair subset.

**CHAIR** - The ones that went home?

**Mr FERGUSON** - No. We have never had those data.

**CHAIR** - You don't know the readmission rate to admitted patients? You don't look at the ones from the ED?

**Mr FERGUSON** - I can commit to you that we will take it on notice and report back on readmission rates from the system in general terms - from admitted patients who have been discharged and then were readmitted within 28 days.

**CHAIR** - Are patients admitted to the ED?

**Mr FERGUSON** - No, patients are not admitted to the ED. They are admitted to wards.

**CHAIR** - I am just clarifying. My real concern here is that the expectation for patients is four hours and you are out of here. I hear from constituents, as I am sure other members do, that they went to the ED and were sent home within the four hours, but their condition worsened or exacerbated to the point where they had to return for the same or a similar condition. It wasn't like they went home and then broke their leg. They had to come back after they'd had an asthma attack, for example. I am really interested in the readmissions to DEM from discharge. This is an outcome of care and if this is not recorded, it really needs to be.

**Mr FERGUSON** - Again, they are not discharged because they are not admitted.

**CHAIR** - That is what I am saying. It is representations to the DEM.

**Mr FERGUSON** - I understand and I believe I don't have access to those data, but we will have no difficulty in seeking it.

**CHAIR** - I am happy with readmissions but I would like to see that reported as an outcome measure of the care they received in the DEM in the less than four hours they were there.

**Mr FERGUSON** - How do we do this? Do you write it down and write to me?

**CHAIR** - You don't have it at all? Is that what you are saying? Then there is no point asking.

**Mr FERGUSON** - That is what I am saying. I don't have either of those data, but I know I have access to data on readmission rate because it is regularly recorded. I think we report it publicly.

**CHAIR** - It's not in the budget papers this year but if we could have the readmission rate at least. Would you look at that for the future, putting in a performance measure around that? It is an outcome measure.

**Mr FERGUSON** - You have known me a fair while now.

**CHAIR** - I know you do things I ask at times.

**Mr FERGUSON** - I do things I promise.

**CHAIR** - The dental care for women who are pregnant in the north‑west was an excellent initiative. I have commended the minister a number of times on that and the positive outcomes it has created for women in the north-east.

**Mr VALENTINE** - On ambulance ramping prior to the DEM, I don't know how you include that in emergency medicine, but it must have an impact on the way the place operates.

**CHAIR** - Is that more appropriately asked under ambulance services, minister?

**Mr VALENTINE** - It is in relation to patients being cared for in ambulances, so I don't know if that is an ambulance service thing or not.

**CHAIR** - What is the minister's view on this? Do we ask it now or in ambulance?

**Mr FERGUSON** - At the ambulance output, I will have the chief executive of Ambulance Tasmania at the table.

**Mr VALENTINE** - One is on ambulance and one is on patients. I am happy to take it whichever way. What impact is it having on the RHH Emergency Department with patients having to be treated in ambulances? What complexities is that causing?

**Mr FERGUSON** - I am comfortable discussing the impact on the ED now. We could speak about what it is like. There clearly is an impact during periods of peak demand. Nobody wants to see ramping, including me.

**Mr VALENTINE** - Can we get some numbers on the patients who are waiting to get inside to be treated properly, or who are being treated in the ambulance because they cannot get inside?

**CHAIR** - Their care is transferred from the ambulance staff to the clinical staff in the DEM?

**Mr VALENTINE** - I do not know.

**Mr FERGUSON** - When a patient is ramped, obviously they are in the care of ambulance.

**Mr VALENTINE** - They are. So you do not have occasions where ED staff are going to the ambulance to care for them?

**Mr FERGUSON** - Yes, we do. I am sure colleagues work together; that is a general point. I am not a clinician so I am very careful not to be too descriptive about things I am not qualified to discuss. However, at the Royal Hobart Hospital we have a four-bed ambulance offload area, which is a four-bed treatment space where -

**Mr VALENTINE** - Is that an EMU? Is that what they call the ambulance?

**Mr FERGUSON** - No, it is not. It was a four-bed unit in the ED that was closed by the previous government and we re-opened it for a different purpose. The purpose was for treating patients who would have otherwise been ramped in an ambulance. They are under the care of a nurse. Is it medical as well, or just a nurse? Probably both.

**CHAIR** - Not just a nurse, minister.

**Mr FERGUSON** - I mean, not limited to a nurse. My mother's a nurse. I love nurses.

**CHAIR** - It is like 'just a mother' - we don't say that either.

**Mr FERGUSON** - I probably should have gone back a step. They are under the care of the ED, but they are in a four-bed unit, the only purpose of which is to support the ambulance offload delay.

**Mr VALENTINE** - Can we get some figures on that?

**Mr FERGUSON** - That is what it is funded to do.

**Mr VALENTINE** - Can we get some figures on the numbers of patients who are going through that unit because they cannot be loaded into the department? If I can put it that way.

**Mr FERGUSON** - In your mind, you can imagine the layout of the ED.

**Mr VALENTINE** - Yes.

**Mr FERGUSON** - The ambulance offload unit is central to that. It is more or less in the middle of it. The care is transferred from the ambulance paramedic staff or volunteer ambulance officers to the care of the ED and the ambulance staff leave.

**Mr VALENTINE** - So they are going through triage?

**Mr FERGUSON** - It is a transfer of care between from the ambulance to the Royal.

**Mr VALENTINE** - So it is private triage?

**CHAIR** - Can I just clarify the operation of this? Does every ambulance that has a patient arriving at the Royal go through that space to offload their patient either into the corridor or -

**Mr FERGUSON** - No.

**CHAIR** - So it is only the ones who cannot directly go into the DEM?

**Mr VALENTINE** - Because there is a block or whatever reason.

**Mr FERGUSON** - Because there would be bed block, yes.

**CHAIR** - That is the number you are after?

**Mr VALENTINE** - That is the number I am after.

**CHAIR** - The number of patients who are cared for in that area because they cannot directly enter the DEM?

**Mr FERGUSON** - It is a really interesting question. I don't know the answer. I have never seen a performance statistic on that or an occupancy statistic on it. It is funded around $1 million a year to staff those four beds around the clock, 365 days a year. There is an instruction to THS that all they can use it for is to maximise availability.

**Mr VALENTINE** - Same in LGH?

**Mr FERGUSON** - No.

**Mr VALENTINE** - Only Hobart?

**Mr FERGUSON** - That is the only place we could find where four beds had been shut in the ED, so we have done that. Naturally it would be prudent to always keep an eye on it. I will undertake to find whatever statistics I can. There may not be an available stat on the occupancy of just those four beds in the ED.

**CHAIR** - Ambulance may keep some figures. We could ask them because they are the ones that are using it. We might need to continue Output group 2.4, Community and Aged Care Services, after lunch

**Mr WILLIE** - I imagine there is a strong allied health element to this line item of the Budget. My question concerns the interface with the NDIS and whether the Government has a plan for people who have a disability but won't qualify for the NDIS. Has there been any research done into the numbers? I guess there is a question for the broader health system because a lot of this will be picked up by the health system: what is the Government doing to ensure that people who may receive a block-funded service now will continue to get the care that they need?

**Mr FERGUSON** - I will ask the secretary to address this question.

**Mr PERVAN** -It is an issue being addressed by the Disability portfolio, which moves into a new department on 1 July, and it has been raised as a background risk to the full implementation of the NDIS for about three or four years now. It has also been raised by health ministers nationally as being a risk intersecting with the health system. As you noted, especially with people with more complex disability, if they can't be supported in the community, there is only place where they are going to go.

A great deal of work is being done, largely in Victoria and New South Wales, to quantify what that risk is. We were successful, in part. I would also like to highlight my colleague, the chief psychiatrist, and the work he did in the development of the Fifth National Mental Health Plan to get psychosocial disability named as a risk and an issue to be dealt with nationally under the Fifth National Mental Health Plan. That part of the risk has been identified and partially covered by the Commonwealth. But the whole issue of complex disability is the one we are working through with the NDIS and the NDIA in terms of how those people will be supported in the community.

At the moment, there is an effort to try to make the NDIS work as a going concern for people with disability rather than just to say that if they are disabled to that extent, the health system becomes their default disability service provider because that kind of lets the Commonwealth off the hook. A national discussion is going on into how we better support people in the community with complex disability.

**Mr WILLIE** - I guess my question then to the Health minister is: when are you going to hold the federal government to account with this interface with the NDIS to ensure the state doesn't end up picking up the tab, and that the NDIS reforms are successful in supporting people with a disability with the care they need?

**Mr FERGUSON** - Plainly that would be a matter for you to address with the Disability Services minister and also the Premier because he is the signatory on the national agreement on this. I am not avoiding the question; it is not in my portfolio. Suffice to say, the Government has maintained a very strong posture on this throughout the negotiations on the NDIS and how Tasmania will participate in that to ensure we get the best value for our community. The Government has already taken a number of steps - again, mostly outside my portfolio - that are extra adjustments to ensure the transition is a positive one.

Just in the last three days, there has been a very positive announcement from the Commonwealth in regard to psychosocial support over the next four years, which was one of the gaps that certainly fits within the category you are concerned for, quite rightly. For people who are not eligible for NDIS but have mental health issues or other social needs, I feel that is a much more positive pathway for them. You might be pleased to know as well that other states are required to contribute or to show effort in this space to qualify for that federal funding. There was a lot of interest last year from Mr Gaffney in our community packages of mental health care. I am pleased to tell you that $11.6 million-investment we made last year has been deemed by the Commonwealth to meet our end of the bargain in qualifying for that extra funding. That was a real tick for our Mental Health Services, and the Government's decision and the staff who deliver that service to see that has been accepted as in kind.

**Mr WILLIE** - My next question concerns federal reforms at the interface with aged care and My Aged Care reforms. In the performance indicators on page 127, for aged care assessments there is a footnote on page 148 that says -

Targets are based on previous years' data and year to date projected figures. They indicate that assessment numbers have increased to a level that was occurring between 2014-15, prior to the major reforms which impacted the Aged Care Assessment Team's work processes.

Can we have more explanation on why the figure has jumped? How are the major reforms impacting on the Aged Care Assessment Teams?

**Mr FERGUSON** - I would ask the secretary to respond to your question. It's a fairly broad policy for us, except for some regional locations. Tasmania, unlike the case some years ago, is no longer a regulator of aged care. We are a provider, particularly in some regional places where there is no private or non-governmental care provider available. For example, we provide aged care in Oatlands, Campbell Town and Flinders Island. We are no longer involved in regulation, but we are involved as a provider. We also handle assessment services through the Aged Care Assessment Teams and are a contracted provider by the federal government. That is the historical and current context of what we are operating in. As for disruptions, I am going to ask the secretary to speak on this.

**Mr PERVAN** - One of the most successful reforms in aged care in Australia has been the implementation by the Commonwealth Government of the home care packages which in Tasmania in particular rolled out faster than we could actually assess people. They have been immensely popular, and there is a knock-on effect on the viability of some of the smaller Commonwealth-funded nursing homes.

The reference is that there have been major changes to the allocation of home care packages in 2017, with the establishment of a national queue. The department is monitoring Tasmania's access and working with the Australian Government to refine the processes related to the operation of the queue. That's been the disruption. It is not a national call centre, but there is a national process we are having to work with as opposed to what was in place. Before that, there was a local assessment and a local queue that worked off the back of our allocation. This was regional for all the home care packages.

The Tasmanian Government operates the Aged Care Assessment Program on behalf of the Australian Government. The federal budget contains funding for the AG to design a single aged care assessment framework for a national assessment workforce from 2020. While we have a national queuing mechanism, there is still local variation in terms of the assessment work carried out and how the local frameworks work. Much like the National Disability Insurance Scheme, they are heading for a single national system we will all have to work with in 2020.

**CHAIR** - We will come back to this after lunch. The minister has requested we have a short lunch break.

**The committee suspended from 1.05 p.m. until 1.40 p.m**.

**Mr WILLIE** - We were talking about aged care reforms at the federal level. Does the Tasmanian Government have statistics for the total number of people waiting for home care packages? How is the state Government holding the federal government to account for those delays, given that if there are delays, potentially a lot of Tasmanians will end up in the health system from not receiving that care on time?

**Mr FERGUSON** - Mr Willie, as we have indicated, obviously you're asking me for an opinion or an expression on what the state Government is doing about another government. It is relevant to my portfolio but not really in the output group. We are more than up to the task of raising issues when required. One of the important roles we have here is ensuring that the assessment process, which is the role the state public service is contracted to provide, serves its purpose, noting there are also benefits in ensuring our service is looking to provide those assessments in the shortest possible time frame.

When that assessment yields that a person might need a home care package, or even a residential aged care package, that can be processed. If you are asking me whether I will look into the waiting times and I raise them with my colleague federally, the answer is yes, I would be happy to undertake to do that.

**CHAIR** - The numbers you also asked for.

**Mr FERGUSON** - What numbers are you actually asking for?

**Mr WILLIE** - People who are waiting for a home care package in Tasmania

**Mr FERGUSON** - Due to changes in the aged care sector with the introduction of My Aged Care system from February 2016, Tasmania no longer manages waiting lists for aged care services. This function is performed centrally on the My Aged Care system. The Australian Government publicly releases data on the number of clients seeking home care packages in the national queue and it has been doing that since 31 December last year. I am advised that - because it is publicly available on that website - 2474 people are waiting to be assigned a home care package in Tasmania.

I am concerned the document I am looking at is an attempt to summarise what is on that public list. I will seek to clarify that because it is data not held by this Government. I am undertaking to determine exactly what the figure is and understand what the waiting times are, which is probably more important than the number. I will ensure the Government raises a concern with the federal government if we agree with you that there is a concern. How does that sound?

**Mr WILLIE** - That sounds fair enough, thank you.

**Mr FINCH** - Minister, the increases in Community and Aged Care Services, as highlighted on page 141, note 4: could you explain the Community Rapid Response? I know the program supports people who need short-term intermediate care in their homes or in the community. Does it involve doctors as well as nurses?

**Mr FERGUSON** - For detail, I will go to the secretary but I will give you an overview, Mr Finch. It has been an innovation of our Government in the last four years. It is a new service that first commenced in Launceston as a replacement for what used to be called Hospital in the Home. That was cut by the previous government before the 2014 election. We promised to restore it and we have done that through the new model, which arose out of a lot of consultation with GPs.

In the new model, and the secretary will fill in any gaps here, the funding provided for Launceston is to run it on and to keep it, because it was run as a pilot and we are funding it to be everlasting. The second thing is that in the Budget we have allocated $5.6 million each for the south and the north-west to pilot it in those regions. We will subject those pilots to an evaluation, as we did in Launceston, to ensure they are delivering the intended outcome, which is to give health care to people who need it, and who would otherwise become an emergency department presentation.

**Mr FINCH** - Will the program continue in the north while those pilot programs go on in the south and the north-west?

**Mr FERGUSON** - Correct. It has gone through its evaluation already. The advice to me was that it should continue. It is providing an effective service. Eighty-seven GPs participated in Launceston and it resulted in 358 referrals. The service is in THS. GPs, with the patient in front of them in their room or at the aged care facility, for example, are the people who will make the referral to the Rapid Response Service.

The Rapid Response Service predominately comprises nursing and some allied health professionals, which makes a commitment to the GP that they will visit the patient within four hours. GPs feel confident they can refer to that service knowing the promise will be honoured. It is intended the patients they refer would be those they would otherwise have referred to an ED. It is avoiding ED presentations, and in the proof of concept stage. I have given you some data already, from May 2016 to July 2017; it also resulted in 3878 service events, or visits. They were mainly for patients in acute need, with minor complexity, requiring responsive, high‑acuity, high-frequency clinical care to avoid ED hospital presentation. He is a mutual friend of ours who will not mind me mentioning his name because he spoke to the media about the project, but Rex Sainty, who has had his own battles, has been receiving care through the Rapid Response Service and raves about it. It means that instead of being sent into the hospital for his health care, he has received it at his own home, with visiting nurses and nurse practitioners. We can only say it has been a success and it has been a positive experience that we are now looking to build into the north-west and the south.

**Mr FINCH** - An assessment is made as to how frequent the visits are by the nursing team. Is that how it works?

**Mr FERGUSON** - By the nursing team, or by the GP as well?

**Mr FINCH** - Or GPs. There is the assessment of the patient at home, after four hours, and then what occurs?

**Mr PERVAN** - It is a comprehensive assessment by the nursing team and a discussion with the referring GP and any hospital services that might be involved with the patient. It is a wraparound service, as we would say. Building on what the minister said, the reason we made the Launceston service permanent - but the $5.5 million each to the greater Hobart area and north-west region for a two-and-a-half year pilot across is two jurisdictions - is that in my experience with these acute diversion services, you need to make sure you have all the relationships organised between the GPs, the hospital and the nursing service driving it, and to make sure your service meets the needs of these particular patients.

With the Launceston patient, we found on evaluation that we had people who had an acute need with some complexity. You need to make sure the nurses are carrying out the right assessment for that, and they are not providing a nice home care service while the person's complexity or their particular condition is deteriorating while they are being kept at home and they end up back in hospital. It is about getting the service right, having an evaluation at two years to make sure we can make some detailed adjustments to the service, ensuring it fits with that region and its population. That is why it has been structured the way it is.

**CHAIR** - Footnote 10, relating to this area, says, 'Work is currently underway to reform the community nursing service delivery model.' What does that reform involve? Reduced expenditure is predicted over the forward Estimates and this is currently in the next year. How are we saving money if we are still investing in community nursing?

**Mr FERGUSON** - The secretary will address the point.

**Mr PERVAN** - The reference in the footnote is a reflection of work done to refine the clinical stream around primary and community care across the state. The initial work that proceeded to make it a statewide service or stream identified complexities that exist between the north-west, the north and the south. The capacity of the THS in the three subregions or those three areas is quite different. There is a much greater proportion of primary and community care resources on a per capita basis in the north compared to the south. It is about refining the service delivery model to optimise what we can produce or the value we can obtain from the local community nursing resources we have.

**CHAIR** - The concern is there should not be a reduction in community nursing across the state, particularly in the regions where there is demand, and particularly timely access to care.

**Mr PERVAN** - There is no plan to reduce community nursing. Everything we are looking at at the moment around acute diversion and acute substitution suggests having a greater presence in the community and trying to depressurise some of the demand coming in to the acute services.

**CHAIR** - That's why I wondered why the expenditure was predicted to fall this current year and the following year. If you look at the expense summary, you have $204.87 million, which is down from $208.225 million, and then down to $196.656 million. I know this doesn't just relate to community nursing.

The footnote mentions additional funding, as the member for Rosevears was talking about, for the Community Rapid Response Service. I am struggling to understand how the expenditure could fall. Minister, could you shed any light on that?

**Mr FERGUSON** - From a policy point of view, the secretary has covered the field so we might be able to get some deeper data mining on the numbers to help explain the fluctuations. There is certainly no withdrawal of effort or change of service that I can point to.

**Mr REYNOLDS** - My information relates to reductions in some Commonwealth payments for MPAs and co-payments. The dental agreement is one where there is a reduction at the moment because we haven't signed up to the final dental agreement. Also the palliative care agreement. It reflects the profile of the Commonwealth payments to the state. There hasn't been a state reduction.

**CHAIR** - We are renegotiating the dental care and the palliative agreements so we could see an increase next year and we will know how much we are getting. Is that what you are saying?

**Mr REYNOLDS** - That is right.

**CHAIR** - Any other questions on 2.4?

**Ms LOVELL** - The document put out by the Liberal Party, *Building Your Future*, contained a very worthy target to have the healthiest population by 2025. I am sure everyone in the room would agree that proper investment in preventative health is crucial in reducing the impact on acute services in the long term and contributing to a healthier population. There is no mention of that target in the 100 Day Plan. What new preventative health measures are there in the Budget to work towards that target?

**Mr FERGUSON** - It is $8 million.

**Ms LOVELL** - Can you point to that?

**Mr FERGUSON** - I can. In Output 3.2. I don't think this is relevant to this output, but I am happy to answer it. The Government will deliver even more funding for community health as part of our recently released health policy. The policy package includes a commitment to provide ongoing funding of $1.1 million per annum to continue to support Healthy Tasmania after the current allocation ceases in 2020‑21. This means that there is more security and increased opportunities to plan and deliver preventative health activities with confidence. That is $2.2 million right there.

The Government will also support community health with a $6.6 million Tasmanian community health fund, which will be used for local groups to upskill volunteers, purchase equipment or deliver preventative health activities that don't quite fit the Healthy Tasmania funding profiles. This fund will be particularly beneficial for rural and regional Tasmanians who may not have access to the same fundraising opportunities as more densely populated area of the state.

Our Health policy also included a $870 000 boost for the Alcohol and Drug Foundation so it can deliver its Good Sports program to 150 more sporting clubs and expand its Healthy Minds program. Both programs are about ensuring local sporting groups are positive environments where members are looking out for each other and healthy lifestyle choices are encouraged and promoted.

There's a fair bit there.

**Ms LOVELL** - So $8 million out of the three quarters of a billion dollars is going to preventative health?

**Mr FERGUSON** - It is more like over $9 million.

**Ms LOVELL** - So $9 million out of three quarters of a billion dollars?

**Mr FERGUSON** - It is $9 million of extra effort for Healthy Tasmania initiatives out of our budget.

**Ms LOVELL** - I have a further question about the Tasmanian Community Fund, but would you like me to wait to the Public Health Services output group?

**Mr FERGUSON** - That would be where it would be funded.

**Mr FINCH** - On the issue of palliative care, are you aware a recent study in Queensland showed a dedicated palliative care facility, which northern Tasmania lacks, costs much less than a bed in an acute hospital?

**Mr FERGUSON** - I am not aware of the study you mentioned, but would not be surprised at the recommendation.

**Mr FINCH** - Are you aware staff working in acute wards at the LGH frequently express frustration at trying to provide adequate care for dying patients and their families while attending to post-operative or acutely ill patients who will hopefully recover and go home?

**Mr FERGUSON** - I am sure there is instances where that has happened.

**Mr FINCH** - That brings me to the situation in Launceston where the dedicated palliative care centre is a 10-bed palliative care centre in Hobart. There is nothing north of Hobart for people who would prefer not to die at home and to be in a facility where they can die peacefully.

We don't have a facility in northern Tasmania. What happens now is that patients are still being admitted to the Emergency Department at the LGH. They are dying in inappropriate areas, like four beds on the medical and surgical ward, with staff who are not skilled in end of life care. Would you be care to comment?

**Mr FERGUSON** - I would be happy to comment. It is of particular interest for me and it's not true there is nothing in the 'north. A range of services are available in the north, and how we link and support the people to get access might be a good place for me to go from here.

There is a private hospital facility at St Luke's Hospital, under the Calvary umbrella. The facility is the Melwood Palliative Care Unit which the closest thing I can refer you that provides inpatient palliative care in single bed rooms away from the busy clatter of hospital trolleys. We have a long-term contract with Calvary, for the LGH to purchase beds from the Melwood unit - I believe it is five, subject to checking. Regional sites might also have access. Public patients are cared for with palliative care in the Melwood unit.

Melwood is a 15-bed unit. I said 5 beds, but it is often the case - and my direction is - that this can be expanded as required. The Government express a general intent that a public patient, who is palliative and coming to their last days should be at the Melwood unit. That is where they should be cared for and the patient should be transferred there.

It is not - and I am not presenting it as - a hospice, but a dedicated unit that includes palliative care among its other services. They do it very well. I have visited quite a number of palliative patients who have passed there. It is a lovely environment and the staff do a beautiful job. I am not presenting it as a hospice because I know many in Launceston would like a hospice along the lines of the Whittle Ward in Hobart, which you mentioned. I can give you a range of other supports that are available in the community, including hospice or palliative care. Palliative care in people's homes is provided as a community service through the Specialist Palliative Care Service, which is a state government service. We go to people's homes and people are supported, particularly those who want to be and who are actively choosing to die at home. There may well be arguments you could make about the need for more, but that is what is provided. It is not true that there is nothing north of the Whittle Ward in Hobart.

**Mr FINCH** - To use your own word though, minister, you did say 'closest'. It is close but it is not that end-of-life palliative care facility we had previously at The Manor in Launceston, which was enjoyed - probably not the right word - but it comforted our community. That facility was available. We lost that and it has been regretted ever since. While the community has campaigned strongly, there is no replacement. Melwood is close to being a replacement but it is not the dedicated palliative care facility required, with the people who are skilled in that area to conduct that care.

**CHAIR** - Is there a question?

**Mr FINCH** - It sounded a bit like a statement, didn't it? The question is -

**Mr FERGUSON** - It is an opportunity for me to say I agree with you. Philip Oakden House closed in 2007. From memory, it was it was a six-bed unit. Three were public and three were private, as I recall.

**Mr FINCH** - With the possibility to expand another four.

**Mr FERGUSON** - I remember walking over the footings which were built to future‑proof it to allow an extra four beds to be built on as well, which would have made it 10. That decision was out of all our control, for a range of reasons, including when it happened. I am aware of the aspirations of many in the community to achieve a hospice again for Launceston.

We did a feasibility study into this specifically during our first term. The feasibility study advised that a dedicated hospice for Launceston is potentially feasible, contingent on some other things occurring. One of those things could be the closure of the Melwood unit at the St Vincent's Hospital but nobody wants that. Even the people who would like a hospice are not calling for that. There are some difficult issues to broker before that future aspiration might be advanced. I can say, and I will be very careful in choosing my words here, and I say it deliberately to give you some indication of where I think this could go: it is Calvary's express intention to include palliative care in its proposed new private hospital for Launceston. On the advice of the Coordinator-General, Calvary's unsolicited bid has now progressed to stage 2, which is a formal sit-down nine-month negotiation between the Government and Calvary. That is a nine-month period where location, service mix and regulatory issues will be explored actively. That provides some sense to you of where opportunity sits.

**Mr FINCH** - Minister, in the meantime there are many suitable buildings within the LGH precinct that could be used while waiting for Calvary to co-locate. The Friends Group has offered the minister a plan for the Allambi Building. Is that not under consideration?

**Mr FERGUSON** - It is not, no. I have taken advice on that. It may well be that people could identify other uses for buildings that have only recently been renovated for their current purpose, but that doesn't solve the problem of the feasibility of the hospice in the first instance, bearing in mind my earlier comments, and unfortunately nor does it provide a solution for the need to then accommodate that range of services and staff in another building. It is a constructive suggestion by the Friends, but it is not one we are able to move on. If I hark back to my earlier comment, the process we are involved in with Calvary is a formal nine-month negotiation in stage 2 of considering that unsolicited bid. I am not putting words in Calvary's mouth. Calvary has said publicly it wants palliative care to be part of the model. Bearing in mind we have an existing contract with Calvary, which is in contract, I am trying to be reasonably direct here that I see an opportunity for it to be a constructive part of the discussions to occur between Calvary and government.

**2.5 Statewide and Mental Health Services -**

**Ms LOVELL** - Minister, you indicated you will be pushing ahead with the plan to move psychiatry into the new K Block, K2 and K3, at the Royal Hobart Hospital. This is despite the Medical Staff Association, the Royal Australian and New Zealand College of Psychiatrists and the AMA all speaking out publicly against the proposal. I will not go through what they have all said because I believe it is already on the public record and I do not want to waste anyone's time, but I have supporting information here. Minister, you claimed you have the support of hospital staff and psychiatrists to move the new ward into K Block. Whose support do you have?

**Mr FERGUSON** - We used to have your support, for a start. We had Labor Party support for this. That is where I will begin.

**Ms LOVELL** - When you refer to hospital staff and psychiatrists, whose support do you have, given the Medical Staff Association, Dr Milford McArthur and the AMA have all spoken out against the move?

**CHAIR** - Is Dr McArthur is speaking on behalf of the college, in his role?

**Ms LOVELL** - Sorry. Yes.

**Mr FERGUSON** - I can see where Ms Lovell is seeking to go. The Government picked up the redevelopment of the Royal Hobart Hospital. Madam Chair, I welcome Dr Aaron Groves to the table. He is Tasmania's Chief Psychiatrist and Tasmania's Chief Forensic Psychiatrist. We welcome him. We recruited Dr Groves in the latter part of last year from South Australia; he previously was located in Western Australia. He has been a welcome addition to our state, including and especially in the work he is doing on the mental health integration taskforce. Dr Groves may be able to support me in answering some of these questions.

I will go back to the beginning. The funding in the Budget confirms the Royal Hobart Hospital redevelopment remains on track for completion in the middle of next year. Unfortunately, I am going to have to tell you some of your history, Ms Lovell, because it was the Labor Party in government that made the quite important decision to demolish B Block, where mental health was being provided - psychiatric care - and for those services to be accommodated in the new K Block tower. History does record that the project was bungled. When we came to office in 2014, we had some initial advice that it most likely could not have proceeded at all.

We put the project on hold for six months while we put the taskforce in place. The taskforce has even reported to this committee. We found a way forward. We provided the extra funding of $70 million. Instead of sending mental health patients out of Hobart's CBD, which the plan of Ms O'Byrne, your colleague, the taskforce found another way for those acute patients to be accommodated on the Royal site. Doctors were saying very strongly it would be wrong for those acute care patients to be taken away from the range of other critical services only available at the Royal.

Now we have the situation where the government, at the expense of taxpayers' $23 million, built the J Block building, which is a temporary facility, so we could care for acute mental health patients on-site. Meanwhile, B Block has now been demolished. It is gone. It has made way for the new, 38 000 square metre, 10-storey K Block, which is currently up to about level 8. We are now building the mental health wards, planned by your party, the Labor Party, to be located on levels 2 and 3, in accordance with the original plan.

At the stage we are in now - pouring concrete on level 8, it could even be 9 - where we are fitting out mental health levels 2 and 2, you raised this issue here today in an attempt to score political points. The recommendations of the taskforce included better models for mental health. It included $2.4 million for a redesign of the psychiatry ward and more outdoor space - six times the amount of space provided for under the plans we inherited.

It also included the addition of further numbers of mental health beds. This was advice to government; it was publicly disclosed on the rescue task force's report and perhaps you would know that there were 13 recommendations. The Government accepted every single one of them and funded them, including the temporary building, which was about patient safety.

You have asked me about who supports it. I am sorry if you don't support that. That is what we are building. It is being built right now. By the way, had it not been fumbled, it would have been finished two years ago and we would have been in it for a year-and-a-half.

As to who supports it, I have already told the House of Assembly who has supported it. It included the chief psychiatrist at the time, senior clinicians and it also included the advice of the task force itself to enable government to make the decision that we confidently go ahead with the redevelopment. You have drawn in a number of other parties into your question. Hopefully by the way I have answered it, you can see how seriously I take this. It is an important redevelopment. I want to do everything I can to maintain public confidence in the project because it is an important one for our city and for our state. The late-stage raising of this issue by your party - which you didn't do during the election campaign and you did not make any commitment to the contrary, while we have fixed the redevelopment that was in a lot of trouble - is rather concerning to me.

Before I wind up this question, I will always listen to what clinicians and stakeholder groups have to say about these things, but the way -

**CHAIR** - Can you answer the question now, Minister? I am conscious of the time - succinct answers.

**Mr FERGUSON** - I just did. The chief psychiatrist at the time, Professor Len Lambeth, had clinical sign‑off. The task force recommended this as well and - I am not going to name him because it does not serve the point - but the clinical director at the time had clinical sign-off. A range of other signatures are on the page and I have seen them. Ms Lovell, your party wanted mental health in levels 2 and 3 of this building. Where we differ is around the fact that we are building it. That is the answer to the question.

**Ms LOVELL** - Minister, where we differ is that we are listening now to current staff, current senior clinicians, who are raising concerns. Thank you for the unsolicited history lesson, but it is not me who is not supporting this plan now - it is the AMA, the College of Psychiatrists and the Medical Staff Association that have all been speaking up publicly about this. The unions have been raising concerns. They are concerned you are pushing ahead with this plan.

My second question is: have you been asked to consider an alternative plan that would include, among other initiatives, psychiatry remaining in the J Block, ICU moving to K Block and the expansion of the emergency department into space adjacent to its current location?

**Mr FERGUSON** - You know I have been asked to consider that because it has been said publicly.

**Ms LOVELL** - What advice have you sought or received on this alternative plan?

**Mr FERGUSON** - As a responsible minister, I would always listen to ideas, feedback and even complaints about any issue in the health system. In keeping with my longstanding tradition, I take advice on these things and I share that advice with my Cabinet colleagues, and I don't share it here today.

**Ms LOVELL** - Going back to my first question, of current senior clinicians and current staff at the hospital, whose support do you have? Quite recently you said publicly that you had the support of hospital staff and clinicians and that is -

**Mr FERGUSON** - Can you read me the quote where I have said that, please?

**Ms LOVELL** - Yes. It was reported on *WIN News* on Saturday, 16 June where, in a statement from the Health minister, you had the support of hospital staff and senior clinicians.

**Mr FERGUSON** - So you cannot quote me?

**Ms LOVELL** - That is the quote. I am quoting you now, so you can go back and watch that news item.

**Mr FERGUSON** - I think we can all see what is happening here. The Government has worked very hard to get the redevelopment of Royal Hobart Hospital rescued, back on track.

We have undertaken a lot of work, working across the spectrum of good people right across our health system. We also engaged, through the task force, a professional reference group that included Mr Andrew Wilkie and the ANMF; the AMA had a representative there, as also did the Master Builders Association.

That is not to try to suggest they are all on the same page on this particular issue at this point in time, but I can tell you that there was a point in time where we were not going to have a redevelopment, Ms Lovell. We did stand it back up. We rescued it. We put in the extra money that was required and we found a safe way to care for acutely unwell mental health patients on site. Doctors feared if we had gone ahead with Ms O'Byrne's plans we would have seen people suffering very poor outcomes.

**CHAIR** - Minister, I would like to take the politics out of this for a minute. As a member of this parliament back when the former government made a decision, I was a strong opponent of a redevelopment of the Royal site. I continue to have that view, but it gets to a point where you cannot turn back the clock. Concerns were raised with me as a health professional by the same people who have obviously been talking to Ms Lovell. I ask you, perpetuating a poor design that was brought in by a previous party -

**Mr FERGUSON** - And a contract.

**CHAIR** - And a contract, yes, but that was not necessarily internal design. Internal design can always be changed at the early stage, when you took over and did your reassessment of the project. K Block, as I understand it, only has one more bed than the current J Block where the acute mental health services are provided. It has about 5 to 10 per cent extra floor space, with very limited open and outdoor space. It seems more of a focus was put into the bedrooms, which are quite large. I'm sure the chief psychiatrist would back me in this - psychiatric patients don't spend much time in their bedrooms. In fact we hope they do not. We prefer them in open areas and outside.

Why was the decision made to reduce the beds from the original 42 to 32 currently? Who provided this advice and what is the long-term trend in bed numbers? I understand the trend is to encourage community-based care, but there will always be patients who are not suitable for community-based care. In any event, we don't have adequate resources in the community to cope with the patients we are talking about and certainly won't have even by the time this is finished.

Why perpetuate a bad model when potentially there was a chance to change it here? The suggestion made to me was similar to what was being made to Ms Lovell, that the psychiatric patients continue to be housed in the J Block. I know it has a time frame that it can exist as a temporary building, then relocate them to the new part of the stage 2 development. There is a series of questions in that but I want to take the politics out and focus on the wellbeing of acute mental health patients in our state.

**Mr FERGUSON** - That is my focus. I would first of all seek to add to my earlier answer because I was being misquoted, unfortunately. I have the correct quote and I feel the committee is entitled to know what it was. This was information provided to WIN TV on Saturday, 16 June. I said -

Acute mental health facilities in K block were subject to significant consultations with the Royal Hobart Hospital Redevelopment Rescue Taskforce in 2014, which included a range of mental health clinicians, the chief psychiatrist at the time, mental health consumers and key stakeholders. The recommendations of the taskforce informed the $2.4 million psychiatry ward redesign and outdoor space expansion, as well as the addition of more mental health beds.

So Chair, to your worthy question I will just make a few other observations. We always welcome the increased interest in providing better facilities and more contemporary models of care for people who are mentally unwell. Whether that is a persistent mental illness or one that is -

**CHAIR** - An exacerbation of a long term -

**Mr FERGUSON** - Or triggered by some traumatic event. We are there to support people. I am not an expert in any of this; I know I am not. I know my limitations and take advice constantly. We are now building a facility. It has more beds than originally intended. I do not have the original figure; the secretary may be able to advise what that was. There was a figure more in the 20s in the original plan for K Block. On the advice of the task force, it is 33. There was a new floorplate design to support this with six times the outdoor space. J Block was never considered to be a long-term proposition, as you said in your questions.

**CHAIR** - I am not suggesting it is.

**Mr FERGUSON** - It never was and we are agreeing with you. You asked specifically about the decision to move from 42 inpatient beds to 32. The question predates me and in part includes my time as minister. The previous government closed six beds and this Government closed four. That was all part of the staged management of further transferring care into the community. That longstanding used to be bipartisan agreement meant we would have an increased effort in the community, maintaining the effort we required for inpatient facilities. That would essentially be the bridge between the two always, so patients could come in and out and only spend the least amount of necessary time in hospital.

It used to be bipartisan because I constantly get blamed for shutting 10 beds by the Labor Party, which, unfortunately, is only half true. We both closed beds. It was reasonable at the point those beds be closed. We were increasing supports in the community. Those beds were not required. The occupancy data will point to that.

**CHAIR** - Do you have principal data to back that?

**Mr FERGUSON** - Yes, it is very high right now. What I was about to say is that clearly demand has increased. Nobody is running away from that. That is why we have a mental health policy that provides for 25 additional bed support in the south, because we recognise that increased demand. I would like the chief psychiatrist to make some additional comments here about the best way to support our patients. I do not appreciate words being put in my mouth to suggest people are being put on the pages supporting something if they do not. I resent, as a visitor to this committee, that kind of proposition being put to me.

**Ms LOVELL** - To clarify, minister, perhaps you should watch that news report.

**Mr FERGUSON** - I am answering, if I may finish, if I can finish - I have just read to you what I provided.

**Ms LOVELL** - The statement you provided.

**Mr FERGUSON** - I do not appreciate being verballed by a member of the committee on something as sensitive as this. I do not like people playing politics with mental health, ever. It is wrong. We are dealing with vulnerable people. They deserve our confidence. They deserve to feel confident in the facilities we are building for them.

**Ms LOVELL** - Can I respond to the point, please, Chair, with one last comment? In answering my question, minister, it may benefit you to realise these questions were put to me by members of the community and by some of the bodies I quoted. These are not my questions. You are accusing me of bringing politics into this committee.

**Mr FERGUSON** - Yes, I am.

**Ms LOVELL** - I am asking these questions on behalf of people who are working in this environment, who have asked me to raise these questions.

**Mr FERGUSON** - They have been raised in the House of Assembly. I have answered them likewise. I am here to discuss the Budget and how we are building this infrastructure. I hope ‑ well, I am not sure now - I hoped the Labor Party would support us building the project the Labor Party intended to build. I suggest, Chair, you ask some other questions. I have the expert here next to me. I am happy to defer to him on inpatient demand and the best models we should be providing, bearing in mind we have committed to a new master plan of the Royal Hobart Hospital. The old one is from 2011.

**CHAIR** - That is my point, minister, you need to make sure you provide contemporary services. I appreciate it if the chief psychiatrist could give his view.

**Mr FERGUSON** - In our health policies there is funding for a fresh master plan for the Royal. The old one is now considered somewhat out of date. It might seem like seven years is not old. However, the redevelopment we are now building is quite different in many respects to the one originally talked about in the master plan.

**CHAIR** - Let us get to these answers, if you do not mind.

**Mr FERGUSON** - Yes, but can I make the point that we will do a new master plan. We do not know what future stages might be recommended through that. They are certainly not funded. There is no guarantee on that, but we need to have a master plan so that options can be considered when funding becomes available. Dr Groves is the Chief Physiatrist.

**Dr GROVES** - I might start by making some comments about clinical planning in mental health in general. I am fortunate to have had a fair bit of experience in clinical planning at a state level in previous states in which I have worked. It might be best for me to say I don't share the same views as the College of Psychiatrists or the AMA about acute bed demand in mental health in Tasmania. The reason for that is that is they are coming from the view of looking at occupancy and utilisation, perhaps not the best approach to think about what future beds needs are. The best way of doing it that we have available in our country the National Mental Health Service Planning Framework, which few people in Tasmania have been trained to use.

As part of the integration task force I have the pleasure of chairing, I have had the opportunity to involve the college and the AMA, most recently, in gaining a better understanding of that planning framework and what it would indicate in beds needed. Without going into the specific numbers - because the planning framework has multiple assumptions and cannot ever been seen to be 100 per cent correct - what is says for Tasmania is that we probably have sufficient acute beds with what would be planned for K Block for at least the next decade or so in the southern half of the state. What is says is that we don't have sufficient subacute beds and that is where the Government election commitment will be important in allowing the system to work efficiently with the smaller number of acute beds into the future.

It also presupposes the community mental health services are working as efficiently as possible. The evidence available to me at the moment is that a fair bit of improvement is probably needed. The model also presupposes primary care, the number of GPs and private office-based psychologists and other mental health professionals are seeing people who might otherwise end up in the public mental health sector. There is evidence that we should be able to make improvements in that regard as well. Through the partnership the department has with PHT, we have been looking closely at -

**CHAIR** - PHT being?

**Dr GROVES** - Primary Health Tasmania is the Commonwealth commissioner of a range of mental health funds in Tasmania. We start to influence the types of programs they purchase so they will support the state-based system to reduce the impact on beds. All of those changes are going to take some time and I need to make that very clear.

That is the role of the integration task force. The integration task force has now had two very lengthy work shops. I am hoping the work of that task force will bring its recommendations via the secretary to the minister, in either September or October this year, to make recommendations as to how we continue to reform the system to get by with the type of system consumers want the most. They do not want a system built around acute beds, they want one built around best supporting their ability to live in the community.

Part of the question is also around clinician support for K Block. I am happy to make my personal views on this known. If I had a choice of providing advice to the minister between J Block and K Block for the mental health unit, in my mind, K Block is far superior to J Block, and it staying there rather in an environment that is unknown. It is a better built fabric for people with mental health conditions than J Block. I am aware that those comments put me at odds with the AMA and the College of Psychiatrists, and I am happy to continue my dialogue with them around the reasons I believe it is a much better space than J Block.

**CHAIR** - We are comparing an inappropriate space with another inappropriate space and that is the problem. There is as yet no funding for stage 2, and that is what the minister has alluded to. I hope this conversation can be ongoing to ensure that if K Block is to be an interim solution, as the Chief Psychiatrist suggests, it may require a different approach that you will keep an open mind on.

**Mr FERGUSON** - I will go on the record and say I didn't know the Chief Psychiatrist was about to say that to the committee. I listened as intently as you did. I don't think anybody has said it is comparing one inappropriate facility with another. I didn't hear that.

**CHAIR** - That is my interpretation of what I am hearing from others.

**Mr FERGUSON** - I didn't want it to be on the record that he said that unless he does wish to say that. I won't stand in his way. If we were starting again with a brand new hospital and perhaps with a greenfield site, things might be done differently. We are working with the realities of life. We don't have the appropriate, best practice facilities we want to provide for mental health. That's what is intended in K Block and we have consulted widely.

We have committed ourselves to a master plan for the Launceston General Hospital and the Royal Hobart Hospital. There are funds to support that and we, as a government, are quite comfortable and willing to be on the record saying we will be open-minded about what the future needs of the Royal Hobart Hospital consist of. We will never stop listening to any of our stakeholders. Let's not forget consumers of mental health services, whose opinions I value very highly. We will remain open-minded about what the master plan might recommend. After that we will be having, potentially, conversations about how we fund that.

**CHAIR** - I have a couple of questions in this important area. Minister, what is the current waiting time to see a community psychiatrist? The Chief Psychiatrist has noted it is a bit underdone at the moment, community psychiatry, and there is more work needed.

How many acute psychiatric patients have been in ED awaiting beds for more than a four-hour total stay? How long have they been there? There is real concern we look at mental health services broadly, including the community mental health services. I heard there was an article on *WIN News* last night. A mother came out expressing her deep concern about mental health patients being in the DEM for extended periods, potentially posing a danger to themselves and others. How are we going to address this in the short-term?

**Mr FERGUSON** - I am waiting on advice on the first question.

**CHAIR** - Your other portfolio will be here shortly. If we don't get this right, the risk is that we see mental health clients in the care of police.

**Mr FERGUSON** - I can answer the middle and last part of your question right away. This Budget you are scrutinising that I have, as part of the Liberal Government, brought down, provides for 25 mental health beds in the south of the state and eight adolescent beds in the north which includes more support for adolescent psychiatry. We see those as stepping up, noting the increased demand.

Four years ago, nobody foresaw today's demand levels on mental health when we were designing and redesigning mental health. When the Labor Party and the Liberal Party closed a few beds, nobody thought it was doing anything other than transferring more of the resource into the community and providing more appropriate care and treatment. We are witnessing increase in demand. When we see occupancy levels at or close to 100 per cent, that's not good enough. It means there is a squeeze on. Patient flow is a critical, desirable thing, so you can have bed access for the next patient requiring one. I agree with you - that is what the 25 extra beds are there for, with significant resources in the first four years to put those in place. There will be some building works required and that is also funded in the Budget.

To the earlier question on community referrals. I have some very initial advice. I am going to get that worked out a bit better and then come back to you.

**CHAIR** - Maybe you can provide it to us.

**Mr FERGUSON** - Would you like me to take it on notice? I can tell you in general.

**CHAIR** - No. I think it would be good to have a breakdown across the state because I believe there is a significant challenge particularly on the north-west coast, and there is an absolute lack of emergency accommodation. I appreciate the adolescent beds, but it is still a long way for a kid from Marrawah.

**Ms LOVELL** - I do. Yes. Minister, again this has been touched on. There is no denying we need more health professionals in this state, especially in the area of mental health. Noting your commitment to an additional 125 frontline staff in the state's mental health service but also understanding the current challenges the THS is having in attracting qualified health professionals to our state, how does the Government intend to recruit and retain the specialist staff required to meet its promise of that access to mental health care?

**Mr FERGUSON** - Well, there are two reasons we should be positive about this. The first is that we have been successful. We have rebuilt the areas that were shut previously. We have staffed them. As I told the Committee earlier today, this Government has an unbeaten track record of employing extra health staff - 630 in four years. That has never been done before.

We have a strong desire to continue to improve, and part of that is about some of the conversation we had earlier about replacing locums with permanent specialists. We also have a very strong mental health agenda, with $95 million over six years and creating new bed spaces and then staffing them. In the south, in particular, a big effort is now on. We have the wherewithal to say we are serious about addressing the unmet demand or, you might say, the unmet need.

Finally, one of the decisions the Cabinet made at its first meeting after the election was the commencement of the new Health Recruitment, Retention and Workforce Planning Unit, which is now up and running. It has active management at the moment, but the secretary is recruiting permanent management staff. We are going to be building a 20-year plan by closely working with relevant stakeholders - not only but especially the university - so that we can plan very carefully recognising our demographic situation, knowing what the upgrade pathway is for our health services, knowing that we are looking to recruit 1300 extra staff. We have a lot of work to do, and so we have decided to set up this special unit with a particular mandate to empower our health system to recruit people to those vital positions.

**Mr VALENTINE** - Referring again our acute health services inquiry, one of the findings of that inquiry was that access to timely acute and community mental health care is inconsistent, lacking functionality and results in inadequate care of patients with mental illness. That is a general statement, in some sense, but that is the way it was seen. During that process, Ms Connie Digolis, the CEO of the Mental Health Council of Tasmania at the time, noted the need for improvement in discharge planning and transition processes for patients exiting acute mental healthcare and transitioning to community-based care. I think we all understand that from what has been said here today that community-based care is quite often far preferable to people being admitted into an acute environment. Can you assist in this by explaining what is being done to improve those discharge planning and transition processes between the acute services and the community services?

**Mr FERGUSON** - Thank you, Mr Valentine. I will very quickly pivot to the Chief Psychiatrist who is Tasmania's subject expert on this. First of all, a quick look back. Last year, at this table, we discussed the Government's extra 100 mental health packages in the community, which has been a very clear signal about the need to build up the care in the community. We are not saying it should be in the community or the hospital; we are saying it should be where it is needed.

**Mr VALENTINE** - Are you talking about staffing packages? You are talking about getting professional nursing staff and the like out into the community?

**Mr FERGUSON** - No, they have been funded through non-government organisations, Life Without Barriers and Baptcare, to provide packages to support people at home. What we are saying is that if you need to be in hospital, we need to be there for you. If you need help in the community, we need to be there for you - wherever it is most appropriate - but if the evidence is that a hospital stay is not required, you should not be in hospital. We want to make sure hospital stays are the right length of time and not longer. Your question goes to how we bridge the gap?

**Mr VALENTINE** - It does. It is the discharge planning and transition processes. What is being done to improve patients not spending long periods of time -

**Mr FERGUSON** - Two answers. One is more resources, which we have touched on already in some detail. The second is integration. We need to integrate. This is a key action in our re‑think mental health plan, universally endorsed by clinicians and consumers. We need to integrate our services so the consumer does not know the difference between a hospital service and a community service.

**Dr GROVES** - Briefly, the integration task force's first two workshops have primarily focused on the precise point you raised. Discharge planning and the way in which community mental health services, primary care and community managed sector work more closely together. There are many models in Australia where those three elements work together. Tasmania perhaps has not matured as well as some of those other systems. The important part of the task force is to focus precisely on how we go about doing this.

**Mr VALENTINE** - The other question from comments made by the Australian Nursing and Midwifery Federation submission to our inquiry. It is in relation to accommodation plans for acute mentally ill patients, part of the RHH redevelopment remains unsatisfactory. One statement on page 40 of the submission -

Research supports contemporary mental health facilities being situated on the ground floor of any setting, with access to therapeutic (and secure) green spaces. However the current temporary and future permanent, mental health facilities are on the second and third floors of the RHH, with little access to the outdoors.

Do you care to comment on how you plan to address that?

**Mr FERGUSON** - Again, I will defer to the Chief Psychiatrist, Doctor Groves. He is the expert on this. As a government, we are providing resource in terms of money for more care. We do not want people's only option to be hospital. We do not ever want that to be a situation and when there is a deficit or a lack of availability, the hospital unfortunately is the go-to. We want people to come to hospital who need to be at hospital, but for others who do not need to be at hospital, we want to support them. That is the first point. Partly that relates not only to community packages of care, but also subacute options, which are just a little away from the hospital. That might mean going from home to a step-up facility, avoiding hospital, but also a step-down, having been in an inpatient acute facility-

**Mr VALENTINE** - Mistral Place?

**Mr FERGUSON** - Yes - 'I am not quite ready to go home, but I do not need to be in hospital, I will go to a stepdown facility.' We recognised the value of outdoor space and went from about 20 to 25 square metres of outdoor space in the inherited plans to more than 120.

**Mr VALENTINE** - On the ground floor?

**Mr FERGUSON** - It is not on the ground floor. Clearly it is not the idealistic outlook some people would like, but one would ask if that were possible in a city block. We are building the facility and the most important thing any responsible member of our Government or parliament could be doing is to ensure we are doing what we can to provide something better than what we have right now.

**Mr VALENTINE** - That is good, but if it is not going to be totally adequate, that is the question that was alluded to - moving into a facility that is not totally ideal. I am neither an expert nor a clinician.

**CHAIR** - Is there a question?

**Mr VALENTINE** - Why not the ground floor? That is the question.

**Mr FERGUSON** - I feel I have covered it to the extent I am able. Dr Groves, would you like to add to anything I have said?

**Dr GROVES** - No.

**Ms LOVELL** - Minister, page 118 refers to a funding commitment of $2.4 million for drug and alcohol beds in Ulverstone. It says here the 2018‑19 Budget provides $2.4 million over three years for additional community-based drug and alcohol rehabilitation beds in Ulverstone. Are they additional to current numbers or are they continuing current numbers, which would have been closed if the funding was not provided?

**Mr FERGUSON** - It is the latter. We have extended the current arrangements in Ulverstone to preserve that service. More importantly, saving them the need to go back to a tender.

**Ms LOVELL** - Thank you. My second question also relates to drug and alcohol rehabilitation. Given the importance of wraparound services in drug and alcohol rehabilitation, particularly post-rehabilitation and the affect this can have on reducing readmission, why did you decide to allocate the full $6 million to beds alone rather than perhaps a split between fewer additional beds but increased wraparound services?

**Mr FERGUSON** - We are going to tender right now so it is in the marketplace. It is a big uplift in support. Thirty places is the judgement our party decided would be appropriate and helpful in the community to help people recover and rehabilitate. I invite you to think about the way you framed the question because when you visit community rehabilitation placements, they are actually very homely. They are intended not to be like a hospital bed, so maybe the use of the word 'bed' is not the best word. 'Places' might be more appropriate.

When you visit places like Missiondale, the Bridge Program in Ulverstone, Pathways in Hobart or the Bridge Program in Hobart, you find more of a hybrid model of what it might be like in a hospital, what it might be like in a home. It is more of a community rather than an institution.

**Ms LOVELL** - Yes, I understand that but what I was referring to was the services that people might need to access once they have left those facilities and gone back to their own home or their own community? You are in that community environment in a rehabilitation facility and then you leave, and it is often not the case that people are able to transition straight home without any additional support.

**Mr FERGUSON** - Yes. I might just remind you that just because something is not listed here doesn't mean it's not happening. The things listed here are the new initiatives. We provide through alcohol and drug services to those allied health services and even specialist medical and nursing services. They continue unaffected by this. This is an increase in the availability of community-based drug and alcohol rehab beds - places.

**Ms LOVELL** - Thank you. Page 127, the second part of table 5.4, the proportion of persons with a mental illness whose needs are met by the Tasmanian Mental Health Services. You have a target there for 2017‑18 and 2018‑19 of 63 per cent. Do you have any comparison with national figures as to how that is sitting?

**Mr FERGUSON** - I am happy to also invite Dr Groves to address this. I suggest it is not just Tasmanian Mental Health Services that is in this space. There are other providers as well. Dr Groves?

**Dr GROVES** - It is very difficult to do state-by-state comparisons. I am aware the proportion of people followed up by the state system varies from as low as in the 40s to higher into the 70s and 80s. It is very much driven by how much primary care is provided, how many private providers there are and how many GPs there are. In states that have less, you would expect the system to do more and in states where this more, you would do less. We are not really comparing like with like here. It is very difficult to do so.

**Mr FERGUSON** - Chair, can I add to an earlier answer to a question Mr Finch asked me about palliative care? I am advised I have given him the wrong number: it is four beds we contract out of the Melwood unit, not five. My other comment about flexing up stands and it does occur.

**2.6 Forensic Medicine Services**

**Mr VALENTINE** - A very exciting area, lots of activity.

**Mr FERGUSON** - There is usually a prize for a good question in this one.

**CHAIR** - He might ask it using interpretive dance, just wait.

**Mr VALENTINE** - I won't do any interpretive dance around this, I will ask a simple question. Can the minister please detail the reason for the 5.7 per cent jump in the appropriation for the 2019-20 budget period?

**Mr FERGUSON** - Yes. I will ask the acting deputy secretary to speak to that. Unfortunately, the answer is less exciting than the question.

**Mr REYNOLDS -** Unfortunately it is. The increase is primarily due to reallocation of corporate overheads from the restructure of the THS and the department.

**Mr VALENTINE** - We have been given that sort of response before. I can understand that. It does dip and climb, though, across the Estimates, if you look. This year it is 0.37 per cent lower; it is 5.74 per cent, minus 0.35 per cent, up 2.49 per cent. Why is it so erratic? You would think in this day and age, with technology the way it is, that you would have a greater demand for the services of forensic medicine. All those Emilia Foxes are out there wanting a job.

**Mr REYNOLDS -** It is a little erratic. One of the issues impacting our forward Estimates, both within this output and others, is that we have a 27-pay coming up in our forward Estimate year in 2019‑20. We are dealing with relatively small numbers in this output. It doesn't require much variation in those numbers for those percentages to occur. A simple thing like an additional pay period, which we have in 2019‑20, has the ability to cause those fluctuations.

**Mr VALENTINE** - To make it balloon. How many staff are there, full-time equivalents?

**Mr FERGUSON** - That is easily obtainable if you are happy to await that advice.

**Mr VALENTINE** - Yes. We will make a note of it at a later point. I am interested in the level of demand for those services on an annual basis. Is it trending up or trending down? You would think their services might be called on more frequently than they have been in the past.

**Mr FERGUSON** - I will ask the secretary to address that. He will have perhaps a more well-rounded knowledge of the Forensic Science Service Tasmania.

**Mr PERVAN -** I was speaking to the chief forensic pathologist recently. He informs me that demand is increasing somewhat, but very gradually. It goes to special areas of interest or concern of the Coroner. The more tests, the more detail they ask about particular matters of evidence, the more work the service has to do.

**Mr VALENTINE** - It is not a burdensome increase?

**Mr PERVAN -** It is not a burden to me, Chris, although from time to time it can be. There hasn't been a staggering increase in the number of autopsies and they're quite efficient in the way they are done.

**CHAIR** - We will move on to 3.1, Ambulance Services. Have we anyone who drives an ambulance here? Minister, would you like to go to Public Health while we are waiting for the ambulance to arrive?

**Output Group 3**

**Statewide Services**

**3.1 Ambulance Services -**

**Mr GAFFNEY** - I appreciate there was no overview given by the minister and there is quite a lot happening in this area.

**Mr FERGUSON** - I was tempted.

**Mr GAFFNEY** - I am aware of time constraints, but it should be noted there is funding for the aero-medical and medical retrieval services, Burnie and Glenorchy ambulance stations, more paramedics in regional areas, secondary triage, Smithton Ambulance Training Facility, State Operations Centre boost, statewide rural ambulance upgrade fund, training equipment, stretchers and volunteer support package.

In saying all those, I understanding my colleagues have read this which may stop some overstating the obvious.

To table 5.5, Performance Information, Output group 3. I have four or five specific questions, minister, you may be able to answer.

Satisfaction in the Ambulance Service has decreased by 1 per cent in 2016- 17. The actual figures are 97 per cent from 98 per cent in 2015- 16. What is likely to cause this decrease and how are those figures calculated? How do you calculate satisfaction?

**Mr FERGUSON** - Secretary, could you please respond?

**Mr PERVAN -** The satisfaction with Ambulance Services as with our wider health service is calculated via a detailed questionnaire, post-people's experience with the health service. It is mailed to their home, collected back and information aggregated.

**CHAIR** - Every patient?

**Mr PERVAN**- No.

**Mr GAFFNEY** - What is the sample? Is it 1000; is it 10 people? What is the number for a valid survey?

**CHAIR** - Are we asking for numbers or percentages of users or both?

**Mr GAFFNEY** - No, just the numbers.

The number of emergency ambulances decreased by 13.25 per cent. This went from 49 000 to 43 000, comparing 2015- 16 to 2016- 17 results, yet the median emergency response time increased by nearly 7 per cent across the state from 12.9 per cent. Is there a reason? How do you explain this result, particularly when there was only a 3 per cent increase of total responses over the same period? The number of responses went down, but the response time went up. How is this explained? I am quite happy if that can be answered at a later time unless you have the answer now.

**Mr FERGUSON** - Chair, I introduce Mr Neil Kirby, the Chief Executive of Ambulance Tasmania.

**CHAIR** - Did he have lights and sirens as he came down the corridor?

**Mr FERGUSON** - He was quickly deployed. He's been waiting upstairs for the right time. Mr Gaffney has been asking about the sample size for the Satisfaction Survey. We can take advice.

**Mr KIRBY** - No, sorry I don't have information on that.

**Mr FERGUSON** - We will obtain that. Mr Gafney's other question here. What are the factors contributing to the response time going from 12.9 to 13.8? Can you also tell him about your more recent progress on that?

**Mr KIRBY -** In terms of the variation in response times, this is the 50th percentile measure. The first date predates my time in the Ambulance Services here. About that time some changes occurred with the new CAD system in terms of how we record using that and the methodology for recording that. From January last year we had a constant improvement month by month in the response time, down to a current average of 12.8 from 13‑14. In fact it got up to around the 14 at that time. We have had a constant improvement.

A number of factors affect the increases we've had and challenges we've had by ramping. We've had new staff go in in the early days to north-west and to Oatlands. Last year there were additional crews into Launceston and Hobart. They've made the improvements we've made. A lot of it is the commitment of our staff, both our comms staff and our road staff, who very conscientiously have worked to improve services.

**Mr GAFFNEY** - On the figures in front of us, the actual and the target figures, medium emergency response times went backwards in all major population centres between 2015-16 and 2016-17. You have just explained that is not the case currently, there has been improvement. Is that correct?

**Mr KIRBY -** Correct.

**Mr GAFFNEY** - In light of that, if you have a look at the targets for 2017-2018 and 2018-19, you are employing more staff, apparently six more. Why are the target figures for 2018‑19 exactly the same as the target figures for 2016‑17, when you have a decrease in 2017‑18? I wonder why you have used those figures. Your targets are actually worse, and you have more staff.

**Mr KIRBY -** I will be honest with you and say that I have asked the same question. The explanation given to me is the methodology they use for projections.

**Mr GAFFNEY** - Who do you ask your questions to? I had better go to the source. Why are those figures exactly the same? I think somebody has made a mistake here.

**Mr FERGUSON** - I am going to ask the secretary to address that. This does happen. I have seen it happen on a number of occasions with targets in future years in performance sections. It is not always a guide to what our intentions actually are. From your point of view it should be, I accept that.

**Mr PERVAN -** The assumptions are made around demand coming in. While there are additional resources rolling out, and they will roll out soon, particularly in regional areas, the targets are set on the conservative side. The reason why they would be based on those 2016‑17 actuals which are seen as measures, if you like, of safety in prediction.

**Mr GAFFNEY** - So this time next year we will have a more realistic view of the impact of the extra staff that you have on board. Hopefully that will have an impact.

**Mr PERVAN -** We certainly hope so.

**CHAIR** - You expect it to show an improvement? Is that what you are saying?

**Mr PERVAN -** Yes, that is what we are aiming for. Given the planned funded initiatives, not just the additional paramedics, but all the other ones in there, we are hoping to see some significant improvement.

**Mr GAFFNEY** - I was surprised when I looked at the suite of initiatives and saw your targets are going to be worse. I am pleased you have explained that. You have had the chance to do that on *Hansard*. The performance information comment noted that a factor affecting response times included the high reliance on volunteer ambulance officers. These people, we know, perform an incredible job. I note there is funding in there to try to assist volunteer ambulance officers.

Is education enough, or does the Government need to reduce over-reliance on volunteers and look at transitioning volunteer positions to more paid roles? Are there any studies or correlation between permanent staff or part-time staff, more so than volunteer staff in response times and effectiveness of your service to the state? That is my overall point.

**Mr FERGUSON** - Mr Kirby will add to what I have to say. It is appropriate that you point out the marvellous work that our volunteer ambulance officers do. I think Mr Kirby will agree with me that we couldn't do it without them. A state like ours, as decentralised as it is - people often think Tasmania is a little state - it is not, it is a big state. It is over 100 000 square kilometres. It is actually quite a big island, plus the Bass Strait islands. It is a marvellous piece of Tasmanian heritage that our volunteers in regional areas are a critical piece of the response pathway.

Increasingly, paid, employed or career paramedics are being resourced in those regional areas and volunteers support them as well. There is always that opportunity, but we have felt that the biggest opportunity for us right now to provide further support for those volunteers is to give them more of a structured support package, which you have highlighted. Mr Kirby, would you address the points? I think we should also touch on the more formal training support volunteers have been calling for, and the retention of our volunteers.

**Mr KIRBY** - We have five different types of station servicing across Tasmania, starting with our community response teams that we have in the very small areas; our volunteer stations, what we call single branch stations; double branch stations, which is the 24-hour paramedic supported by a volunteer; up to our urban stations in the major cities.

We are constantly reviewing the case numbers and workload response time performances et cetera, of all those stations to investigate where our priority is in terms of additional staff. We have been allocated a significant increase in staff, purposely directed towards supporting the regional areas, which is obviously by definition a lot of the volunteer areas. We are in a process at the moment of going around, not only analysing the statistics and the data but talking with communities to try to analyse what that mix is between response times and availability and backup opportunity - all those things, to determine the best priorities, where we put either volunteers or urban stations, or a mixture of both.

We have invested in our volunteers, as the minister has indicated. There is a new management position that has been identified to give specific focus to the volunteers. We have resourcing at the moment assisting in the education and reviewing the education to make it more appropriate.

We are analysing their equipment so that we can better resource them, all within the view of improving the support and structure around the volunteers, to make it easier to come on board as a volunteer, easier to do the training and then the programs to keep their ongoing training going to keep their interest and enthusiasm to stay with us.

**CHAIR** - There has been a bit in the media recently about the stress particularly for those who receive the 000 calls are facing. What support are you giving those people? Is it becoming a growing problem, or are you managing a publicity campaign to put a lid on that?

**Mr KIRBY** - It is something the minister witnessed first-hand himself when he visited the comms room. I don't know if I am speaking out of school in saying that the minister had tears in his eyes as he stood beside a comms operator who was taking a life-threatening call and giving life‑saving instructions to the caller. The call taken beside her was explaining to him a recent call he had handled with a choking baby. They face these issues every day. I cannot say enough to commend out our comms staff and all our staff.

The mental health issue is something we take very seriously. We have invested in it. Only in the last month we have had a full-time position start as our mental health coordinator; we are working with the Tasmania Police, with their wellbeing program as part of that, we introduced peer supporters last year. We already have excellent programs like the CISM running.

**CHAIR** - CISM being?

**Mr KIRBY** - Critical Incident Stress Management program. The peer supporters add another layer of support to that. As you have seen in the media nationally, it is a very real issue. We believe we have a number of strategies in place to tackle it and it is high on our agenda.

**CHAIR** - People don't behave rationally when they have a choking baby on their hands, I can assure you. Having been in that situation myself, it is pretty stressful.

**Mr KIRBY -** I commend our call takers who handle that on a routine basis and handle it very well.

**Ms LOVELL** - In your capacity as Minister for Police, Fire and Emergency Management you have introduced a policy on funding to protect the income of police officers while they are on workers compensation. Perhaps you have the same intention here and it is not reflected in the budget. Why is the same policy not being introduced for paramedics, nurses, doctors or those other workforces?

**Mr FERGUSON** - That is a policy we took to the last election in respect of police officers. I would be happy to explore that during the Police outputs if the committee would like to. The act that applies to workforce generally is in place and supports people who require workers compensation and that is appropriate. I am not aware of any alternatives. That is where we have landed and where we believe the next steps belong in this case.

**Ms LOVELL** - Why do you not have that policy for paramedics?

**Mr FERGUSON** - No, it is not by exclusion as may be suggested in the question. The act applies to all workers in Tasmania, but we have proposed to take a bill through parliament, and the funding is provided to underpin it, in respect of step-down provisions for police. I am happy to explore that during the Police outputs.

**Ms LOVELL** - My question relates to your capacity as Health minister, why you are not introducing the same policy for your health workforce, your nurses, your paramedics, doctors and others who work in the hospital system, who are equally serving the community and potentially under equal amounts of stress and risk?

**Mr FERGUSON** - I understand the question, and you might ask me why we are not changing it for the whole community? The answer is we have recognised a particular case for police that we have supported and, subject to it passing parliament, we have provided the funding to underpin the extra cost to the taxpayer it would entail.

**Mr VALENTINE** - Did anyone ask questions about ambulance ramping and how -

**CHAIR** - I asked that in the other output, do we have a question on notice?

**Mr VALENTINE** - It is specifically about how it impacts on the provision of ambulance services. Every time an ambulance ramps, that means that ambulance cannot go back out on the job - correct me if I am wrong, but it used to be that way when I was in the service. It then means that another ambulance has to come in and cover where the ramped ambulance has come from, in order to provide the service. Can you give us some understanding as to how ambulance ramping impacts on the delivery of all services, and whether there is a dollar amount you can put to that in ambulances covering for those that cannot go back out on service?

**Mr FERGUSON** - I will give you some overview comments and I will ask our subject expert, the chief executive to add to that. I am hearing your interest in how it affects availability and response times. I will allow you to come to your own conclusion, but I think you will find we have very good people in that area. We recognise that ramping, also known as ambulance offload delay, does occur. We want to reduce that quickly and as much as is possible. An ambulance may be parked at a hospital but that does not necessarily mean it is ramped, as is it sometimes represented. It can take time for the paramedics to hand a patient over to ED staff.

**Mr VALENTINE** - There can be a lot of them there, though, at once.

**Mr FERGUSON** - That is right. I agree. The Government recognises that. Nobody says it does not happen and no-one says it has been fixed. Providing more ambulance resources is part of the solution but the real solution is more acute care beds. I will hand over to the chief executive around the comments and questions made. Please also tell the member how you are addressing response times.

**Mr KIRBY -** Thank you, minister. As the minister indicated, you see a lot of ambulances at the hospital because we have many cases. We are doing 250 cases a day or thereabouts in Tasmania, so that means a lot of visits to the hospital.

**Mr VALENTINE** - Is that 250 cases involving the hospital?

**Mr KIRBY** - No, total workload, total cases or thereabouts. We work closely with the hospital in managing that interface around the ramping. I have constant meetings with the CEO, who is in the room at the moment; we talk regularly at the hospital operations face to address how best we can manage our ambulances on the ramp. Our crews do a wonderful job with the interface and managing patients to ensure that patient care doesn't suffer in any way, shape or form. We continue the care of the patient right through that process. The patients are prioritised and triaged appropriately as well as part of that process.

We are working with the hospital to identify ways we can improve the mechanism of managing the response. Only Friday last week we held a workshop about looking for fresher ideas on how we can improve those processes around ramping. The report from that meeting is yet to be given to me because we have been busy this week here. That is indicative of what we constantly try to do to maintain that improvement.

We have many other programs in place to address that issue, including our extended care program. We have funding in the Budget this year to coordinate that from the dispatch centre or our state operations centre. We have funding to initiate our secondary triage program, where we can start managing some calls that don't need to go to the emergency department.

Overall, we are combining all those factors into better managing that interface and compensating for any delay in ambulances. We indicated before that while we have had some serious challenges with ramping, we have been able to maintain an improvement in response times over the last 18 months. That is an indication that we are managing it well.

**Mr VALENTINE** - Of those 250 cases, how many would go to the hospital, as opposed to being resolved?

**Mr KIRBY** - I don't have the breakdown of that.

**CHAIR** - This is statewide we are talking about. We are not just talking about the Royal here.

**Mr VALENTINE** - I understand that. I am just wondering how many of those end up going to the hospital as opposed to being resolved by your staff. You don't have that figure?

**Mr KIRBY** - Unfortunately, I don't have those figures in front of me.

**Mr VALENTINE** - Is it possible to get that figure?

**Mr FERGUSON** - Of course we can. We will obtain that figure.

**Mr VALENTINE** - That would be good if we can get that.

The other aspect is information being transferred to the hospital while you are en route - has that improved? Are you doing that across the airwaves so that the hospital is ready for that patient when they arrive?

**Mr KIRBY** - Through our dispatch room, there are communications with the hospital, including if needs be with the vehicle directly. We will give them information about the patient prior to arrival.

**Mr VALENTINE** - They used to have a system - on a Toughbook, I think it was - whereby they fill that out-

**Mr KIRBY** - No, we use the electronic patient care record. Our officers complete that and then submit it when they get to the hospital.

**Mr FERGUSON** - We will take that on notice.

**3.2 Public Health Services**

**Mr FERGUSON -** May I add to a previous answer, please? Public Health Services - I invite Dr Scott McKeown, acting director of Public Health today, who has been a wonderful member of the team. I would like to add to an earlier answer from Mr Gaffney about a survey sample size. I am advised the ambulance satisfaction survey sample size is 1300 and that is tested each year.

**Ms LOVELL** - Minister, going back to the Tasmanian Community Health Fund. As we touched on earlier, $6.6 million out of the $9 million invested into new preventative health measures is allocated to this fund. This is an allocation over two years. What is the intention after the first two years? Is that the extent of the funding?

**Mr FERGUSON** - It is the extent of the funding. It is an innovation of our Government. We want it to be meaningful in the community. I discussed this with the Estimates committee in the other House yesterday, where there was interest. We want to do further work with the department and Public Health Services to help guide criteria on this. We want to get the very best out of the community grants we have already started. They are at an early stage; only round 1 of those has commenced. We will be monitoring and evaluation those closely. We will be stepping forward with these grants and ensuring we can partner with grassroots communities. The intention is about government working hand-in-hand with Tasmanian communities to ensure greater cut-through and support initiatives the communities know will work for them in their local area. That doesn't only mean regional communities; it can also mean a community that works across the state. It is something we will run with in the Budget which we believe will make a positive contribution to the health of our Tasmanian community.

**CHAIR** - In your policy document, 'Building a Tasmania we would all be proud of', you note we have a few health challenges. This is about No. 73, 'Have the healthiest population in Australia by 2025'. Smoking rates in Tasmania are above the national average; physically inactive people are above the national average; high cholesterol is significantly above the national average, as is the statistic for people who in Tasmania who are overweight or obese. Cardiovascular deaths are responsible for 31 per cent of deaths. I am interested in the national comparison for individuals who are overweight or obese in Tasmania, and the cardiovascular disease comparison, too. I know there many programs; we talked about various grants that go toward some of those programs. More importantly, how do you measure the outcomes of individual programs set to achieve this goal of the healthiest population by 2025?

**Dr McKEOWN** - Evaluating public health programs is a specific discipline in itself. There is considerable expertise in public health services to implement evaluation strategies alongside the implementation of the actual public health initiative and activity. All the actions funded under Healthy Tasmania are intended to work towards that goal of Tasmania being the healthiest state by 2025. Specifically, some targets relating to smoking and obesity rates have also been included as part of those goals. The 24 activities included in Healthy Tasmania are across the four priority areas - smoking, physical activity, improving nutrition and community connections, of which the Healthy Tasmania innovations grants were a key action. Chronic conditions screening and management are all intended to take a strategic approach to achieving those goals and that long‑term vision.

**CHAIR** - How are they reported back to us? We don't often see outcomes measures; I am interested in how we are going to report these outcomes.

**Dr McKEOWN** - I am the Deputy Director of Public Health, the Director of Public Health is away today because he is currently writing the State of Public Health Report, a five-yearly report that will be tabled in parliament this year. That report intentionally provides a strategic view of health at the population level in Tasmania. To sit alongside it are a group of health indicators that set priorities and are used to inform the activities that public health services implement.

**CHAIR** - I must say that previous State of Public Health reports have been very informative.

**Dr McKEOWN** - Yes, so that will be updated this year and will help set that direction.

**CHAIR** - People are more willing to consider the flu vaccine as an option, in view of last year's particularly bad flu season. We heard about the national shortages, particularly for the vaccine aimed at the older age group, 65 and over. How has Tasmania fared, and have we met demand?

**Mr FERGUSON** - I am agreeing with the Chair, it is an important question, doctor, and I am inviting you to answer.

**Dr McKEOWN -** Thank you, minister. Tasmania has delivered 150 000 doses of influenza vaccine to general practice under the National Immunisation Program.

**CHAIR** - To general practices and pharmacies?

**Dr McKEOWN -** No, this is funded, free vaccine for people eligible under the National Immunisation Program and the state-funded program for children up to, but not including, five years of age. This year 150 000 doses have been delivered to general practice.

**CHAIR** - Of the flu vaccine?

**Dr McKEOWN -** Of the flu vaccine, compared to 111 000 doses last year. At least 33 per cent greater volume has been delivered because there has been a greater demand. There has been good delivery of the vaccine for Tasmanians most vulnerable to severe flu - that is, Tasmanians 65 years and older. That has been delivered very well into the community. Adults have taken it up - those adults who have underlying chronic conditions - and the vaccines delivered into general practice targeting children less than five years of age have been taken up as well.

There have been some national shortages. There was a period earlier in June where there were some challenges. We were able to work through those challenges. We have received additional vaccine and are expecting further vaccine to be delivered in early July. We are expecting to manage demand for those Commonwealth- and state-funded vaccination programs. There may be some short periods when a practice will need to be resupplied. Our state supply of the two vaccines for older Tasmanians is very good.

**CHAIR** - I know pharmacies were also providing them at a cost. Do you have any idea how many people take it up through that avenue?

**Dr McKEOWN -** Not at this stage. We do not oversee that program; it is between pharmacists and suppliers to the private market. We have a sense of it at the end of the year, the extent to which vaccine has been delivered to the community.

**CHAIR** - It would be interesting to know the total figures.

**Mr FERGUSON** - I can help you with that. I found those figures while Dr McKeown was speaking. We do not have 2018 figures yet, but when we first started this initiative in 2016, 9000 vaccines were administered through pharmacies, by pharmacists, which is the new initiative. Last year it was 25 000. It is only set to be bigger in 2018.

**Dr McKEOWN -** Anecdotally reports are that a lot are going out.

**CHAIR** - This output group also covers application of the Radiation Protection Act. Have there been any breaches under the act?

**Dr McKEOWN -** I do not have that information with me at the moment, as far as I am aware.

**CHAIR** - Could you check? We are talking about radioactive waste underneath the old St Marys Hospital.

**Mr VALENTINE** - Radioactive waste.

**CHAIR** - Have there been any breaches in the Radiation Protection Act that the public health department administers?

**Dr McKEOWN -** I do not have that information at the moment.

**Mr FERGUSON** - The deputy director's lack of awareness is a good sign, but I will happily take it on notice and inform the committee.

**CHAIR** - Are there any other questions on public health?

**Mr VALENTINE** - With respect to e-cigarettes, is that on your radar? We have seen a bit about that in the press of late.

**Mr FERGUSON** - It is on our radar. It was an action in the Healthy Tasmania Five Year Strategic Plan. We made a decision as part of our work in consulting to our five-year plan with a particular effort to focus on tobacco smoking, as well as obesity and healthy eating, as part of our key initiatives. We changed the Public Health Act - and thank you for your support, Mr Valentine - to regulate e-cigarettes so far as sales are concerned as if they are tobacco. They are now regulated in the same way.

**Mr VALENTINE** - They can easily be nicotine-based if you buy them over the net.

**Mr FERGUSON** - The purchase of nicotine for delivery through e-cigarettes is not legal in any jurisdiction. Tasmania joined a number of other states, maybe even all of them by now, to introduce new laws last year to control the sale, use and promotion of e-cigarettes.

That is now the case. It is in place. They cannot in any circumstances be sold legally to a person under 18, whereas previously that was a possibility.

If you are interested, you are? There are 36 retailers in Tasmania licensed now to sell electronic cigarettes. E-cigarette sellers also have to obtain a sellers licence.

The jury is still out on this subject. We put in place these measures while the jury's out as a preventative approach. We have said publicly, and we stand by it, that if the evidence becomes more clear in favour of electronic forms of delivery of - anyway, e-cigarettes, if there is an evidence base in the future that can be demonstrated to support cessation of tobacco smoking, we are quite happy to consider that if and when.

**Mr VALENTINE** - It is not just the nicotine content, is it? It is boiling up some concoction.

**CHAIR** - Whatever else.

**Mr FERGUSON** - The clear advice to me at the time is that people who were then and may still be using e-cigarettes, especially using products they have bought online, do not know what they are consuming. We have taken a preventative approach. Not that we necessarily have a plan one way or the other, but we are willing to say we are open to emerging evidence.

**Capital Investment Program -**

**CHAIR** - A lot of these questions have been asked as we have gone through other items. Do any members have additional questions?

**Mr VALENTINE** - When you look at the Budget figures - $132 million, $93 million, $138 million, $49 million, $20 million - in the last two years, it doesn't seem like there's a lot of activity on, or you are not planning forward to do, major infrastructure developments. I am talking about appropriation; it is on page 140. Page 135 is your CIP; on page 115 you have a whole heap of projects too. It is interesting that this particular line item seems to have a low two years. Why would that be? Is it that because you have not planned that far forward?

**Mr FERGUSON** - I will invite the acting deputy secretary to respond to that.

**Mr REYNOLDS -** I am referring to table 6.2 in budget paper 1, which details all the infrastructure projects for the Department of Health.

**Mr VALENTINE** - What page is that?

**Mr REYNOLDS -** It is page 101. This table lists funding for all infrastructure projects for each department, and the profile you mentioned reflects our investment in infrastructure. As we discussed, the redevelopment of Royal Hobart Hospital is a major factor in that. In 1918‑19 a budget of $212 million, $193 million the year after, and, as that project concludes, the capital program declines sharply, down to $49.8 million and then $20 million in the final out-year. It is merely a reflection of what our capital program looks at, at this stage.

**Mr VALENTINE** - It is not a reflection of not having planned anything into the future, like regional locations getting an upgrade or -

**CHAIR** - Waiting for another election.

**Mr PERVAN -** All I was going to add to the deputy secretary's comments is this is actually a reflection of planning because the whole-of-government capital planning process takes multiple years to get to the point of funding and construction. So you will find it goes up and down like that because the projects in the wings are coming through.

**Mr VALENTINE** - Okay, I will take that as an explanation.

**Mr FERGUSON** - Ministers have visibility of how SIIRP bids are going and because it is budget process we do not talk about it. I can tell you numerous projects are always in different stages of development through the SIIRP process. They mature when they turn up in the budget after going through that.

**Mr VALENTINE** - There is the RHH redevelopment, St Helens Hospital and the Kingston Health Centre.

**Mr FERGUSON** - My advice is each case is on track for full delivery as per the publicly given commitments. For the Royal Hobart Hospital, I have given a fair overview earlier. It's on track for practical completion in August 2019, as per the redevelopment website for the last two years. Management involved can tell the Committee I am not advised of any delay in the project. Very good news. Concrete is being poured this week on level 9.

**Mr VALENTINE** - St Helens in St Helens not St Helens in Hobart?

**Mr FERGUSON** - Correct. A $12.7 million project. Construction is progressing well. Roof and wall structures are almost completed, with internal plastering and floor coverings to commence next. Construction is on track for completion in December this year. Transition of the existing hospital will be undertaken in early February 2019, to take into account the Christmas holiday season.

**Mr VALENTINE** - The Kingston project?

**Mr FERGUSON** - That project is funded with $5.2 million dollars in 2018- 19. This is anticipated to be the final allocation. Construction has commenced, with the current focus being structural works for the ground and first floors. Recent storms have resulted in a slight delay. There is no impact to the scheduled completion in December this year. Same as St Helens. Relocation services into the new centre is expected to be completed by March 2019. The race may be on for the two.

**CHAIR** - Thank you, minister, we are finished with the Health portfolio. We have gone a bit over time

**Mr FERGUSON** - I thank you and your Committee. Thank you for your questions on notice, which I will do my best endeavours to respond as quickly as possible. I thank, on record, our wonderful staff for their work in assisting me today.

**Mr FINCH** - Minister, will the crew do a collective interpretative dance as they leave?

**The committee suspended from 3.44 p.m. to 3.54 p.m.**

**DIVISION 7**

Department of Police, Fire and Emergency Management

**Public Safety**

**1.1 Support to the Community**

**Mr FERGUSON** - Good afternoon again, Chair and MLCs. I am very keen to get on to your questions, but suffice it to say we have a very significant investment in Tasmania Police. We want our state to be the safest place in Australia, indeed the world, and we are very grateful for the remarkable service that is Tasmania Police, for the uniformed and non-uniformed personnel in the agency, together with the commissioner's top brass, who work very hard to bring justice to victims of crime and to assist with crime prevention initiatives.

I will also mention that in our Fire Service and State Emergency Service, Tasmania is very blessed to have very committed workforces determined to help Tasmanians through difficult times. They shine when the state is under threat, and we are very grateful to them all. As a government we are strongly supportive of them and this Budget demonstrates that. I am happy to take your questions as you guide us.

**CHAIR** - Thank you. Josh, you have the lead on the first output group, 1.1 Support to the Community.

**Mr WILLIE** - Thanks, Chair. I don't know whether it fits with this line item, but I would like to preface this line of questioning by saying that like most members of the Council, I have enjoyed great engagement and courtesy when it comes to visiting government facilities and engaging with departmental staff. I will give a couple of examples.

Shortly after I was elected, I rang Mr Rockliff and said, 'Can I go and pack up my classroom?' He said, 'It's a bit ridiculous, Josh, that you have to ring me and get permission.' He said, 'In the future, if the principal invites you onto a school premises, you don't need to come through my office. It's the same for child and family centres.'

So, thank you very much. I continue to enjoy a great relationship with the local schools, and offer my assistance and support where I can, which I think is incredibly important for members of parliament. Just recently, I was given the opportunity by Ms Archer, after I requested to visit the maximum and medium security prison at Risdon upon my appointment as shadow minister for Corrections. After my election, I continued to have a good relationship under former Police minister, Mr Hidding, with the Glenorchy Police Station; I shared advice and concerns and have great discussions with its members.

There seems to be a change of policy under the current minister. In April, I was invited by a detective inspector to discuss youth justice and youth matters in the Glenorchy area, which are particularly prominent at the moment, as the commissioner knows - he is nodding. We arranged to meet. I have been there a few times. I have even taken them morning tea, and thanked them for their service to the community. I had some great engagement with Sergeant Christopher Hey in the past - I know he is not there any longer. But it seems to me that some roadblocks have been put in place by the current minister. I was told that the meeting could no longer go ahead, that I would need to make a request to have a meeting in writing to the Police minister.

So I did that, I wrote to Mr Ferguson, who sits before us. In the letter, I said -

It is important that every Tasmanian feels safe in their home, in their community. Tasmania Police do an outstanding job, and it is critical that we are working together in the best interests of the community.

I seek your approval to meet with Detective Inspector Craig Joel to discuss community concern in the northern suburbs of Hobart, specifically issues relating to youth crime and youth justice provisions. Your consideration is appreciated.

I received a letter in response from the minister saying -

I refer to your recent correspondence requesting a meeting with Detective Inspector Craig Joel of the Glenorchy Criminal Investigation Branch. I understand that you wish to discuss matters of community concern in the northern suburbs related to youth crime and youth justice with Detective Inspector Joel. If you would instead outline these matters in a letter to me, I would gladly seek advice from Tasmania Police for you.

That approach deeply concerns me as a member of parliament who has a role to play in my community as a community leader engaging with all sorts of people, whether they be constituents or community organisations.

**CHAIR** - Ask your question?

**Mr WILLIE** - Yes. Why has there been a change of approach under your leadership, minister, from the former Police minister? Do you agree it is important for members of parliament to maintain good relationships with their local divisions of police in the event that if an emergency arise, community concerns can be directly dealt with in an appropriate way? Why are you putting roadblocks in front of members of parliament? To put some further context to this, I know that my colleague, the member for Derwent, recently was denied permission to visit a community morning tea. My other colleague, the member for Rumney, has been restricted when it comes to engaging with Health services. It seems to be, minister, a pattern of behaviour from yourself, not other Cabinet ministers, as I have highlighted. Why are you putting roadblocks in front of members of parliament when engaging with local Police divisions?

**Mr FERGUSON** - I am glad there was finally a question in that very long speech. I must say, Chair, I am happy to address the matter Mr Willie has discussed. I would like to look a bit more into this and examine your claims. Certainly I can say that anything I have sent to you has clearly been on advice. I am happy to consult that again and have another look. I do not see there is a particular problem here.

**Mr WILLIE** - I do.

**Mr FERGUSON** - I can see it is being experienced by you. I can also tell you the matter you raised, I do not know, with or without Mr Farrell's permission, but I have, or am in the process of apologising to Mr Farrell about the other incident you referred to. Do you have his permission to raise this today?

**Mr WILLIE** - Yes, of course.

**Mr FERGUSON** - Okay. The issue there was a complete misunderstanding. It was a community event people from the community were invited to attend. I would not have regarded Mr Farrell as even requiring my permission. It certainly was not denied.

**Mr WILLIE** - In respect to this matter, do you agree it is important for members of parliament to maintain good relationships with local divisions in their areas, to work on matters of community concerns together in a collaborative way? Do you agree with that statement?

**Mr FERGUSON** - Of course I do, yes. I am not sure the extent to which there is a real problem here, Mr Willie. The matter you raised in regard to Mr Farrell has not been brought to my attention as a request for permission. I have not said no to it, either. Ministers do have the courtesy. The way these things work is permission is required. I will undertake to have a good look at your request and make sure we are not putting unnecessary roadblocks in your way. Of course, I want Government and non-government members of parliament to enjoy positive working arrangements and relationships with senior members of the Police department. I am happy to have another look at it.

**Mr WILLIE** - In this instance it was by invitation to go and discuss the matters I have highlighted.

**Mr FERGUSON** - You have made your point. I have undertaken to have another look at it for you. I have agreed with you - it is important MPs enjoy good relations with senior police.

**CHAIR** - Another question?

**Mr WILLIE** - Yes, I have more questions on 1.1. We can move on from that matter. I appreciate the minister looking into it and hope in future reasonable requests are honoured. Minister, will the Government continue to fund the Fuel Reduction Unit from the consolidated revenue forward Estimates after the current funding ceases, or would this need to be borne by the Tasmanian Fire Service?

**Mr FERGUSON** - Mr Willie, the commitment the Government makes in this Budget is a four-year commitment of $9 million per annum to ensure the continuation of the fuel reduction program. It has been a stellar success for our Government. The Fire Service - TFS - has done an excellent job in implementing it. Other partners have contributed very significantly. It is a tenure-blind and risk-based approach. My advice on the success of the program, from the chief officer, is that it has strongly been touted as one of the best in the country. We are committing our funding to it. There should be no question about our commitment - after all, we started it. It was advice given to previous governments that was not accepted. We believe it is a really positive program.

I will say that the only surprising thing about this program is the lack of complaints I, as minister, get about it from communities otherwise concerned about smoke. It seems to me the communication is excellent. There is a lot of collaboration with local communities around what to expect, when to expect it and how it is actually a process helping them to be safer. Since the program commenced in 2014- 15, over 500 burns have been completed. The burns have been strategically located to reduce the risk of bushfire to communities. The burnings have been undertaken across all tenures, not just on public land.

From 1 July 2017 to 31 March 2018 we had 100 burns on private and public land across more than 14 000 hectares. A number of other burns are planned to be conducted pending suitable weather conditions and the closing of the autumn burn season. I hope that is of assistance to you.

**Mr WILLIE** - My next question is on fuel reduction burns. We just talked a bit about that. Massive increase. I am referring to page 201 in budget paper 2. It says there is an increase in the fuel reduction burns - the amount of land - that goes from 33 to 148 without a similar increase in funding. Can you explain that increase in land mass?

**Mr FERGUSON** - Could you please repeat the last part of your question?

**Mr WILLIE** - Could you explain the increase in the target on budget paper 2, page 201, fuel reduction burns for reserve land?

**Mr FERGUSON** - I am going to Ms Sandra Whight, director of Community Fire Safety Division to discuss this question. I am not sure if you have it in front of you, Sandy? I can share with you the area Mr Willie is pointing to, which I highlighted, and he is asking for some clarity on the targets for future fuel reduction burns and how that interacts with our provided funding.

**Ms WHIGHT** - The program is in its initial stages, so it's been running for four years. Now we are moving onto another sequence of four years. The focus has been very much on a risk‑based program. Our primary focus, where we are trying to do our burns, is very much addressed to how we can reduce risk to communities, in particular in urban interface areas, but also on reserve as well as private land.

The hectares are set as a target to ensure activities are happening. The actual primary goal of what we are trying to achieve with the burns is largely risk reduction effectiveness. That is really where we are looking to target the burning. If I was really honest with you, I could say that a 5000-hectare burn in a remote part of the state wouldn't be a very effective risk reduction activity, but a 150-hectare burn on an urban interface would actually achieve a considerable deal more for risk reduction.

So the focus of the burns and the focus of the way the unit across all agencies approaches the burns is to reduce risk. We have the hectares targets there to make sure we are active and we are actually working. However, our primary focus is on reduction of risk.

**Mr WILLIE** - Minister, can you confirm if there are plans to merge the Fuel Reduction Unit with the bushfire planning unit?

**Mr FERGUSON** - Sandra will respond to your question, including discussing with you directions as well as stakeholder engagement on this.

**Ms WHIGHT** - The establishment of the Fuel Reduction Unit was part of when the new program money came on four year ago. At the same time the Tasmania Fire Service already had a bushfire planning and policy unit in place. That was in a separate division of the organisation and functioned in a similar area in terms of understanding bushfire risk and bushfire policy.

With the commitment from Government for ongoing funding, it was important for the Tasmania Fire Service to look at how those two units functioned together and what the reporting lines would be. A decision was made to look at integrating those two units, maintaining the integrity of the fuel reduction program but forming a new bushfire risk unit within the Community Fire Safety Division of the Tasmania Fire Service. The bushfire risk unit's function and purpose is to have a single holistic approach to understanding bushfire risk in the landscape and to look at different mitigation activities we can put in place to address the risk. Those range from things like the Fuel Reduction Unit, which is very important, all the way through to how we deal with things like planning frameworks, where we actually build houses and how to manage risk in the landscape that way.

That's been an ongoing process and we have consulted with staff over a number of months. It's also been consulted through the unions. The affected unions are the United Firefighters Union and the Community and Public Sector Union. It has been discussed with key stakeholders and already raised once through the steering committee through the Fuel Reduction Program and through the State Fire Management Council. It is really looking at the internal coordination and cohesiveness within the Tasmania Fire Service and the Fuel Reduction Program, with its current governance through the steering committee, which will remain in place.

**Mr HINE** - The Fuel Reduction Program was transferred from Department of Primary Industries, Parks, Water and Environment to our department. I chair the committee. It has been before the steering committee to ratify and make sure we are getting efficiencies in looking at amalgamating the unit. It has to come back to the steering committee after all consultations have come forward to make sure what we are trying to achieve is being achieved. While we are moving down that track, it still hasn't been signed off fully by the steering committee.

**Mr VALENTINE** - It talks about reserve land. Are we talking about World Heritage area reserve land or other reserved land? I have a little bit of a background on some of this with environmental biology. I somehow got onto *Hansard* as having done geology at university, but, to correct the record, it was environmental biology. Does it include this because it can intrinsically change the landscape?

**Ms WHIGHT** - Yes, reserved land in the context of the Fuel Reduction Program includes some parts of the World Heritage area as other national parks, reserve lands, conservation areas, and nature reserves.

There is money provided through the $9 million to the Parks & Wildlife Service to have a strategy specific to the World Heritage area to address bushfire risk for the values this area has been set aside for. There is a program of burns included as part of this, specifically for protection of values within the World Heritage area.

**Mr VALENTINE** - Would this include rainforest or landscapes not necessarily forested in the World Heritage area?

**Ms WHIGHT** - We would never burn rainforest.

**Mr VALENTINE** - I am simply asking the question.

**Ms WHIGHT**- We could have a good lengthy discussion about fire ecology, a personal passion and background of mine. To overly simplify it, we have divided the state's vegetation. It is classified into what we would consider flammable or treatable fuels versus non-treatable fuels. For all of our fuel reduction programs, be it risk reduction work at the urban interface, we specifically target treatable fuels where we know there is an ecological adaption that enables those plants to respond safely to fire. We look at things like return intervals so we are not burning with a frequency too great for those species to withstand. In the World Heritage area, the target would be for large fuel types like buttongrass plains or some of the coastal heath and some of the coastal scrub zones. The buttongrass plains do butt up quite hard to wet forest and rainforest at times, so the importance of treating those buttongrass plains is that under summer wildfire conditions, you don't get a fire ripping through the buttongrass plains and launching into the rainforest.

**Mr VALENTINE** - That clarifies it excellently, thank you.

**Mr HINE** - As you remember, back in 2016 with the major bushfires in the Tasmanian Wilderness World Heritage Area - TWWHA - a big report was completed after that to look at all those various issues. I sat on that, along with the chief fire officer. The fire retardants you use in those areas are so important. A major report was done that influences the way fuel reduction burning is done in that area.

**Mr VALENTINE** - To reduce the impact?

**Mr HINE** - Yes.

**Mr VALENTINE** - Thanks - well described.

**CHAIR** - It goes a bit to Mr Willie's question about us as members engaging with our local police and things like that. I run into them in the street often enough, only because we are walking up the street at the same time as opposed to them trying to arrest me - just to clarify that. I am sure the commissioner is aware that Wynyard tends to have some youth behavioural issues and challenges. I have spoken to the local police in the street about this problem. One of my discussions with them was around that visible police presence in the streets and around the town.

In Wynyard, for example - and I am sure this is not unique to Wynyard, I am raising it because of my direct experience with it - when Wynyard Police Station is not manned all the time, it is sometimes difficult to have that police presence. I did ask the police where was there any impediment to just sitting in a cafe and having a coffee in uniform? If you are obviously having a coffee there, people can approach you. It seemed that wasn't happening much. I remember, as a nurse, you used to get criticised for sitting on the bed or beside the bed talking to a patient because that wasn't work. I am just wondering what your view is on this in encouraging police - and putting more police on the beat really helps with that - into that visible presence, so that police are seen as a normal part of our community, making it a safe place to go?

**Mr FERGUSON** - It should be encouraged. I am on page with you on this, commissioner.

**Mr HINE** - I couldn't agree more. I encourage our people to get out and into the community and to go into the coffee shops and have a coffee with the local community. I do it quite often myself and I encourage that. In fact, through Neighbourhood Watch, there is a program called Coffee with a Cop, in which we are patrolling with Neighbourhood Watch. They have given us some money and we have put some money into it as well. The local police officer goes into a coffee shop and invites members of the community to come along and have a coffee with a cop. We are trying that and it seems to be working really well, and I can see that expanding. I couldn't agree with you more - it is a matter of getting into the community - do your shopping in uniform and have a coffee with the community. It is amazing, but there is one drawback: it is very hard to leave that coffee shop because people want to talk to you, which is fantastic.

**CHAIR** - That is when you get your colleague to ring to say, 'I've got an emergency'.

**Mr HINE** - The pagers used to be really good at that, but the phones are good. I couldn't agree with you more and we encourage it as best we can to get out there. There is Adopt-a-Cop in schools'; there is Police in Schools -

**CHAIR** - Which I think has been quite successful, from all reports.

**Mr HINE** - It has. The police officers do it in their own time, they volunteer to go along. I encourage it as much as I possibly can. It is not only putting a human face to the community, but a human face to a police officer in the schools, no matter what age they may be. In fact, we did a tour of some schools around Hobart. The schools certainly wanted to see the police there in an informal basis so when the kids interact with the police, it is not always a bad thing - it is a good thing - a positive interaction.

**CHAIR** - On that question, in some of our rural areas, and there might be only one police officer around at the time - I could tell you a funny story but I won't do it on the record, I must do that on the break - and when police officers visit a school, I understand that they can't take their firearm with them, they have to leave them at the station. Am I correct in that?

**Mr HINE -** No, they normally take their firearm unless they are interviewing a child. There are a couple of reasons for that. They need to take their firearm if they are called away to a job. It is having the community become comfortable with seeing a police officer's equipment; it is what it is. You never know when a situation is going to occur, no matter where it is. They need to be fully armed; they cannot be fully operational unless they carrying their equipment.

**CHAIR** - I am glad you have clarified that because I was led to believe that was not the case. I thought that would be a challenge, if you were at a school, the station is some distance is from the school and you are called out on an urgent matter.

**Mr HINE -** Twelve years ago that was a policy, but under work health and safety, we have to make sure police officers are fully equipped, in case they need to react to a situation, such as at the school. We encourage police officers to interact with the schools and we say to those who are parents, 'If you have your child at school and you are working, go there and watch in uniform.' It is great to interact with the school community.

**CHAIR** - Minister, in terms of performance information noted on page 201. I note, 'Satisfaction with the police services', and 'Satisfaction with police in dealing with public order problems', the figures are there but it says the expectations are greater than the national average. What is the national average? Does it change? Why don't we have it there because it is otherwise meaningless as a comparator? It says greater than the national average, which is the majority on them.

**Mr HINE -** I have all the figures here, I am happy to table it or to read them out.

**CHAIR** - Table it, please. It would be easier because there are a lot of numbers.

**Mr HINE -** That is all the figures there. For example, Satisfaction with the policing service: back in 2014, the target was 75 per cent, the national average, and we reached 77 per cent. The national target in 2014-15 was 77 per cent; we reached 77 per cent. In 2015-16 the target was 75 per cent; we reached 79 per cent. In 2016-17 the target was 73 per cent; we reached 79 per cent. The survey is done three or four times throughout the year. If we take it up to 31 March, the target is 79 per cent and we are sitting on 86 per cent.

**CHAIR** - Well done to your Police force, minister. Could you please table that?

**Mr GAFFNEY** - The other statistic that often comes up throughout the targets is the greater or less than three-year average. Is that how it happens across Australia? Last year the spike in the poppies was 2.97 per cent, well above any other year, but the targets are less or greater than a three-year average. Is that how it is in most jurisdictions?

**Mr HINE -** It is trying to gain an accurate picture, rather than an aberration, over 12 months. We have aggregated some of these figures statistically over a three-year period. Statistically, it stacks up better than an aberration over a 12-month period. We are trying to obtain the best figure that is meaningful. Sometimes you use a five-year figure across Australia, sometimes a three-year figure.

**Mr GAFFNEY** - If you see a trend in something more than a spike, because a spike would be a bad year out, it is more of a -

**Mr HINE -** For example, our fatalities on the road are a sad thing. We all remember the 9 July back in 2009, when nine people died on the road in one day. The saddest day we'll ever -

**CHAIR** - We were sitting that day, I remember it well.

**Mr HINE -** A sad day. It was one of those aberrations in which, unfortunately, we had a number of deaths. In the course of that year we had 64 deaths and that was an aberration. It is a matter of trying to even it out to see if there is a spike and see whether there is a concerning spike. We look at these figures daily to see if there is a spike over a day, 12 months or a three-year period. It is about trying to obtain an average across Australia that is statistically accurate. I chair the National Crime Statistics Unit, which is supported by the ABS. We try to bring what we can do in the state to compare across Australia, but also give ourselves an accurate figure to see if there is any concerning trends we need to address.

**Mr GAFFNEY** - Is that consistent with the way they do it in other states? Do they use that?

**Mr HINE** - There are national counting rules we add into and there are also state counting rules. We have a team of two statisticians. That is all they do - help us with our statistics.

**Mr GAFFNEY** - That is fine. I needed an explanation.

**CHAIR** - Are you able to provide that to the secretary and she can -

**Mr HINE -** Can I keep it in case I am asked some questions? This is my only copy.

**CHAIR** - Okay, right.

**Mr VALENTINE** - It was partly answered but statistics is an interpretive dance. Different people look at things in different ways. Are you saying exactly the same questions would be asked in New South Wales, as to satisfaction with police services, as are here?

**Mr HINE -** Yes, that is in the Report on Government Services, satisfaction with policing services. That is what we call the ROGS. That is where that information comes from. Not all the figures are from a national perspective, but those questions about how police are performing are what form part of the Report on Government Services, which every state and territory contributes to.

**CHAIR** - Going to the family violence incident reports, there was a drop over the last two years. Do we have the figures for this year?

**MR HINE** - Family violence is something we are very committed to. There are some good news stories with it and there are others. I think it is more of a positive than a negative, but the number of family violence matters is going up.

**CHAIR** - Reports?

**Mr HINE** - Reports. I have seen figures of between 45 and 85 per cent that go unreported. That is concerning to me. I can find the latest family violence figures for this year, if you would like?

**CHAIR** - Yes, please.

**Mr HINE** - Again, this is on a daily basis.

**CHAIR** - While the commissioner is looking, minister, I commend the Government on the work they are doing in this. It is important and, as the commissioner noted, many go unreported. Has any consideration being given as to how reporting can be encouraged? It means more work but we want these to be reported so they can be dealt with, otherwise they tend to recur.

**Mr FERGUSON** - The answer is yes. Consistent with what the commissioner shared, we would have a preference for full optimal reporting so that as many offences as occur are reported, or allegations of offence are reported. They can be properly investigated. The Premier and my colleague, the Minister for Women, both have a great portfolio responsibility in this area and they play a key role in this. It is in the provision of the services, knowing that if we can build confidence there will be a strong and supportive response, which, if coupled with strong measures around education, means we are much more likely to promote reporting. That is the advice given to me, and that is what I have come to understand as a member of a Cabinet subcommittee. The commissioner's comments and the data he is about to share from the publicly available corporate report demonstrates reporting is up and that, reluctantly, we say is a good thing.

**Mr HINE** - Thanks, minister. If you look at the same time last year, we had 2651 family violence matters or incidents reported to Tasmania Police. This year we have 2800. If you look at a three-year average, it is 2500 incidents until the end of April 2018. There are a number of categories we place -

**CHAIR** - I was going to that, yes.

**Mr HINE -** Family violence incidents? So far this year we have seen a 7 per cent reduction in high-risk categories. Those ones where significant violence has been perpetrated, normally against the woman.

**CHAIR** - We are talking about physical violence?

**Mr HINE -** Any violence, as in - I talked about -

**CHAIR** - We are talking about physical, sexual, emotional, and financial?

**Mr HINE -** Yes, and emotional violence can be just as violent as broken bones. I always talk about there is several trauma and violence. While there has been a 7 per cent reduction in the high risk, there has been a 5 per cent increase in the low risk.

**CHAIR** - What do you classify as low risk?

**Mr HINE -** Where there is an argument, where police are called to make sure there is no further threat going on - basically where police have been called and get involved. Where no-one is arrested, we may make an order to keep the peace or to keep people safe. That is a low risk, where the chances of it continuing on are very low. We have seen a 5 per cent increase in that. What that tells me, is that people - and again 85 per cent of the victims are women - women are more likely to come forward and report a low-risk matter.

**CHAIR** - Earlier, before it escalates?

**Mr HINE -** Yes, which I think is really encouraging. As the minister said, it is sad we are seeing an increase reporting family violence matters, but at least we are seeing a lowering of the high-risk matters and an increase in the low-risk matters. It is encouraging that people feel more confident to come forward and report it to police or get help through other services. Hopefully, in a number of years' time, we can sit here and see a reduction in both areas, but I also want to make sure people feel comfortable about coming along and reporting it.

**CHAIR** - Minister, have any actions been taken in regard to emotional violence or financial violence or coercion in this area? We have talked about physical violence, which is a little bit easier to see. Sexual violence is again not always easy to see.

**Mr FERGUSON** - I am not expert in answering the question, but I can tell you that the answer is broadly yes. The Tasmanian Government action plan, or Tasmania's Family Violence Action Plan specifically deals with that, does use that language and does support the definition in that respect. It captures as much of the forms of abuse and violence as can be to encourage families to live safely together and to understand there are punitive actions that can be taken where the law has been broken - but as important as that, it is to encourage people to be able to report confident in the knowledge their report will be taken seriously. I think anybody listening to the commissioner just now will gain a sense of comfort in that.

**Mr HINE -** If I may add to that, we have had some prosecutions in relation to emotional and financial abuse. As you would understand, it can be difficult to prosecute, but we have had some success with prosecutions. Again, once it gets out into the community we are prosecuting people, it has a positive and an encouraging effect for other people to come forward.

**CHAIR** - It is really pleasing to hear. So many - usually women - are impacted negatively. It is really hard. It has been. Women have not been believed for a start, and have not been able to easily make a case.

**Mr HINE -** Our philosophy is we will always believe people. It is a different case what we need to prove to go to court, but we will always believe, as you said, mostly women, or any victim of family violence. That is also why we have over nine specialised trained prosecutors to help with prosecuting through the courts. We know a lot of women out there are suffering emotional and financial abuse. It is good people are coming forward. We have a lot of work still to do.

**CHAIR** - The commissioner has been very consistent in his message for a number of years on that point. I am not sure this is where firearms legislation sits. Is that in investigation of crime? Where is that, minister? We know that there was a bit of a kerfuffle around the introduction of firearms reform just prior to the election. It was not widely understood, or necessarily widely supported in the community. It has been reported that there was advice provided at the time from the former minister for Police, Mr Hidding, to the Premier regarding the policy that was to be brought forward, and that fact that it didn't breach the National Firearms Agreement. Minister, have you seen that advice?

**Mr FERGUSON** - I am not commenting on that because I am not one of the parties involved in the discussion. The Premier has taken a substantial range of questions on that and has answered them, and I don't intend to add to it.

**CHAIR** - No, I asked: have you seen the advice? I didn't ask you what is in it.

**Mr FERGUSON** - My answer is the same. The question you are putting to me, and the public commentary around it, relates to advice from a former minister to the Premier, and I have nothing to add to the record on that matter.

**CHAIR** - So as minister yourself now, have you had any advice as to whether the proposed policy breaches the National Firearms Agreement?

**Mr FERGUSON** - I always take advice from my agencies.

**CHAIR** - So have you had advice regarding that?

**Mr FERGUSON** - The public record shows I have had advice. I will always take advice.

**CHAIR** - So you haven't sought to find out what the advice was previously?

**Mr FERGUSON** - I am simply saying that as a responsible minister, I take advice of my agencies always very seriously and respectfully. I don't share that advice because I want the advice to be given to me in a full and frank way. If I were to start sharing what that advice is, then -

**CHAIR** - I am not asking you to share it, minister.

**Mr FERGUSON** - But I am providing context. I know that you haven't asked me to share it. In the interests of a full answer, I want to encourage public servants who report to me to give me full and frank advice always. Yes, I have had advice.

**CHAIR** - But the policy hasn't changed. The question is: has the policy changed since the former minister - Mr Hidding - proposed it, to what you are now have carriage of?

**Mr FERGUSON** - The answer to the question is no, the policy hasn't changed. We still have the same policy. However, what has changed is that the Government is content to await the findings of Mr Dean's committee and its report before we will take any further action. Not that it is a change, but for additional clarity, we re-emphasise whenever we have the opportunity that we will not be doing anything that compromises Tasmanians' safety. While the intentions of the policy are very squarely around a practical, sensible improvement of how the law operates, given, of course, that it is now a 22-year-old act, for legitimate firearms users, we are not going to be moving on it until the inquiry has had an opportunity to consider all the issues, to test the claims being made and to consider advice. That is my message to you and the Committee: there will be no further action taken in regard to any legislation to parliament until then.

**CHAIR** - Did you have any discussions with Mr Dean around the establishment of the select committee into this?

**Mr FERGUSON** - Yes. I speak to parliamentary colleagues on a range of matters all the time.

**CHAIR** - This House establishes government administration committees that look at particular areas, as this committee today. Government Administration Committee A now is Police, and that was determined when the ministerial portfolios were distributed following the last election. Why didn't you encourage him to refer it to Government Administration Committee A where it would normally have sat rather than potentially pick people who may just support the Government's view, potentially, rather than have a committee that is just established under our standing or sessional orders?

**Mr FERGUSON** - I don't know. That would be reflecting on a vote of your Council.

**CHAIR** - No, it wasn't a vote.

**Mr FERGUSON** - There was a vote in the Council that established the inquiry and the committee.

**CHAIR** - Yes.

**Mr FERGUSON** - I am not reflecting on that. I have no opinion on it, only that I discuss a range of matters with MPs in my party and not in my party, in both Houses, on a range of matters, but I don't discuss those conversations outside, for good reason. In respect of your question, we have supported the inquiry being commissioned and started. I have no opinion on whether it should ever have been a select committee or a government administration committee A or B. I have no view on that.

**CHAIR** - Did you encourage Mr Dean to do that?

**Mr FERGUSON** - I am not going to outline my discussions with Mr Dean, just as I wouldn't do that to you with others of your colleagues.

**2.1 Investigation of Crime**

**Mr FINCH** - Minister, there is a steady increase in allocation in the forward Estimates, and that is encouraged. Footnote 1 says the increases primarily reflect the Government's First‑Class, Next Generation Police Service initiative. Can you tell the committee something about that initiative?

**Mr FERGUSON** - Thank you for mentioning the name of our policy. That was the initiative we took to the election. It was a big commitment we made to build our policing numbers. In the previous term of parliament, we made a commitment we would restore police numbers back to what they were prior to the budget cuts in 2011- 12. During 2014, through to the current time, a number of recruit training courses were conducted and since June of 2017, there have been four graduations. I am pleased that last Friday I had the honour of performing the role of reviewing officer at the graduation of the most recent course, the third for 2017. With this group of graduates, we have met entirely our commitment to restore numbers back to previous levels.

Your question around the progression of funding in 2.1 together with 1.1 is supported by our policy to increase police numbers even more, by 125. We are increasing Tasmania Police to an authorised strength of 1358 full-time equivalent positions over the next four years. There are 10 scheduled recruit training courses over the next four years. In 2018- 19, we will see two further graduations, with course 1 of 2018 scheduled to graduate in December this year and course 2 of 2018 scheduled to graduate in April of next year. Recruit course 1 of 2019 will start in February next year with a graduation date of September 2019. There will be two accelerated training programs, commenced and completed during the 2018- 9 financial year. These programs are fast-track training for former police officers to upskill and come back into the service. This includes interstate - shall we say future - Tasmanians, who might like to return home or transfer from interstate or other territories.

**Mr FINCH** - Recruiting former police officers and encouraging them to come from the mainland, does that reflect a circumstance where you have some trouble recruiting the type of people you are looking for?

**Mr FERGUSON** - I have consistent advice that is not the case, but the selection process provides for the full range of applicants to put themselves forward.

**Mr HINE** - In fact, we have a specific recruiting drive for women. We had a 700 per cent increase in the applications from women, an overrun which is a fantastic position to be in and we would like to think of ourselves as an employer of choice. However, we get applications from police officers who have seen the light and want to come down to Tasmania and work with Tasmania Police in a better environment. It is amazing how many people want a tree or sea change to come and work in Tasmania.

**Mr FINCH** - It is a safe place to live and work.

**Mr HINE** - Exactly, and it is a different environment to raise kids and all those things. We give the opportunity for those experienced police officers to come down and do a very short conversion course, to understand what the legislation and practices are in Tasmania. Sometimes we will have between six and 10 people, to give them the opportunity, so we can get the value of their experience and put them out in the street quickly.

**Mr FINCH** - If I might just extrapolate the recruitment out to the Tasmania Fire Service, are similar credentials needed for people who apply to become a firefighter or join the fire service, or who join the police service?

**Mr HINE** - It is probably one of those benefits of having an integrated organisation, having the fire service for employment aspects sit under the minister's portfolio. If we get the opportunity to see someone and say, okay, the fire service is recruiting, maybe think about that, and vice versa. There are different recruiting tests and conditions you have to meet for each different service. Again, it gives that opportunity to cross-pollinate, to say police are not recruiting at the moment, maybe you can have a look at fire. Fire and the police were well oversubscribed with really good applicants.

**Mr FINCH** - Did you want to add more, minister?

**Mr FERGUSON** - I just wanted to add, more for your interest, that the recruitment training program is now very intermeshed with the University of Tasmania. Graduates from that eight‑month course receive official recognition from the university for their studies - the Associate Degree Arts (Police Studies). This is a recent innovation and one that recruits, when I spoke to them last Friday, were very pleased with.

**Mr FINCH** - As you mentioned, minister, the Budget provides for an increase in police numbers. When all the new officers are trained and deployed, what will be Tasmania's ratio of police to the general population? If there is not a figure, I am happy to take that on notice. I would also like to have some sort of comparison with Tasmania in those numbers to South Australia and Victoria.

**Mr FERGUSON** - I believe we can provide you with that information. It is publicly reported. We will obtain that for you and will provide it to the Committee as soon as we have it.

**Mr FINCH** - Minister, we are told that the old style -

**CHAIR** - Before you go on, I want to ask one question along the lines you have been asking, then come back to you. In terms of diversity in the force, are you able to give us some figures on the male-female mix and other diversity measures you may use?

**Mr FERGUSON** - I can tell you that in the new course - that is, five or six weeks in - a majority of the new recruits are women. Please go on.

**Mr HINE -** We have done a lot of work about diversifying our workforce. We had a specific recruitment strategy to get more women to apply to Tasmania Police. It is really pleasing, if you take it on head count, that we are at 33 per cent women in Tasmania Police in the sworn ranks. We are the highest in the country.

**CHAIR** - What about at more senior levels? Is there work to do there?

**Mr HINE -** We do have some work to do. But if you go sergeant level, my aim is to get at least 33 per cent in all levels. At the moment we do not have that. We have had some work from a national level. I chair what we call the Australian New Zealand Policing Policy Agency. We are doing some work on diversifying the workforce nationally. We have to do more work in relation to keeping women in the workforce for the first couple of years. They tend to leave for various reasons. We have to do some work there.

**CHAIR** - Not just for family, to have babies?

**Mr HINE -** For various reasons. We are also an ageing workforce. We are doing a lot of work around diversification of our workforce. We are doing really well. There are some jurisdictions that only have 20 per cent women in their workforce. We have leadership programs just for women. Donna led some of what we call our ' balance program', a leadership program just for women, to encourage women in our organisation to get the skills and the expertise. We can use their expertise in the leadership program.

**CHAIR** - Other areas of diversity? In parliament we have done beautifully with the female‑male diversity, 50:50. But we lack other areas of diversity.

**Mr HINE -** I chair our multicultural strategic working group as well. I agree, we need to reflect the community we police. At the moment we don't. It is not only by looking internally that we can diversify our employment. A couple of graduations ago we had a Congolese woman graduate. It was fantastic to see the family along. We have to do some more work. We are working with the University of Tasmania to see what we can do to further diversify and get other groups in the community to join Tasmania Police. We have worked really hard with them. We have some internal strategies and some external strategies to make sure that we are a diverse workforce.

**CHAIR** - How are you supporting members of the LGBTQI community?

**Mr HINE** - It is one of those groups that sometimes we don't do that well in so that's why I have taken to chairing those myself. I chair the LGBTQI working group with Rodney Croome and various other groups are on that. In fact we are recognised: police from Hong Kong came over especially to have a look at our program. We have various policies as well and we expanded it to include the Fire Service, Ambulance Tasmania and the State Emergency Service as well. We have a group and we have just started, just quietly, a support group as well. We give specific training to those people to be able to support anyone else who is recognised within the LGBTQI community. We are doing some of our recruitment through our contacts in the LGBTQI community as well, to make sure people in those communities are aware of our recruiting practices and the training we have. We have liaison officers. We have done a lot of work and we are about to launch our new support services very shortly.

**CHAIR** - Thank you.

**Mr FINCH** - On this subject, chair and minister, you would be aware that we twin with the Commonwealth Parliamentary Association with Samoa. There have been discussions about an arrangement for training that might be offered to Samoan police officers here and perhaps some reciprocity with officers going over to Samoa: are you aware of any of that development or could we hear about what might be developed there?

**Mr FERGUSON** - I am not personally aware of that, Mr Finch.

**Mr HINE -** Normally the Australian Federal Police does those programs, but I know some states have various training programs. In fact, the deputy and I met with the Indian High Commissioner the other day. They were certainly interested about having some police officers come down to Tasmania and maybe look at our training program, as they do in Queensland. It is normally with those Pacific Islands, and New Zealand police and the Australian Federal Police are the ones that assist them if they do meet for training purposes.

**Mr FINCH** - Samoa has not been discussed within your purview or within your discussions that you have about this reciprocity of service?

**Mr HINE** - No, there was a brief discussion, I think, with Richard Herr; I think he goes to some others - there was a brief discussion, he was going to have a look at it from his point of view but it hasn't advanced apart from brief discussions.

**Mr FINCH** - Thanks. Going back to investigation of crime, is it correct when we are told that old‑style investigative policing is giving way to a much more sophisticated model, and in what ways? What style is changing?

**Mr FERGUSON** - I will take you immediately to the subject expert on this, our trusted commissioner, but the answer is both. I will ask the commissioner to respond more fully to your question.

**Mr HINE** - Thanks, minister. It is fair to say that the Peelian principles, which are often referred to as the birth of policing 150 years ago, still apply as they are about ensuring the community is safe, ensuring there is no violence in the community - the police are the community and the community are the police. However, we know crime is getting more sophisticated and we have to keep abreast of that. Computer crime and identity theft is becoming more and more prevalent, in fact it is almost what we call a volume crime. We have to make sure our police officers are well trained in how to investigate and gather evidence. We have a project in relation to a capability review; so we need to look at the next five or 10 years and what we need to do to keep abreast of policing. As we know, the state can get hit any time by computer‑related fraud. We need to investigate it and we need forensic accountants to assist us in some of the more complex crimes.

Crime is definitely changing. We know criminals communicate with each other differently now. They will use a very sophisticated computer network and they use the dark web, if you are familiar with that, and that is -

**Mr FINCH** - No, no, I deny it.

**Mr HINE** - Basically that is an internet within the internet, and that is what criminals use. It is very hard to identify people. That is how Bitcoin and all those things are used, to make sure no-one can trace these transactions. It is very sophisticated; it is quite horrifying what you can deal with in the dark web, but again, we work with our partners -

**CHAIR** - And what you can get that way.

**Mr HINE**- It's quite frightening what you can order and organise. That is where we work with our partners, including the AFP, other state forces and ASIO, to make sure we have a really sophisticated network right across Australia and the world. The Government has given us some money to look at these capability and workforce reviews to see what we are going to look like in the next five and 10 years. You have to start looking out for that. Computer technology changes well within every six months, so you have to keep on top of that.

**Mr FINCH** - In the exchange program with the Australian Federal Police and other agencies, is it on a regular basis that our officers travel to other points of the compass - Canberra, Sydney, other major centres - to have that discourse with fellow law enforcement officers?

**Mr HINE** - I sit on various committees, including the Australian Criminal Intelligence Commission - ACIC - which is all the police commissioners around Australia - and other Commonwealth Government agencies, including taxation, ASIC, ASIO and the Australian Border Force. We all sit around the table looking at national crime trends, serious and organised crime. We have regular meetings. We then have meetings at every level within our organisation. The deputy commissioner sits on several national committees, ranging from counter-terrorism committees to emergency management. Assistant Commissioner Frame sits on our Serious and Organised Crime Coordination Committee across Australia and, again, New Zealand.

At every level we have in the organisation we are well-positioned; we are an equal partner across the country and, again, we include New Zealand. They are an equal partner with us as well. We have equal capability, and if we don't have the capability, we will get it from another jurisdiction. We have a resource-sharing arrangement with other states and territories. We are well-linked with information and intelligence-sharing and capabilities. I am satisfied we are well‑linked at the right levels within the organisation, whether from the State Service or from a police position.

**Mr FINCH** - Forensic science is becoming more efficient every year: is most of it carried out in Tasmania or do we share Victorian services?

**Mr HINE** - The world-class Forensic Science Service Tasmania - FSST- comes in under our department and the minister. It is well recognised across the country. Under the Australian and New Zealand Policing Advisory Agency - ANZPAA - arrangement, which I chair, sits the National Institute of Forensic Sciences. It is well recognised and well served by the FSST.

I commented before that we have investigated a couple of matters, including one where a leech was found at a crime scene which someone picking it up. The FSST identified that blood from that leech was belonged to a criminal involved in a nasty crime. Some years later that person was caught through someone really thinking and working collaboratively from a forensic science perspective. It was a really good outcome, and it was throughout our forensic unit. It goes to show we have a world-class forensic unit. We rely on other states sometimes if something is more specialised. Our ballistic expert within Tasmania Police's forensic unit is well regarded and world-renowned. He is often invited to Palestine to do training over there. He often gives evidence in other matters around the country and in New Zealand.

**CHAIR** - Is he Tasmanian born?

**Mr HINE**- No, he wasn't Tasmanian born. We were lucky he wanted a tree change many years ago and he came across. He is a sergeant who works with us and he is recognised as a world-class expert.

**Ms LOVELL** - Minister, page 202, the data on the investigation of crime - total offences, in particular total serious crime and offences against property: the 2017-2018 target is less than or equal to the three-year average. Do we have up-to-date data?

**Mr HINE** - I should have done a number of copies. I apologise for not thinking ahead.

**Mr FERGUSON** - We will take it on notice, and the answer is yes.

**Ms LOVELL** - Has that increase in offences, that trend we have seen in the last two years, continued into this past year?

**Mr HINE** - I am pleased to say that if you take total offences out of the last three years, we had a 10.4 per cent drop and last year we had 9.4 per cent. We had a 5 per cent decrease for this year. As a three-year average, we are going down. If you go back about 12 years ago, we were investigating about 60 000 crimes and offences. We are down to about 25 000 now. Our clearance rates are the highest we have seen. For example, serious crime is about 89 per cent clearance rate and overall crime is at a bit over 50 per cent clearance rate. It's due to these sort of things - various technologies, the hard work of detectives, better training and better interaction with the community - I can't say it is all down to police because the community assist us; economic situations. You have to have that really good partnership with the community.

Crime was a concern when it went up last year, but through the leadership of the deputy and Mr Frame, we are starting to get on top of it. Apart from some areas of concern, like motor vehicle stealing and burglary of houses, we are finding that often people don't lock their houses - simple things - or leave valuables in their cars. In a recent operation, some kids were getting into houses, finding the keys to the cars and driving them away.

**Ms LOVELL** - It was my parents a few years ago.

**Mr HINE** - While we hate educating the community to be target-hardened - I was on Flinders Island last year and if you locked your car, it was almost like it was a slight on the community; I would love to live in a community like that - unfortunately we have to take the opportunity away from criminals.

**Mr VALENTINE** - You can't go too far on Flinders Island.

**CHAIR -** I spoke to one of the police officers over there on one occasion, saying perhaps they don't go as hard at that on King Island because they don't lock their cars. There's no need to. It is a nice community to live in. He was being a little bit overzealous as the new officer there.

**Mr HINE** - They started locking the police car because someone played a joke on them and moved the car one day. Island policing is different and it is fantastic. Again, we have to keep educating the community to work with us because if we don't have the backing of the community, our job is so much harder.

**CHAIR** - Are there any hotspot areas where there is more crime? The commissioner talked about the economic circumstance of people improving and that has probably had an impact on the overall number of offences, but are we still seeing more crimes in those lower socio-economic areas?

**Mr HINE** - We map our crimes every day; we have areas in each district, and all they do is map crime. Overnight they get on top of it straightaway to make sure we can see whether there is a trend. If you asked whether as a general rule crime is committed in lower socio-economic areas, the answer is probably no. We had a recent operation called Operation Saturate. About nine youths were involved and they were charged with about 26 to 900 offences. They were out of control. Again, this showed up through various policing methods, and they set up a task force to make sure, but if you said it was the lower socio-economic areas -

**CHAIR** - It is important the message is there because there is a perception crime is an issue only in those areas - a certain cohort of individuals, whether young people or people from a certain suburb, but you are saying this is not necessarily the case? It is broader?

**Mr HINES** - For where the crime is committed, it is broader than that. Sometimes, it is the individuals. Sometimes, the individual causing us the greatest amount of crime comes from different area. We have a really good youth intervention policy, where we send 50 per cent of people to courts. It is about intervening at the right time, and getting onto the right hotspot, making sure we are intervening to stop them continuing to commit crime. Again, in some of these areas, while they have a bad reputation, 95 per cent of people are decent people and law-abiding.

**CHAIR** - And law-abiding.

**Mr HINES** - There is a small percentage, unfortunately, who cause the issues we need to target, but we know the vast majority of people in those areas are hardworking individuals who help their community.

**Mr FINCH** - They voted for Ivan Dean. Yes, that is right. Often.

**CHAIR** - He is getting too much airplay today.

**Mr FINCH** - A story from West Tamar. We have a particularly safe area, and are very pleased with the way the police conduct their business. We had a string of crimes occurring, but it was discovered by Scott McConnell and others that a drug dealer had moved into an area further up the Tamar and the criminals coming to get their drugs were committing crimes on the way up and back. That gave a spike in our activity.

**Mr HINES** - It is actually working with the community and giving the confidence to the community to report those matters to us. Whether it is through Crime Stoppers or directly through their local police officer, where we can have the greatest value is making sure we have the community on board. It does not happen all the time. To get the community interaction to make sure we have those good relationships, where they feel comfortable, whether it is family violence or a drug matter, to actually report it to us. If we cannot do something about it, obviously we need to explain we are working on it, but sometimes it is the little bit of information that fixes the puzzle.

**CHAIR** - There is one not here -the offences against persons - do you have information on this?

**Mr HINES** - Yes, the offences against persons in the Budget - are you happy for me to fill this in?

**CHAIR** - Yes, the form's information talks about offences against property, but unless it is somewhere else, I have missed it.

**Mr HINES** - Again, this all the information we put in our online report. Offences against persons until the end of April this year had an increase compared to last year. Last year it was 3599; this year it is 3859. Again, getting back to Mr Gaffney's point, with a three-year average, it was 3408. So we are above the three‑year average this year, which is a concern. It is in the budget.

**CHAIR** - Is it? What page?

**Mr HINES** - Page 201. It is on the 'Support to the Community'.

**CHAIR** - It is, too. I highlighted this when we were there before.

**Mr HINES -** Again, we look at any trends across the various districts and break it down to local government areas, and then break it down to towns. Again the clearance rates are really good, but I would rather prevent then actually have to clear it. Our clearance rates against the person is particularly high; if we have a look at our annual clearance rate, we are 95 per cent against the person. But -

**CHAIR** - Which improved in 2016‑17?

**Mr HINE** - I would rather go into prevention and not let these things happen. One of our prevention measures is to say that if you are going to commit an offence against a person, you are 95 per cent likely to get caught. That is a prevention measure initiative in itself, but it is something we need to keep an eye on.

**Mr VALENTINE** - In regard to officer safety when you are investigating crime, what is the policy these days? Do you send single police to a scene?

**Mr HINE** - We worked very closely about two years ago with the Police Association because officer safety is a concern for them and it is certainly a concern for us. Through a lot of hard work we developed what we call an operational safety model. There are certain categories of calls given to police where it is mandatory two police officers must attend. There is no question they must attend in line with the operational safety model -

**Mr VALENTINE** - And that does not matter how minor it might appear?

**Mr HINE** -There are various categories we break it down to. If someone goes to it and believes it's not as bad as they thought, a supervisor has to validate that. We are in the process of evaluating that with Assistant Commissioner Cowling and the Police Association. It has been a successful model. We're are looking after the safety of the police officers and we're looking after the safety of the community. As I keep telling our recruits, there is nothing more important for us than the safety of police officers.

**Mr VALENTINE** - Cannot do much crime if you have lost a police officer.

**Mr HINE** -Yes, that is right. Unfortunately it is a dangerous occupation at the best of times and -

**Mr VALENTINE** - At least you cannot solve much crime, I should say.

**Mr HINE** - No. We certainly want to make sure that when they go to work, they should come home. We cannot eliminate risks - we understand that - but we want to try to reduce the risk the best we can.

**Mr VALENTINE** - It must be difficult, though, for isolated locations?

**Mr HINE** - Whether you are at a one-person station in an isolated location or you are in the city, the operational response model applies equally. So if you have to wait before you can go to the job, you can stand off and have a look. We have a cluster arrangement with the one- or two‑person stations to make sure they have backup. When they first get the call, the nearest car will go, the backup is on the way, and they will sit off and maybe observe. Then when their backup arrives, they can go. We are in evaluation at the moment. Other jurisdictions are looking closely at what we are doing because they think it is a good model. The extra 125 we get through the Government will help support that model.

**CHAIR** - We received the table, minister, and it is an impressive set of numbers. You must be very proud of your police force.

**Mr FERGUSON** - I am sure we all are. As a new minister, I do not claim any credit in it. I thank Commissioner Hine and his team. I don't mind mentioning the remarkable leadership shown by my predecessor, Rene Hidding. He was very supportive, including in the area the commissioner has just been dealing with, on supporting staff to be safe as they go about their work.

**2.2 Poppy security -**

**Mr GAFFNEY** - This should not take too long, it is very cut and dried. How many individuals were charged with poppy-related offences in the last season?

**Mr FERGUSON** - While the commissioner is seeking that information, I can provide an answer to Mr Finch's earlier question. I have information here that provides a comparison for Tasmania with other states and the national average. Tasmania has nine fewer operational staff than the national average per 100 000 population. On my rough maths - I have not been a maths teacher for about 16 years - when we achieve 45 of our extra police, we will meet the national average on operational staff members. That is provided to the committee for your benefit. It shows other states as well.

**Mr GAFFNEY** - How many individuals have been charged with poppy-related offences in the last season?

**Mr HINE** - In relation to the poppy season, going back through a number of years to give you a trend - in 2012‑13, we had 2900 capsules stolen and from there, 3900, 331, 516, respectively. Last season 12 000 poppy capsules were stolen. During that year, eight people were charged but as at 1 May this year, 1430 capsules stolen have been through 14 different interferences with crops, but we haven't charged anyone to date.

**Mr GAFFNEY** - Were any people hospitalised or any deaths relating to poppy theft in 2017‑18 that you are aware of?

**Mr HINE** - I am not aware of any at the moment. Normally we do, but I am certainly not aware of any at the moment.

**Mr GAFFNEY** - Did Tasmania Police change its approach and policy relating to preventing or detecting offences in the last season or the season just gone? If so, how and was it effective? Obviously it has been effective because of the number of capsules, especially with the increase on the year before. Was there any change in the way you operated in poppy security?

**Mr HINE** - Basically no. We integrate our poppy security investigation within our drug squads and the country uniform areas as well. We have a very good working relationship with the Poppy Advisory and Control Board. While we haven't changed a great deal, we have an integrated approach to it. Our general uniformed people in the country area keep an eye on the crops and they are supported by the drug squad. We have a person who liaises with the Poppy Advisory and Control Board as well. While the number of hectares is going down, the year before was a particularly bad year, we charged eight people. The number of thefts this year was certainly down.

**Mr GAFFNEY** - With the world environment changing, the decrease in the US market, and Turkey and Spain producing more poppies, and even now in Australia - Victoria came online in 2014, and 2000 hectares was planted in New South Wales this season - we have seen our markets go down by two-thirds. Even now farmers are steering away from poppy production as a viable crop because of decrease in its value. I notice the continuing increment rise over the next four years is $80 000, which will take it up to $1 million. I know you still have to do the same type of work but surely, with the decrease in the amount of production in Tasmania, there might be a decrease in the funds required to monitor the poppy security? I wonder how you evaluate that and who comes back to you, saying 'We don't need to continue our poppy security money forever and ever.'

**Mr HINE** - A very good question, Mr Gaffney. You need a certain cohort of people to investigate drugs in general and the poppy investigation arm is a part of that. You need a cohort of people who look at this as well as the general uniformed policing. Even though the hectares and the value of the crop are going down, you need a core group of people within the drug bureau to investigate it. It is probably just indicating we have the same amount of effort, and we may have to review it in the out-years as part of the budget process as well. We find drug offenders will offend not only in poppy areas, they will offend everywhere, so you need that core investigative capacity to support it.

**Mr GAFFNEY** - While the line item is poppy security, it is poppy/drug security because it branches out into other areas. Even though the medicinal cannabis is in the hothouses and that is a different environment, you are still going to need that arm of policing.

**Mr HINE -** Because it is so interrelated. The offenders and those committing the offences are so interrelated with other drug offending, which is why we changed our tactics a number of years ago. If you have them sitting outside the investigating environment, you are not providing the best service for the community and the best investigative capacity in relation to it. You basically hit the nail on the head.

**CHAIR** - There was a levy imposed on the industry to fund this activity. Is this still the case?

**Mr FERGUSON** - Out of my portfolio, but I am aware of a reform my colleague, Mr Rockliff, brought through the parliament in relation to poppies. I would need to get the advice before I proclaimed an answer on levies.

**CHAIR** - It does not feed into this line item. Does it go elsewhere in DPIPWE? Just wondering if any of the money came into your line item here or whether it's in others? Is it funded entirely from the Consolidated Fund?

**Mr FERGUSON** - It may be directed to DPIPWE outputs; I would not know.

**2.3 Fisheries Security**

**Mr VALENTINE -** In the forward Estimates we show no significant resourcing increase to fisheries security activity. There is an expectation more offenders will be detected. Can you provide details on how the marine police are improving the efficiency of detection or why they do not need an increase in staffing? It is being suggested it will go up by 10 per cent. Is this simply because of the new vessel being able to go further offshore to catch more people?

**Mr FERGUSON** - I will pass that to our commissioner to answer. I assure you when my small vessel was recently checked over by a member of Tasmania Police, it was given a clean bill of health. All required items were on board. The friendly police officer even helped me to pull it onto the trailer. There is information here but I will let the commissioner bring this to the table. From 1 July through to 31 March this year, a total of 4500 thousand sea patrol hours were completed by Tasmania Police vessels.

Tasmania Police works in very closely with DPIPWE in coordinating regulatory activities. It also conducts joint operations, and shares intelligence and prosecuting matters. Tasmania Police also works closely with the Australian Government in relation to its waters and assists with surveillance flights. As to the increasing upgrades to our police vessels, there is increased scope for onshore and water-based compliance activities.

**Mr VALENTINE** - Hence the 10 per cent projection. In 2015- 16 to 2016- 17 there was a 10 per cent growth, but my question was about the lack of change in staff numbers.

**Mr HINE -** There are an extra four staff due to the extra investment by the Government in bringing the PV *Cape Wickham* into action. We put an extra four staff on to help crew that vessel. It can do additional hours and so we have additional police there. We now basically have two sister ships, with PVs *Van Dieman* and *Cape* *Wickham*.

**Mr VALENTINE** - The PV *Dauntless* is gone?

**Mr HINE -** The PV *Dauntless* is still here. In fact it is out of the budget. That is the next one to be replaced.

**Mr VALENTINE** - When is that likely to occur?

**Mr HINE -** There is a small amount of money in next year's budget, but the budget for the year after that s where the majority of the money to replace the *Dauntless* is. It is an 11-metre vessel, a catamaran. Money has been earmarked in 2020‑21 for the replacement of PV *Van Diemen*.

**Mr VALENTINE** - With quite a significant growth in aquaculture operations, do you get much call on your services because of crimes committed in and around those facilities in any way, shape or form?

**Mr HINE -** The short answer is no, we don't get a lot of marine police activity apart from the normal activity we do in those waters. I'm certainly not aware of it.

**CHAIR** - Catching escapees occasionally when you are out and about.

**Mr VALENTINE** - I am not talking about the escapee fish.

**Mr HINE -** Fishing rods are not allowed on police boats. We banned that some time ago. Our role is to enforce and not to get out there and catch fish. Obviously in certain circumstances they can do that. The short answer is that there is not an extra call now on our resources to help police that area.

**Mr VALENTINE** - That is encouraging. It may be because of all the video surveillance they do themselves as well. Can you detail recent fisheries offence data again, year to date, in terms of the seriousness of the offences, perhaps by type of protection, commercial or recreational, fines levied, whether prison sentences have resulted or whether there have been warnings, and percentages of all of those?

**Mr HINE -** Yes, we have all the facts and figures here about the vessel patrol hours and all the various inspections as well. I am just trying to have a look. We can certainly supply these. I am trying to get all the offenders and offences as well. Please bear with me.

**Mr VALENTINE** - If you want to table the document, I am happy with that, for the sake of time.

**Mr HINE -** For the fishery offenders, these are not settled figures because we normally wait a month before they are settled in relation to briefs -

**Mr VALENTINE** - Sorry, is this year to date?

**Mr HINE -** This is year to date, as in today. These figures are up to date.

**Mr VALENTINE** - For this financial year.

**Mr HINE -** Yes. There is one brief - there are 521 cautions, eight informal cautions, 90 infringement notices, 17 commercial fishery offences, 201 recreational fishery offences, 400 offenders [inaudible], 864 MAST offenders, 10 briefs and 794 cautions. Most of these are on our internet site.

**Mr VALENTINE** - Could you table that document or send it to us?

**Mr HINE -** Yes. We normally wait until these figures are settled, about three weeks.

**Mr VALENTINE** - That is fine, it is not a problem. We want a whole year's data.

**Mr HINE -** With our statistics because they tend to change - as in offences - we normally wait for what we call the 'settling period'. It is normally two or three weeks before we publish those settled figures.

**Mr VALENTINE** - That will show which ones went to court et cetera, and which ones ended up in infringement notices or cautions, or prison.

**Mr HINE -** We don't actually keep which ones go to prison. I am not sure how easy it would be to find the ones who go to court and end up with a prison sentence. We would have to search some of the Justice system. That might be a little harder.

**Mr VALENTINE** - If it is not easy to get, don't worry about it. If you can get it, that would be good.

**CHAIR** - I have one question on this: what about the ones that get away?

**Mr HINE -** The fish or the offenders?

**CHAIR** - The fish don't get away, that is the thing. You talk about the total number of offenders detected. There are plenty that are not detected because they have all sorts of ways to avoiding that. Do you think you are finding half the offenders? Is it more than that? I know it is impossible to tell for sure -

**Mr VALENTINE** - Unknown unknowns.

**CHAIR** - Yes, but these are the ones who are not detected but who are still committing offences, particularly in the recreational area. The commercial area is probably much easier to police, but I could be wrong about that.

**Mr HINE** - I think you are right. The commercial industry is between ourselves and DPIPWE, and is well regulated. A lot of policing activity is in relation to that. It is a bit like the Donald Rumsfeld - you don't know what you don't know. That is where we have intelligence‑gathering on marine offenders. If people see or suspect someone is committing a marine offence, we have contact numbers or Crime Stoppers. They can give that information to us. Again, it adds to that picture. It is like any crime or offence. We are aware of a lot that we keep an eye on because -

**CHAIR** - You still have to catch them at it.

**Mr HINE** - That is exactly right. We keep encouraging people to give us that information because it could be an offender we are not aware of. This could add to that because it is a natural resource that is a valuable commodity to the state and we have to make sure that we protect it.

**2.4 Support to Judicial Services -**

**Mr GAFFNEY** - I think we have covered some of this in the overview. Last year I stated there was a significant increase of 6 per cent. State charges prosecuted increased by approximately 8.6 per cent between 2015-16 and 2016-17. Do we have an update regarding figures for 2017-18?

**Mr HINE** -About state charges prosecuted?

**Mr GAFFNEY** - Yes.

**Mr HINE** -Yes, it will be on that table we have -

**Mr GAFFNEY** - What is the present three-year target the department's trying to exceed?

**Mr HINE** - State charges prosecuted - at the moment, the target is sitting at 35 387 and our actual is 40 016. We are exceeding the target of state charges prosecuted.

**Mr GAFFNEY** - Last year you explained it was because you had more staff doing the work, so that is not a bad thing.

**Mr HINE** -Yes.

**Mr GAFFNEY** - Last year we talked about the Department of Education having some funding, you said, 'The Education Department does supply funding for that program as well. We need to continue to work with the Education Department.' It was highlighted that most of the work you did in the colleges happened in the colleges, but now with the devolution of the high schools extending to year 12, you are going to come up with the situation in the not-too-distant future in which the colleges are not going to be the one-stop shop for 17- and 18-year-olds. It is going to be in other schools as well. Last year, Mr Hidding said, 'It was a good thought, we will bend our mind to that.' I said, 'I will ask you the question next year to see what has occurred in that space', and Mr Hidding said, 'I will be ready for it if I am here.' I think this plan has been on the cards for quite a while.

It is something that needs to be considered if the Department of Education is doing that. There is a good case. My wife works at Don College and the support they receive at that college, in times when it shouldn't be up to a staff member to have to deal with that, the police have been exceptionally invaluable. It is about developing the relationships between the young people and the police, which is more of a supportive one. How do you budget for that and how do you spread your wings into the school system in addition to the college system?

**Mr HINE** - We had a good discussion last year in relation to it. It comes back to our approach being active rather than reactive. This is part of our approach, as in we are now building numbers back up and we are doing this resource and capability review. That is one of our areas and one of our business priorities is to look at how we can be more proactive. The youth space is one of those areas we need to get better at. I think two colleges dropped out recently. We are in five colleges and two dropped out.

We are doing a review to make sure that having police officers in the colleges is still working for us and the Education department. Do we need to interact more with the other schools, whether primary schools and high schools, to make sure we are interacting with the right age groups and the cohorts? That will be part of the review we are conducting at the moment. It is an area I am quite concerned about, where we can make sure we have an impact.

**Mr GAFFNEY** - When you say you are doing a review, is that an internal review or a review that will then come to us with the results of your investigations? I think it is an important one for the community. The younger staff you have now, police officers, are connecting with the 17- and 18-year-olds. I think it is a very good program.

**Mr HINE** - We received $100 000 in the budget to do a workforce plan and we are combining that with the capability review. Hopefully we will start implementing in March and April next year. Our intention is not to have general public consultation, but to have targeted consultation with various groups. Education is obviously a major stakeholder. I agree that sometimes there have been questions asked about whether we are targeting the right people, the 17- and 18-year-olds. I mentioned that tour of the various schools. Some of those said, 'Look it would be great if you could get more police into the lower age groups as well'. We want to try to get that balance.

We have youth teams within the department around the districts. How can we use them to intervene best? It is going to be a target for our review. We know that it is a good investment and we get a really good return for our investment.

**Mr GAFFNEY** - I think targeting 17- and 18-year-olds has the advantage that you are actually targeting young people who may be targeted by others within the community.

**Mr HINE** - I agree with you. There are a lot of experts we can draw on to make sure we do get the right combination.

**Output group 3**

**Traffic policing**

**3.1 Traffic policing -**

**Mr WILLIE** - I know this line item is more to do with targeting high-risk driver behaviour on highways, breath testing, drug testing and things like that, but I raise this as a local issue. In my electorate of Elwick we have a bike track, which has many pedestrians and bikes on it. That intersects with quite a number of arterial roads. From time to time constituents raise pedestrian safety issues with me. We have had a number of inquiries about hooning. I have written letters to the previous police minister and to the council. How does the triangle between your policing of traffic, State Growth and local government work, and how so you use all three to manage traffic and improve safety?

**Mr HINE** - We have regular meetings with State Growth at the deputy commissioner level and the assistant commissioner level when those sort of issues come up. As soon as you mention the words 'pedestrians, cycles and vehicles', there is an emotional attachment to some of those responses - especially the cyclists versus motor vehicles. We're trying to get the best outcome for all involved because we know that pedestrians and cyclists are vulnerable users. There is no protection around you, but it always invokes that emotional response.

When we put some of the issues up on our Facebook site, we get lots of comments, including some quite concerning comments. The triangle is there - throw in local government as well to make it a square or a rectangle - to try to get that altogether. From a policing point of view we have the inspectors in charge of the area to make sure. The inspector, local government, State Growth, cyclists and motorcycle groups get involved as well as the Road Safety Advisory Council, which we sit on with State Growth. It would be great if there was a really easy solution. Pedestrians, motorists and cyclists do the wrong things, and the three wrongs do not make a right. We are certainly concerned about cyclists and pedestrians, because they are vulnerable users.

**Mr VALENTINE** - Pedestrians feel neglected.

**Mr HINE** - Yes, they do. Again, I understand the situation you face and there is no easy answer. We are trying to have a problem-solving approach, but road design is certainly not our purview and it takes it quite a while to do it. If everyone were a courteous road user, no matter what form of transport or walking, we would all get on really well. Of course you always get people who push the envelope even more strongly. I understand your problem, and it is one we need to continue to look at. Enforcement is certainly an aspect and we can enforce some of the laws. Education is another aspect. If you do not educate your community and do not enforce it, it will be a poor [inaudible] for a start. It is going to be a combination of things.

**Mr WILLIE** - Is there a trigger point that says you have a certain amount of fines in one area?

**Mr HINE** - No. The sad thing about it is that sometimes the trigger point for the community is when someone dies. We regularly interact with State Growth with meetings. We encourage our districts and local inspectors to put it through the district commanders, so it comes to the deputy commissioner and the assistant commissioner, and we can raise it with State Growth. Enforcement is certainly one of the things in our purview, but also problem-solving is in our bailiwick. You cannot book everyone for doing the wrong thing. Again, it is part of the education process. It is a really tough issue.

**Mr WILLIE** - There are so many main roads that dissect walkways.

**Mr HINE** - It is those combinations with that - pedestrians, cyclists and cars - that are a really tough mix to get right.

**Mr WILLIE** - And an elderly population trying to cross the street.

**Mr HINE** - Exactly.

**Mr VALENTINE** - You mentioned road design. Is there communication between police and those designing the road projects in terms of what the commissioner is saying?

**CHAIR** - It is part of the long-term structure planning.

**Mr VALENTINE** - I am on the Public Works Committee, so I am interested in that.

**Mr FERGUSON** - The Commissioner will respond, but there is some very good open data on road crashes, deaths and serious injuries available. With another hat, we have been putting it out actively, by publishing the dataset in a project called GovHack, where the data is visualised. It has been quite useful. State Growth, which is principally behind the government's road design rules, obviously looks at the information, particularly in the decision-making process, to decide what the next priority is for investment.

**Mr HINE** - The statistical data through the crash management system State Growth operates is used for policy-making. The Road Safety Advisory Council gives advice about shoulders on the road for vehicle run-off and also cyclists, pedestrians and so on. They certainly interact this way, but obviously engineers and road design is a State Growth issue. They take into account accident statistics and data from the police and the Road Safety Advisory Council. Matters come up before that also.

**Mr VALENTINE** - I was thinking more of situations where you might be about to pursue a vehicle on a major highway, but you have these - I call them cheese cutters because I am a motorcyclist - barriers and you can't do a U-turn and chase. That must present some issues. I don't want to create a debate here but how long is it between turning points and those sorts of things?

**Mr HINE** - I know they need to take into account whether it's a police vehicle or a fire service vehicle or an ambulance to turn around. We have a very strict pursuit policy, as you know. Also, from an ambulance and fire service point of view, they take into account how far they can have it before there is a turning point, especially on the major arterial roads.

**CHAIR** - I am conscious of the time. Are there any more burning questions in this area?

This talks about your visibility of patrols on highways. We often have the discussion about marked cars as opposed to unmarked cars. Can you tell us how many marked cars in the fleet are involved in road patrols as well as unmarked cars? If people knew there were so many unmarked cars out there, they might take a bit more care.

**Mr HINE** - We have 14 marked motor cycles; 16 high-visibility vehicles; 193 marked vehicles; 18 unmarked, non-operational vehicles, no lights and sirens; and 133 unmarked operational vehicles, including covert lights - that totals 374 vehicles.

I agree with you wholeheartedly. With every car behind you, the motoring public should be thinking, 'Is that a police car or is that not a police car?'

**CHAIR** - If the badge is not glittering in the window, it is a bit hard to see.

**Output Group 4**

**Emergency Management**

**4.1 State Emergency Services**

**CHAIR** - Kerry has indicated he has some questions he has been meaning to ask in 2.4 but we will do State Emergency Services. We can probably combine State Security and Rescue Operations and the State Fire Commission for the ease of questioning. Minister, are you happy to do that?

**Mr FERGUSON** - I'm happy to deal with Mr Finch's questions now since the right people are still here. We will have a change in personnel.

**Mr FINCH** - I wanted to go to the services, particularly to Corrections officers. Five new Corrections officers have been trained and will start prisoner transport and security duties in Launceston next week to replace Tasmania Police officers to allow them to go back to frontline duties. This has already been happening in the Hobart Supreme Court since the 1990s - I am not 100 per cent sure of the date.

In the north-west, police are still sitting in as security and having to transport prisoners. A project manager has been appointed to investigate options, but there is no solid plan for Corrections officers to replace police in the north-west. I wonder if I can get something definitive about what might be in the offing and what might be in the planning stage for that, please.

**Mr FERGUSON** - Mr Finch, both the commissioner and I will answer your question. It's been a very positive development in relation to the project to swap out police for Corrections officers for court security. I do know that this would be a matter that will be perhaps constructively raised with my colleague, the Minister for Justice. I don't think she has appeared before the Legislative Council yet.

**CHAIR** - No. She is downstairs on the other committee.

**Mr FERGUSON** - This would definitely be a matter to raise with her. There is a different set of issues than has been the case in Launceston. I do not want to talk across another colleague's portfolio. Suffice it to say that, operationally, Tasmania Police are ready, willing and able to continue to support port security on the north-west coast until such time as a different model is identified by Justice.

**Mr FINCH** - Do you have any time frame on that, minister?

**Mr FERGUSON** - I can say no, there isn't, but I would be reluctant to say too much more about another minister's portfolio. That is my understanding and that is our willingness to continue to support as we do right now.

**Mr FINCH** - Yes, and you would be looking at having those officers back on the beat and available to do other duties by having Corrections officer work in the courts.

**Mr FERGUSON** - Yes.

**Mr HINE** - Through the minister, it was in the media today that the Corrections officers are taking over from the police. With the additional eight police officers who graduated last Friday, of which the minister was the reviewing officer, an extra eight went into Launceston and those additional police officers who aren't doing court security in Launceston will go back to operational duties.

**Mr FINCH** - That is a situation you would prefer to see on the north-west coast, is that right?

**Mr FERGUSON** - If Justice can find their way to a different model, the police resources could be utilised in the community in a different way.

**Mr FINCH** - Thank you.

**4.2 State Security and Rescue Operations -**

**Mr FERGUSON** - Thank you for the way you have proposed to go ahead with this. Chair, if you are happy I would offer that you skip over 4.1, and we deal with 4.2 with the same personnel at the table. After that we might go back to 4.1 and deal with the SES and the State Fire Commission.

**CHAIR** - Okay, that is fine.

**Mr FINCH** - It was my task to look at the State Fire Commission and the circumstances around the budget allocation and the responsibilities et cetera, and there was such a variety of responsibilities for the State Fire Commission, unbelievable -

**CHAIR** - Kerry, we are focusing on the state security and rescue at the moment.

**Mr FINCH** - Yes, which seems to dovetail into that operation; am I correct there, minister?

**Mr FERGUSON** - I am not sure if you might have heard, the Chair has agreed we might switch the orders. It was suggested we might come back to 4.1 soon.

**Mr FINCH** - Okay. It all seems to be such a grab bag but I am happy to proceed with what the Chair rules.

**Mr FERGUSON** - We will answer it now or at 4.1, as you see fit.

**CHAIR** - Yes, we might leave that for now because it is more related to the State Fire Commission and we don't have the right people at the table for that.

**Mr FINCH** - Okay.

**CHAIR** - We are short on time but with regard to the state security, minister, we know terrorism remains an ongoing threat to us all. If we look around the world, we see vehicles being used in many attempted or actual terrorist activities. What action is your Government taking - we don't want to se bollards everywhere and big concrete blocks, hopefully - but I think of Dark Mofo recently, where it would have been pretty easy to plough into crowds with a vehicle from many directions, and other major events like AFL games. What is the level of threat is here and what are you doing in that area?

**Mr FERGUSON** - We have very clear advice on this. We take that advice extremely seriously. There are regular meetings at every level, including at executive, to ensure there is a shared understanding of the threat level and any intel that needs to be understood by the Premier and the Minister for Police, Fire and Emergency Management. We back our services around that. While we do all those actions and tactically respond, we also want to send messages to the community about things they can be doing and to be aware of the world around them, but also to assure them we are keeping our state safe.

**Mr HINE** - We are well resourced in relation to the national counter-terrorism arena. I will hand over to the deputy commissioner in a minute, if the minister is okay with that, to discuss some of the finer details. We must have a capability equal to every other state because if something happens in Tasmania, we need to have that capability to respond, whether it is a special operations group, negotiators or a bomb squad - we need to have those capabilities.

We have several plans in place relating to counter-terrorism. We Acting Assistant Commissioner Geoff Smith helped on the Australia's Strategy Protecting Crowded Places from Terrorism report that was commissioned nationally. Geoff was on the writing group that travelled around the world to make sure we are well prepared. We engage the public sector in relation to that as well as shop and facility owners.

Deputy Commissioner Tilyard sits on the Australia-New Zealand National Counter‑Terrorism Committee.

We brief the minister and the Premier every month on the current issues. There are no known threats in Tasmania. As I often say, it is the ones you don't know about that could potentially do the most harm. If you are happy, I will hand over to Mr Tilyard.

**CHAIR** - I noticed there is also a decline in the Budget appropriation in 2019‑20 and the expenses, if there can be some explanation in the deputy commissioner's comments regarding that?

**Mr TILYARD** - The minister and the commissioner covered the key points. The national terrorism threat level was elevated to probable in September 2014. A new threat level scale was introduced shortly thereafter. What that means is that a terrorist attack in Australia is deemed likely. I am pleased to say the threat environment does vary somewhat across the various jurisdictions. In Tasmania it is not as high as it is in places like Melbourne, Sydney, southern Queensland and those areas. That does not mean something could not happen here.

As the commissioner mentioned, there are national arrangements for the Commonwealth Government and the states and territories to work together in a collaborative way to counter the threat of terrorism in Australia. They are longstanding and well-tested arrangements. We are very much a part of that. One of the key focuses in recent times has been threats to crowded places, which were previously referred to as mass gatherings. We have seen attacks in other countries targeted at large groups of people. Using vehicles has, in more recent years, come to prominence as one method of attack. They are fairly unsophisticated attacks, and vehicles and trucks are readily available. That is a trend we are seeing.

Acting Assistant Commissioner Smith, as the commissioner mentioned, has been a key part of preparing Australia's national crowded places strategy. That strategy was launched in the middle of last year and we have done this in Tasmania, by conducting regional forums with business operators and critical infrastructure operators to enhance their awareness and to support their own security arrangements in relation to their infrastructure. That includes major shopping centres and those sort of locations. We work very closely with local government in Hobart, for example, with the Hobart City Council, in planning events like Taste and Dark Mofo, which has just been held. We assisted them with protective security advice to supplement their planning arrangements.

Even in places like Tasmania we now take into account hostile vehicle threats and we implement measures designed to mitigate those risks. We are plugged in nationally and with our overseas partners on what is best practice in this particular area.

**Mr HINE** - For example, the Run the Bridge was conducted this year in conjunction with State Growth. We decided to close the bridge for that two hours, while runners go across. It is helpful in a counter-terrorism threat or if someone has a medical episode. Vehicles can be deadly so we have to put that security envelope across everything we do now. The Government has funded us to look at reintroducing a full-time special operations group as part of our capability review.

**CHAIR** - They are diminishing that in 2019-20 in the Budget, are they?

**Mr TILYARD** - The State Emergency Services - is that what you are referring to?

**CHAIR** - No, it is in this line item. In 2018-19, there is $9.183 million; in 2019-20, $8.897 million is appropriated for this line item. There is no footnote. The expense summary is $10.299 million in 2018-19 and $10.013 million in 2019-20.

**Mr FERGUSON** - While you are on that point, I know you are not suggesting it is a deviation, but I am happy to just -

**CHAIR** - In terms of implementing a special operations branch. You can take it on notice.

**Mr FERGUSON** - Are you asking about the revenue from appropriation or the expense side?

**CHAIR** - Both drop away, minister; it is similar.

**Mr FERGUSON** - What if we were to report back on the output group expense somewhere, which is the larger figure, and how that fluctuates?

**CHAIR** - That would be fine. I am sure it will be the same reason. While you are here at the table, do any members have questions on the Capital Investment Program?

**Mr VALENTINE** - Total helicopter hours: you have state security and rescue operations, but do you have a breakdown of how much is being used for security versus search and rescue?

**Mr HINE** - Mr Crawford is our helicopter expert.

**Mr VALENTINE** - It has gone up 20 per cent.

**CHAIR** - We need to move on or we will run out of time. We have science and technology to come.

**Mr CRAWFORD** - We don't have at hand a clear split of the breakdown between that output group against those two issues, helicopter and state security. However, helicopter hours have significantly increased; with the helicopter contract, it is consistently going up.

**Mr VALENTINE** - Not cheap.

**Mr CRAWFORD** - Not cheap, largely a result we are seeing from a policing and a rescue perspective of increased visitations to the state, particularly in national parks. There has been an across-the-board increase there and we are seeing rescue jobs reflected in that increase.

**Mr VALENTINE** - Are you looking at drones to do some of the work helicopters might otherwise do?

**Mr HINE** - Thank you for that question. The Government has committed the $100 000 per year to look at, not only hooning, but at how drones can be used to combat hooning. Part of our capability review is to see how we can use those drones, not only to combat hooning, but also for search and rescue. As we know, we have used them before. They can search a riverbank quicker, easier and more cheaply than a helicopter.

**Mr VALENTINE** - A cheaper exercise, and/or drop gear.

**CHAIR** - Let us keep going with it. I am conscious of the time.

**Mr HINE -** FLIR thermal imagery, as in the heat-seeking technology, can also assist in searching. The answer is yes.

**CHAIR** - Capital Investment Program, anyone want to ask specific questions, on page 205? There is some good commentary in the key deliverable section of the Budget papers that describe most of this. We will come back to SES and the State Fire Commission.

**4.1 State Emergency Services**

**CHAIR** - You have been waiting a long time.

**Mr FERGUSON** - I thank the commissioner and the deputy commissioner for being with us and supporting the committee. I introduce the chief officer, Mr Chris Arnol and the director of the State Emergency Service, Mr Andrew Lea.

**Ms LOVELL** - Minister, the June 2018 issues paper states work is currently being undertaken on the development of a sustainable funding model for the SES. Can you detail what work is being undertaken and when it will be completed?

**Mr FERGUSON** - Thank you, Ms Lovell. I will ask the chief officer to assist me. We are reviewing the Fire Service Act 1979 right now. The Government has already commissioned that and it has commenced. I think you even mentioned the paper, didn't you?

**Ms LOVELL** - I did, yes.

**Mr FERGUSON** - That has just gone out. It was discussed in the other committee yesterday. The comprehensive review of the act in all subordinate legislation is considered timely. It is particularly the case with the State Emergency Service, now reporting through to the chief officer, TFS, and the resulting opportunities to further align the TFS and SES are to be reflected in legislation. You mentioned the sustainable funding model, which is a goal in part of this project. The review is expected to develop a more sustainable funding model for both the State Fire Commission and the SES. It is intended the steering committee for the review will assess their respective funding bases, undertake an analysis of future funding options, and also provide recommendations for a more sustainable model. This may also require amendments to the Emergency Management Act 2006.

**Mr ARNOL -** In short the funding source for the SES is shared currently between local government and state Government in a couple of different guises. Unlike the State Fire Commission, which is a central, more strategically allocated way of dispersing our funds, we take it as a central pool and then consensually allocate it. The money for the SES is held at local government level for many of those things. Whether the local government has the wherewithal to support the SES, you may or may not have the unit. That funding model is quite critical for the SES, but we do see that tied to the current legislation, which may see something like a similar funding model in the State Fire Commission.

**Ms LOVELL** - On page 200, on the output group expense summary, there is a significant drop in funding for State Emergency Services. Can you elaborate please?

**Mr FERGUSON** - That goes back to the integration.

**Ms ADAMS -** Thank you, minister. The SES transitioned to the State Fire Commission back in 2014-15 and since that time additional funding has been provided by the state Government for SES through the State Fire Commission budget. Over the last three years, in total there has been $4.9 million in support provided for that transition of SES across to the State Fire Commission.

In addition, government has provided also some $5 million in debt reduction for the State Fire Commission, and has provided additional funds for a number of emergency service projects for which all emergency services are provided with a benefit. The ESCAD computer‑aided dispatch system is one of those.

The Tasmanian Government Radio Network is also a major project to provide us with a cutting-edge radio network. Also, the SES and TFS will benefit from that.

The Government has also provided further money for the wellness program, which is to provide health and wellbeing support to our emergency responders. This additional support has been provided as SES transitions to the State Fire Commission, and the Fire Service Act review will then look at the further governance arrangements and funding model for SES into the future.

**CHAIR** - We have to finish at 6.45 p.m. We still have Science and Technology, so I would like to wrap this up in about five minutes, so if members could be succinct with their questions and answers.

**Ms LOVELL** - Bearing that in mind, I am happy for you to take questions on notice. Minister, can you detail the various components of funding for the State Fire Commission?

**Mr FERGUSON** - Yes, I can. As for time management, I am completely in the committee's hands as to how you wish to use the remaining time, whether it is all on this or shared with Science and Technology - it is your decision.

**CHAIR** - We will need to have some time on Science and Technology.

**Mr CRAWFORD -** The State Fire Commission budget is made up of revenue from a range of sources. I am assuming we are talking about the revenue side of the budget. The Fire Service contribution is approximately 50 per cent of the revenue for the State Fire Commission. The insurance levy makes up a significant component, approximately $17 million in the current financial year. The motor vehicle levy is another reasonable component, approximately $7 million this year. In addition to that, there are state Government and Commonwealth Government contributions, and sundry income, largely raised through the commercial business units.

**Ms LOVELL** - Is the fire levy paid by Tasmanian households through their rates a major component of funding for the State Fire Commission?

**Mr CRAWFORD** -That is the Fire Service contribution I referred to in the previous comment. It is approximately 50 per cent of the revenue for the State Fire Commission.

**Ms LOVELL** - Does that then mean the fire levy is effectively being used to cross‑subsidise the operational costs of the SES?

**Mr FERGUSON** - We have had this question already. I am not sure quite why there is that view out there with some, but I believe the advice is clearly that the answer is no.

**Ms ADAMS -** The answer is no. The Government has provided additional funding to support SES through the transition to the State Fire Commission, and that has totalled $4.9 million over the last three years. It was $1.5 million in 2015-16, $2.012 million in 2016-17, and $1.431 million in 2017-18.

**Mr FERGUSON** - A lot of support has been provided. We recognise that the independent review is going to take a while to conduct and generate its range of solutions. The Government and I support the independent review's methodology, which is about asking all the questions that need to be asked and allows the full range of responses and thinking that need to go into that. We remain open-minded about where that would go. We think the independent review is a good mechanism to help resolve some of these issues. In the interim, the additional supports that would be needed to make that integration functional have been provided. We have moved in the right direction ever since that was started.

**Mr FINCH** - An independent review. It has probably been mentioned, but would you clarify that for me, minister? That is an independent review of what?

**Mr FERGUSON** - We have an independent person chairing that work, and we are going to ask the chief officer to give you a breakdown of the governance around that. But we have an independent reviewer - or the independent chair - already in place on that steering committee. That person has now have been appointed - Mr Michael Harris is doing that work. The governance structure for the review includes oversight by a steering committee, which is responsible for guiding the overall review, and also decision-making about how the review makes its findings and recommendations.

So the steering committee consists of representatives of the Tasmania Fire Service, the State Fire Commission, the State Emergency Service and the departments of Treasury and Finance, Premier and Cabinet, DPIPWE, State Growth and Police, Fire and Emergency Management. The use of the word 'independent' was better applied to the chair, given the nature of the steering committee is cross-government. The initial paper is out. We want people to have a good look at that.

What is the next stage, chief officer?

**Mr ARNOL** - We have the issues paper out for comment until 7 September, when we will take all the issues back in. The steering committee will look at that process and with our project manager we will look to see it feed into a new set of legislation the committee drafted.

**Mr FINCH** - This is about the governance structures of this operation - State Fire Commission et cetera?

**Mr ARNOL** - The Fire Service Act covers a range of issues with general themes, such as governance, finance, operations and community safety. In broad terms, that is the structure of the act, and that it is how we themed up the paper.

**Mr FINCH** - Thank you. Are the police involved?

**Mr FERGUSON** - No.

**Mr ARNOL** - The police per se are not involved in this. A stakeholder, yes, as are a number of other agencies. But the department, of which we are now part - Police, Fire and Emergency Management - is involved.

**Mr FINCH** - Okay. Looking at the State Fire Commission, I found it quite daunting to try to work out the operation of the State Fire Commission, and all of these responsibilities. I can't help but get a sense that there might be siloing here in respect of the way it functions. Is the idea of the review to bring these organisations together in a more cohesive way?

**Mr FERGUSON** - The answer is yes. However, there are some key questions in the issues paper that try to encourage readers of the paper to make responses to the paper, to ask them to think through the value of that, and to make a constructive submission to it. You will see in the paper that has gone out that there are no proposals at this stage. There are questions and it is asking people to think about them. It reminds me of the green and white paper process we went through with Health. We just ask people to have a good look at the issues and start to consider what the potential solutions might be. So the independent chair has explained to me a philosophy that I think is very appropriate and sensible. That's the approach, with the best will in the world on all parties to develop a new vision for how governance and funding can both be modernised, compared to an act which is nearly as old as I am.

**Mr FINCH** - I am pleased, because it is a long time since I have had this operation in this area. I am new to this committee. But that concerned me. It would have been a recommendation that there be a review of the way things are done. Can you give me a breakdown of the remuneration that goes to the State Fire Commission and to the lead officers, and to the person heading up the independent review and other salaries involved in the operation? I can take that on notice.

**Mr FERGUSON** - The people to my right, for example, our top brass? We are more than happy to do that. Do you want it broken down by individual, or collectively?

**Mr FINCH** - No, by individual, as much information as you care to provide. This might help me with a restructure or a review. I will have some evidence to refer to and see how things are unfolding when I come to the budget Estimates next year.

**Mr ARNOL -** We have it available but the commission operates differently to the committee set up under Mr Harris. The commission members are paid and it is like a representative board, some of them generously choose not to take that pay, but that is available to you.

**Mr FERGUSON** - Isn't that a separate issue? You were asking for numbers on both; one is salaries of our top officers, but didn't I also hear you ask about the cost of steering committee?

**Mr FINCH** - Yes, and the commissioners. I do not understand the structure of the State Fire Commission. Some idea of how that is set up and the remuneration that goes with it would be great.

**CHAIR -** Rob has another one; he has the lead on the final output group in your portfolio. If we run out of time, it is Rob's fault. I am aware members of your team are waiting outside, minister.

**Mr VALENTINE** - The cash position of the Tasmania Fire Service increased substantially in 2017-18 due to increases in grant funding. However, the cash reserves of the commission have increased by a similar amount to the level of increased grant funding at the end of the period. If you look at page 101, you will see cash and deposits at the beginning of the reporting period of $299 000. Cash and deposits at the end of the reporting period are $5.579 million. The additional grant funding appears to be about $5.014 million. Can you explain how the grant funding was expended during 2017-18, and why the cash reserves have increased by an amount similar to the increase in grant fund? Was it simply not spent?

**Mr FERGUSON** - There is a good explanation for that. Mr Crawford, Director of Corporate Services, will explain that to you.

**Mr CRAWFORD -** The Government provided $5 million in additional funding to the State Fire Commission at the end of the financial year for the purposes of reducing debt. That was still within the commission's bank accounts and in its possession at the end of the financial year. It was used in July the following year to pay down $5 million in short-term debt the commission had. It is not a coincidence the money, the $5 million in grant funding, was the same as the increase in the cash position at the end of the financial year.

**Mr VALENTINE** - It wasn't a forward payment?

**Mr CRAWFORD -** No, it was not.

**Mr VALENTINE** - I notice cash and deposits at the beginning of the reporting period for 2018-19 is $8.520 million, and all the others; the end of the reporting period and beginning of the next are all equal, $9.339 million and $9.339 million, $9.675 million and $9.675 million, and so on. However, this financial year to the next is different - $5.579 million to $8.520 million.

**Mr CRAWFORD -** Yes, that is correct because they are both budget figures. The first is a budget figure, the 2017-18 Budget, so it is consistent with what was in the previous budget papers. The next is a budget figure adjusted for actual year performance, off the previous one. It is reflective of the end of year performance, the real position at the end of the year.

**Mr VALENTINE** - It reflects that grant that was provided.

**Mr CRAWFORD -** In part it is an improved financial performance of the commission, given it had estimated it would have $5.5 million in cash reserves at the end of the period and the balance was $8.5 million. That is why the opening budget for the next period was adjusted upward.

**Mr FERGUSON** - Isn't it the case reflects the timing of when receipts and expenditures came in very lumpy time frames?

**Mr CRAWFORD -** That is correct. The cashflows for the organisation are largely quarterly in their cycle, reflecting a $10 million income from the fire service contribution. That is raised quarterly and comes to us on this basis.

**CHAIR** - Thank you, minister, and thank you, team, for responding very promptly to those questions. We will allow a brief time to change the guard.

**The committee suspended briefly from 6.26 p.m. to 6.28 p.m. to allow change of portfolios.**

**DIVISION 8**

Department of Premier and Cabinet

**Output group 3**

**Electronic Services for Government Agencies and the Community**

**Mr FERGUSON** - Good evening, Chair and Committee members. I introduce to my left Ruth McArdle, Deputy Secretary, Department of Premier and Cabinet, and to my right, Dr Glenn Lewis, Tasmania's recently recruited, whole-of-government chief information officer to assist you with considering output groups 3.1 and 3.3.

**CHAIR** - Output group3.3 as well? Do we have that in our list? I am sure Rob can manage.

**Mr FERGUSON** - I am comfortable given the time if you would like to ask questions ranging across both or either of those, and you can treat them together.

**Mr VALENTINE** - Minister, can we identify which policy documents the Office of eGovernment has been concentrating on and has prepared since this time last year?

**Mr FERGUSON** - Thank you, Mr Valentine, I will pass to Dr Lewis. In the short time he has been with us - less than one year - Glenn has made a fantastic contribution and has been working within the Office of eGovernment, the ICT Policy Board and his counterparts in each agency, with separate responsibility for managing IT in a coordinated fashion across government. Quite a lot of work has been done and I will ask Dr Lewis to talk about that.

**Dr LEWIS -** Absolutely, in terms of policy, our key focus has been on strategy for whole-of-government digital services - that is, how to improve services within government and how to improve services provided by government to Tasmanians.

Associated with that is a very strong focus on cybersecurity and policies associated with cybersecurity. Those range from education awareness policies and procedures through to incident management and response, and cybersecurity resilience.

We have also been looking at a range of policies and procedures around whole-of-government communications, and unifying and collaboration around government.

**Mr VALENTINE** - Thank you. Can you identify the extent to which those particular policies have been adopted by government departments and agencies in terms of getting some traction?

**Mr FERGUSON** - I know there have been, without exception, government agencies working very enthusiastically in this space. Everybody recognises we have a significant task to bring our government IT services to a constantly higher standard.

**Mr VALENTINE** - It is not always easy.

**Mr FERGUSON** - Often not easy. We have some legacy issues, and we talked about this at previous Estimates committees. We have overcome, indeed broken the back of, some of the worst of those legacy issues. In particular the out‑of‑date and well-past-its-prime government data centre in Bathurst Street, which we are now out of, and have been for some time. There is a constant need and increasing effort we are able to share with you today around building a capability to tackle the cybersecurity challenge.

I will tell you because your question was: what sort of support? I think without exception there has been a lot of support from agencies.

**Dr LEWIS** - All agencies have been very collaborative and supportive around cybersecurity, in particular, and the strategy we are developing in draft - that is, around the approach we have taken, which is to try to consult and collaborate with them and have a collective strategy, rather than one that is siloed.

**Mr VALENTINE** - I am not going to ask the details because it would not be sensible to do so in that regard. Does the unit still organise professional development programs to keep the State Service up to speed with innovations in the sector, including project management courses?

**Mr FERGUSON** - I gave Dr Lewis a heads-up of your interest in project management and he is well prepared.

**Dr LEWIS** - In terms of project management and more generally in terms of capability development across government in terms of digital and ICT capability development, it is something we do. We are running a course tomorrow on cybersecurity which will have over 50 attendees.

With respect to project management, we have taken a broad approach, not just revising and reviewing the current project management frameworks and the guidelines, which is an important aspect, but also working on how we develop and support capability. We have done that through a number of mechanisms, including establishing an embryonic but a very good community practice across government to ensure collaboration and share learnings and experiences and provide membership to more junior project managers. We also have some agreements with the Australian Institute of Project Management that provide a number of benefits for the Tasmanian Government in terms of collaboration and widening that community of practice.

**Mr VALENTINE** - That is not a bad way to go, I guess. Do you still provide project management services to departments out of the eGovernment unit? Because sometimes they used to fly in, help fix the problem and come back out. Is that still occurring?

**Dr LEWIS** - Our focus at the moment is more on running whole-of-government projects from within the Office of eGovernment rather than outsourcing. We have limited resources to do that, but we are certainly trying to support agencies with their project management through the strategies that I have mentioned.

**Mr VALENTINE** - What is your FTEs these days?

**Dr LEWIS** - We have eight FTEs in the office of e-government.

**Mr VALENTINE** - Government strategic planning for infrastructure is happening on a 10‑year timeframe now through the Infrastructure minister. Is there an idea of doing this by engaging the ICT community or the likes of TasICT, to sit down with you and look at what the future might hold? As long as you can manage the conflicts of interest, I suppose you could do that.

**Mr FERGUSON** - The answer is yes. I can understand why you might ask in the context of managing conflicts of interest, but we actually have a shared interest in any respect. Without wandering too much into the procurements area, we have a lot in common. I don't mind saying that when the Government commenced building the NT III network services panel to build a new architecture for government, before we went to the market for any of those services, I made the decision, and DPAC obediently went first to our own industry with a paper that explained the range of solutions we would be looking for, to tell us what we might need to know before we went to market and how we could improve our purchasing decisions. That was very successful. We have secured the whole panel. That is a fantastic piece of work was done. We are in a better position than ever before.

On Infrastructure, you would be well aware that in last year's budget the Government provided $50 million for a digital transformation fund. Now we are turbocharging our capital investments in digital transformation in government. For good discipline reasons, for good project management, it is not a fund that can just be allocated and spent. It is a fund that has been nominally allocated and has to be earned through the usual SIIRP process.

**Mr VALENTINE** - Is this the Digital Ready for Business?

**Mr FERGUSON** - No, this will be the digital transformation program, which you may not see easily on your current budget papers; it was in last year's budget and spread over future years. We have a significant effort there and agencies are now busy working more or less to their nominally allocated budgets. Nonetheless, they will have to do a business case and have very clear discipline about how that investment is a good investment by the state. It will be awarded just as capital usually is, though the SIIRP process.

**Mr VALENTINE** - Very quickly, do you have a list of the major ICT projects currently being implemented across the State Service of any note through the Treasurer's Structured Infrastructure Investment Review Process?

**Mr FERGUSON** - We have some that we can speak to now, to give you some headline projects. If you would like to explore any details, I can take you there. The main ones would be Project Unify, in Police - our commissioner might have mentioned it in an earlier discussion. According to the budget paper, we have funding of approximately $13 million allocated. That is a project aimed at replacing a number of ageing legacy police information systems. That project is currently underway and is expected to be completed in December next year.

Justice Connect has been allocated $16.6 million over the five years commencing in the coming financial year. That is a big project that has been called for a number of years. Justice Connect is a program of work addressing the shortcomings of existing systems, processes and data supporting the criminal and civil jurisdictions managed by the Department of Justice. You might already be aware of some of those shortcomings - for example, in how justice issues and people have been managed.

The Children and Youth Services system replacement has been given an estimated funding allocation of $6 million. That project, which again was indicated about a year ago, is about better supporting frontline Children and Youth Services workers to help vulnerable children and their families.

**Mr VALENTINE** - Help with the notification process and all those sorts of things?

**Mr FERGUSON** - Again, we need modern systems to be able to do that reliably, given the risks of having old, dated legacy systems that aren't keeping up.

Health has an allocation of $18 million and that consists of dealing with a number of projects, not just one. We have quite a number of ICT risks that are being actively managed in Health. We have a new chief information officer within Health. His name is Graham Coles. He was here for most of the day, able to take questions if we had time. He has been dealing with some very significant legacy issues which we have been reluctant to talk about publicly until and unless they are addressed one by one.

**CHAIR** - Were some of these raised by the Auditor-General in his recent review?

**Mr FERGUSON** - Yes, they certainly were and we gently expressed we felt in some cases there were foundation projects Health has now achieved that did not seem to be recognised in the updated report from the Auditor-General. This might be something to watch in future. Health has been working very hard. One of the main projects in the foundation work was placing data in contemporary up-to-date data servers. The projects also include replacement of wifi and phone systems, because we are aware of risks there and also ICT resource requirements for the Royal redevelopment and My Health Record.

Finally, Treasury is a bit further along. Treasury has $5 million and is replacing the public account reporting system and the public account cash management system.

**Mr VALENTINE** - Thanks for that. That is very good and those were my last questions.

**Mr FINCH -** Minister, Ms Lovell mentioned earlier today that part of our job is to bring the concerns of the community to the ministers available to us. One concern is how you will be able to invest time in Police, Fire and Emergency Management portfolio as well as in Health and Science and Technology. Concerns have come particularly from those in the science and technology industry, who are worried the bigger portfolios might get more of your priority. Could you give me an answer?

**Mr FERGUSON** - A quick answer is they command more of my attention than the Science and Technology portfolio, but they are all equally supported by me and we have excellent engagements. I am aware of where the concern has come from. I have spoken with the organisation and am quite satisfied we can continue the very strong engagement we have had. I am not bragging, when I say industry tells me it has never had engagement as positive as we have been able to achieve in the last four years. I only want to add to that and consolidate on this because we have achieved some really positive things. There may have been a time in the past where the IT portfolio was a bit of a garnish on the minister's list of portfolios. I have really embraced it and we have worked in a different way with industry. We have said to industry, 'You tell us what it is you need to build your industry even more strongly', and one of the key outcomes has been the call for a fresh workforce development plan, which we are funding in this Budget. I am aware of the concern you referred to. I can assure you while Health and Police will always command more of my time, the reality is we have excellent people working in DPAC and State Growth who support us and deliver the programs we are funding. Whenever our IT stakeholders look for engagement with me, they get it.

**Mr FINCH** - Can I assure Ms Lovell that was not a Dorothy Dixer?

**CHAIR** - Bearing in mind the time, I will make this the final question, minister. This area looks at cybersecurity, and we know the Auditor-General has made a couple of comments over the last few years about that needing attention. Are you confident for the whole-of-government, but particularly areas you are responsible for, Health and Police, which are terribly important in personal privacy, that security risk is under control and managed?

**Mr FERGUSON** - Yes I am. What time do we have, by the way?

**CHAIR** - We finish at a quarter to.

**Mr FERGUSON** - I have one minute?

**CHAIR** - Two.

**Mr FERGUSON** - The answer is yes. We recognise the cybersecurity environment is rapidly changing and evolving. We need not only to deal with legacy risks, but also to anticipate upcoming risks and make sure we are patching our systems with fresh updates. We also need to ensure our architecture, our physical security, is attended to. We take significant advice from federal bodies. We are installing best practice. Dr Lewis has been quite instrumental in sharing with his colleagues in different government agencies the expectation about how to manage that. We are aware of the 2015 report of the Auditor-General. We have taken it very seriously. To help you understand why we do the things we do, I do not talk about our risks in public. I am very cautious not to because what you should expect of me and what you are getting is a minister and a government absolutely determined to deal with risks we become aware of - to deal quietly with them and let you know about them after they have been fixed.

**CHAIR** - Thanks, minister, for your time. We did probably crib an extra two minutes at the beginning of the day and used our full allocation. We appreciate your time and the time of all the people you have had assisting you today.

**Mr FERGUSON** - Thank you. I would like to take a quick moment to say thank you to each of the agency staff who have worked so hard to prepare and advise me today and I include Health, State Growth, DPAC, DPFM and my office.

**The committee adjourned at 6.45 p.m.**