Tuesday 4 June 2019 - Estimates Committee A (Ferguson)

LEGISLATIVE COUNCIL

ESTIMATES COMMITTEE A

Tuesday 4 June 2019

MEMBERS

Mr Finch
Ms Forrest (Chair)
Mr Gaffney
Ms Lovell
Mr Valentine
Ms Webb

SUBSTITUTE MEMBER

Mr Dean

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, Senior Adviser
Emma Fitzpatrick, Senior Adviser
Chris Edwards, Senior Adviser
James Ritchie, Adviser
Ben Gourlay, Adviser

Department of Police, Fire and Emergency Management

Darren Hine, Secretary DPFEM and Commissioner of Police
Scott Tilyard, Deputy Commissioner of Police
Chris Arnol, Chief Officer, TFS
Bruce Bryatt, Deputy Chief Officer, TFS
Ian Whish-Wilson, Acting Assistant Commissioner of Police
Jonathan Higgins, Assistant Commissioner of Police
Donna Adams, Deputy Secretary, Business and Executive Services, DPFEM
Todd Crawford, Director Business Services

Jemma Ball, Acting Manager, Media and Communications
Matthew Brocklehurst, Acting Director, SES
Chris Collins, Acting Director, Community Fire Safety

Department of Health

Michael Pervan, Secretary, Department of Health
Michael Reynolds, Deputy Secretary, Corporate Services
Ross Smith, Deputy Secretary, Planning, Purchasing and Performance
Tony Lawler, Chief Medical Officer
Eleanor Patterson, Deputy Chief Financial Officer
Craig Watson, Chief Corporate Officer, Tasmanian Health Service

Neil Kirby, Chief Executive Officer, Ambulance Tasmania

Mark Veitch, Director of Public Health
Peter Boyles, Chief Pharmacist
Aaron Groves, Chief Psychiatrist
Ben Moloney, Project Director, Royal Hobart Hospital Redevelopment

Department of Premier and Cabinet

Ruth McArdle, Deputy Secretary, DPAC
Glenn Lewis, Chief Information Officer
David Briggs, Director of Service Delivery and Operations

Department of State Growth

Bob Rutherford, Deputy Secretary, Department of State Growth
Lara Henricks, Acting General Manager, Business and Trade Tasmania

The committee met at 8.59 a.m.

CHAIR (Ms Forrest) Welcome, minister.

Mr FERGUSON - Thank you Chair. Good morning to your committee colleagues.

CHAIR - Minister, did you want to make some opening comments, fairly brief if you do not mind, regarding your Health portfolio responsibilities?

Mr FERGUSON - I don't propose to give an overview statement as such but I would like to emphasise that the Government has been working very hard in the Health portfolio to make necessary reforms so Tasmanians can receive the care they deserve when they need it, where they need it and in the time frame they need it. There are significant challenges in our health system and we acknowledge that, particularly with increase in demand. Whether that is for elective surgery or emergency care, we are absolutely committed to addressing those challenges and working hard, including through the budget process. Despite a significant writedown in revenues of over half a

billion dollars that I know the Treasurer would have discussed with you yesterday, we are protecting our election commitments and we are providing $8.1 billion for the Health portfolio over the Budget and forward Estimates. This is a new record and it is a significant increase on the last Labor-Greens budget over four years. It is a massive increase, something like a third more. We will continue the effort and I am happy to discuss the Budget and the relevant details with you today.

CHAIR - Thank you, minister. Last week, in good faith, I asked for the estimated outcomes for each line item for expenditures in this area because it helps inform us as to where we are headed and what we have spent. Can you please provide them now? I ask that we could have them earlier next year. It helps us prepare for this week as we have limited time and many portfolio areas to look at.

Mr FERGUSON - Yes. I can provide you with this information and I have a version of this I can table. I will table that now as I read through the figures. In 1.1, Health Services System Management Estimated Outcome - these are all for 2018-19: $182.720 million for admitted services; $945.771 million for non-admitted services; $203.845 million for emergency department services; $136.748 million for community and aged care services; $222.404 million for statewide and mental health services; $124.517 million for the Forensic Medicine Service; $2.484 million for ambulance services; $90.982 million [inaudible]; and $31 632 million for public health. The document I have tabled for you provides last year's budget, estimated outcome and 2019-20 Budget so you can conveniently read it across the line.

CHAIR - Is there any reason we could not have been provided with that information last week, minister?

Mr FERGUSON - I thank the department for immense amount of work it has done in preparing for today. This is how I make sure I am always prepared with the answers for the budget Estimates committee and I have provided it for you today.

CHAIR - Is there any reason that information could not have been provided last week, minister?

Mr FERGUSON - I like to make sure the information is accurate and double-checked and in order for your committee to look at.

CHAIR - Was that information available last week, minister?

Mr FERGUSON - Lots of work has gone into this. I am not sure what you are getting at but I have provided it through the appropriate process.

CHAIR - I am asking why it could not have been provided last week. Was that information available last week, when was it prepared, when did you know what the estimated outcome would be?

Mr FERGUSON - Again, I don't know how to answer the question.

CHAIR - It is pretty simple. When are the estimated outcomes figured out in dealing with the Budget?

Mr FERGUSON - I am advised it is an estimated outcome, it is not an actual outcome - we will not know the actual outcome until it actually occurs. The figures are best estimates from the department and I have provided them to you. That is a reasonable question for you to ask me and I provided it last year and I have provided it again this year.

CHAIR - Minister, I know they are not actual figures, I know how the system works, I know you cannot have actuals until the end of the financial year. Most of us across this side of the table well and truly understand that. When did you receive this information?

Mr FERGUSON - Well, I would have received it in the course of my briefings and the folders I religiously read over the weeks and the days between the Budget itself in preparation for these Estimates committees.

CHAIR - It was available to you last week and it could have been provided.

Mr FERGUSON - It may have been, but -

CHAIR - Well, you said you read the papers religiously over the last few weeks.

Mr FERGUSON - Yes, but, look, I'm providing it for your committee in good faith now. I'm certainly aware of your interest in this and the commentary you've made about it. The information needs to be accurate and the deadline for complete accuracy, the date for me, is the date of the Estimates committees. If I had been asked for them yesterday, I would have been able to provide them in House of Assembly committee yesterday -

CHAIR - Yes. Well, it would have been helpful if you had considered the request in good faith to provide them ahead of time. It helps us to prepare. We have a lot of reading as well. You have your folders to read. We have all the budget papers and all the output groups we're responsible for. I'm taking it for your answer and a simple yes or no will do: this information would have been included in your papers, which you've had for the last couple of weeks, as you've read through them -

Mr FERGUSON - No, you're not correct on that, but that's okay.

CHAIR - When did you receive them?

Mr FERGUSON - Well, I'm not in a position to give you a date but that's not in the remit of the conversation, as far as I'm concerned. I'm simply telling you, you've asked for the answer to the question and I'm providing it in good faith to you at the earliest opportunity -

CHAIR - No, it's not. I asked last week. That was when I asked in good faith and you have indicated the information would have been available because you had that information then.

Mr FERGUSON - Well, I have the information for you. I hope that assists in the consideration that you -

CHAIR - It will.

Mr FERGUSON - will give to the Budget. Things have been said in relation to the preparation and the giving of this information in past years that hasn't been accurate. I approach this in good

faith on behalf of the Government and there's nothing to hide. We're proud of our record investment and the estimated outcome figures demonstrate that we have honoured our commitment to meet recent demand through the budget process. We're a government that's prepared to do that.

CHAIR - You said you take pride in meeting health demand. Is it your expectation that health demand in admitted services is likely to fall?

Mr FERGUSON - I don't think anybody is expecting health demand to fall in admitted services. We are -

CHAIR - We'll get to that in a moment. This is a broad question. We're not going to 2.1 yet.

Mr FERGUSON - Well, you asked me about admitted services -

CHAIR - You made the claim that you were proud of meeting the demand in Health -

Mr FERGUSON - Yes.

CHAIR - but this information you've provided to us would indicate that the estimated outcome, which may become worse because it did last year. The estimated outcome is $12 million or $13 million more than the Budget this year, coming up.

Mr FERGUSON - Okay. I'll ask the secretary to assist in interpreting how this works in practice, but -

CHAIR - Minister, are you expecting demand in admitted services to reduce, being as you've spent more so far. It could be more than that once we reach the end of the financial year and your annual report is released. I don't need the secretary to answer this; I'm asking you: are you expecting demand to fall in that area?

Mr FERGUSON - I've already answered that question. You've repeated the question and the I ask the secretary to support the committee by asking him to supplement my answer or to fill in any gaps I leave behind. However, what you're not recognising is that the budgeted allocations by output groups do not include the additional $30 million which is available in the Budget through Finance-General.

Mr PERVAN - Thank you, minister. In addition to the $30 million the minister has described, we're also awaiting confirmation from the Commonwealth of additional funding for elective surgery as well as their election commitments. The whole picture of our financial resources isn't simply contained within the outputs as they're set out. We expect demand to increase and we have put that through on the outputs and the performance measures in a way that represents what we think the demand will be.

Mr FERGUSON - We had a discussion yesterday about the predictors for emergency demand, for example. There was a fair bit of interest, which you may care explore, in the performance information that shows an increase in emergency department presentations. The secretary gave quite a long explanation as to how that's calculated using nationally consistent models.. The answer is - I can't remember how you framed the question, Chair - no, we're not budgeting nor planning for demand to decrease. The challenge we have as a government is how we meet that increase in demand. We certainly have a strong plan for opening more beds, which I'm sure you would agree

is a real pinch point for us. Many times emergency departments are over-demanded and our wards are at capacity. This a transparent view of the Budget. You can now see plainly not just what the 2019-20 Budget provides in each output group, but together with the estimated outcome from the current financial year - and not to forget the $30 million we have available to us in Finance-General and the contributions we are yet to have - not so much confirmed from the Commonwealth, but confirmed in terms of the profile and in what years they will sit and how that will help us design our service plan for the next financial year.

CHAIR - The Auditor-General's report into emergency departments really reflected on the whole of the hospital system. It is like the canary in the coalmine, as he put it, the emergency department being the canary. His report makes a number of recommendations. One of the overarching views is not just about money, so what do you intend to do to address the issues that aren't just about money? I'm talking about across the whole Health portfolio, not specifically the Emergency Department because, as we understand, it's not just the Emergency Department.

Mr FERGUSON - I applaud you for your description of that, Chair, because that's the fairest description I've heard from any of the elected members in our parliament so far outside of Government. That's exactly what the Auditor-General has said. The Auditor-General is more or less silent on the need for more government money. I don't think he addressed it; he didn't call for that, but he might argue in his absence that wasn't his role. What he's pointing to is the need for efficiency within the health services to break down the barriers of silos that persist in Health. He brings a call to arms in terms of culture and a focus on inpatient bed utilisation so that we are reforming services in a way that patients who are safe to be discharged are discharged in a timely fashion, and ensuring that admission pathways are as effective and as rapid as they ought to be so that patients are not left in the lurch. He suggests - and I haven't had this validated - that as many as 3000 bed days could be available to the public and to the health system if those things were to occur.

Your question brings me to action. The Government will be looking to hospital leadership teams to focus more on removing those silos and barriers to patients being admitted to the care they should be getting. These are exactly his words. We will be endorsing that approach so it's within the remit of hospital leadership teams to take the lead on this. We will be bringing everybody to the task, particularly later this month when we will have the Access Solutions meeting where we bring together a wide range of stakeholders, including people in leadership and from the health stakeholder groups and our own people so that we can develop a clearer consensus about the way in which we can take advantage of those other challenges the Auditor-General has laid down. I hope that that's a very productive exercise.

CHAIR - Minister, the Auditor-General also referenced previous reviews that had been undertaken, including one that made 52 recommendations in 2014-15 when you came to government and to the Health portfolio. Very few of those recommendations have been implemented. Have you been asleep at the wheel in dealing with some of those challenges?

Mr FERGUSON - No, I don't think I have a reputation for being asleep at the wheel. I've being one of the most active and engaged Health ministers that the state has had and I am committed - I'm not shying away from the challenge. I'll leave that perhaps where it fell.

We are absolutely committed; we have been a reforming government and we've never hesitated from meeting this challenge. It has been a huge job and a huge effort by all our people. I'm not sure, but are you referencing the commission report when you mentioned that?

CHAIR - There was another report that was done as well, but -

Mr FERGUSON - You asked me about a report with 52 recommendations. Are you referencing the commission report? Most of our One Health System reforms are based on that.

CHAIR - I'll find the name of it.

The problem is, minister, I have sat in this place a long time. I have sat on a number of committees looking at acute health services as well as preventative health and mental health. Over the 14 years I've heard the same story almost every time - are you surprised by that? - from the people out there - there's a cultural problem; there's a leadership problem; it's not necessarily financial problems that need to be addressed.

There has been constant change, most of which I have supported in terms of trying to get a framework, and we had to take a significant step back at one stage for political reasons - that was before you so it's not like it should be news to you that these problems exist. Silos have existed; cultural problems exist; leaders and leadership and good governance problems exist. You knew about that when you came to your position.

Mr FERGUSON - Actually, I didn't know about the Monaghan report because that was by the previous government and had been hidden, but we did uncover it in more recent years.

CHAIR - But it's not just that report.

Mr VALENTINE - There is Dave Sullivan's report and the Patients First report.

Mr FERGUSON - They have been around, I accept that. I don't dismiss the point you are making about leadership and culture, but I'd ask you not to overlook the fact that the Auditor-General actually made a very complimentary comment with regard to our Government. In his written media statement he makes it clear that the Government has recognised these challenges and has introduced significant reforms to address them. What he argues for is that the reforms that the Government introduced in 2018 to provide greater operational decision-making at the local level should be leveraged to ensure we get these improvements that patients deserve, and that's exactly what I support and what I want to see occur.

CHAIR - How are you going to progress that? This is not new. You might have slightly specific examples that are perhaps new in some areas but overall, the message has been the same. Health's not easy, I'm not saying it is easy. If anyone had a simple answer, it would be fixed by now.

Mr FERGUSON - Yes, I think that is true. I will ask the secretary to add to everything that I've just said but there is a significant cultural piece of work here.

I've been engaged in a debate in my house in recent weeks because there's a lot of hot air around what people wish to use in reinterpreting what the Auditor-General is saying. He's not calling for any blame game. He is calling for a combined effort around culture and removing silos within hospital teams so that patients can be shepherded through the health system in a way in they deserve. It is exactly what we want.

We have seen improvement in this over the life of our Government at least, that's all I can speak of. Moving to the One Health System was a big step in achieving that, which many said couldn't be done, but fortunately -

CHAIR - It should have been done much earlier.

Mr FERGUSON - when we moved those reforms in 2015 there was political consensus around that which was really enabling. I have always appreciated that from around this place. That work is not 'set and forget', we've got to keep our eye on it and never allow the bad behaviours to return.

Just very quickly, before I ask the Secretary to add to this, there will be some very challenging decisions for policy-makers and for the Government in the next few months. There will be some big decisions because there is a mixture of opinion in the clinical community about what is the best way forward. When people put their minds to the task of identifying where these barriers are and removing silos, there will be a sense for some people that this is not the way forward, and I fully expect that they will be the ones who are the nosiest in the public square.

CHAIR - They usually are.

Mr FERGUSON - Yes, that's how it is, right?

CHAIR - That shouldn't surprise you.

Mr FERGUSON - It doesn't, but I am anticipating the usual political row which would then ensue where, in my experience, I find my political opponents usually leap upon whatever is the loudest voice in the public square and demand that the Government do that. If we come to that point, you have a recipe for stalemate in no-one's interest.

CHAIR - Keeping everyone in the tent should avoid that.

Mr FERGUSON - This is what we have to try do and why my statements are geared around engagement and encouraging people to cease the blame game that doesn't help anybody. If the Government was cutting half a billion dollars out of the Health budget, the Opposition might have a point.

We are not - we are adding significantly more money but what the Auditor-General is calling for, I believe, is regardless of the financial contributions being made, we have to make sure we use our resources as efficiently and effectively as possible. This will mean challenging some behaviours in the health system.

Mr PERVAN - To expand on the points the minister made, there are two ways of approaching what are very longstanding cultural problems in the service - one is the top-down approach. We have been through this in the evolution of the Tasmanian Health Service Act over the last five years. We have gone from three Tasmanian Health Organisations - THOs - into one with a board with its own chief executive officer and Tasmanian Health Service - THS - executive and a separate department to where we are now where there is a single clear line of accountability from the minister through me into health services.

One of the challenges we have had that reports, such as the ones you have named, have made recommendations saying that someone should do something, and it is generally the THS or the

department. It has been left generically like that, and there has been confusion about the individual who has accountability to deliver, not so much to implement or direct the implementation and there have been a lot of directions. Then after this confusion there are competing clinical opinions as to what is the best way, what is best for the patient and, in some cases, what is best for the individual service within that.

The top-down approach we have finally refined to a point where we can act on things and have over the past 12 months achieved a lot with some small and larger initiatives across the health service around patient flow and things like that. The other big piece of work on cultural change - the first recommendation of the Auditor-General - is a very specific and rather interesting chapter in the final report of the Commission on Delivery of Health Services in Tasmania.

CHAIR - It is not new.

Mr PERVAN - It is very difficult to run a cultural change program when everyone is flat out meeting demand coming through the door. You have to pull people away from the bedside to actually have the conversation about values, about why we are here and why it is incredibly important for the focus on the patient to work across the health service not just in terms of your department of surgery, your department of medicine, your department of cardiology , or whatever it happens to be.

This is the cultural change we need to undertake, somehow working from the bottom-up. This is the conversation I hope we will be starting at the Access Solutions meeting in a couple of weeks' time. How we do that while we are in the middle of winter? How do we get the conversation going because it is critical we do. There are other health services to learn from, but speaking to the other CEOs at AHMAC last week, all hospitals around Australia particularly the bigger ones are facing similar challenges. Even the newest, biggest, most expensive in the world - the new Royal Adelaide - is having internal problems in terms of getting multiple clinical disciplines to work collaboratively around more and more complex patients. This is the big cultural change we have. The patients of 100 years ago with infectious diseases and physical injuries are not the patients we have the challenges with today. That is also part of the cultural change.

CHAIR - My son is a doctor who works in one of the big hospitals in Melbourne, and it is interesting some of the methods they use.

Mr FERGUSON - We learn from them.

CHAIR - I am sure you could and you need to pick the best of everywhere.

Ms LOVELL - In relation to recruitment across the THS, so it does cross over a number of output groups and I am hoping you would be happy to answer as an overview question.

Can you confirm there is an employment committee where departments or areas put in a business case to seek approval for filling vacant positions?

Mr FERGUSON - I would expect that is the case for new initiatives.

Ms LOVELL - For new initiatives, is that the case for current funded positions?

Mr FERGUSON - What if I ask the secretary to address that?

Mr PERVAN - The THS does run an employment review committee. With a process of devolving that central committee down to the local level. The process whereby they assure themselves of their responsibilities under the act and under the Financial Management Act, there is available funding for the positions before they are advertised. It is a high traffic area, but not withstanding that. we have 88 vacancies advertised and are proceeding to fill on the internet and media at the moment.

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

Mr PERVAN - It meets weekly.

Ms LOVELL - How many business cases are before the committee at the moment?

MR PERVAN - I will have that checked for you.

Ms LOVELL - What is the average length of time to have the approvals required so those positions can be filled?

Mr FERGUSON - We have a prepared one on this because we have actually been able to reduce the length of time taken to go from the need for a recruitment to occur and the final step to an advertisement. Maybe we can have the detail in the output groups when the agency executives will be here. I do know from memory that it is 21 days shorter than one year ago.

CHAIR - Just reaching to the advertising stage?

Mr FERGUSON - We have shortened our process by 21 days.

CHAIR - Yes. It is a bit like getting onto the waiting list.

Mr FERGUSON - Well, that is a cheap shot really, but the fact is -

CHAIR - I do not think so, it is a reality.

Mr FERGUSON - There is bureaucratic process to do the work the secretary has outlined to make sure it has gone through its various steps. The Nurses Union in particular has asked the Government to streamline this and I thought you would welcome that.

CHAIR - I do, but it is still only one step in the pathway though, there is still a way from appointing someone.

Mr FERGUSON - Slight correction, it is actually 21 days of the full life of the process, not only the advertisement.

CHAIR - That sounds much better.

Ms LOVELL - Twenty-one days shorter now for the overall process one year ago, okay. Good, we can come back to that. Minister, your secretary has spoken about moving to decentralise this committee, what will look like after that process?

Mr PERVAN - Sorry, I will need a bit of clarification on the question. Do you mean how will it look like at a local level?

Ms LOVELL - Yes, who will take responsibility for the process/

Mr PERVAN - It will be the executive directors of operation at the two, north and south, Mr Eric Daniels in the north and Ms Susan Gannon in the south. They will chair their committee with regard to the jobs in their service and the budget they are responsible for.

Ms LOVELL - Okay, thank you.

Mr VALENTINE - I am interested in the spread of the matters to be dealt with in the access solutions committee or meeting you are going to set up. Can I be one of the first to say a great move to bring political parties together? Are you only looking at the emergency department access or at the whole of hospital operations?

Mr FERGUSON - Your question is my answer, you are absolutely spot on and together with the Chair's observation around the language of the canary in the mine, the ED is where you see the access block. Of course, access block turns up in ED because it is access-blocked in the wards. You understand this because we have discussed it numerous times, and exactly what the access solutions meeting is geared towards is achieving better patient flow, which means better patient access at each step of the patient journey including discharge.

Mr VALENTINE - Are you going to include clinicians in the meeting with information from the coalface and having them talk to you about the solutions rather than politicians reading -

CHAIR - He did suggest they'd be there.

Mr FERGUSON - Your observation is spot on, Mr Valentine, and the answer is yes. We've worked very carefully to invite the key people who can bring us the greatest opportunity for some consensus about change and steps forward that can alleviate the pressures that are unacceptable to me and this Government. We do not ever want to see ambulances ramped. We do not ever want to see patients in an emergency department waiting room waiting for their treatment in turn. I know that there's very high rate - it's 100 per cent. Its' a perfect score of patients being seen within recommended time for the most urgent priority. It's the less urgent priority of people who are still in pain and injury who at times are waiting too long. It is unacceptable to the Government when people are waiting too long in an emergency department, having received care and the treatment they needed but are waiting for admission to a ward. We have worked very hard and we've opened up every possible treatment area physically available to us. As you know, we are building more and we earnestly look forward to opening those facilities and providing more capacity.

In the meantime, it behoves the Government and the clinical community to work together on finding a better way to use the resources we do have. There are significant, really good people who are saying to me that we can do better with what we have, and that's wonderful to hear because it demonstrates a commitment to change. The Australasian College of Emergency Medicine and the Government are co-hosting the meeting. Its fellows, members emergency department clinicians, consultants and registrars are the people who have to deal with the backlog in their zone. What they are looking for is an emergency department solution, they want to provoke and be catalysts for the whole of the hospital; to embrace the need for change and be willing to do things differently, we can share the load rather than land it all in one place.

Mr VALENTINE - Are you also going to be dealing with the external services that are pretty critical, especially with mental health and the community-based services for people with mental health issues? Are you going to be looking at a holistic approach to -

CHAIR - As part of this meeting, do you mean?

Mr VALENTINE - Yes.

Mr FERGUSON - I'll go to the Secretary, if that's okay, in a moment. I don't want to look to enthusiastic or discouraging about your suggestion. We'd need to be careful we don't try to fix everything at once. The point you're making is a fair one. One of the initiatives we're introducing in southern Tasmania this year is the rapid response model, which we've already piloted and have now permanently funded -

Mr VALENTINE - Is this in Launceston?

Mr FERGUSON - Yes, Launceston. I hope that will be part of the suite of solutions we bring to this. What an opportunity, to make sure that when we bring that online later this year it's done in a way that is sympathetic to the other initiatives.

Mr PERVAN - It was interesting listening to the references made to previous reports because I know someone who wrote a Churchill Fellowship report on access to emergency medical care in 1998. One of the observations made in that report was that, by and large, what impacts the most on access to hospital, particularly emergency medical services, is what happens outside the hospital and at the discharge point.

Services like ComRRS, the rapid response service the minister referenced, and the Mental Health Hospital in the Home Unit we've initiated are services around a secondary triage that we're starting to roll out or develop from ambulance. All these things give people care in accordance with the urgency of their need and the priority they need, but not necessarily in the hospital ED. Similarly, making sure that patient flow is working, not only at the backdoor of the ED, right through the hospital and back into the community is important. Where necessary and possible, we are considering where people can be discharged into supported community care. That might mean looking at things like providing outreach services to residential aged care, so they can take patients who are slightly more complex than they normally would. All these things can be explored at the Access Solutions meeting because they all have an impact.

Recently, a PhD was passed by one of the nurses in the emergency department at the Royal. It indicates that one of the key cohorts we need to manage differently are people aged 75 and over with two or more diagnosed chronic diseases. A huge amount of analysis went into that and that issue is very much focused on the Royal, you can't translate that to Launceston, Burnie or Mersey. Now that we've identified that cohort, it's matter of how we manage that group differently in the emergency pathway through the hospital and back to home, or how we keep them safe at home so they don't have to come to the emergency department. All these things can be explored and certainly will be, I hope.

Mr VALENTINE - This is only focused on the Royal, this Access Solutions meeting?

Mr FERGUSON - I think again we'll both answer this but it is primarily focused on access block at the Royal. However, I've ensured, and again the Secretary can speak to the detail, the input that goes into that is shared with the north and the north-west, and that the outcomes also from it are able to be implemented or considered, at least, in the other hospitals. We also have access block at the LGH, not as bad. It can be very problematic at times.

Mr VALENTINE - Sometimes, it can be as bad.

Mr PERVAN - On an ongoing basis, it's not as pressing as we've seen at the Royal but it's not be dismissed. In the north-west it is significantly less challenging but it does have its peaks. The answer is yes. The focus is the south right now but we don't the outcomes to be restricted to the south.

Output Group 1
Health Services System Management

1.1 Health Services System Management -

CHAIR - In this area, I note there are quite different footnotes; one related to the appropriation chart on page 128 and in the expense summary on page 112. In the appropriation it talks about cessation of the Rural Alive and Well - RAW - funding. In the footnote in relation to the expense it talks about the cessation of the improving health services in Tasmania commitment. I'm trying to understand why they're different? We might come back to some of the commentary in budget paper 1 in relation to the National Partnership payments relating to Health that have changed significantly.

Mr FERGUSON - Sorry, go on.

CHAIR - That's it. The footnote in one area relates to RAW and another relates to improving health services in Tasmania. I'm interested in why there are different things in expenses.

Mr FERGUSON - Mr Reynolds will assist, but the outgroup expense summary includes all sources of revenue. Table 5.8 refers to revenue from appropriation, which is state funding. Perhaps this partially answers your question.

Mr REYNOLDS - That is the answer.

CHAIR - That's what I thought it might've been.

Mr REYNOLDS - That's the answer. As the minister rightly points out, table 5.8 is reflecting the state appropriation. As the minister also correctly points out, table 5.2 has all sources of funding including Australian Government funding sources in there as well.

CHAIR - When we look at budget paper 1in relation to the commentary around national partnership payments on page 103, you have health and hospital funds, which deals with the Royal, for which there is another $54.7 million - that is from the Commonwealth. Is that additional funding or is that pushed-out funding in the top line?

Mr FERGUSON - It is not additional. That is the funding provided to the state under the MPA that supports the federal funding for the Royal Redevelopment stage 1.

CHAIR - Is this the capital or is this operational funding we are talking about here?

Mr FERGUSON - It is capital funding provided through the instrument of an MPA. It is going back a number of years, as you know, before my time.

CHAIR - It is just that last year it was only $10 million in that line item; it has gone up to $54.7 million.

Mr FERGUSON - That would be a surprise to me.

CHAIR - I can show you last year's budget papers; they are under the table if you need them.

Mr FERGUSON - I don't think this is the answer to your question, but I can say that the numbers have moved around on the basis of cashflow advice from the project team as to when the cash is needed to be paid to the managing contractor. I couldn't explain why the actual total numbers would have been different from last year's.

CHAIR - Maybe you could get your people to have a look at that and provide some advice a bit later.

Mr FERGUSON - You did say that it only showed $10 million in last year's?

CHAIR - In 2019-20 - I will have a look at it myself.

Mr REYNOLDS - Maybe it's the cash management project. What we are seeing here is the Australian Government funding getting drawn down by the state as we require it as the bill progresses, as the minister outlined. The quantum the Australian Government has committed to this project hasn't changed in total; it is just as the bill has moved in time and progress, the amount we have to draw down can vary. That's reflected in these numbers here.

CHAIR - I will just find it here and look to make sure we're being accurate about what we are saying. In last year's Budget, in 2018-19, it was $17.5 million, the same, and the estimated outcome remains the same; then in 2019-20, in last year's budget it said $10 million - this is $54.7 million - so it seems it hasn't been pushed. I would be interested to know why there is so much extra. We have only two years to look back on. In last year's budget, in previous years' budgets, which was $15 million.

Mr FERGUSON - I totally accept what you are saying. I don't think we can explain that right now. I suggest we ask for advice on that.

CHAIR - We will make a note of it.

Mr FERGUSON - We will be able to provide an answer today to that, I am sure. If not today, as soon as possible.

CHAIR - Whenever you get it. The other comment you made, and I think the secretary referred to, is renegotiation of elective surgery funding; and there was one other area you mentioned.

Mr PERVAN - Our $30 million fund?

CHAIR - This would be under a national partnership arrangement, or are we talking about some other arrangement of that additional funding? Are you saying that is why the estimated outcome remains lower, that there are other moneys to come? Would that be via a national partnership payment or how do you expect to get that?

Mr FERGUSON - I'm not sure where you're looking at the moment.

CHAIR - It's a broad question; I'm just trying to understand where the money will come in terms of the additional funding for elective surgery that has apparently been negotiated.

Mr FERGUSON - The secretary referred earlier today to a meeting he had in his role as secretary with other CEOs, directors-general and secretaries from around the country only last Thursday and Friday. The advice received at that meeting was that initiatives that were committed to by the re-elected federal government are going to be delivered to the states in the vehicle and instrument of MPAs.

CHAIR - They'll all be tied funding for those purposes?

Mr PERVAN - Yes. In addition to the elective surgery funding and the profile in that over the next three or four years, we still don't know what the detail of that is. There will be the issues around the capital contribution to the second LINAC device at the North West Regional Hospital and the refurbishment or additional birthing suites in the Launceston General Hospital. There are a few other initiatives they have committed to.

CHAIR - So, mostly capital we're talking about here?

Mr FERGUSON - A lot of it is capital. We've got about $34 million-worth of services funding. It might actually be more than that, but off the top of my head with elective and the TAZREACH commitments - I have a summary - a lot of them are capital.

We know that the funding was committed to in the - what would you say, in the parliamentary term? - but until the Commonwealth provides us with a draft MPA to consider, we won't know in what financial years each of those is intended to be stepped out with.

CHAIR - I think you will get to why I am asking this in a minute. Is the additional money for elective surgery also capital funding?

Mr FERGUSON - No.

CHAIR - Right. I am just trying to understand how you are going to improve the Budget in some of those areas that are service delivery areas as opposed to capital.

Mr FERGUSON - I can give you a very quick snapshot and it's not everything, but the key initiatives in that are sets of commitments: $20 million for elective surgery and endoscopy; $14.7 million to support TAZREACH for outreach specialist services; $10.5 million to trial an adult mental health centre in Launceston - I don't know if that will be funded in partnership with the state Government or through a non-government organisation; $10 million for capital at the NWRH; and $10 million for capital at Kings Meadows Community Health Centre.

That doesn't add up to $117 million - that's not the full list - but they are some of the major initiatives that will be delivered to the state, I believe, and we are advised, through the vehicle of an MPA, which is how we do it.

CHAIR - Yes, I know it's how we do it. I am interested in how you inform the parliament of these sorts of things when the agreements are struck? Is there a process for notifying?

Mr FERGUSON - Yes, there is a key process but the secretary is more expert than me. For us, one of the key issues is to ensure we give as much of that service funding to be included in our upcoming service plan, which will be laid before parliament when it's completed. That will be one way in which that transparency can -

CHAIR - Including the capital or just the operational funding?

Mr FERGUSON - The services funding. It will be delivered as services through the Tasmanian Health Service.

CHAIR - It's easier to use the word 'operational' because that is what you are talking about. You are operating the service, you are providing the service.

Mr FERGUSON - As for capital, I would be pretty confident that the federal government, when the MPA is agreed, will be keen to let people know.

CHAIR - Put it out in the media.

Ms LOVELL - Minister, are you expecting to have that agreement with the Commonwealth before the service plan is finalised - is that what you are saying?

Mr FERGUSON - I don't know if we will have the agreements squared away but we would certainly have enough - let me take advice on this. We want to provide the service plan as soon as possible.

Ms LOVELL - There are time frames under the act that need to be adhered to.

Mr FERGUSON - The service plan is a legislated process. It also can change when information is updated or the service plan changes if there is a shock or extra revenue that you receive, you can do that and update the plan.

I don't have an ability to guarantee that the MPA it will be signed off and gone through both Cabinets - it probably won't be in that sort of time frame - but we will nonetheless, on good faith advice from the Commonwealth, be prepared to include any expected revenue in our updated service plan.

Ms LOVELL - To clarify comments already made, at this stage there is no information on how that elective surgery and TAZREACH recurrent funding will be profiled over four years?

Mr FERGUSON - In the Budget we have assumed $5 million a year for the 20 of elective surgery funding. We have made an assumption in our budget that it will sit in admitted services.

Ms LOVELL - And that assumption is based on advice you have received?

Mr FERGUSON - It is based on the $20 million commitment made by the Commonwealth before the election.

Ms LOVELL - Yes, that is right.

Mr FERGUSON - We regarded it as not being dependant on who won the election and so we placed it in the Budget.

CHAIR - It is already there.

Ms LOVELL - Yes, I understand it is already there.

Mr FERGUSON - For the service planning point of view, we are not in a position to assume $5 million next year.

Ms LOVELL - That is right, that is my concern.

Mr FERGUSON - Before we finalise the service plan, it is not a concern; it is a prudent measure we are taking to make sure the service plan is reliable. The Commonwealth, for example, might decide to do the $20 million over two years and it is $10 million a year.

Ms LOVELL - My concern is they might decide to do it over two years further down the track, you have said it was during this term of parliament.

Mr FERGUSON - It was a three-year term.

Ms LOVELL - Yes, so there is no guarantee it will be brought forward this coming financial year.

Mr FERGUSON - We do not know, but we have made an assumption for the purposes of preparing the budget, which is the fairest way to assume, that it would be spread evenly across the four years. Until we see the MPA, it would be prudent to be careful before issuing a service plan.

Ms LOVELL - If they do profile it differently and, for example, have it over one or two years over a shorter time period, do we have the capacity to deliver those surgeries?

Mr FERGUSON - We have done it before. We spent $20 million in one year, three years ago.

Ms LOVELL - Okay.

Mr FERGUSON - It is a lot of work for people, but they delivered and surgeons often say to me, 'We will deliver'.

Ms LOVELL - Okay.

CHAIR - On 1.1 the commentary regarding this output group on page 114 of the budget paper 2 talks about grants provided. Can you tell us what grants are provided under this line item, Health Services Systems Management?

Mr FERGUSON - A vast array of grants is actually provided through that output.

CHAIR - Someone will get that for you. While that is coming, I might also ask minister -

Mr FERGUSON - Would you like to know what dollar amount of that budgeted amount is in grants?

CHAIR - It would be good if you have that level of detail. I am more interested in which ones are administered under this area.

Mr FERGUSON - Until somebody disagrees with me, I would say most, if not all, grants through the Department of Health would come through this output.

CHAIR - Okay, all the grants we see in relation to health are dealt with through here.

Mr FERGUSON - I do not want to make a hard and fast rule about it in case I am wrong.

CHAIR - While you are waiting, I might go onto another question in relation to this. It also notes centralised Statewide and Mental Health Services are funded under this line item, the finalisation of the Rural Alive and Well funding, but what other statewide and mental health services are funded through this line item? While they are beavering away over there, minister, I might put the next one to you.

The Salvation Army Street Teams are part of a national partnership payment. Are these to be statewide? How will they assist those needing care in a drug and alcohol centre? Outreach or teams do in the community, but they identify a person who actually needs care and treatment perhaps in a drug and alcohol centre: how does that work?

Mr FERGUSON - I might need to come back to you with some deeper advice but my understanding is that it's not funded under an MPA, unless you've seen that somewhere?

CHAIR - Well, it was somewhere.

Mr FERGUSON - It might have been in BP1 as well, but -

CHAIR - Yes, it is -

Mr FERGUSON - As an MPA?

CHAIR - Page 103, Outreach Support, Alcohol and Drug Services, $300 000.

Ms LOVELL - I don't think that's it.

CHAIR - Isn't it?

Ms LOVELL - That's $900 000 and it's only $90 000.

Ms WEBB - The Salvation Army Street Team is only $90 000. It was $70 000 in 2018-19 -

CHAIR - Where is that funded from?

Ms WEBB - and then nothing.

CHAIR - Does it come from the state?

Mr FERGUSON - It's being funded by the state through this output, through the Department of Health -

CHAIR - How is it going to work?

Mr FERGUSON - It's a support for the Salvation Army and I believe it's for the Launceston Street Teams.

CHAIR - It's only Launceston?

Mr FERGUSON - I believe so, yes.

Ms WEBB - Is it only for two years?

Mr FERGUSON - Yes, as it's funded there. By the way, it's additional. I believe that was in response to a request, although it does mention the waterfront areas. It may not be restricted to Launceston. I'm very happy to ask for some more information for you.

CHAIR - Yes.

Ms WEBB - My understanding is it's a Salamanca-based program.

CHAIR - It'll be interesting to know where it's supposed to be, because drug and alcohol problems are not confined to Launceston. It's great that you have teams in the community -

Mr FERGUSON - I'm pretty confident this was a request we received from the Salvation Army for more support.

Ms WEBB - Above a regular amount of funding, an ongoing recurrent amount?

Mr FERGUSON - Yes. What's the name of that place for safety and -

Ms WEBB - It is a sobering up unit? Do they still run a sobering up unit?

Mr FERGUSON - I know they do. There's one with a different organisation in the north-west, for example. It would be wise for me to bring you a well-advised response.

CHAIR - Yes. If you tell us how much they're currently funded annually. It seems they receive some money already. This is additional and how is that intended? Is it that they can't do what they're already doing with the money they have, or is it an expansion into other areas? Many areas around the state could do with that sort of service. How do they access the limited physical drug and alcohol services for people, rather than outreach?

Mr FERGUSON - Yes. So, I'll ask for that advice for you from the department.

CHAIR - All right.

Mr FERGUSON - The Salvation Army is a significant delivery arm for government through drug and alcohol programs, particularly for the residential rehabilitation program, the Bridge Program, in the south and in the north-west.

Ms WEBB - It would be good to understand how this additional funding fits into that profile of services and whether there were linkages or a particular reason for the two years.

CHAIR - So, do you have answers to the other questions we're waiting on?

Mr FERGUSON - You asked about the mental health element of this output. I'm advised that's to cut the cost of the Chief Psychiatrist and his office.

CHAIR - That's the only thing?

Mr REYNOLDS - That's right, Chair, they're the costs associated with the Chief Psychiatrist's office in the department. It's effectively the policy and directorate, as we describe it, and sits within the department and the costs -

CHAIR - There's no service delivery.

Mr REYNOLDS - No.

CHAIR - It's only policy and administrative.

Mr REYNOLDS - That's right. We describe it as the directorate. They provide the Chief Psychiatrist's office with policy support and assistance for him to perform the role. It's not a -

CHAIR - Policy is statewide.

Mr REYNOLDS - It is, but it's not a service delivery area.

CHAIR - Right.

Mr VALENTINE - Where is that situated?

CHAIR - Hobart.

Mr REYNOLDS - That would be in the output groups 2.5 -

Mr VALENTINE - No, I mean physically.

Mr REYNOLDS - They reside with us at 22 Elizabeth Street.

Mr VALENTINE - Thanks.

CHAIR - It's in 1.1, that's where we are now, Mr Reynolds, in terms of my question. If you look on page 114, the fourth dot point under 1.1 is 'centralised functions in relation to the delivery

of Statewide Mental Health Services'. You can see why I'm confused. It talks about delivery of statewide services. I'm wondering what's provided through this line item that's not provided in 2.5.

Mr FERGUSON - This is the policy part of the department and the planning commission, as well as working specifically within the agency with the non-government work and THS service delivery. It is that centralised planning part of the department.

Mr REYNOLDS - The Chair is interpreting 'delivery' as 'providing service', whether that word is quite right in this meaning.

CHAIR - Maybe you need to add the word 'policy' or something like it.

Mr REYNOLDS - For the purpose of this committee, it would clarify it.

Mr FERGUSON - You could almost strike out delivery, to be fair.

CHAIR - You are talking about community-based as well as acute mental health services. The policy goes across the whole spectrum. You understand why I was confused.

Mr FERGUSON - I think we will not see that word next year.

CHAIR - I will put a mark on that to check if it is gone. I don't have the grants provided.

Mr FERGUSON - We will provide it later in the day.

CHAIR - That is fine. I will make note of that. I will cross it off the list if we receive it later in the day.

Output Group 2
Tasmanian Health Service

2.1 Admitted services -

Mr FERGUSON - I would like to introduce Mr Craig Watson, Chief Corporate Officer of the Tasmanian Health Service. He will be with us for all of output group 2.

Ms LOVELL - Minister, can you please confirm for the committee the number of inpatient beds currently situated at each of the four major hospitals - Royal Hobart Hospital, Launceston General Hospital, the Mersey and the North West Regional Hospital?

Mr FERGUSON - Noting, as I am sure the committee will, that the Government is totally committed to providing a full range of services can be safely delivered, using our physical capacity to the maximum. The provision of hospital services is part of that commitment. Bed numbers are measured annually to provide comparable data across all sites, consistent with national data definitions. May 2019 is the period we have measured for the Estimates committee. Tasmanian public hospitals had the following beds available for admitted patient care -

- the Royal Hobart Hospital, 505, noting this is 29 more beds than the previous year and includes 22 new beds that we opened at the Hobart Repatriation Hospital and the expansion of the assessment planning unit

- the LGH had 404 beds, an increase of 17 from April 2018, largely due to the opening of additional medical beds in ward 4D

- the North West Regional Hospital had 145 beds, five beds higher than last year and incorporates the new acute medical unit that opened in January of this year

- the Mersey Community Hospital had 95 beds, also five beds higher than last year due to additional medical beds.

The term 'available beds' relates to the measure of the average number of fully funded, fully staffed beds available to provide admitted patient care. It is measured in accordance with the same definition to supply in every other jurisdiction.

Ms LOVELL - Those numbers are the available beds at each hospital?

Mr FERGUSON - Yes, available beds.

Ms LOVELL - Minister, can you advise the committee how many additional available beds there will be at each hospital from 1 July 2020? How many are you expecting?

Mr FERGUSON - I had that information prepared for the other Estimates committee. I might just ask for that to be reprinted and bought to your committee. I have done that across the states.

Ms LOVELL - Thank you, that would be good.

Minister, I have some questions about pharmacy services in the hospital, are you happy to take those under this output group, but again they cross over a couple of different ones.

Mr FERGUSON - It may be the best output.

CHAIR - We are talking about pharmacy for inpatients.

Mr FERGUSON - It is really up to you.

Ms LOVELL - It can be for both so that is why I would ask it here. As a result of some changes to the federal budget, there is a decrease in the amount of funding available to pharmacies. Pharmacists in Tasmania have raised this as a significant concern because they judge the impact to be between 15 and 20 clinical pharmacists' positions across the state. Some comments were made in the media by a Government spokesperson who said they did not believe these funding changes would impact on Tasmania. Are you able to elaborate or confirm, minister?

Mr FERGUSON - Thanks, Ms Lovell and colleagues. I am advised the Government has been assured by the Commonwealth that public hospital pharmacies will be no worse off as a result of this policy decision and any change in PBS funding will be directly offset by an increase in National Health Reform funding for in hospital pharmacy services. We are going through the negotiation phase of the next health agreements with the federal and state governments. We will certainly be looking forward to further details working with the federal government on how this will operate in practice. The secretary has had some contact and is happy to inform you. While I am here, a big message of thanks to our hospital pharmacists because they do an amazing job. They are part of

the solution with patient flow and helping people to be safely discharged home. We are supporting them with a nearly $4 million-facility redevelopment in Hobart. Secretary, do you want to add and bring up the process before implementation, please?

Mr PERVAN -. As indicated last Thursday, on Friday I was chair at the Australian Health Ministers' Advisory Council. These changes were raised as a significant issue by all states and territories. The Commonwealth deputy secretary advised there will be a meeting organised within the next month for all jurisdictions to attend, so we can raise our issues with the Commonwealth and they can consider the impact of their policy change around the PBS, before they implement it. While the Commonwealth Government did flag the change, there is an opportunity for us to adjust its position. With the impact on Tasmania with the many pharmacists, the impact on NSW, Qld and Victoria is massive. I would absolutely back up what the minister said about how important pharmacists are terms of patient flow and safety, quality and service. We will be making a very strong and robust representation to the Commonwealth.

Ms LOVELL - Thank you. Minister, how many neurosurgeons are currently employed in the public health system and in which regions are they located?

Mr WATSON - I will have to check the figures and obtain the exact figure.

Ms LOVELL - Okay, thank you.

Mr WATSON - Can we just provide that during the day as we have obtained it?

Mr FERGUSON - We will provide it as soon as I have it.

Ms LOVELL - If we cannot get it by the end of the day, I am happy to put it on notice.

Mr FERGUSON - I will definitely provide it today.

Mr WATSON - We will get headcount and FTE, because they may be different.

CHAIR - And geographic location - there are not many in the north-west; they do not to neurosurgery up there for some strange reason.

Mr VALENTINE - Some would like us to.

Ms LOVELL - Thank you. You may not have this at hand either, but can we add the current average waitlist time for neurosurgery?

Mr FERGUSON - We will take on notice; it might be not as straightforward. If I can provide it today, I will.

Ms LOVELL - Perhaps if we could have that broken down by category, it might be helpful as well.

Mr FERGUSON - Can we have that one on notice, please? I commit to give the headcount and FTE today.

Ms LOVELL - Thank you.

Minister, we have asked this question at previous Estimates hearings and been advised that this data in the past has not been available. I am interested to hear what percentage of time has been spent at each escalation level at each of the four major hospitals over the last financial year.

In the past you have told the committee you don't collect that data because it's not a performance measure, but I am aware that data has been collected for a period of time by the THS and that data was reflected in the Auditor-General's report.

Has that data continued to be collected; if not, why not? It's an important indicator or reflection of how services are being provided in the hospitals.

Mr FERGUSON - I will make a few comments. The secretary is an expert in this and I will defer to him in a moment, but it's actually not an indicator.

Ms LOVELL - The Auditor-General thought it was.

Mr FERGUSON - It's not an indicator of performance. I don't think he claims that it is either.

Ms LOVELL - Not of performance but of how services are being delivered, of how Tasmanians are able to access services.

Mr FERGUSON - It is unfortunate the performance escalation, which staff asked the Government to implement because previous governments refused to allow it on an evidence base, is actually a tool, it's not an indicator. I appreciate that people want to know what it was today, what it was yesterday and what it was the day before, and what it was each day over the last year, for example.

The secretary can speak for himself in a moment on whether that data is collected. I think that it is problematic because even the Auditor-General's data was point-in-time data, it wasn't continuous. It's very dangerous for politicians to draw conclusions from that. I will defer to the secretary and ask him to speak to it. I'm seeing over his shoulder what the charts say and it appears to be periods of time at certain escalation measures. I am not sure that is accurate but -

Ms LOVELL - Before the secretary does speak, minister, do you accept that the escalation levels and the times spent at those indicate periods of high demand?

Mr FERGUSON - Yes.

Ms LOVELL - And periods of time where issues like access block impact on patient flow in the hospital and the ability of people to access patient care?

Mr FERGUSON - I am not sure I would agree exactly with the way you have explained the last point because the escalation is to facilitate patient flow, but it would be fair to say it's a reflection of demand, but I suppose all of our Budget reflects that demand.

Mr PERVAN - The Auditor-General's report states that although THS acknowledges some limitations in the data, the analysis is concerning and, in a way, it is. The problem we have with the data we have is that it is based on literally a single point in time on any given day, and that's the patient flow meeting at 10.00 a.m., so if they are at level 4 at 10.00 a.m., it's recorded at level 4.

They might be at level 4 for an hour or 24 hours - it's that duration of time on a daily basis that's not recorded because, as the minister said, it's a tool to enable management of patients during periods of peak demand.

What we have is a collection of days at 10.00 a.m. where the hospitals have been at specific escalation levels, not so much the duration of time, so it's not really a good indication of how quickly they went up and then down, which is a lot more relevant to assessing how well the hospital is coping with peak demand or, in the alternative, how long they've gone up and stayed up. They can come up and down multiple times during a 24-hour period, and at one point they were.

What we are seeing is greater stability. Over the last couple of months we have seen the LGH come back to level 1, which it hasn't been at for quite some time. For a number of reasons we are very hopeful for, we have seen recently the number of days when we are getting those level 4s being reported at 10.00 o'clock in the morning from the Royal coming back down to a level they haven't been at for some time. We can speculate on what's causing that. We're hopeful that it's some of the things we've done, as well as what's happening with our nearest neighbour, to the RHH, and some improved flow through that hospital and their ED being open more often.

CHAIR - On that point, I guess you could pick any point in time during the day as a point where you measure it; 10 a.m. in the morning may or may not be the best time to get an assessment. I'm sure you would understand that if you have that level of activity, if that's the way it's measuring, late in the day and you have no way of clearing it, unless you send patients home during the night, 10 a.m. in the morning would be a reasonable time to think, 'If we have this overcapacity situation facing us at 10 a.m., we have to do something to clear out some beds.'

It is an indicator of what you need to do, sure, but is there any value in measuring it again in the afternoon? You're saying that it can go up and down, but if you measure it again at, say 3 or 4 p.m. and it's still up, clearly you haven't done much. You have either had a whole heap of people come in the front end and patients who need to be discharged should be discharged by 3 or 4 p.m. They shouldn't still be there. It there some value in measuring it twice and reporting it that way to get a better indication of what actions are happening? How do you know your actions are working if you don't track it a bit? Or are you tracking it? That's the question.

Mr FERGUSON - We have performance indicators [inaudible].

CHAIR - Do you have performance indicators for that?

Mr PERVAN - We have performance indicators for access flow. The minister's absolutely correct. It's more that what causes a level 4 escalation can change radically on any given day. It's not simply a matter of having inadequate discharges.

CHAIR - If you have three or four code blacks, you are in a spot of bother, aren't you?

Mr PERVAN - There's that and also, hypothetically, so this isn't a specific example. We were just talking about pharmacy. If we have four pharmacists on sick leave so we can't get the discharge medications out, that will cause an escalation because it is slowing down discharge. Or similarly, if all the patient transport services are booked and we can't get the patients out.

On a particularly bad day about two months ago, the Royal, through its escalation processes recorded the highest number ever discharges on any single day. It was something like 160

discharges on the one day. Because of something that happened within that next 24 hours - and we still don't know what that something was - there was a sudden surge in demand and so they were back up to level 4.

CHAIR - They all came back. Did you check that?

Mr PERVAN - No, they were actually different patients that came back.

CHAIR - You're sure?

Mr PERVAN - Yes.

CHAIR - This is what happens sometimes though. They get sent out a bit early and they come back. It's the reality.

Mr FERGUSON - I am not sure we are agreeing with you, I'm just paying you a compliment; you are very consistent on that.

Mr PERVAN - There are very structured processes within the hospital. In terms of how we keep an eye on that there are dashboards and other systems such as FYI or ClickView that we also use to keep an overview of what's going on in the hospital. Patient Flow Services in the Royal actually send me a text message every time they go up or down, so I am alerted as to what's going on such that if we see the escalation going up and it stays up for any more than a few hours, I'll contact the Executive Director of Operations of the hospital and see if the department can do anything about finding them some surgical beds in the private sector, getting them some additional help through Call the Doctor services to try to depressurise them so that they can get to a situation where they are managing. It is very much a whole-of -system collaborative effort.

Ms LOVELL - On that point, minister, the secretary is notified when there's a change in escalation level. Are you notified when there's a change, and if so, at what point?

Mr FERGUSON - I'm not always notified and nor would you necessarily want me to be intervening on that kind of basis. I'm certainly aware, when I need to be, of how our health system is travelling. I regularly look in on those matters, but I'm not a part of the supply chain for solving escalation and bed pressure issues. That is for the clinicians. The Government has enabled the escalations to be implemented, which was previously not allowed. I don't know why; you'd have to ask your colleagues why it wasn't' allowed before. I have a significant interest, particularly when the system is running under significant demand. I'm very aware - it's usually a phone call between me the secretary to ensure we are providing the kind of support he has described.

Ms LOVELL - There's not a standard process whereby, if it reaches level 3 or level 4, not necessarily that you're asked to intervene but that you're notified of that situation?

Mr FERGUSON - The important thing is that the people who can support a hospital, when it's over-capacity or highly escalated, are immediately advised of that.

Ms LOVELL - That's a no to my question.

Mr FERGUSON - No, I'm not part of the automatic distribution list, for example -

Ms LOVELL - Thank you.

Mr FERGUSON - but I'm not sure you'd want me to be. You might want to be but the people who are there to solve the problems are not usually the politicians. A politician's job is to have the policies in place and provide the necessary funding.

Ms LOVELL - That's correct but, given the impact it has on patients and staff in the hospital, I wouldn't be surprised if it were something the minister responsible would want to be aware of.

Mr FERGUSON - I show a significant interest in it, particularly on very busy days.

CHAIR - Yes. I want to go back to the funding of this line item, being one of the most money-hungry monsters in the whole budget. I put together some figures from last year as a comparator, to show that sometimes estimated outcomes are a bit off. Not so much in this line item but in others we'll go to. The original budget in 2017-18 was $819.545 million. The estimated outcome came in as $109.481 million, which is significantly higher. It dropped away in the actuals to $902.333 million, which is $7 million less.

When you look at the figures you gave us earlier today, the budget was $879.435,000 million last year, 2018-19, and the estimated outcome is $945.771 million, which is significantly more. The budget for this year is $932.379 million. I want to focus on the actuals for last year that we don't get until the end of the financial year, as we discussed earlier, which was $902.335 million. It is $30 million more than actual spend last year. You claim a $30 million increase from actual expenditure last year. You said earlier that this doesn't include the $30 million in Finance-General, or does it?

Mr FERGUSON - It does not, you're correct. You've remembered me correctly, it does not include that finance available to us through Finance-General.

CHAIR - Notionally, we have an uplift of $30 million in this line item from actual spend last year.

Mr FERGUSON - That is potentially the case, yes.

CHAIR - Yes.

Mr FERGUSON - I'll come back to that if you like, but go on.

CHAIR - Yes. You say there's additional money to come from the Commonwealth. What sort of quantum are you expecting from the Commonwealth?

Mr FERGUSON - I don't think we could put any clarity on that today but we have assumed that the elective surgery funding, which you would ordinarily expect would go straight into admitted services, we have -

CHAIR - That's already included.

Mr FERGUSON - We have included that in this line.

CHAIR - Yes. What additional funding are we expecting from the promises made in -

Mr FERGUSON - I don't know if we'll expect any in that line. Of the funding we have, most of $117 million would be capital.

CHAIR - Right. The federal funding, the money for elective surgery, is included in this. It's $30 million more we're spending on Health this year?

Mr FERGUSON - Is that from Finance-General, do you mean?

CHAIR - No, in the Budget. There's still an extra $30 million sitting over in Finance-General. I assume you used the last $10 million last year, or the year before, in Finance-General? There was an allocation a year or two ago in Finance-General as well. We checked with the Treasurer yesterday and that was spent. I can't believe it's put there. It's like a pretend amount over there that we know is going to be spent in Health. Where else is it going to go?

Mr FERGUSON - We spent that and more.

CHAIR - I just want to be clear that it really is a $30 million increase from last year's actuals in the Budget.

Mr FERGUSON - You have the advantage over me as you have read all the figures out. I don't have the actual figures today with me.

CHAIR - The table there is of figures I have put together. The actual figure comes from the TAFR.

Mr FERGUSON - Yes, I'd agree with you that it's nearly bang-on $30 million budgeted compared to actual on the basis of what I have just seen.

CHAIR - This is the reality; we hear the rhetoric around millions of dollars more, and I would have to go to *Hansard* to see how much extra you said was being put into Health, and maybe you are talking across the whole spectrum rather than just admitted services -

Mr FERGUSON - I was, plus admitted services hits a billion for the first time ever in this Budget, in 2021-22.

CHAIR - Forward Estimates are just that. You have to admit it might be more than that in 2021-22 because we have gone from a budget last year of $819 million to $932 million this year, so you could see that could jump quite a lot.

I just wanted to clarify that. In percentage terms it's not a huge amount in a budget this size, but I go back to the Auditor-General's points - it's not just money that needs to change here.

Mr FERGUSON - I completely agree with that. We will do both. I'm going to make that commitment again. I am being very careful here and I suppose you will detect that. It's really important we don't just turn up to a meeting and say, 'We have $30 million, how do you want to spend it?' That's not what we are going to do.

CHAIR - From Finance-General?

Ms LOVELL - It's a one-off, it's not going to -

Mr FERGUSON - It's not a one-off; it's essential to bring forward bed openings which are funded from the 2020-21 financial year, so that is the potential we have. You know we are funding hundreds more beds and people are saying to me, 'Wouldn't it be great if we could bring forward some of those bed openings?' While it is one-off in the Finance-General sense, if it brings forward bed openings in the current Budget, that is perpetual in the recurrent budget, that's potentially what we will be able to do.

It would be wrong, imprudent and a kneejerk-type action if we just went to the meeting and said, 'Hey, everybody, how are we going to spend this $30 million?' That's not what's going to happen. We have to hold out the opportunity for more bed openings, including some that could be opened sooner. What we really must do is address our internal silo issues and the cultural piece, which I believe we have made significant gain on the last five years, but clearly there is more work to do, particularly if we are going to have any chance of realising any of those potentially 3000 bed days the Attorney-General suggests may be available.

CHAIR - It's the policy and parameters statement where the $30 million appears in Finance-General's line item, but also under Health, there is another health demand line which says THS and ambulance is $50 million. One would assume this $50 million is in the policy and parameters statement is included in both.

Mr FERGUSON - Yes.

CHAIR - Is that spread across? Some of it is obviously ambulance. Is it spread across all those other output groups or is it just admitted services and ambulances?

Mr REYNOLDS - Yes, you are quite correct, Chair, that we've allocated across a number of the output groups within output group 2, so it is not just a $45 million allocation to 2.1.

CHAIR - Not $50 million?

Ms LOVELL - It's $5 million to ambulances.

Mr REYNOLDS - Yes, $5 million is to Ambulance Tasmania, but you are quite correct, the $45 million has been spread across output group 2.

Mr FERGUSON - Can I come back to a couple of other matters? I would like to add the Street Teams answer and to my answer to you, Ms Lovell, on escalation reports. My office gets daily reports sent to a staff member, including on escalating levels by hospital. That is brought to my attention when it is particularly challenging, but we are not part of the systematic advice that is provided routinely because we are not part of the daily solution. It would be almost problematic if we were, because you would be interfering in clinical decisions to clarify my answer.

Ms LOVELL - A staff member is notified but you are not necessarily.

Mr FERGUSON - We receive the reports on a day-by-day basis. It is brought to my attention when either I show an interest or because it is hot, very busy.

Ms LOVELL - Would that be level 4?

Mr FERGUSON - No. Sorry?

Ms LOVELL - When you say it is brought to your attention when it's hot - at level 4?

Mr FERGUSON - Yes, levels 3 or 4.

Ms LOVELL - Always?

Mr FERGUSON - Routinely, but from an operational point of view, we are not part of the solution.

Ms LOVELL - No, I am not suggesting you should be, minister, but I would have thought it would be something you would be interested in being beware of.

Mr FERGUSON - I show a significant interest. This would probably be news for a lot of people because we wouldn't want people to imagine that going to a particular escalation level means 'Oh, you beaut, now we get the minister to help us.' I would love to and would if I could on a daily basis, but that is not my role.

Ms LOVELL - I don't think that is what anyone is expecting.

Mr FERGUSON - I appreciate the point.

I have an answer on the Street Teams. This is funding for both Launceston and Hobart. The funding supports an existing service particularly in Hobart, but will also now allow the Salvos Launceston's teams to be out more often. I am informally advised at the moment those street teams in Launceston are out about once a month and are hoping they will be able to now go once a fortnight, but they want to put a caveat on this - subject to their planning, this is what they hope to do.

Ms WEBB - The funding has been provided for two years?

Mr FERGUSON - The answer is yes.

CHAIR - Did they only ask for two years or did they ask for more?

Mr FERGUSON - I don't know.

CHAIR - It seems like a short time to be asking for funding.

Mr FERGUSON - Obviously, they have a lot of other sources of revenue. That is my advice.

Mr VALENTINE - It is called the 'sleep out'. You are welcome.

The committee suspended from 10.32 a.m. to 10.52 a.m.

CHAIR - Thanks, minister. We're still on 2.1, Admitted Services. I'm sure you're aware that the AMA has voiced its concerns about budgetary matters and has provided a series of questions. I will ask some of these questions and seek your answers to them.

Regarding the operating budgets, this is a level of detail below the actual high-level line item, what is the operating budget for Royal Hobart Hospital, Launceston General Hospital and North West Regional Hospital? How much will each increase be in absolute terms in 2019 compared to the actual expenditure of 2018-19?

Mr FERGUSON - Yes. I will invite the deputy secretary and Mr Watson to address it. We can't provide those figures. The same question was put to me yesterday. I can't give those figures with definition. I have tabled the budgets from the 2018-19 financial year for the other committee and I can provide those again here.

CHAIR - Okay, thank you.

Mr FERGUSON - What if I provided explanation for that as well as process, Craig?

Mr WATSON - In terms of -

Mr FERGUSON - Setting hospital budgets?

Mr WATSON - budgets?

Mr FERGUSON - Yes.

CHAIR - Individual hospital budgets, yes.

Mr WATSON - We have to be careful about what a definition of a hospital budget is because we fund services. Services are delivered out of facilities such as the hospitals but in some cases, they are local and they provide a statewide service in others. For instance, we have a statewide pharmacy service with facilities in each of the hospitals but the statewide manager is at the establishment of the south. You could potentially treat that as a Royal Hobart Hospital resource because that is where he is based, but he is part of the statewide service. We need to be careful when we discuss these questions about a hospital budget. We do not budget that way. We budget the services consistent with the activity-based funding model that applies to most acute services. The process followed is that the state budget that comes down, we will be issued a service plan and, when approved, that will outline the funding envelope for the THS and be broken down into the different components of acute admitted, non-acute and the various services.

CHAIR - In each hospital or only -

Mr WATSON - No, on a whole-of-THS, a whole-of-state level. This current year we are in the THS constructed a budgetary mechanism to replicate that funding model internally to form the budgets for the individual hospitals, facilities or services. Previously, those internal budgets were based on historical amounts from years ago and there wasn't an alignment between the two. We very much wanted to align them, so the allocations to services within the hospitals reflected the activity profile in the service plan and the national efficient price, for which we are funded to deliver the service. This current year was the first time we had those budgets. We are continuing to refine

them and work is commencing, preparing for when the service plan arrives for us to produce the budgets for 2019-20 and provide those to local management in the first week of July.

CHAIR - Minister, did you want to table the document?

Mr FERGUSON - This is one we prepared earlier. I am happy to table for you the operating allocation for 2018-19 for each facility.

CHAIR - Thank you. Going on to other questions posed, I will combine these two. Would hospital management of the Royal Hobart Hospital, Launceston General Hospital and North West Regional Hospital and, I assume, the Mersey be asked to make cuts to budget expenditure in 2019-20 relative to actual spending in 2018-19?

Will management of the hospital be required to reduce staff? If so, how many FTEs from each hospital? Will any of these be staff in a role with direct patient contact, which includes nurses, doctors, allied health, cleaners, sitters, administrative clerical staff who are in direct contact with patients, or administrative clerical staff who provide direct support to frontline clinical teams in hospital clinical departments? The further question to that is: will the minister guarantee that all staff with direct patient contact in clinical support roles in each of the Tasmania's public hospitals be exempt from any and all FTE reductions? This is being posed in the context of the efficiency measure the Treasurer has no idea how he is going to facilitate.

Mr FERGUSON - It doesn't sound like something he would have said.

CHAIR - It is my interpretation of it, minister.

Mr FERGUSON - With regard to the efficiency dividend, the chief corporate officer and the secretary can add to this. The efficiency dividend is considered a very modest approach to dealing with a very significant writedown of revenues. Faced with choices, the Government opted to not cut services as we have seen in the past. We want to protect services. We want to and we have protected our election commitments because we are a government that still believes in honouring election promises. We still need to deal with the reality of a declining revenue shock.

Treasury, as I am sure the Treasurer would have said to you yesterday, will be working the agencies to identify savings. Through that process there will be a strong focus on minimising the impact on service delivery and looking to expenditure such as consultants, travel and advertising together with a target of vacancy control, natural employee attrition, without affecting frontline essential services as well as reviewing returns from government businesses. That ought to be music to your ears and those of the AMA, but it doesn’t mean it will be easy. No-one would be suggesting that but it is a far better approach than the lazier budget approach of shutting down wards and cutting services.

In my portfolio of Health and I will say the same later in police, we are committed to protecting frontline essential services and minimising any impact on service delivery.

Ms LOVELL - Minister, we have heard the term 'frontline' used by a number of ministers repeatedly, including the Treasurer. How would you define a frontline essential service?

Mr FERGUSON - Frontline is clearly services delivered to the Tasmanian community. Roles that facilitate those services being delivered to the Tasmanian community are clearly their frontline roles.

Ms LOVELL - Human resources, for example?

Mr FERGUSON - Roles that provide a service to the community are frontline services and so if an individual role specifically relates to providing services to the community then that would fit within the view of what frontline means.

Ms LOVELL - Can you give us an example in Health of a role not be considered frontline?

Mr FERGUSON - No, I am not going to start cherrypicking for you about who is not frontline but I can speak in general terms - we are going through a process. It has not started yet. We went through this in some detail yesterday in the other House. We have an efficiency dividend that we are applying to our bureaucracy. We want our bureaucracy to be leaner, to help to deal with the revenue write down. That is a prudent, fair and humane approach to protect services as much as we can and that is the approach we are adopting.

Ms LOVELL - Through the process and that approach, are you expecting to find roles or departments or areas not considered frontline within Health that would not impact on service delivery?

Mr FERGUSON - I would hope so, otherwise what is the point? We are looking to find expenditure by government and particularly starting with those areas I have named, which doesn't mean a fear campaign can be struck up any time soon. We are going to be prudently going through the process and assisting the whole-of-government effort around ensuring we have a bureaucracy in our agency fit for purpose and efficient for the public. In doing so, we can protect those frontline services.

Ms LOVELL - On that point, nobody is looking to strike up a fear campaign, but if you are one of those people working in the public service who consider their job is not frontline, they would be feeling quite fearful about their future.

Mr FERGUSON - I hope not, but all of us who serve the community should be satisfied in our work and feeling we are providing a valuable service and the Government appreciates that. I know I do.

As we carefully go through this process we will treat people with complete respect. If there are reform initiatives that can be engaged to make our bureaucracy leaner and more efficient which allow us to put the same resource and keep or protect a resource in the frontline service delivery model, all of our obligation is to do that.

CHAIR - You indicate the majority of the efficiency measures will be targeted at the bureaucracy and gaining efficiency measure gains there. Do you have the actual operating expenditure budget for the administrative bureaucracy you talk about?

Mr FERGUSON - If that is in any way related to the AMA question, I have actually taken that on notice in the other House. Is that the question you are posing?

CHAIR - It is along those lines.

Mr FERGUSON - I did not have it and do not currently have that number.

CHAIR - It would be helpful if we could get that today. The overall Health budget is large and it would be interesting to know what portion of it this area actually takes up. You and the Treasurer have also talked about efficiency measures being predominantly sought in travel and consultant costs. How much of the Budget is currently spent on travel and consultants, across the whole health service, but specifically in this area with the bureaucracy? It is important we understand because if it is not very much, it is going to be really hard to make the savings we allegedly need.

Ms WEBB - It is allegedly more than .75 per cent if it is only a smaller amount.

CHAIR - That is what I am saying so we do need that information.

Mr FERGUSON - I have already given a commitment to the other committee. It might have been to Ms O'Byrne. I do not need to take it on notice, I will give you a commitment that I will give you the same information as soon as it is available.

CHAIR - We would also like the breakdown of travel and consultancy costs.

Mr FERGUSON - I will see if we have any of that now. The administration budget -

Ms WEBB - The non-frontline -

Mr WATSON - In the way the AMA defined it in the question, yes [inaudible].

CHAIR - We can come back to that.

Mr FERGUSON - I will come back with what I am able to during the day and if it is not satisfactory, I could take something else on notice. The way some of these questions have been asked is not congruent with the way we usually present our accounting. A fair bit of effort went into the document I tabled earlier to provide that to you. For the reasons Mr Watson outlined earlier, the meaning needs to be understood.

CHAIR - Overall, the wages are at least 70 per cent of the cost of running the health services. I am not sure of the total amount of wages and consumables costs. There is some information in the budget papers that will indicate what it is but if you still have the 2 per cent wages policy, the increase in the Budget, which we have now established is $30 million, does that go anywhere near covering those costs?

Mr REYNOLDS - Yes, you are right, Chair. The Government's wages policy is 2 per cent and we have funded 2 per cent for salary expenditure across the forward Estimates.

CHAIR - The $30 million increase in the Budget, from actuals, will cover a 2 per cent wage rise. How much does the 2 per cent wage rises cost?

Mr FERGUSON - How much does a 2 per cent wage rise cost?

CHAIR - In Health.

Mr FERGUSON - Predetermined by Treasury through the budget process, the 2 per cent uplift in wages is implicit in the agency allocations, even if even in the absence of an agreement with a union, it is still assumed for the purposes of the agency allocation.

CHAIR - There is not much extra and that will soak up a fair bit. What is 2 per cent of the wages bill in Health?

Mr FERGUSON - We could provide that for you. I am not sure it will assist you very much- _

Ms WEBB - It will be of interest, as to whether it is greater than $30 million.

Mr FERGUSON - Would you like a dollar value of 2 per cent?

CHAIR - Yes, of the wages bill in Health.

Mr FERGUSON - We will draw out the indexation components.

Mr REYNOLDS - I can provide you with an estimate in dollars right now. It would be approximately $24 million.

CHAIR - There is only $6 million extra, thank you.

Mr FERGUSON - There is also the $30 million we have allocated -

CHAIR - That is sitting in Finance-General, which is going to be spread across the various areas. You have a copy of the AMA questions. When did you receive them?

Mr FERGUSON - I don't like playing these games.

CHAIR - I am interested in when you received them.

Mr FERGUSON - I don't like it because it doesn't help the public interest that I received them on Saturday afternoon.

CHAIR - The same time as us. I wondered whether you had them earlier than we did.

Mr FERGUSON - That is why I don't like answering these questions. It doesn't serve a purpose but I received them by email on Saturday afternoon. I was told they were in embargoed until the next day but I happened to notice they were up on Facebook that night.

CHAIR - How many of FTEs in permanent medical staff positions are vacant, how many are unfunded and how many are requiring locum and temporary cover at each of the four major hospitals, if you count the Mersey? Do you have the vacancies, locums -

Mr FERGUSON - Yes. I provided that yesterday. We can provide those now. I have vacancies and new recruits.

CHAIR - Okay. Do you have a breakdown of locum costs across each of the hospitals?

Mr FERGUSON - Yes, I do. The question is framed in a way that requires me to pull briefs from three places. Please -

CHAIR - You're the minister, that's why you're here.

Mr FERGUSON - In an attempt to comprehensively answer, allow me to share with you the following. The question was about SMPs, specialist doctors. For the pay period ending 23 March 2019, we have 965.09 FTE salaried medical professionals, which represents an increase of 165 FTEs over the life of this Government. It is a big increase and the largest number of doctors we have ever employed in Tasmania. We also have 39.15 FTE visiting medical practitioners, noting that a lot of those are part-time. That puts us over a thousand doctors FTE, and that's unchanged from 2014, down by 0.88FTE, a small change. That's the first part of the answer.

The second is about job advertisements. In medical, we have 18 current advertisements in the market on the jobs website for medical practitioners out of a total of 88. We have 19 nursing, 12 administrative or clerical, 11 allied health, 5 operational and 4 in other roles; a total of 88 current job vacancies being recruited to. This puts paid to the claim that there's an employment freeze. I don't think you asked me for new starts but it's been handed to me. At the end of the calendar year 2018, not up to the end of March, we've had a total of 1132 new starts of staff, and that is inclusive of nurses and salaried medical practitioners.

CHAIR - It doesn't tell you how many have left in that period.

Mr FERGUSON - It doesn't show the number who left but the figures I gave earlier were net.

CHAIR - We can do the sums, okay.

Mr FERGUSON - Yes. That's interesting, it is also the highest number of new starts.

Ms LOVELL - Does that new start figure include casual nurses?

Mr FERGUSON - I do not think so, because they are salaried medical practitioners. Does it include casual nurses? I would say no, but let me check. New starts.

MR WATSON - It may include nurses getting their first casual appointment. We have to confirm.

Ms LOVELL - It is counted when they are appointed, not necessarily when they have worked hours?

Mr WATSON - Starts is about being appointed.

Ms LOVELL - Thank you.

Mr FERGUSON - Because of your question asking me for follow-up, I will ask the secretary to speak to the generally favourable turnover figures.

The last thing is the locum expenditure, by region, which I do every year for you. We anticipate this question. It is all prepared.

Ms LOVELL - I would have thought you would have anticipated all of these questions.

Mr FERGUSON - Sorry?

Ms LOVELL - I would have thought you would have anticipated all of these questions from the AMA.

CHAIR - Lets keep going.

Mr FERGUSON - We have worked pretty hard and I take the whip to these bureaucrats.

CHAIR - Let's get the answer so we do not run out of time otherwise Police will not be here till 4 o'clock.

Mr FERGUSON - I am answering the question as best I can. The locum costs by region are all to 31 March 2019. They add up to $25 million - in the north, $8.2 million; for the north-west, $11.9 million; and the south, $4.9 million. The grand total to the dollar is $25.022.215 million which I am advised to say, if you wanted to project the 2018-19 figures to the full financial year that can't be extrapolated due to a number of outstanding invoices due for payment as at 31 March. I am advised it is expected it will be between $1 million to $2 million less than last financial year.

CHAIR - It is still a fairly high cost. Particularly in the north-west.

Mr FERGUSON - Last year the full financial year effect was $39.096.772 million.

Mr PERVAN - I will now go through all the health professions and administrative professionals in the THS and touch on some of the medical practitioners. The current turnover rate for SMPs is 26.98 per cent - down from 36 per cent in 2014; for VMPs, it is 2.48 per cent - down from 3.6 per cent in 2014; and for nurses, it is at 5.63 per cent, which is more or less the same as 5.65 per cent in 2014. What is interesting is the percentage of turnover for nurses at 5.63 per cent is significantly lower than the national average, which a couple of independent reviews, one in particular from Deakin University, estimates at around 14 per cent. So our turnover rate is very low.

CHAIR - Is it overall or nurses in particular you are talking about?

Mr PERVAN - Just for nurses.

Ms WEBB - You do not have benchmarks for the others?

Mr PERVAN - No, I do not unfortunately. It was a piece of research Deakin did about nurse turnover.

So, 5.63 per cent of our nursing workforce jobs comes in at about 200 vacancies. What it means is that at any moment in time, we are going to be recruiting 200 nurses.

CHAIR - What is the average age of nurses now? It was pretty high.

Mr PERVAN - It is pretty high and there is variation within the age groups of nurses as to their turnover rates. Younger nurses like to travel. They are more interested in development and

career opportunities and move more than the older nurses, who are more settled, have families and other things that stop them from moving nationally and internationally.

CHAIR - Do we have the average age?

Mr PERVAN - I do not have the average age, but I can find it. It is in the fifties, I do know that.

CHAIR - I can still go back to work then if I am not here?

Mr PERVAN - Never too late. We would welcome you back in the workplace, Dr Forrest.

CHAIR - I'd probably be off this side of the table then.

Mr FERGUSON - If I can make a quick comment and not to slow it down, occasionally you see things circulated by individuals and unions which actually pronounce a number of vacancies for nurses or any other group as a negative for the Government. Isn't it terrible there are 200 nurse vacancies? That is a bit hard to take because they are where we are at in the recruitment field offering job opportunities to people. Based on the turnover rate you anticipate at least 200 nurses per year are going to retire or resign or take jobs in other states. It's interesting on the one hand the same people are claiming a wage and employment freeze and on the other they claim that it is terrible that the Government has 200 vacancies that they are recruiting.

CHAIR - One of the questions I would like to ask, and it is alluded to in the AMA's questions, but on transferring patients to private facilities - and the secretary mentioned this as one of the measures used when the escalation level is high - how often have we transferred public patients to private facilities to access care we can't provide at the time?

Mr PERVAN - Minister, if you want a specific number we would have to look that up. It's not something we record generally.

Mr FERGUSON - Can you speak in general terms?

Mr PERVAN - In general terms, if we can break it into two categories of patients, from surgery and medical patients: medical patients would be the ones we would look to move to private beds when we are at peak capacity. At other times we send surgical patients to the private sector almost every day; in fact we have done that since we got the panel contract up.

CHAIR - Because they have private health cover or because you haven't got space?

Mr PERVAN - No, it is more that that's how we manage the rising and falling demand for medical patients in our hospital. To maintain surgical activity, one of the things the surgical departments do - it is all run by the directors of surgery and clinicians - is if there is a higher demand for admissions from medical patients from the ED, we will reduce the demand that surgery is putting on those beds on that day and we will look to do those operations in the private sector through the panel contract.

CHAIR - What is the cost of providing public patient care in the private system?

Mr PERVAN - I have Ross Smith behind me, but the contract as it was negotiated was for the public price.

Mr FERGUSON - We set up these panels about four years ago.

Mr PERVAN - We did indeed.

CHAIR - What was the total last year?

Mr PERVAN - I will have to ask for that information to be provided.

Mr FERGUSON - What if I was to take that on notice?

CHAIR - Yes, we can put that on notice.

Mr FERGUSON - I reckon there's a bit of work in that. Would that be okay?

CHAIR - Yes, that's fine. I think some of the other questions we have answered along the way. Do any members have questions in the admitted patients line item?

Mr VALENTINE - There is one on the interstate transfers. The AMA asked a question about patients requiring interstate transfer due to any medical staff vacancies. If so, what is the cost related to such transfers? Are there any adverse clinical outcomes as a result of local service unavailability and the need to transfer patients interstate?

Mr PERVAN - We are not aware of any patients who have been transferred interstate because of a local staffing vacancy. Occasionally such arrangements are organised as a safety measure, but in the interim, the cases I am aware of we have actually managed to get a locum specialist in, so we don't have to transfer especially unstable patients interstate. I am not aware of any specific case. Where those arrangements have been organised it has only been as a fail-safe.

Mr FERGUSON - A quick rider is that we are quite open and transparent about the reality that there are some services we don't provide in Tasmania, or don't wish to provide in Tasmania on safety grounds. That is all set out in the role delineation framework in the white paper. We willingly say these patients ought to be cared for in another facility in another state, but I think we all understand that.

Mr VALENTINE - I don't know whether this is right place to ask this question, but I wouldn't be the first person to think why is the Government looking at re-leasing a private hospital that is right alongside our public hospital system when we are having so many issues with beds and space and all sorts of things. Why wouldn't the Government look at simply taking that space back and relieving some pressure?

There are funding issues for nurses and services to be able to open beds, but why would we not look at re-leasing the space? Is admitted services the right place to ask this?

Mr FERGUSON - Well, no, it is fine and totally okay.

The secretary and deputy secretary have been very involved in this. The Government has taken a very strong view on this while the current Healthscope lease is due to expire on the 13 December of this year -

Mr VALENTINE - That's right.

Mr FERGUSON - The opportunity to have a well-functioning private hospital, catering for privately insured patients who are able to pay for their own treatment and as a flexible resource for our next-door public hospital, is really important.

Mr VALENTINE - We have heard you provide the opportunity for private patients to be serviced in public hospitals. Couldn't you simply expand the concept and allow more private patients to be seen at a public hospital and then have more control over the spaces?

Mr FERGUSON - The secretary might be prepared to talk about the financial implications, but we are far better off as a public health system provider to have a high-functioning and effective private sector also operating in the city. We have taken a very strong view it would be the wrong thing to do to simply roll over the current lease with Healthscope. That would not have tested the market.

The Opposition was calling on me and the Government to give them another lease. We were not prepared to do that because we have experienced significant problems in the past. It has been unfair that the Royal Hobart Hospital has, far too often, had to cater for public and private patients because private emergency departments have been on bypass.

This is not a criticism of Healthscope per se, but it is appropriate with such a strategic asset that the Government gets very strong advice about the best way to test the market. We have acted on that advice.

I will give you a quick run-down. The request for proposals process has opened through two stages - one was an information stage, the other was a formal RFT, which closed on the 8 May. The critics are totally wrong. There was strong interest in the asset and the proposals are currently being evaluated under strict probity and governance guidelines. It is our expectation that we not only focus on the potential rent return - the taxpayer ought to receive a fair rent return, right?

Mr VALENTINE - Do we know what the rent return is at the moment, or can you share that?

Mr FERGUSON - We will not be discussing that.

Mr VALENTINE - Okay.

Mr FERGUSON - In the fullness of time I am sure it could be known. The taxpayer should have a good return on the leasehold, but our actual procurement process is focused much more on having an operator who will offer strong service and support the Royal Hobart Hospital next door better in times of high demand.

We expect an announcement will be made later in the year, with a new lease to commence next day on 14 December.

Mr VALENTINE - When you are looking at those arrangements, will you put stronger processes in place where you are not so exposed to closure of emergency departments and those sorts of things?

Mr FERGUSON - Mr Valentine, you are right on the money. We are going to have significant performance obligations in any new lease agreement.

Without breaching the confidentiality, we have to respect - what can we say, Mr Reynolds?

Mr REYNOLDS - You are quite right, minister. When the Government decided it was going to the market, the minister advised we were looking for an enhanced service provision and certainly ED was front of mind when the announcement was given. We are looking for an enhanced performance from the provider, be it Healthscope or whatever.

Ms LOVELL - Minister, when you said that later in the year you were expecting to be able to announce the new provider, can you be any more specific when in the year, given they will obviously need a transition before that date of the 14th, when they need to be taking over?

Mr FERGUSON - Yes, thanks. There are actually some public communications on this. We're being careful about that, as you would appreciate, but we expect that the transition period is open, the process will be open to any bidder to be awarded the contract, including Healthscope. But in the event it's a transition - I'll now leave brand names out of this - transition to a new contract period would be August through December.

Ms LOVELL - So, you're expecting those negotiations to be finalised by August?

Mr FERGUSON - It would also mean we would expect, on the current time frame, to announce that before August.

Ms LOVELL - Thank you.

CHAIR - Moving on to elective surgery - again, some of these questions are posed by the AMA but normally we ask a lot of these questions anyway, so we hope you will have the answers. I'm asking for the total number of patients on both the surgical and endoscopy waiting lists and the breakdown of urgency category of those, then the waiting list breakdown in clinical urgency categories, including the percentage of patients who are over boundary in all the disciplines. I won't read them all out because I think you know what they are.

Mr FERGUSON - Yes. That's where I've seen that list before because I've taken that one on notice, that latter one -

CHAIR - Right.

Mr FERGUSON - in the other committee. So that's -

CHAIR - We ask most years about the waiting lists and the urgency categories.

Mr FERGUSON - Yes, okay.

CHAIR - If it's a table, Minister, you may prefer just to table it.

Mr FERGUSON - Yes, I can table this, there's no coffee stains on it. It's fresh off the press. This is data I provided to the committee yesterday. This is for the preparation of budget Estimates. It's actually later than -

CHAIR - More up to date, do you mean?

Mr FERGUSON - It's up to 31 March - that's what I'm trying to say. This is broken down by categories 1, 2 and 3.

CHAIR - In terms of the waiting lists in endoscopy?

Mr FERGUSON - No, just the waiting list for elective surgery.

CHAIR - That doesn't include endoscopy?

Mr FERGUSON - Correct.

CHAIR - Right, okay, so you've got endoscopy somewhere else?

Mr FERGUSON - Yes, I will definitely come to that.

CHAIR - Okay.

Mr FERGUSON - One step. The second step is I didn't have this yesterday, I have it now. So, we had better give it to the other committee. This is a breakdown by specialty, which I'll table.

CHAIR - Do you have the clinical urgency of those, the category they're in, in the waiting list?

Mr FERGUSON - We do. As at the end of March 2019, 5799 patients were on the waiting list for endoscopy procedure. That's inclusive of gastroscopies and colonoscopies.

Ms LOVELL - Sorry, minister, can you repeat that figure?

Mr FERGUSON - Yes. As at March 2019, 5799.

Ms LOVELL - Thank you.

Mr FERGUSON - And by category - please bear with me. Chair, I don't have the -

CHAIR - Categorisation?

Mr FERGUSON - number broken down by category, but I can rapidly get that during the day.

CHAIR - Okay.

Mr FERGUSON - One thing I can share with you is that this is being pushed very heavily as a result of the National Bowel Cancer Screening Program, which is sending out testing kits to increasing cohorts of people. Pleasingly, increasing numbers of people are responding and using the kit.

CHAIR - Early detection is much better than other outcomes.

Mr FERGUSON - Despite the significant increase in demand, I think the committee would like to know - and nobody is bragging about performance here, by the way; not me - the average number of days of people over boundary - that is, treated outside of their clinically recommended time - has reduced from 184 days in 2012-13 to 163 days. But it's still not good enough.

CHAIR - Across all?

Mr FERGUSON - That's blind of category.

CHAIR - Yes.

Mr FERGUSON - Sorry, no it's not, because it's over boundary and each category has a different boundary.

CHAIR - Is it across all categories?

Mr FERGUSON - Across all categories, it is reduced. It is a challenge. The longest wait time in 2012-13 was 1721 days; the longest waiting patient. It is down to 1104 now but it is still a really long tail. We look to the clinicians to make judgments about who should be seen most urgently. Given the size of that list, I commit to give the committee a breakdown by category by the end of the day.

Ms LOVELL - While you have that information to hand. I have a further question about endoscopy. My question is about the outpatient waiting list and waiting times.

CHAIR - Keep it until the next output, you can ask it then.

Mr FERGUSON - She has given me fair warning. It is of the outpatient waiting time for endoscopy. I don’t think there is one. This is our waitlist on the basis of GP referrals. There isn't another one, so that would be zero.

CHAIR - When you add up the endoscopy and surgery waiting lists, there are 15 192 people waiting at the moment. Do you have a comparison of the total number of patients waiting the last three or four years?

Mr FERGUSON - We do for elective because we provide it every year. We might have to consult, we don’t usually -

CHAIR - It sounds like an awfully large number, over 15 000 people.

Mr FERGUSON - That is when you combine the two but, for our funding purposes, and I wish it was different, the colonoscopy is not activity-based funded as elective surgery is.

Mr PERVAN - It is funded largely by the state but it is funded as a normal inpatient episode and not regarded as surgery because it is primarily diagnostic.

CHAIR - We will see if you can find the total of the endoscopy waiting list over the last few years. We are dealing with them specifically as a separate category now, aren't we?

Mr FERGUSON - Yes, that is a good way to describe it. It is a diagnostic procedure and not a treatment. It doesn't qualify for ABF. Health ministers have raised this at the national level. We need to do endoscopy better and there needs to be more work done.

I can give you a quick anecdote. About three years ago we had a spare $1 million. This was repeated to me by a gastroenterologist. He said, 'Michael, you gave us a $1 million to do 500 more endoscopies and we found one cancer. Do you think that was the best use of that million dollars?' His answer was no, it wasn't. Was there another way to have identified that one cancer through a better use of public funds? There is some work to do. Health ministers at the state, territory and national level have agreed on a review on our endoscopy services provided nationally. I can't put too much definition on that without the brief but the number is large. Some might argue that it is a very expensive diagnostic screen and we might need to find ways to reach those same groups of people at risk of cancer and help them detect sooner and maybe work force reform is needed.

CHAIR - Is it mostly coming through the bowel screen referral process? We are seeing a lot of false positives.

Mr FERGUSON - That is exactly the point I am making. Occasionally, I have to write letters to people to reassure them that, while I am not a doctor, a faecal occult positive doesn't mean that you have cancer, it means you need the follow-up diagnosis. The vast majority are false positives.

CHAIR - Things change. Things like pap smears are now up to five years, which is another output group, but a clear one because techniques change.

Mr FERGUSON - We are not satisfied at all with this area. We are not satisfied with seeing people waiting so long over-boundary, but we look to the clinicians to make the judgment about assessing the GPs' referrals and triage those. For example, people with family history would be put more to the front of the queue than others who have had a similar positive.

CHAIR - One bad story changes everything. Any other questions on 1.1?

Mr VALENTINE - Yes, I wanted to explore the issue with emergency departments going on bypass and look at where this happens across the state. Whether it happens in Launceston.

CHAIR - Can we ask under ED as you are talking about ED bypass.

Mr VALENTINE -Yes.

CHAIR - Yes, we will ask it under that. Another question from the AMA before we move onto the next output. Can the minister give his assurance no surgical training program positions will be at risk due to the lack of [inaudible] elective activity?

Mr PERVAN - The minister or I cannot give that assurance because it really depends on the Royal Australasian College of Surgeons and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. and all the other surgical disciplines because they set the standard. If we say yes now and they suddenly double the number of surgeries required to maintain accreditation, that is completely outside our control.

Mr FERGUSON - They have made their point.

Mr VALENTINE - Waste management is a big issue for acute health services which use a huge amount of disposable product. There are concerns with happens to that product, whether it is going into landfill or recycled. Can you give me some understanding as to what the hospitals across the state are doing about waste management to reduce their impact?

Mr FERGUSON - Can I answer this in two parts. I will make some comments based on my knowledge, which will be limited, but the Chief Corporate Officer here would be more knowledgeable but, also, I am happy to take it on notice and give you a more comprehensive response, which I think will please you.

Now we use more product disposed of and re-used, and hygiene is the driving factor. You are right, it does generate more waste, particularly in the area of soft plastics. There are special efforts underway to recycle and recover the resource. There are actually companies actively asking us to provide this so they can turn it into other products. But a lot of the other things that assist the service to reduce hospital acquired infections. It is obviously a key part of us maintaining our hospital quality safety. Do you want to add to this?

Mr WATSON - You have covered this well, minister. We have had some longstanding arrangements, recycling of PVC may have been one. In some cases, the suppliers themselves can offer support for programs to recycle. We have various committees or working groups within services who look at this. We have a number of very passionate advocates within our services who are very keen on waste reduction, including clinical advocates.

Mr VALENTINE - Do you measure, for instance, weight of product you actually try to recycle or dispose?

Mr WATSON - We have some information, but no, not as a general practice or activity. It can vary and we have to be led by the clinicians and the clinical appropriateness of whether something should be a reusable item or whether it should transition.

Mr VALENTINE - I understand and am not suggesting -

Mr WATSON - It can be changeable in that regard. I am not aware, certainly not at a THS executive level, of any regular reporting on volumes.

Mr VALENTINE - Okay. Is there a case to actually record some of this stuff? It is quite a considerable amount of product going to landfill or special disposal.

Mr FERGUSON - I take your point. Would it be helpful if we took that on notice? I will provide the committee with a solid brief on it.

Mr VALENTINE - Thanks for that. I really appreciate that. What you are doing to reduce energy consumption and the like? How should you implement mechanisms to reduce energy consumption and other climate change issues?

Mr WATSON - We have various reviews of our electricity usage and there is a whole-of-government initiative being done in relation to energy usage which we would participate in. I had

some correspondence on it. I am aware we have provided some information about our facilities and energy sources of those facilities - electricity, gas and so forth. That is something our corporate managers manage and often review. One of the things we are considering is the current future of the cogeneration plant at the Launceston General Hospital and its appropriateness in our future energy mix. It is an actively managed area.

Mr VALENTINE - Are they diesel generators?

Mr WATSON - No, it is gas cogeneration. It was put in at a time when gas prices were quite different. Regarding the LGH master plan, we are looking at whether that is the most appropriate infrastructure for us to maintain.

Mr VALENTINE - Okay. I will wait for the response.

Mr FERGUSON - I am perfectly happy and would like to take both those questions in the same notice of question, if that's okay?

Mr VALENTINE - Yes.

CHAIR - A couple of things, minister. Of the 180 nurse graduate positions in six years, can you give us an update as to how many of those graduates have been employed? Which hospitals have the nurses being employed at? How many specialist nurses have been employed? They may not be employed under this initiative because we are talking about graduates. Would they not be employed unless a graduate is a specialist in that area? Do you have an update?

Mr FERGUSON - Yes, we do. We have significantly increased our funding for transition to practice nurses in our service. I will do my best to answer that. It is a bigger number than I remember. Commencing in January this year, transition to practice nurses are being progressively appointed to vacancies where they can be appropriately supported across the state. This is news; 192.42 FTEs started their careers with THS in 2018. As I recall, the earlier figure when we came to office was more like 115 per year. That's a significant increase.

CHAIR - There was an additional 180 you were going to -

Mr FERGUSON - Over six years, yes. There's the full-year impact of that in 2018.

CHAIR - Some of those are nurses you were putting on anyway, weren't they? Are we talking about extra nurses or is this -

Mr FERGUSON - Yes, we are talking extra nurses.

CHAIR - How many extra nurses were there?

Mr FERGUSON - The baseline figure when we came to office - I am going back to 2014 - was 115 per annum, which we wanted to build on. The extra 30 per annum over those six years gave us the 180, but we had already increased that number from 115 in our first term. We are building on the back of that increase.

CHAIR - Have they been across the board, across all hospitals?

Mr FERGUSON - Yes. We haven't restricted it to registered nurses, either.

CHAIR - All right. Enrolled nurses as well?

Mr FERGUSON - Yes.

CHAIR - Last year, with regard to the estimated amount of activity, I believe it referred to activity in the admitted services area, you advisor stated that the Commonwealth assumes a 3.5 per cent indexation increase while you assume a 4.1 per cent increase based on population and a 2.5 per cent indexation in the forward Estimates. Is it the same this year. Why do you have those different projections?

Mr FERGUSON - Could we take that on notice, please?

CHAIR - Yes. The other one, too. I asked last year about whether the Commonwealth funding, the 45 per cent of activity growth funding, is keeping up with demand. Is that a concern for you? We seem to have quite a high growth in demand in Tasmania. Is that Commonwealth commitment to the 45 per cent of growth keeping up?

Mr FERGUSON - Well, it's actually the old agreement which is timing out and we're currently now looking to move into a new agreement. Of course, you can reliably expect that this Government will do everything it can to get the best possible outcome, and we'll do that by working constructively with the federal government, and no doubt other states. The 45 per cent is a reference to the amount, the percentage, the Commonwealth will pay on growth of funding. As the state will grow its contribution, the federal government will increase its up to 45 per cent of the growth. The only limitation on that currently, correct me if I'm wrong, is that population growth and CPI are both taken into account.

CHAIR - Our population growth is rising, but slower than the mainland, the national rate.

Mr FERGUSON - Yes. Do you have anything you want to add?

Mr PERVAN - In addition, the Commonwealth manages its financial exposure two ways. One is to limit its contribution to growth as 45 per cent of the total, but they also have a cap on total activity that they will support. After that, the state would bear the entire financial risk of any growth beyond that. We are not approaching the cap as yet. We're close, but we don't project that we're going to breach that cap in the coming financial year, or indeed the year after.

CHAIR - Okay, thank you.

2.2 Non-admitted Services -

Mr VALENTINE - In the notes at note 4 you talk about elimination of internal transfers between the Department of Health and THS. Can you describe what that is in a bit more detail to give us an idea what's changing under the new models? On page 128, note 4.

Mr FERGUSON - I'll get the deputy secretary to address that, Mr Valentine.

Mr VALENTINE - Thank you.

Mr REYNOLDS - The department provides some business network services for the THS to avoid the double-counting. It's necessary to do an elimination treatment to ensure it isn't double-counted and overinflated. We ensure -

Mr VALENTINE - What isn't double-counted?

Mr REYNOLDS - We provide business services on behalf of the THS and there's a transfer for the cost of those services. To ensure that, like any consolidation process, we eliminate that particular entry to ensure it doesn't inflate the expenditure you would otherwise see.

Mr VALENTINE - Okay, so this is not as a direct result of the restructure of going from regional to central?

Mr REYNOLDS - No.

Mr VALENTINE - It's nothing to do with that?

Mr REYNOLDS - No. No, we've always had these eliminations when we're presenting whole of Health numbers.

Mr VALENTINE - Okay. Minister, can you detail the reason for the almost 10 per cent jump in the appropriation between 2018-19 and 2019-20?

Mr REYNOLDS - There has been a $12.4 million increase between those two financial years. We mentioned earlier the health demand funding we are receiving; approximately $5.9 million of that is associated with -

Mr VALENTINE - That's part of the $180 million?

Mr REYNOLDS - That's right, over the four years. We have also have had an increase of $4.7 million in Commonwealth funding as a result of increased activity which is reflected in those budget numbers. We have an increase of $1.5 million, reflecting increased activities from our own-source revenue, including changes to pharmaceutical benefits.

Mr VALENTINE - I also note, when compared to last year's budget papers, it appears a 4.8 per cent increase has been applied to each of the out-years in this year's budget papers. That's about $5.5 million each time. Is that the extra $5 million for the Royal Hobart Emergency Department? What is that about?

Mr REYNOLDS - No. This additional money would be in the other output group we have discussed, 2.1 Admitted Services. This reflects that first number I mentioned.

Mr VALENTINE - That's about the Emergency Department?

Mr REYNOLDS - Sorry, 2.3, it is a forward Estimate or impact of the additional health demand money we are receiving.

Mr VALENTINE - It is about the health demand money.

The footnote states the subsequent increases from 2020-21 reflect the 2019-20 Budget initiative, which is health demand, to address increased demand within the THS. However, despite this suggested increased demand, the Estimate for 2022-23 represents an increase of less than 0.9 per cent over 2021-22. That's not a lot of increase and it's more reflective of reduced resourcing perhaps; it would barely meet the increases in wages costs, let alone the suggested increased demand. Can you explain how these Estimates have been struck, and is this the efficiency dividend coming into play?

Mr REYNOLDS - It is certainly no impact of any efficiency dividend; they have not been cast through any of the numbers we are looking at today. In fact, it's an issue we've identified through the budget development process where it is a matter of working with Treasury on it to confirm what is going on there. We described it as an anomaly in our numbers. We are working with them at the moment to see the actual issue behind the numbers we are seeing here.

Mr VALENTINE - You say the efficiency dividend hasn't been cast yet through the Budget. I've been through the efficiency dividend process in the department; I was there for 20 years, in ICT admittedly. I question the benefit of an efficiency dividend like that. Don't you think there is an opportunity when that sort of thing happens, that people start to focus on their own future rather than on the work they are doing for the department and how well they are doing it? They start to protect their own future and don't pay as much attention to the needs of the department. That's what I have seen, and I am interested to know whether you have taken that into account when you are looking at taking another 0.75 per cent efficiency dividend off THS when it is in such dire straits at the moment.

Mr FERGUSON - I think I will take that on board as a comment and an observation from your history. We certainly wouldn't want it to be perceived that way.

Mr VALENTINE - How do you expect to apply the 0.75 per cent across the health services delivery sector? Is it through staff redundancies? What other mechanisms are you looking at or will you look at?

Mr FERGUSON - I can't really add to my earlier answer, which was as comprehensive as I was able to give as a portfolio-holding minister. The process is to be led by the Treasury working with agencies. I can only repeat my earlier point that we will be working very hard to protect our frontline services and those who support the delivery of those services.

Mr VALENTINE - Okay, I will leave it at that. The target for people accessing clinics is going down by 409 on page 116 in the Budget papers.

CHAIR - The performance indicator information?

Mr VALENTINE - The performance indicators look at outpatient attendances. The actual 2017-18 was $561 286, but then the target for 2018-19 was $581 409. We are not at 30 June so can give me the final figure for that? Then the target for 2019-20 is $581 409. I would have thought with a population that is supposed to be ageing and becoming sicker, outpatient attendees would escalate, not decrease.

Mr FERGUSON - May I introduce Ross Smith, Deputy Secretary, Planning, Purchasing and Performance, who will be better at answering the questions as to how targeted number of outpatients attendances has been determined.

Mr SMITH - It is an estimate based on the number of clinics we are now counting and running and not a target per se.

Mr VALENTINE - It is still lower than the target was last year.

Mr SMITH - At this stage we need to be able to finalise what is happening in terms of the service plan and the figure as a target and funded level of activity.

Mr FERGUSON - Can I ask a question on behalf of Mr Valentine?

Mr VALENTINE - That is novel.

Mr FERGUSON - Why not? Do we have access to the number of attendances, say, to 31 March; if not, can we get them?

Mr SMITH - We could get them.

Mr FERGUSON - Why don't we do that, it might assist the thinking.

Mr VALENTINE - If you can give me the figure, that would be good. Will that come today?

CHAIR - We will put it on our list; if it does, we will take it off.

Mr VALENTINE - Looking further with regard to performance page 117, BreastScreen percentage of clients assessed within 28 days of screening.

CHAIR - Breast screening is another output group.

Mr VALENTINE - Is it? It is mentioned -

Mr FERGUSON - You are actually quite right. A couple of years ago we moved it into THS.

CHAIR - I apologise.

Mr VALENTINE - This is 97.9 per cent actual in 2017-18, but the target is 90 per cent for both the end of this year and next year.

Mr FERGUSON - A quick response, this is a nationally-agreed target, given BreastScreen is funded in a partnership agreement with the Commonwealth with an action plan that would support a 90 per cent target rate. We are obviously exceeding this.

Mr VALENTINE - In this line item, there are organ donations, BreastScreen, which we have been dealing with, National Bowel Cancer Screening - three major initiatives. We do not any information as to throughput on any of those for the state. Is there any way we can capture that?

Mr FERGUSON - In the performance information?

Mr VALENTINE - Yes.

Mr FERGUSON - We could certainly consider doing that.

Mr VALENTINE - How many people from Tasmania are returning their bowel cancer screening kits and, if it is at all possible, knowing the quantum of cancers detected or the number of false positives, that would be -

CHAIR - I think that it is what it is going on, minister, with the endoscopy -

Mr FERGUSON - It is and I can speak to it, but it's not as you've identified. It's not listed as a performance indicator in -

Mr VALENTINE - No, it's not.

Mr FERGUSON - in these papers. I think you're advocating that it could be.

Mr VALENTINE - Yes, why couldn't it be? That's the point.

Mr FERGUSON - If you wanted me to, I could give you some performance information. We can be accountable for our follow up, for example, on BreastScreen, which is why -

Mr VALENTINE - BreastScreen has a unit; it might be able to provide some of that information measuring -

Mr FERGUSON - I can take that on board.

Mr VALENTINE - Yes, perhaps it could be considered for next year.

CHAIR - The other thing we need to remember is that women only use the screening service when they haven't had a positive test. Once you've been diagnosed with cancer, you don't go back to the screening, you go back to the hospital and drop out of the screening program. You only have the first -

Mr VALENTINE - How would you link that information?

CHAIR - Well, that's the problem. You're only going to pick up first-time diagnoses.

Mr FERGUSON - It's a screening service.

CHAIR - Yes. It's not diagnostic, it's screening.

Mr VALENTINE - No, okay.

Mr FERGUSON - We are going to provide public mammography for women as result of the re-election of the Morrison Government, which is a fantastic commitment.

Mr VALENTINE - One in 100 men have it, too, don't forget.

CHAIR - Yes.

Ms LOVELL - I have two brief questions. Could you advise the current outpatient waitlist for neurology and the same for gynaecology, please?

Mr FERGUSON - Can I take those on notice, please?

CHAIR - Do you want them by region or only totals?

Ms LOVELL - By region, if you could.

Mr FERGUSON - What if I took it on notice to provide you with a breakdown I'm able to obtain, I can definitely do it by service, by speciality -

Ms LOVELL - That'd be good, if we could have the number of people waiting and the average wait time for those two specialties, please.

Mr FERGUSON - I'm taking that on notice.

Ms LOVELL - Yes, thank you.

Mr FERGUSON - Yes. Do you want the global figures now?

Ms LOVELL - Look, if you have them, but -

Mr FERGUSON - Well, if you don't, somebody else will ask -

Ms LOVELL - I'm sure they will, yes.

Mr FERGUSON - I may as well volunteer it. If we can be clear about those and make sure people who have been listening will get those two specialties inquired into. The number on the outpatient waiting list as at 31 March 2019 is 31 238. Some caution is required, for which I will provide a narrative: we have only been publishing this list since this Government has been elected. It was hitherto known as the 'hidden waiting list'. Now we publish it and we make a disclosure of it with a monthly figure every three months. It's now a different measure because we've been working to improve the consistency and reliability of recording of outpatient clinic data. The problem we found is that we keep finding clinics that were not previously recorded.

CHAIR - They were very hidden, weren't they?

Mr FERGUSON - Extremely well hidden. Collection of outpatient waiting list data commenced in February 2015. I hope you're sitting down. Since that time, we've identified over 50 additional clinics that were not previously counted. They've now been added to the dataset. The figure I have now reported to the committee takes account of all those clinics. I hope we don't find a few more but, if we did, we would add them next year.

Worth noting is that the outpatient data covers a range of non-admitted patient services including medical, surgical and allied health clinics. Therefore, outpatient data covers a broader group of patients than those who might be waiting for an elective surgery service. The department advises me - and Mr Valentine already zeroed in on this - it is expected to deliver 521 409 outpatient attendances in 2018-19, or approximately 11 000 appointments per week. The number of people

on the outpatient waiting list equates to approximately 5.4 per cent of expected attendances for the year. This suggests a significant proportion of people do not need to wait for an outpatient service.

Mr VALENTINE - Are you saying the March figures are 581 409?

Mr FERGUSON - No.

CHAIR - That is the target.

Mr FERGUSON - No, that is an expectation for the full year to 2018-19. I was asked whether we could have the number that occurred in the nine months. I'm sorry, I do not know if I can obtain that for you and will take the other specialities. You have asked for the number and wait time for those specialities, which I took on notice.

CHAIR - By region.

Mr FERGUSON - By region if I can.

CHAIR - I have a couple of questions, minister.

Mr FERGUSON - You didn't ask me how many people were waiting in those 50 clinics we found? I wrote that down and it accounts for 4909 people who previously were not counted.

CHAIR - Where were those clinics hidden?

Mr FERGUSON - They were not collated. I will ask one of these accountable public servants to help me with this. They were not counted previously?

CHAIR - I understand but, where are they?

Mr FERGUSON - What I am saying is there has been an effort to comprehensively report on any appointment or specialist clinic, including allied health, which is not medical, so we are faithfully reporting all out-patient appointments. That is why I do not call them specialist clinics. In this regard, I call them out-patients.

CHAIR - Around the state?

Mr WATSON - Around all our hospitals.

Mr FERGUSON - It was 4909. You might as well go back in history and add those to my previous reports. If you do, you will see our out-patient waiting list is pretty stable.

CHAIR - Minister, a couple of questions requesting north-west maternity services. It is a bit hard to know where they belong?

Mr FERGUSON - It would have been admitted.

CHAIR - It is it admitted?

Mr FERGUSON - They are both, aren’t they?

CHAIR - With the existing election commitments about the maternity services north-west antenatal clinic upgrade, there was some expectation it would be open this year. Is that still the case; if not, when will it be open?

Mr FERGUSON - I can have the specialist answer during the capital outputs. It is a funded capital investment, but I can still speak to it in general terms. It's not really this output.

CHAIR - I can ask it then? That is all right.

Mr FERGUSON - I can talk about the service here or the building, which is very important to us, but it has not commenced.

CHAIR - No, there was a real expectation it would have at least commenced by now and basically be ready to open. What has been the delay?

Mr FERGUSON - I wonder if we are at cross-purposes because the new maternity clinics at the Mersey are built and open now.

CHAIR - I am talking Burnie.

Mr FERGUSON - Yes but they are the best in the state.

CHAIR - Some come from a fairly low margin.

Mr FERGUSON - Yes, but they are beautiful and what we intend for Burnie. I can ask and certainly be on notice that when we get to CRP we will be ready to address this.

CHAIR - The review of the integrated midwifery service was conducted and a report finalised in 2017. Can you provide a copy of that report?

Mr FERGUSON - I can provide something. Secretary I will throw to you.

Mr PERVAN - There is a copy of the report. There is also a cover letter from me, which is pertinent to the report, because further discussions were held with the reviewers and the health service which populated my covering letter to the minister. We can provide both.

CHAIR - Today?

Mr PERVAN - Yes, we can.

CHAIR - It will be interesting to see the whole report. One of our committees requested that and only received the recommendations, not the full report, which is quite disappointing.

Mr FERGUSON - Are we talking about the same thing? I am not sure we are.

CHAIR - We are talking about the review into the North West Integrated Maternity Services.

Mr FERGUSON - Can I please take some advice? I would have thought I was going to provide you with the same documents given to the ANMF and I would need to take advice if a broader document needs to be retained within government.

CHAIR - We are talking about the report into the review of the North West Integrated Maternity Services, which was completed end of 2017. We received copies of the recommendations, but not the content of the report. Are we talking about the same thing or is there another?

Mr FERGUSON - If you already have it, what are you asking?

CHAIR - No, we do not have it; I want the whole report and the covering letter if that is what the secretary was referring to.

Mr FERGUSON - I appreciate your natural curiosity to see everything. I am not in a position to assure you that I will provide the full spectrum of documents. I have been advised to be cautious, but did think I was agreeing to table for you the same documentation provided to the union.

CHAIR - I do not know what they received, so I cannot comment on that.

Mr FERGUSON - I guarantee you I will provide that today, but I cannot guarantee the full scope of documents. It includes patient information.

CHAIR - I imagine a report you are going release to the ANMF would not.

Mr FERGUSON - That is exactly my point and I will provide you with whatever I have provided the ANMF. We will provide this to you today.

CHAIR - Do you have last year's rural hospital occupancy rates and can you provide a table if it is in table form?

Mr FERGUSON - These figures are to March 2019, nine months of the financial year, they should be treated as an average of that period, not at the point in time, does that make sense? New Norfolk District Hospital, 84 per cent; Midland Multipurpose Centre at Oatlands, 40; Beaconsfield, 103 -

CHAIR - Three people to a bed up there.

Mr FERGUSON - It is actually two beds at Beaconsfield from my memory, so there is a statistic.

CHAIR - You are hot-bedding there, in bunks. You should probably look at your information before you give it. I am sure the secretary can confirm the public hospitals do have 100 per cent occupancy at times. There are not usually two people in the bed at the same time.

Mr FERGUSON - Somebody may have needed care for a period of time and there were two other patients already using the two beds. I will just let that be. Campbell Town, 92 per cent; Deloraine, 59 per cent; Flinders Island, 38 per cent; George Town, 63 per cent; NESM Scottsdale, 49 per cent; St Helens, 35 per cent; St Mary's, 43 per cent; Health West Queenstown, 35 per cent; King Island, 29 per cent; and Smithton, 41 per cent.

CHAIR - Aside from Beaconsfield, there is a bit of capacity there. We have talked about this in years gone past. I am just interested, minister, because of the pressures that particularly our major public hospitals are experiencing. Is any additional work being done to encourage transfers to rural hospitals post-op or for non-acute medical care? If that opportunity is being looked at, are hospitals adequately staffed in terms of their skills mix as well as nursing staff and allied health staff numbers to facilitate this?

Mr FERGUSON - The answer is yes. I will ask the secretary to put the definition on that because while we don't want to be pushing patients out to rural hospitals unless it is clinically appropriate for them to receive their care in that setting with around-the-clock nursing care but the visitation of the local GP, we need to be careful on patient selection. I know that you know that. I will ask the secretary to describe the actual work underway to encourage that, including the in-reach.

Mr PERVAN - You have kind of answered the question for me. This is something on which the minister does pursues us regularly because, in his travels and his visits to rural hospitals, he does observe some capacity. What we are managing at the same time is both the work going on in patient selection and in-reach from the rural hospitals and some GPs to repatriate patients to their local rural facility. We are also dealing with issues of complexity that we were not expecting to see in the volumes we are experiencing them in communities like St Helens, where increasingly they are having to deal with not only an increasingly aged population, but one with an increasing occurrence of dementia and altered states and things like that, which the facility is just not designed for.

It's not just a question of the local skills of the nursing staff and the general practitioners, it's the design of the buildings, the extent to which they can be secured and so on. It is a complex process but one we are reminded of regularly, so we look for every opportunity, particularly while we are dealing with the escalations that we have had over the last 12 months, at patients we can move out there. Once again, safety comes first, so if the local GP is not comfortable taking that patient, or if the nursing staff don't feel they can take a patient of that complexity, we won't push that.

CHAIR - What I am talking about here is more likely to be post-op people who just need wound dressings, not high-acuity care, otherwise they should be staying where they are, and the medical care. That might be IV medications that require them to be in a facility at least. At that level of acuity, are those rural hospitals adequately equipped with the skills mix to provide that care, or is that a barrier to putting patients into them?

Mr PERVAN - It's not a barrier and those were the types of patients we focused on initially. What we are seeing is that those patients are, more often than not, sent home with home support, as opposed to going to a rural facility first. It is that next level of complexity up that we are having trouble with repatriating at the moment, particularity since they require more observation and supervision around the clock as they convalesce towards discharge.

CHAIR - I have been informed we have moved to 2.4, which does not mean we not going to do 2.3. Any other questions on non-admitted services?

Mr VALENTINE - Are there any risks that concern you for this line item with the new National Health Agreement being finalised and signed on 30 June? What are the major risks if that is defunded or degraded in funding?

Mr FERGUSON - Can you please clarify which agreement you are referring to?

Mr VALENTINE - The National Health Agreement that is being considered right at this moment.

CHAIR - It's considered a risk in the budget risks.

Mr FERGUSON - It's still current and the Budget assumes a continuation of a funding agreement.

Mr VALENTINE - Yes, but if it does not come up trumps with the amount of funding that you received last year, what are the big risks in this line item? Are there any?

Mr FERGUSON - For non-admitted services?

Mr VALENTINE - Yes.

Mr FERGUSON - I am not aware of any specifically relate to non-admitted services. The activity-based funding is not the only thing canvassed in the health agreement, but it is predominately about activity-based funding. Core funding is also provided. I acknowledge that is a documented risk that needs to be acknowledged by the Treasury, which does its work identifying all the risks it can. I don't feel uneasy about it, no.

CHAIR - The Treasurer was optimistic; he did say the line item we asked him about yesterday was a holding pattern with an expectation of something.

Mr VALENTINE - We haven't got long to wait.

2.3 Emergency department services -

Ms LOVELL - Minister, can you advise through this last financial year to date or the most recent you have available, the average length of stay for mental health patients in the emergency department, and also the longest stay for a mental health patient? We had that last year and I am interested to see a comparison.

Mr FERGUSON - Can I go in reverse order to your question? I can provide the committee with the number - did you ask for the time that a patient was admitted into an ED but waiting for an inpatient bed?

Ms LOVELL - Yes.

Mr FERGUSON - I don't have that, so I can take it on notice. I can only promise to provide our best endeavours on that. I can provide you with the number of mental health presentations which you should draw out of the total number of presentations in the budget papers. The number is 5868, which compares with 7516. To clarify, the 5868 is to March, the nine-month effect; the 7516 figure is for the full year, 2017-18. I will take the latter part on notice as to -

Ms LOVELL - Length of stay in the emergency department for mental health patients and the longest stay in the emergency department.

Mr FERGUSON - I will take that on notice on a best-endeavours basis, no guarantees.

Ms LOVELL - This one you may need to take on notice as well: the number of presentations to the emergency department of patients who reside normally in an aged care facility, broken down by triage category if that is available.

Mr FERGUSON - I doubt that we even collect that.

Mr PERVAN - I would be very interested in the answer to that. We might have to look into that.

Mr FERGUSON - We've never been asked that before.

Mr PERVAN - It is an interesting discussion. I had to keep talking about last week. Of increasing interest to all emergency departments around Australia are people who present in EDs who are recipients of an NDIS package, and people who are coming in either from residential aged care or have a home aged care package because it impacts not only on the information coming in but on discharge and all sorts of other things. No state currently collects that information, but we can look at we do collect and answer that, probably by the end of the day.

Mr FERGUSON - We will respond to the question, but clearly we won't have the hard and fast numbers. We'll look at some way of responding, particularly given that some of our leading nurses are doing some research into who are our patients presenting to the ED. If you have gold star awards for first-time questions asked, you'd get one.

Ms WEBB - Would you be planning then to collect that information if it is something of interest nationally and is our point of discussion?

Mr PERVAN - At the moment it is a national point of discussion about where that adjustment to the dataset occurs, the AIHW, whereas we do it by way of the healthcare agreement.

Mr FERGUSON - It is a good question, I don't dislike it, but you could have asked me of the number of presentations from schools because they had an accident at school.

CHAIR - It is a very different question, minister, and I will tell you why.

Mr FERGUSON - Data collection is of that nature.

CHAIR - The implications on discharge are significant. There is so much more work to do in discharge planning. If they are admitted, it ties up an inpatient bed much longer.

Mr FERGUSON - No, I am not dismissing the question. I like it because when the federal government was working up its terms of reference for the Royal Commission into Aged Care Quality and Safety, we asked them to have a good look at this. We wanted the interface between aged care, residential facilities and our hospitals to be as functional as possible. They have significant resources and if they need a little more support to help keep people in their own home, which is their health aged care facility, that will support the patient and the hospital.

CHAIR - It is often better for the patient if we can keep them out of the place.

Mr FERGUSON - That is exactly the point. We have specifically advocated and achieved that thinking in the terms of reference. The royal commission is looking at that interface with the healthcare system as it looks at the provision of care in aged care.

Ms WEBB - Are psychiatric emergency nurses funded under this output group or does that come under statewide mental health?

Mr WATSON - I am pretty sure the PENs are on the mental health establishment. You would suspect they would be in mental health budget.

CHAIR - We can do that on later. The AMA has some questions about EDs, being the canary in the coalmine. When will planning begin on the expanded emergency department? I assume they are referring to the Royal Hobart Hospital. Who will be doing this work?

Mr FERGUSON - Asset management will be taking charge of that for the foreseeable future. They Royal Hobart Redevelopment Project focus is, as appropriate, on delivery of stage 1. The Emergency Department expansion is one of five elements in stage 2, which is now fully funded. The ED and ICU expansion are both considered high priorities for our stakeholders. The planning process for the ED expansion works has commenced, with architectural consultants expected to be engaged as soon as next month.

Stage 2 is expected to be delivered within three years, noting the importance of not disrupting existing hospital services and the need for cable op to be commissioned to provide a suitable decanting space. Governance and project resourcing are being determined by the Department of Health. I put it to the committee that this is one of the singular positives out of this Budget - that we have been able to fully fund stage 2 before stage 1 is finished. Considering the master plan was only completed in February, it is a fantastic outcome.

CHAIR - Another question from the AMA following from that: if it is the redevelopment team, what additional resources will be provided to the team to ensure this work does not stall while moving into K Block and dealing with inevitable teething problems?

Mr FERGUSON - I hope I have answered that.

CHAIR - Yes. Do you want to add anything?

Mr FERGUSON - Not really, no.

Mr VALENTINE - With this access solutions meeting you plan to have, what happens if they identify critical issues in the ED?

CHAIR - That require money -

Mr VALENTINE - Yes, money, but it might require redesign.

Mr FERGUSON - We would be open to feedback. This Government has already expanded the Hobart ED. We did that on the advice of its local team and found money perhaps two years ago. We are looking to expand that ED as far as Argyle Street and around the corner. Consideration needs to be given as to how it will work in practice but we hope we can provide an additional entry point for psychiatric ED presentations. That's going to be fantastic.

CHAIR - It will be a very positive outcome if you can do that.

Mr VALENTINE - Regarding process, there may well be something to come out of that Access Solutions meeting, I wonder whether the architectural work will have gone ahead -

Mr FERGUSON - It won't have. We would be more than comfortable. We would invite any feedback on that, which is what we would do anyway. That architect is only being engaged the following month. We will start with the good people talking to each other about the best way to implement this, which supports staff and our patients.

CHAIR - With the extra emergency department registrar and medical registrar working on evening and overnight shifts, can they be made permanent appointments? If they are, is there funding for that?

Mr FERGUSON - We had something moved on quickly in May. We received a cry for help from the registrars, who were looking for some more support. I totally respect the way they conducted themselves. The way they raised that was very professional; it was others who took it into other places. I support what they were seeking to do, which is provide safer care for their patients and better support for them as trainee clinicians or specialists-in-training. The positions will remain in place for as long as they are needed. I also note the need to review the operation of the ED as K Block is commissioned and when additional beds are opened, which we hope and expect will reduce access block. They will remain in place as long as needed.

I want to reiterate how much we appreciate their work. It is very stressful for them. They feel the burden of responsibility for unstable patients. When they are not feeling the whole of the hospital is there to support their patient flow needs, they are left carrying that baby and I applaud them for their deduction and the commitment they show. We are really grateful for them.

CHAIR - I am sure we all are, minister. When you talk to people who work in those spaces, it is really tough and they can't move their patients through. They're treating patients in sub-therapeutic areas.

I don't think Ms Lovell asked this question: how many patients wait longer than 8, 16, 24, 48, 72 and 96 hours for an inpatient bed in the Emergency Department? Did she ask for those answers?

Mr FERGUSON - Yes, in relation to mental health.

CHAIR - Are you able to provide that?

Mr FERGUSON - Our best performance measure is identified here. That's a different way of asking for the same information, which is the extent to which we are meeting people in time.

CHAIR - There are two different things. When you visit the ED, there is a time until you are seen. We are talking about patients who have been seen and identified as requiring admission. How long are they waiting in the ED to be sent to the appropriate bed, whether it be a mental health, surgical, medical or other bed?

Mr FERGUSON - I draw your attention to page 116, toward the bottom of the page where we show our current performance about patients waiting, who deserve a bed, should be given one or discharged within that four-hour National Emergency Access Target. That's indicated there.

CHAIR - That's the overall figure but -

Mr FERGUSON - You might ask me about the longest wait, for example, or the number of patients who waited after a certain time frame.

CHAIR - Yes, that's what I'm asking you, for a breakdown of patients in that category who are identified for admission, regardless of whether it's mental health or other, who wait longer than 18 hours, 16 hours, 24 hours, 48 hours, 72 hours and 96 hours.

Mr FERGUSON - I don't have that information in my hands, I'm prepared to take it on notice but I won't commit to those specific time frames. I will commit to giving some effort to address what the point of the question is: how long are people waiting for?

CHAIR - On how many are waiting.

Mr FERGUSON - I will endeavour - I will take it on notice, but I can't and will not guarantee giving it with all of those points in time.

CHAIR - Okay.

Mr FERGUSON - Twelve and 24 comes to mind.

CHAIR - There are stepping points, because there's eight, 12 maybe, or 12 then 24, which is one day; 48, which is two days; 72, three days.

CHAIR - Trauma and retrieval would be under ED or ambulance? Probably ambulance, is it? Trauma and Retrieval Service?

Mr PERVAN - It is not ED. I actually would have put it under -

CHAIR - Under ambulance?

Mr PERVAN - Under 2.1, but -

CHAIR - Okay. Is it under 2.1?

Mr PERVAN - Trauma and retrieval.

CHAIR - Because they go out. Can I ask it and see how we go? And if we can't answer it or whatever, I would have thought it was further down in emergency. Minister, is Tasmania's trauma and retrieval service currently fully staffed with doctors, nurses and administrative support staff? How does this compare against relevant nationally accepted benchmarks? How many FTE medical, nursing and support staff related explicitly to the trauma and retrieval service are currently fully and permanently funded? Are any positions vacant or in jeopardy of becoming vacant?

Mr FERGUSON - Strange question because we have just built the service from almost nothing. That's an odd question because if you cynical, you could think somebody is suspecting it is not as good as we have had before. Well, it is new. So, I can say we are very proud of building that service. A huge amount of public money is going into staffing and building. I have seen it in operation and it is up and running right now.

CHAIR - This is in addition to the NETS team, or the Neonatal Emergency Transport Service./ This is an adult -

Mr FERGUSON - It is an integrated model now.

CHAIR - Does it include NETS?

Mr FERGUSON - Well, it certainly is included in the model. I would not say it is part of a funded model. We have introduced a dedicated team of clinicians who are ready to go, right now; don't have to be called in off the road, or out of hospital.

Mr VALENTINE - When did that start?

Mr FERGUSON - This year. We discussed it last year as part of last year's budget, because it was an election commitment we made of over $30 million. It is up and running now, but no doubt there are -

CHAIR - So, it is fully staffed? That's the question, minister?

Mr FERGUSON - I am not saying it is fully staffed.

CHAIR - All right.

Mr FERGUSON - It is operational now. I am happy to take it on notice for the purposes only of answering are there still more staff to come. We are tremendously proud of the service.

CHAIR - So, how many times has it been utilised?

Mr FERGUSON - We could get that information during Ambulance.

CHAIR - Yes, it does crossover a little; because you have to get the ambulance to go out.

Mr FERGUSON - Well, that is not for all, but for many. It can be an internal request. But often these ones are managed through the State Operations Centre through ambulance or police because it might a search and rescue job.

CHAIR - Okay.

Mr FERGUSON - Okay, who's got something else to say?

CHAIR - I didn't put it together.

Mr FERGUSON - I mean I would rather not take it on notice if I can avoid it. Okay, could I introduce Professor Tony Lawler who among his multiple talents is the Chief Medical Officer. He's

also been, and is, the Chair of the Clinical Planning Taskforce which advised me on the future master plan for the Royal. So, can we just pose this to you?

Dr LAWLER - One of the challenges of providing a cohesive answer to this one is the trauma and retrieval services are actually two separate services that work in concert. The staffing of the trauma response is within the THS, particularly within the Royal Hobart Hospital. And that also has an interface with NETS/PETS service which is funded by neonatologists, paediatricians, neonatology registrars who are employed within the paediatric and the Neonatal ICU. And they interface effectively with the Aero-Medical Retrieval Service. That is a business unit within Ambulance Tasmania that employs retrievalists, who are predominantly intensivists, anaesthetists and emergency physicians, paramedics, flight paramedics and registered nurses working within the service. They liaise effectively with the dispatch and State Operations Centre to interface with clinicians at the receiving hospital, the transmitting hospital and the retrieval services. There is a clear linkage on the NETS and PETS end. Although they have their own paramedics and nurses, they utilise the retrievalists who are employed substantively within the neonatal and paediatric ICU within the Royal. From a point of view of adult retrievals, those staff are employed by and provided from Ambulance Tasmania.

CHAIR - It does cross over beautifully. Thank you, that was very helpful.

Mr VALENTINE - How long has it been in place? You say it is operable.

Mr FERGUSON - The integrated service has been up and running this calendar year.

Mr VALENTINE - Do you know how many months it has been?

Mr FERGUSON - Yes. March was when I went to see it in action but it has been scaling up during the course of the financial year.

Mr VALENTINE - It is not something that started at the beginning of June?

Mr FERGUSON - No.

Mr FERGUSON - We have doubled the helicopter capability; you might see one in the sky but it is now one of two. This is through our contract with Rotorlift, which is a combined effort with the Police portfolio. I will tell you something that will blow you away. I spoke to a doctor when we launched the service those few months ago and I asked them how long they reckon, statistically, until we would be able to say this service has saved a person who would not have otherwise survived because of the delay. He estimated it is already two to three. That is due to reducing the delay from about 53 minutes to about 12 or 14 minutes. Saving those minutes has saved those lives and it is something to be celebrated.

Mr VALENTINE - Have you stationed a helicopter in the north?

Mr FERGUSON - No, they are both based in Cambridge where the retrieval team is also based and the search and rescue capability is also located in the south. Maybe you don't want a long explanation but the service is predominately for people who don't live in Hobart who need to get to Hobart. That is why the service is based there.

Mr VALENTINE - Okay, thank you.

2.4 Community and Aged Care Services -

Ms WEBB - The community rapid response sounds like a really positive program being rolled out more broadly around the state. Can you tell me why the funding for that drops away across the forward Estimates? I am looking at the table on key deliverables on page 102.

Mr FERGUSON - Can I ask you to clarify for me where you see number dropping away? Are you seeing it on page 102?

Ms WEBB - Yes.

Mr FERGUSON - Mr Watson and I will jointly answer this. We have made the service permanent in Launceston only. We piloted it in Launceston and it is a genuine innovation in Health. A quick recap; we promised to restore Hospital in the Home which was abolished by the Labor government back in 2012. Before doing so we redesigned a model around GPs being at the centre of service planning but the service is delivered by THS. We piloted it in Launceston; we said that is what we would do in advance. Having reviewed it, evaluated it, we have then made it permanent. At the moment we are delivering on a new commitment for the Hobart area -

Ms WEBB - Do these numbers relate to only the Hobart rollout or the north-west as well?

Mr FERGUSON - The north-west would be included in that because we are rolling it out in the north-west and the south as a further pilot. I believe that will be the answer.

So $5.6 million is being provided for a three-year pilot program, with an evaluation of the service after the first two years. If it is as successful as the Launceston one has been, the Government will turn its mind to whether we can make it permanent.

Ms WEBB - The areas being covered by that service now are all parts of the state, or only centralised around major urban areas?

Mr FERGUSON - Not all parts of the state; we don't try to represent it that way. In Launceston it started out as a smaller number of doctors' surgeries being part of it and over time it has grown to encompass all of the Greater Launceston area - I think it might even reach to George Town - but it doesn't attempt to cover the full north-east corner, for example. The same will be the case in the south and north-west as the service is designed.

It is intended as a hospital avoidance measure, but, as important as that is, supporting the person with better care, our number one advocate for this would be someone like my good friend Rex Sainty in Launceston, who has been enjoying the service. Not only does it avoid him taking up a hospital bed - and I know he won't mind talking about his case because he has been speaking publicly - but he likes it better because he can be at home and can do his work duties as well, knowing the Community Rapid Response Service will come to him.

Ms WEBB - How many people in each region are employed in that service?

Mr FERGUSON - Could I take on notice the actual numbers? Our election policy does have numbers in it. What if I obtain for you the actual numbers for Launceston at this point, because north-west and south are still in the phase of recruiting right now? I will take that on notice.

Ms WEBB - Sure, that's fine.

Mr FERGUSON - I hope it's a great success, by the way.

Ms WEBB - Why would you pilot again in other regions when you've successfully piloted it in one and absorbed into the health system because it was so successful?

Mr FERGUSON - I guess it recognises that it's an innovation and we want to get the engagement right. We have a budget that allows us to do it for three years, so we want to do that. But if it works, there's a question for government. Does this mean that this is a better model to provide that takes pressure off the Royal? I guess I could answer the question by saying the circumstance of pressure on the emergency department in the south is really very different to that on the north-west. We want our service to be adaptable to the local scene, and you wouldn't want the rapid response to be the same design in the north-west as the south for that reason. It is just our approach on this.

Mr VALENTINE - How does it work in with the after hours doctor service, which is a Commonwealth-funded exercise? Do you work them together?

Mr FERGUSON - Not really, but they are complementary. The after hours home-visiting doctor program is in place in some but not all communities in Tasmania. I welcome it; I think it's good. First of all, it's the Commonwealth that pays for it through the Medicare system, through the primary care funding mechanism. I wouldn't make this point too heavily, but it does take pressure off other services to some extent.

Mr VALENTINE - It certainly takes pressure of EDs, you would think. If people don't think they can get to a GP, they'll go to the ED.

Mr FERGUSON - There are some who do, were it absent.

The other point is that the rapid response model works where GPs themselves make an assessment about whether that patient is appropriate for the rapid response model and is not taken out of the loop in terms of the delivery of the health care provided by the other organisation, THS. GPs really love it in Launceston and I'm sure the ones in the south will come to it as well.

Ms WEBB - Very briefly, the palliative care programs that were being funded and are coming to an end in this Budget, why are those not being continued? Is the work they are doing under Palliative Care Tasmania a project that is ending or is it simply that the funding is ending?

Mr FERGUSON - There is limited-term funding involved here, some of which is because this is money we were able to obtain on behalf of Palliative Care Tasmania through the Commonwealth.

I can give you a quick scan of our commitments and you may have other questions.

We are certainly building a lot more capacity for our system than has been the case in the past. We recognise that palliative care is something people understand more and more now and want. We are committed to ensuring that people, regardless of their scenario, are getting the best possible care at the end of life.

We have committed funding of $132 000 over two years to Palliative Care Tasmania. That is the Tasmanian Government's support we have provided. It is fixed term funding for two years which we are committed to doing. We would always consider in the future what more we can do but at this time that is our commitment.

We have also committed funding of $400 000 per annum over two years for three new palliative care clinical nurse educator positions. I am advised they have been established and filled now, one in each region - north, south and north-west.

The whole point here is for these people to facilitate and support the development of the nursing workforce more generally by planning and promoting, coordinating, implementing and later evaluating education programs across regional specialist palliative care services.

Ms WEBB - That's ongoing?

Mr FERGUSON - No, it is not. It is over two years to build up that capacity. This is not the end of the story. We are always going to have to continue to monitor what other supports we can provide for palliative care.

CHAIR - I want to go back to the money spent in this area. I overlooked mentioning it in the emergency department services item, but it is not quite as bad in this area. When we look at the original budget from last year, the estimated outcomes and the actuals, the estimated outcomes in this line item from last year were $205 695 000. The actual was $222 025 000, which was an increase from the estimated outcomes of $17 million. It is a fair way short.

In the emergency department, there was an uplift of $28 million, so the estimated outcome was well short. When we go to this year's Budget, and the estimated outcomes you have provided, the estimated outcome for 2018-19 provided earlier in this line item was very close to the actual figure last year.

You are now going to spend only $209 million, when the actual figure was $222 million last year, and you are spending $201 million this year. You are not budgeting as much as was even spent last year after the estimated outcome was $17 million short last year to the actual figures.

Can you explain why you are falling behind in this area? What required the additional funding last year that is basically not being funded, if that is the case? Where have the cost pressures disappeared?

Mr REYNOLDS - There are some reductions we have budgeted for, as you can note from the global number. We are expecting a decrease, I am advised, of about $1.8 million in DVA expenditure.

CHAIR - Of $1.8 million?

Mr REYNOLDS - There is also an increase in some of the carryforwards we have from last year into the Budget now which relate to the Commonwealth Home Support packages and community aged care services, and that is $1.3 million less that won't be spent this year. There are some reductions coming there. We have allocated $6.2 million in state health demand funding we spoke about from the $45 million.

CHAIR - That is included in this figure?

Mr REYNOLDS - That is included in that figure. There is some money also for the rapid response services in the north-west and the south, as we discussed previously.

This is the budget this area will be required to manage within. It may be less than what they had to expend this financial year, but they will be asked to work within this Budget for the coming budget and over the forward Estimates allocations.

CHAIR - Minister, to meet that budget, if the health demand funding is included in this, not including Finance-General, but the other health funding, it is really either no increase or a small decrease. How can this area deliver the services it is responsible for with an either completely flat or slightly negative budget from last year? From actual expenditure last year and before you lay any efficiency measures over the top?

Ms WEBB - It might explain some of the drops in the targets in the performance information across some of the line items. A range of them are going down.

Mr FERGUSON - We certainly would not agree with that point that it is wanting it to go badly. We certainly would be putting forward the Budget in good faith as to best using our available funding. I will ask the secretary to add to this in a moment, but the areas included have helpfully been explained by the deputy secretary in terms of some of the dollar amounts that have to be realised here to show a rationale for why some of the allocations have changed.

Did you mention dental? Dental is one where it shows a reduction of $2 million in 2020-21, in the absence of a replacement Commonwealth State Dental Agreement, which I am completely optimistic we will have.

CHAIR - You might see some additional funding come into this line item from the Commonwealth?

Mr FERGUSON - I am very confident we will.

Ms WEBB - Does the unconfirmed funding from the federal government explain why some of those oral health services performance targets go down in 2019-20? For example, I am looking at adults' occasion of service general and adults' occasion of service episodic, which have dropped distinctly in 2019-20 in the targets. What is the explanation? They go down lower than they have been for a number of years.

Mr FERGUSON - I will be happy to inquire further on how the performance targets have been calculated on advice to government. I am confident about a successful new dental agreement with the Commonwealth. I will seek advice.

Ms WEBB - Combined with a waiting list distinctly increasing. The general adults waiting list goes up distinctly also, as well as the dentures list. Less service and greater waiting lists.

Mr FERGUSON - Thank you for the question. I am going to ask Mr Watson to respond, which will provide some clarity, but again dental has actually been one of the very good achievements we have been able to make with waiting lists in Tasmania. We have seen some very

positive improvements. I will ask Mr Watson to explain some of the financials and how they represent in the targets.

Mr WATSON - In regards to the forward performance, we are assuming continuation of the Commonwealth-funded programs. In past years we have carried forward some of Commonwealth money. It hasn't been expended in a given year and there has been increased activity, particularly in the 2018-19 year, catching up and expending the money. If you ran baseline over a four-year-period, it would be a particular average, but there is year-to-year lumpiness based on when they do expend the funds in Oral Health Services.

The 2018-19 year was one in which we had a reasonably significant amount of funds, carried forward funds, utilised to deliver extra services over and above what would have been the baseline requirement.

Ms WEBB - The numbers for 2019-20 are lower on occasions for service and higher on the waiting lists than they have been for the last three years, not only 2018-19. Is that the same or is there a different explanation?

Mr WATSON - Yes, because we had the Commonwealth money, we were obviously going to have some length of time. I do not know historically, particularly early on in, getting the activity ramped up to utilise all the Commonwealth money - obviously we have to recruit staff. In past years there has tended to be a carryforward of funds in each year, which we then use to supplement baseline activity in the next year.

CHAIR - We might stop for lunch. Did you want to add something, minister, before we do?

Mr FERGUSON - I would like to share the performance data on oral health. Tasmanians have waited, on average, eight months less for general dental care this financial year to 31 March compared to 2012-13. There has been a significant improvement there.

Since 2014-15, waiting times for general care have dropped from 31.7 months to 17 months. Waiting times for denture services have dropped from 5.9 months to 2.4 months. As at 31 March 2019, there were 181 people on the dentures waiting list, with a median waiting time of under three months.

There's been an extraordinary effort in the last four to six years and the Commonwealth has helped to pay for this, and it has significantly improved. We acknowledge there is always more to do. Administering with, comparisons between targets and past actuals. In previous years the service exceeded its targets. The actual is a particularly high number and while we always want to set appropriate targets to work to, you don't want all [inaudible] services by over-exceeding the target they want to achieve. Oral health is a good, diligent service.

Mr FERGUSON - Can I quickly add to an earlier answer for context in regard to this particular output? We have $14.7 million coming to TAZREACH from the Commonwealth. We do not know if this will come through the state budget or go directly to TAZREACH. Nevertheless, the $14 million has not been included in these figures. Consider the impact of those federal funds which remain subject to negotiation, but again are not part of these finances.

The committee suspended from 1.08 p.m. to 2 p.m.

CHAIR - Thanks, minister, welcome back. We will start will some answers you have to table before we move into output group 2.5.

Mr FERGUSON - Good afternoon again. In answer to the question on outpatient appointment numbers, I don't have the information to the end of March but I have it to December 2018. The number of outpatient appointments for the major hospitals was 29 690 service events from July to December 2018. This is within the national reporting scope, Independent Hospitals Pricing Authority data for January to March, which I thought I would be able to give you but is not yet available and will not be available before 30 June 2019.

CHAIR - Does that satisfy, Mr Valentine?

Mr VALENTINE - Yes.

Mr FERGUSON - The average age in the Tasmanian Health Service nursing workforce is 43.99 years.

CHAIR - Someone texted me the number 46.1 years; it is a lot younger than it was.

Mr FERGUSON - It's 44 years.

Information for Mr Valentine regarding climate change actions. This is taken from our annual report 2017-18 and there is more information to come in regard to waste and recycling. I will table that. Grants from output 1.1 are allocated across mental health; alcohol; tobacco and other drugs; home and community care; and planning, purchasing and performance, together with their dollar amounts.

This answers one of the AMA questions: the 2018-19 expenditure budget for statewide support services and THS management is $64.9 million. This includes THS administrative bureaucracy but is broader, with the vast bulk of the expenditure relating to hospital support services provided on a statewide basis, to provide functions across all operational sites, including human resources, finance procurement, funding through the Executive Director of Nursing and other central THS roles.

Ms Lovell asked about neurosurgeons. The THS employs four neurosurgeons, two in a full-time capacity and two in a part-time capacity. They are all based at the Royal but participate in monthly north and north-west clinics, and 50 per cent of the elective cases they perform are on north and north-west patients. Treatment is in the south. I am advised the level of staffing is consistent with previous years.

I will ask Mr Reynolds to speak to this if the committee wants further explanation. This is what would appear to be a different set of numbers in regard to the Royal Hobart Hospital redevelopment cashflow from the Commonwealth. I am advised it is down to the application of new Australian Accounting Standard AASB 15. Revenue from contracts with customers prior to 2019-20 revenue was generally recognised when it was received. From now on, all, National Partnership payment - NPP - revenue will be recognised over time in accordance with that accounting standard as the performance obligations are met.

CHAIR - That is fine. It answers the question, I understand that, and we spoke outside.

Mr REYNOLDS - There is an explanation in budget paper 1 that gives an overview of the accounting standard change.

CHAIR - It does, there is a whole chapter on it there.

Mr REYNOLDS - And there is more information being prepared.

2.5 Statewide and mental health services -

CHAIR - Minister, to go back to the financial information we will start with on this occasion and the information that you gave us earlier today, there is an estimated outcome for this current year that we are in of $124.512 million. The budget you have set for next year is only $119.621 million. the actual last year, from the annual reports, was $129 million.

It is less than the actual. What I am interested in is: does this contain the majority of your capital expenditure proposed in this area? If it does, I am not sure -

Mr FERGUSON - No.

CHAIR - No, so it is all operational. If the actual was $129 million this year, we are looking at $119 million this year. How are we going to achieve a level of care when we have seen patients in the community, young people with mental health issues perhaps, struggling to get access to the services they need currently? This is effectively a $10 million less budget than was actually spent last year.

Mr FERGUSON - Before we address the question, I will introduce Dr Aaron Groves, who is the Chief Psychiatrist and also the Chief Forensic Psychiatrist. He is our number one adviser, at least I regard him as my number one adviser on mental health reform and initiatives. Thank you for joining us. Turning to the explanatory notes for this output item, please, Mr Reynolds.

Mr REYNOLDS - Chair, did I hear you correctly saying the outcome last year was $129 million?

CHAIR - No, that was actual last year.

Mr REYNOLDS - The estimated outcome for 2018-19 we were budgeting or assessing as $124.5 million this year, so there is a $5 million difference between the estimated outcome for this financial year as compared to the budget for next year. There is a $5 million variation.

CHAIR - No, the actual figure for the year before. Last year's actual figure - we can't have this year's actual figure because it's not the end of the year yet.

Mr REYNOLDS - No, but the estimated outcome that we are suggesting at $124 million is the more likely outcome, as compared to the prior year's.

CHAIR - Last year's actual, or the previous year's actual figure.

Mr REYNOLDS - That is right, $129 million, so what I am trying to identify is that the variance I see is the $5 million between the Estimates outcome and the Budget.

CHAIR - Assuming they are right.

Mr REYNOLDS - Assuming they are right, but given how far into the financial year they are, I suggest they are reasonably accurate as to what we anticipate to be the outcome for this financial year. What we have identified is that in 2019-20, we are actually making an allowance for a decrease in our locum expenses.

CHAIR - That's $5 million less in locums, effectively?

Mr REYNOLDS - Indeed. Also, my notes indicate that there is a move towards implementing lower-cost services such as the mental health hospital [inaudible], which I hope would drive down a number of the costs here. As a result we are seeing a lesser allocation in the Budget as compared to the estimated outcome for this year.

CHAIR - Can I just go back to the estimated outcomes and how they are supposed to be fairly close? Over the 2017-18 year - not this year, the year before, and I'm just talking about the accuracy of estimated outcomes - in statewide mental health services in 2017-18, the estimated outcome, which was provided around the same time of the year as this, was $120 million, roughly, and the actual was $129 million, so it was $9 million out.

I am not sure it's that close. Talking about accuracy of estimated outcomes, community health and aged services was $17 million out; emergency department services was $28 million out; non-admitted patient services was $11 million out. It could be these were all out in the wrong direction; they were that much higher. Admitted services were less, by $7 million, so I am saying here that the estimated outcomes, while they should be fairly close, obviously are not always. We are seeing here a reduction in spending. As you have explained, the $5 million, if you want to go from estimated outcome assuming it is reasonably accurate, but if there is another nine on top, we are looking at $14 million and some savings you have mentioned. Ultimately, it seems we are really not having any significant increase in the mental health budget. I do not know whether you want to make any more comments, or perhaps that is more for the minister.

Mr REYNOLDS - We spoke about the $45 million provided generally for health services. In this particular area over $3.5 million has been allocated for health demand. There are additional funds of $2.1 million for the establishment of the additional 27 mental health beds in southern Tasmania. There are additional funds going into these particular initiatives.

CHAIR - Is that the building or the staffing of the beds?

Mr REYNOLDS - Staffing.

CHAIR - Staffing. Right.

Mr REYNOLDS - As the minister pointed out before, these statements reflect expenses, not capital items.

CHAIR - Okay. It still seems we are facing an uphill battle providing the mental health services Tasmanians need. Some of the election commitments talked about the mental health beds being promised. There is a whole list of amounts being spent on mental health beds. Can you tell

us exactly where and how many mental health beds there will be in each area of the state and how many will be dedicated adolescent mental health beds?

Mr FERGUSON - I will immediately ask the Chief Psychiatrist to address the question. We are establishing more facilities, which is the big initiative in this output group, with 27 additional beds in southern Tasmania where we have seen significant increase demand manifest.

The commitment here recognises it will take some time to build those facilities at the Peacock Centre and St Johns Park. We are not going to make people wait for us to build those facilities while we provide the additional care. Hence, the Government made a decision to use differently the funding budget for Mistral Place, extra 10 beds. We took advice there is a better way forward for there and in any case they would have taken time to build. We are able to use that resource to provide Mental Health Hospital in the Home and currently we are offering eight extra beds equivalent for that service in the community. This is classified as an acute service, which is a real innovation. The chief will speak to this also. You asked me for the number of mental health beds in each region, which I will definitely need to take on notice if you want a regional breakdown of what we have and how many beds at the conclusion of these election commitments being delivered.

CHAIR - Also, which ones are specifically for acute impatient adolescent.

Mr FERGUSON - We can address that now - I do not need to take it on notice. Chief, if you could address that and please bring in both north and south.

Mr GROVES - In answer to your question about adolescent beds. There will be 16 adolescent beds at the Royal Hobart, eight at the Launceston General. The proportion to be allocated to mental health is yet to be entirely defined and will be on the basis of usage. At the moment, the models of care for those two units are being finalised and until they are, I cannot actually tell you precisely how many there will be. I can indicate the actual occupancy of children - that is, people under the age of 18 - is about 6.5 bed per day throughout the year. We would expect to meet demand as we are going to be meeting something in the order of 6.5 beds in the start.

CHAIR - Are you talking about adolescent mental health beds?

Mr GROVES - That is right.

CHAIR - You said they were adolescent beds, but you were not sure of the mix of use; can you clarify what you are talking about>

Mr FERGUSON - Can I give a covering context to assist? It has actually been worded in a way that brings more clarity, because at different times the Government, the chief and the department have referred to 'adolescent units' and at other times 'adolescent mental health'

So that we all understand, we are talking about two adolescent facilities - one in Hobart and one in Launceston. Both of them are currently under construction and both of them will provide for adolescents. Additionally, both of them will provide for mental health but we don't want to leave people with an expectation that all the beds will be dedicated to mental health.

The service is currently consulting and planning the best mix of those beds and the model of care for those beds. I've asked that it not come to me until the Chief Psychiatrist has approved that model.

CHAIR - We are looking at adolescents from 12 to 18 - is that the age we are looking at?

Mr GROVES - That's generally what is accepted as being the age range.

CHAIR - So a 12- or 13- or 14-year-old who needs surgery or who needs some medical care for, say, a medical problem, would be in these beds?

Mr FERGUSON - I would stay more with medical. I don't know how you'd go with surgical.

Mr GROVES - That's still being defined within the model of service for the whole of the adolescent beds, but that's what's presumed to be the case. I need to indicate that in building those units though, some of the beds have been specifically built such that somebody with mental health problems would be more appropriately in those beds rather than, for example, a kid who might have cystic fibrosis or need surgery or whatever it is. Within those units, that's already been done but there will need to be -

CHAIR - How many of those rooms in each unit will be specifically capable of having an acutely mentally unwell adolescent in them?

Mr FERGUSON - There is obviously a spectrum of illness here to deal with and I think in answering this question we need to highlight - I might suggest the words 'high risk' - rooms equipped for high-risk patients.

Mr VALENTINE - Also being able to be isolated from a general surgical patient who is adolescent?

Mr GROVES - I will answer the first question, minister. The important aspect in being able to provide good care is to be able to have the right staff as well as the right rooms. At the moment we have sorted out the number of rooms that would be in each that would be dedicated to just mental health, but, as the minister has pointed out, some people would still be in an adolescent unit with mental health problems who have lower levels of need and they would be able to be managed in any of the beds within the adolescent unit. How precisely that works is part of how the model of care is being sorted out at the moment.

Minister, if you don't mind, I'll answer the second part of the second question.

For those people who need to be closely supervised so they may not interfere with the medical care of other people within the adolescent unit, the way in which the unit has been designed, at least as best design overall, from the Royal Hobart Hospital, will be able to easily facilitate that. I am less familiar with the design features of the Launceston hospital, but I have been informed that would be easily able to be achieved as well.

I think the process is really about determining how many of those kids need that. I know from practical experience we usually have only one or two at any one point in time at the Royal Hobart Hospital who need that sort of intensive care, which is what we have built into the design of the Royal Hobart Hospital's adolescent unit.

Mr VALENTINE - It is important not to unduly isolate them.

Mr GROVES - That's absolutely right.

CHAIR - Just going back to the point, if you want to use the minister's terms, how many high-risk beds, or beds that could be suitable for adolescent patients with high-risk mental health needs, are there in each unit?

Mr GROVES - My understanding is there are two in each, and that would fit well with what the current need is in Tasmania, across the state.

CHAIR - Obviously, they need to be staffed with appropriately skilled staff. I am not sure if we have psychiatric-trained nurses able to look after paediatric patients as well as adult patients?

Mr GROVES - Yes, we do. We have currently across what is called the Child and Adolescent Mental Health Services in the state, 64.8 FTE staff. A number of those are mental health nurses who are specifically child and adolescent accredited and they would be able to provide assistance. What is more important though is moving forward those individual beds, and those two units need to be specifically funded. I've seen a proposed staffing profile for the models of care, which would be the new staff who would need to be employed who would be in addition to those of our staff in CAMHS who are currently working in the community services.

CHAIR - How many are we talking about?

Mr FERGUSON - There are 16 in the south and eight in the north.

CHAIR - Right. Does that include an adolescent and paediatric psychiatrist?

Mr FERGUSON - They're funded but it's subject to the model and the mix. I'm waiting for that -

Mr GROVES - The proposed staffing model I have seen has both child and adolescent psychiatrists as well as other child and adolescent medical staff who are trained in mental health together with child and adolescent mental health nurses and other allied health staff. Exactly how that will work is the issue that needs to be sorted out with the model of care.

CHAIR - Okay. Sarah had a question.

Ms LOVELL - Yes. I want to clarify the number of beds. You said 16 in the south and eight in the north. Are they mental health child and adolescent beds, or child and adolescent beds and is the mental health number still to be determined?

Mr FERGUSON - Yes. They're adolescent bed numbers. Work is currently underway - and I can't describe it in more detail until its completed - to determine the best and clinically advised mix of those beds and a model of care that supports each of those.

Ms LOVELL - It is a mix between mental health and medical beds, is it?

Mr FERGUSON - Non-mental health might be another way I would put it, bearing in mind it's connected to the paediatric service.

Ms LOVELL - Okay. On the staffing profile, I appreciate the number is yet to be finalised but when that number is finalised, can you confirm that those beds, the number of mental health beds, no matter the number, will be staffed 24 hours a day, seven days a week, with specialist mental health staff regardless of whether they are occupied by mental health patients?

Mr GROVES - That's my expectation.

Ms LOVELL - Thank you. I have one last question in relation to a media release you put out on 30 May, minister. It's entitled, 'Adolescent Mental Health Units Already Been Built'. One paragraph says -

> To be clear - the K block facility is designed and built as a dedicated Adolescent Mental Health Unit, and the Ward 4K Redevelopment will provide a new 36-bed contemporary facility, which will include Tasmania's first dedicated Adolescent Mental Health Unit.

Do you accept that that is - I don't want to say misleading, but it is - misleading and that people may have read that media release and expected a dedicated mental health adolescent unit rather than child and adolescent units with some mental health beds, the number of which are yet to be determined?

Mr FERGUSON - We don't mislead the public. I hope the explanation we've given is very clear, together with our statements in parliament, our election policies and the budgets over two budget years, which have been very consistent. So -

Ms LOVELL - The explanation you've given now, which is that the number of beds is yet to be determined, I would say is much clearer than this media release issued in your name.

Mr FERGUSON - Good.

CHAIR - Most members regularly receive complaints, requests and concerns about access to mental health services for adolescents. I've been saying to them ad nauseum that these beds are being built, yes, I've heard it a hundred times now, but I also held the belief that these were all to be mental health beds. That's the way it's been promoted; that's the way it's been put, and that media release would confirm that. I encourage you to put out a new media release that makes it very clear.

Mr FERGUSON - Well, I am being very clear. You should expect we will take advice from expert clinicians on the mix of beds and -

CHAIR - I'm not disputing that, but you need to be clear about the public expectation.

Mr FERGUSON - it would be quite wrong to do otherwise. I don't believe that is inconsistent.

Ms LOVELL - To be clear, what I heard was that there will be two beds allocated for, in your words, minister, high-risk mental health patients in each of those locations.

Mr GROVES - There are two beds in each of those units that have been specifically designed for people with high mental health problems. The rest of the beds will be able to be used look after other people.

Ms LOVELL - Is that the rest of the 16 in the south and the eight in the north?

Mr VALENTINE - My question involves adolescents who may be new mums. One thing I'm acutely aware of are mother and baby units and their availability in Tasmania, let alone Hobart. There is only one in St Helens Hospital. Quite clearly it is possible there might be adolescent mums with babies. Is it possible some of these beds being provided now could cope with or cater for an adolescent mum with a young child?

Mr GROVES - I am most familiar with the built design around the Royal Hobart adolescent unit. If there were an adolescent who had a newborn and had severe mental illness, they would be able to be catered within those two special beds. There is quite a degree of exclusive access to areas which would mean that young mother and her child would be able to be nursed in a protected manner.

CHAIR - What about Launceston?

Mr GROVES - I am not familiar enough to inform the committee.

Mr VALENTINE - That runs to the point of at least one bed or one unit being available in each area, each region because imagine a young mum in Burnie who desperately needs mental health services.

CHAIR - She ends up in Spencer Clinic.

Mr VALENTINE - Ends up having to try to find a service somewhere able to handle them. They certainly will not want to travel to Hobart for that service. They would not have any networks or family to help them. Will any in the foreseeable future be provided in the north-west and the north?

CHAIR - To clarify the question: are you talking about a dedicated mother and baby unit?

Mr VALENTINE - Mother and baby unit.

CHAIR - As opposed to using these beds?

Mr VALENTINE - Yes, that is right.

CHAIR - I think the question is: is there any support for mother and baby unit beds outside Hobart?

Mr VALENTINE - That is right.

Mr GROVES - Minister, are you happy for me to answer the question?

Mr FERGUSON - Yes, please, and I have some other information I would like add.

Mr GROVES - As part of the master planning process for the Royal Hobart Hospital, I was a member of Professor Lawler's Clinical Planning Taskforce. We did detailed planning of the entire acute inpatient bed needs for mental health for the state, including those which I would say are highly specialised, such as mother and baby beds. We provided advice to the Clinical Planning

Taskforce that there was on average a need for four beds in the state and we recommended that should be included in when thinking of the capacity of stage 3. The announcements the Government has made in relation to the Repatriation Hospital site and the mental health precinct there would include the capacity to have a designated child and adolescent bed and perinatal beds within the number recommended to the task force. Clearly, that is still some time away and considerable planning still needs to be done, but work has been done to recognise the need to have highly specialised mental health beds.

As somebody who has practiced perinatal mental health in times gone by, I make the distinction between the needs of, for example, a young mother in Burnie who has postpartum depression and needs to receive good care from highly specialised mother and baby unit, which tends to be more for people with a puerperal psychosis. Both are needed and so there needs to be a consideration of what you can provide in hospitals close to where people are and those where you really only need one in the state.

For example, I would say it is highly unsafe to manage somebody with a puerperal psychosis in Burnie, no matter how well they might look and we need to have one unit for the state. I would make the distinction between, for example, treating depression, postpartum depression, from treating puerperal psychosis - they are different conditions.

CHAIR - Why would you not put that bed in Launceston? You have a woman who has puerperal psychosis, who can be in hospital for a period of time. She is often separated from her baby and definitely separated from her family, if she is not geographically close. That would be my strong recommendation because in terms of access half the population lives north.

Mr GROVES - If I can answer the question as somebody who originally grew up and worked in Western Australia. There was one mother and baby unit for the whole of Western Australia with eight beds. It meant there needed to be a model for somebody who was a mother in Broome or Carnarvon or Geraldton. I would argue exactly the same thing applies for a geographically smaller state like Tasmania. In my view, if it was puerperal psychosis, you would not be safe in Launceston because the staff there would not have sufficient specialist skills to look after a person with that particular condition. They should be able to look after severe postnatal depression, for example, but not puerperal psychosis, which is a highly specialised area. It is in fact the condition that has the highest morbidity for women in the first 12 months after giving birth. This is what people die from; it's not to be trivialised and I believe it should -

CHAIR - As a midwife, I am not trivialising it.

Dr GROVES - I understand that and I wouldn't, if it were my wife, have a patient with puerperal psychosis in Launceston if there were a statewide designated unit.

CHAIR - What I am saying is that the statewide designated unit is in Launceston, not that there is one in Hobart and one in Launceston, that there be one unit and you resource it effectively there. Are you saying it can't be done there? Is that what you are saying?

Dr GROVES - At the moment, the psychiatrists who are most expert in perinatal mental health in this state reside in Hobart. If there is none in Launceston to manage it, I suggest until you can get someone, it wouldn't be a good idea to plan on that basis.

CHAIR - But we are not talking about this facility being built in the next - it's stage 3, so we're still a couple of years out. Those sorts of considerations we should put to the next minister.

Mr FERGUSON - They already are but I have other important news to remind you of if you don't already know. The federal government, which I am pleased was re-elected a fortnight ago, committed $4.5 million specifically for perinatal service improvement here in Tasmania for the north and the north-west.

CHAIR - What would that include? We are talking about a really specific issue here at the moment with Dr Groves: puerperal psychosis. We are not talking about, for want of a better description, 'run of the mill' perinatal services. This is really highly specialised. I accept Dr Groves' comments that you need to have those very specific specialist skills.

I have looked after women who have developed puerperal psychosis, and it is a frightening thing. It's frightening for everybody.

Mr FERGUSON - I don't think there's any argument with any of that.

CHAIR - Those women struggle enormously with their mental illness, where they lose touch with reality for a period, but then to have your family five or six hours away in addition to that, if there is a way that critical aspect of the service could be provided more centrally, surely that provides a better outcome for all women, the small number of women and their families who would need to access it?

Mr FERGUSON - I don't think we are disagreeing with each other. I think Dr Groves is pointing out the importance of the skill mix being done in a sustainable way so it's safe. I know you are very familiar with those arguments from other health reform initiatives, but I want to make a point about the federal commitment. That $4.5 million is for services in the north and north-west, and we will obviously want to work with the Commonwealth so the services are designed and built in a way that complements our existing services and is supportive of them so that they are working well together.

CHAIR - We are getting off the point of mental health here because I'm assuming this is not about mental health necessarily, or is it about perinatal mental health?

Mr FERGUSON - It includes that. It's perinatal care, and mother and baby services.

CHAIR - Which is much broader than perinatal mental health.

Mr FERGUSON - It is. It can and should include perinatal mental health wellbeing. I am not proposing, and I don't think anybody is suggesting, that we could replicate the service that exists in the south for the very high acuity cases. But who knows, we will work with the -

CHAIR - On that point, minister, what services are provided currently for women with puerperal psychosis?

Mr FERGUSON - I can't answer that, I would need the expert to answer that. I am simply trying to make a point that -

CHAIR - I am trying to understand what's here already.

Mr FERGUSON - There's an important resource that will add to perinatal mother and baby services.

CHAIR - I accept that.

Mr FERGUSON - I think it's something we will be working with the Commonwealth funds to deliver.

CHAIR - That's welcome, minister, but I am talking about a specific issue here.

Dr GROVES - At the moment, someone who has severe puerperal psychosis is likely to be admitted to one of the adult units, whether it's Launceston, Spencer Clinic or the Royal Hobart Hospital. In my view, we have room to improve the overall excellence of those services by providing a statewide service.

CHAIR - That's a work in progress?

Dr GROVES - Yes.

Ms LOVELL - Back to the mother and baby unit and the one public bed that is currently available, is there a waitlist currently for that bed? There's one public bed and one private in St Helen's.

Dr GROVES - I don't know whether there is a wait list on a day-to-day basis.

Ms LOVELL - Are we able to find that information?

CHAIR - This may be a question for you after we have finished with Health. In 2013 or thereabouts I chaired a committee looking at mental health reform, a review of the legislation, which identified the challenges for police having to escort predominately mental health patients to the accident and emergency department if they couldn't ascertain whether they needed medical care or time to dry out. Is that still occurring and is that only presenting problems in the mental health area? Are police being tied up in providing care for mental health patients?

Mr FERGUSON - The police will be very pleased to give you an operational report when they join the committee. It does still happen and sometimes it is desirable. Police are designated as mental health officers under the Tasmanian Mental Health Act. They are particularly needed, as the deputy commissioner said yesterday, as police are one of the few public services that are available 24/7 and there are times when they are the best people to help transport somebody to a facility for assessment. The police can take that person to have an assessment made and a treatment offered, if needed.

I would be more than happy to talk about that in more detail later. On behalf of the health service, the Chief Psychiatrist has been working on an updated MOU with police. This is toward clarity as to who is doing what but we would never suggest police do the work that is properly done by paramedics or vice versa. There are incidents in which ambulance staff are not prepared to go to an address without a police escort because it is not safe and it has been designated as a known risk address. The services are working hand-in-hand, and there are times when that is challenging, which we look to them to manage.

Mr VALENTINE - With respect to community and mental health services waiting lists, do you have any detail that can be shared?

CHAIR - There are a couple, one is community psychiatrist waiting list and other the community-based mental health services.

Dr GROVES - We try not to have a waiting list for community psychiatrists. We work with multidisciplinary teams, we expect that an assessment is undertaken and that the person gains access to people they need, depending on their clinical acuity. Each day, the psychiatrists have re-prioritise their own lists to see those people they need to see that day versus those people who might have booked in to be seen that day and who may need to be seen later because of the workload. That is because the community mental health model is very different from, for example, a community health model because much of the care they provide is the equivalent of acute care.

Access to community psychiatrists varies considerably around the state. Even within Hobart, there would be some parts of Hobart where it would be easier for psychiatrists to respond to the urgency and see someone that day, and other parts of Hobart where we are more reliant on locums. Mr Reynolds has already talked about the initiatives to reduce the number of locum psychiatrists we have in mental health. In those areas where we only have locums, it is much more difficult to achieve the same level of activity from them as people who are otherwise permanently employed. If I were to give you numbers, it would vary week by week. It would depend on whether we have permanent people or locums there and their work volume.

Mr VALENTINE - To give us an idea, how many, for instance, adolescents would be waiting for an assessment? Could you give us that figure and the length of time? Because I have heard in one case it has been up to nine months, a significant period of time.

Mr GROVES - The comments I made before related to adult mental health teams. We have a separate child and adolescent mental health program. You are correct saying the wait time to get into the Child and Adolescent Mental Health Service is much longer. They provide a very different model of care. I have had discussions with the secretary of the department about whether we need to modernise and update that model of care. I would be keen to see the access to child and adolescent psychiatrists drop dramatically. But I would point out even in modern child and adolescent mental health community programs, it is still a multidisciplinary approach. I would still expect access to psychologists, mental health nurses, psychiatric social workers would be an important part of the model. Not every kid or adolescent who needs to be seen in the community is necessarily going to be seen by a psychiatrist because they would not need to be.

Mr VALENTINE - No. Any understanding of how many adolescents might be waiting for an assessment?

Mr GROVES - No, but it is fair to say lots.

CHAIR - A lot.

Mr VALENTINE - Okay.

CHAIR - Yes.

Mr VALENTINE - Because this points to the urgency for services to be provided, really.

Mr GROVES - Yes. The other thing to add is in the last 10 years in this country there's been an emerging model known as Headspace -

Mr VALENTINE - Yes.

Mr GROVES - where the Commonwealth provides a child and adolescent mental health program for people with lesser problems than the traditional child and adolescent mental health services have. There still remains confusion for GPs, schools, youth services about when they should be accessing Headspace or when they should be referring to the child and adolescent mental health program. And something that would better align, so kids are not being referred to the wrong services and waiting too long when they could be seen by a service more quickly, is an important thing we need to look at.

Ms WEBB - Would it be fair to say between Headspace, which is a milder, and CAMS which has very particular sorts of things you have to meet to receive a service, there is a vast gap for adolescents in this state at the moment in terms of services and care available?

Mr GROVES - And in relation to the Commonwealth Government has announced the expansion of Headspace. The state Government is continuing to look at its child and adolescent model so we can bring those two things closer together.

Mr FERGUSON - Together, with a $10 million dollar eating disorder service for Hobart in the -

Mr VALENTINE - How many psychiatrists would be available to do that adolescent mental health work?

Mr GROVES - I think it's six, but it may be more. At the moment we've got -

Mr VALENTINE - Across the state?

Mr GROVES - That is right. At the moment we have somewhat extended leave, which means we have less available than we would normally have.

Mr VALENTINE - Okay.

Mr GROVES - They are very difficult to fill, those positions, at the best of times. When people take protracted leave, it is very difficult.

Mr VALENTINE - What is the current FTE number of specialist adolescent mental health services, psychiatrists, clinical psychologists and nurses in Tasmania. Do you have a number?

Mr FERGUSON - I would not expect Dr Groves to know that off the top of his head, although he is doing very well.

Mr VALENTINE - No; he is doing okay. Happy to take it on notice.

Mr FERGUSON - If you know the answer, please say.

Mr GROVES - The question for the child and adolescent mental health program?

Mr VALENTINE - Yes.

Mr GROVES - It is 64.89 FTE.

CHAIR - There you go. You are doubting him.

Mr FERGUSON - I did not expect you to know that.

Mr VALENTINE - It was 64.89?

Mr GROVES - As at the date we produced the briefing, which was about three weeks ago. Again, these FTE figures change daily.

Mr VALENTINE - That includes clinical psychologists and nurses?

Mr GROVES - That is right.

Mr VALENTINE - Okay.

Mr GROVES - That is for the whole of the child and adolescent mental health program. It includes medical staff, so specialist medical staff; psychologists, social workers and mental health nurses in -

Mr VALENTINE - And that is within the acute health services space and the community space?

Mr GROVES - That is right; for both acute and community. It is total state population.

Mr VALENTINE - Thank you.

CHAIR - Doesn't seem a lot.

Ms WEBB - Remembering it is quite narrow -

Ms WEBB - You have to meet very narrow requirements to receive those services.

Mr PERVAN - Hence why we want to review the model of care to make sure it connects with all the other services on the outside.

Ms WEBB - My understanding is that for children or adolescents experiencing the impact of trauma, it doesn't fit into CAMHS. They don't receive the services through CAMHS right now, even though they might be having incredibly acute impacts on their lives from the impact of trauma.

Mr PERVAN - Yes, there are some services. That is why we are doing a lot of collaborative work with the Department of Communities Tasmania and education toward the more complex cases under our broader exceptional needs program.

CHAIR - This really concerns me when I go back to the Budget and we have a minimal, if any, increase to provide it. We need more people in this area. We will leave that with you to answer next year.

Ms WEBB - This kind of issue crosses departments.

Ms LOVELL - Minister, if we could go back to the psychiatric emergency nurses. What is the number of funded PEN positions at the Royal and LGH?

Mr FERGUSON - I will come back to that.

Ms LOVELL - Further to that, is that the number of positions funded broken down by the two hospitals? What is the current headcount in FTEs for PENs? What is the breakdown between the two? Are those positions currently held by permanent employees, agency staff or temporary contracts?

Mr FERGUSON - That is three very complex questions in one; if you place them all on notice, I commit to give the committee a proper understanding of the staffing complement and funding base.

Ms LOVELL - Thank you. As to child adolescent mental health beds at the Royal and LGH, can you confirm when these beds will be open and able to take patients?

Mr FERGUSON - The new adolescent unit at the Royal is funded from the 2020-21 financial year. The 16 beds at the Royal are funded in that financial year, not the one upcoming, the following year. The beds for Launceston are funded in the 2019-20 financial year.

Ms LOVELL - Do you have anything more specific in that financial year, as to when you are expecting those beds to be open and operating?

Mr FERGUSON - The critical work is that which we discussed earlier - the service design, the staffing complement and the right mix of beds together with the model of care, which is well and truly outside my expertise. I would be reluctant to describe it without that advice but that is work underway at the moment -

Ms LOVELL - We have covered that, but I am wondering about the time frame. When are you expecting the work to be done and those beds to be open?

Mr FERGUSON - I see what you mean. I have answered for the Royal. I would, however -

Ms LOVELL - You have given me a financial year.

Mr FERGUSON - Yes.

Ms LOVELL - Can you be more specific than the year?

Mr FERGUSON - No, I cannot.

Ms LOVELL - It will be some time in the 2020-21 financial year?

Mr FERGUSON - That is the answer.

Ms LOVELL - Okay.

Mr FERGUSON - That is not to say that if we need to do it sooner, it is possible that we might be able to do so because I have an allocation of $30 million specifically for access.

Ms LOVELL - You could probably argue that you need to do it now but it is more a case of whether you are able to do it when the beds are finished.

Mr FERGUSON - The problem is that Labor ruined the project that should have been finished three years ago but we are still building it. You asked me to delay it further, so what gives? As soon as we have built it, we will be in a position to have that conversation, but the good news is that it is in its final stages, which is great.

Ms LOVELL - Excellent news.

Mr FERGUSON - It is. I agree, we agree. In Launceston, the progress of the building project is more advanced in that it is a much smaller project. I hope you all understand the LGH Ward 4K is one stage of a multistage project, the first of which allows us extra space by the end of this calendar year. Because of having to rotate some services around, as they are completed, we then actually want to refurbish the old spaces. Some decanting operations are being planned. I expect and assure you the extra beds for the adolescent unit at Launceston are funded for 2019-20.

Ms LOVELL - On the Mental Health Hospital in the Home - I appreciate you discussed this at length yesterday and I was hoping to be able to read the *Hansard* - and no criticism of Hansard because I know they are working incredibly hard - but your transcript was the only one not up this morning before we came in. I apologise if we repeat things, it probably means you will be able to answer it more easily.

How many patients have been treated in the Mental Health Hospital in the Home since the service commenced?

Mr FERGUSON - I will ask for one of our operational policy chiefs to answer. I was not asked that yesterday, so is it a genuine new question in terms of the number of patients who have received a hospital in the home visit? I wonder if we need to take that on notice?

Mr GROVES - Minister, I would have to take that on notice. More than 20 people have actually been accepted into the service and had an episode of carers part of [inaudible] that is more than the visits because, they will often make assessments without necessarily taking them into the program. The average occupancy of the unit has been about six of the eight beds.

Mr FERGUSON - We will take it on notice for a better answer.

Ms LOVELL - Six out of the eight beds. And that is the occupancy rate? Eight beds are currently staffed out of the intended full capacity of 12? Do you know when you expect that program to be operating at full capacity?

Mr FERGUSON - We are looking for approximately five additional staff to make up the full complement to allow us to offer a full 12 bed service. Dr Groves, are you able to comment on likely time frames for the recruitment of those extra staff?

Dr GROVES - I checked last night. It is actually 5.6 FTE short out of the total. I do not have an expected time. The person responsible for service and the THS has gone through a second round of recruiting. I am unclear and not probably in a position to say where they are at with that. I do know they still won't have all the staff and need to do a third round of recruiting.

Ms LOVELL - And that is 5.6 FTE nursing?

Dr GROVES - Yes, and what I said yesterday may have been misconstrued. The total staffing is 17, but there's nursing, peer workers and allied health within the total. All the other disciplines are full, it is only the nursing discipline we are struggling with.

Ms LOVELL - Yesterday there was a discussion around staffing and I wanted to confirm some of the hospital in the home staff come across from another THS department. For example - Department of Psychiatry maybe? Are any of those roles still vacant that people from Hospital in the Home have moved out of? Are any of those roles still currently vacant?

Dr GROVES - The answer is yes, they are. We have difficulty recruiting mental health staff everywhere in Australia. There is a nationwide shortage. When people move to take new positions, unless we have new graduates coming through, it is often the case you leave spaces elsewhere.

Ms LOVELL - Minister, given what Dr Groves has brought to light around the shortage and nationwide shortage of mental health workers, what recruitment strategies are you putting in place to guarantee you will have the staff we need to deliver mental health hospital in the home to its full capacity? Also, the other new mental health facilities - the beds in the hospitals, the Peacock Centre and St Johns Park and all the commitments you have made?

Mr FERGUSON - Are you supporting the Peacock Centre rebuild yet?

Ms LOVELL - I might wait and see what other information you can give me today?

Mr FERGUSON - I hope I can bring you along on that one, because it is a good thing to do.

Ms LOVELL - I still have my concerns.

Mr FERGUSON - Do you?

Ms LOVELL - We might come to that?

Mr FERGUSON - That's a fascinating qualifier. I will ask Dr Groves to outline the overall approach on building our service, which, importantly, involves all staff. One of the strategies has been a very proactive approach in reaching out to other services. Dr Groves led a team to the U. earlier this year, which resulted in 19 applicants. We are not counting our chickens before they hatch; however, offers of employment have been made to 11 people to come and work in Tasmania as mental health nurses. We hope they will take up the offer - after all, they did apply for them. Dr Groves might be able to put detail there about the broader strategies.

Dr GROVES - I might make some additional comments. We offered positions to three people, and we thought we were successful, but unfortunately they decided not to take the positions up. It is not only nurses; we have also offered a position to a psychiatrist who has accepted the position, as best as I understand. This is good news for us.

In addition, because of the recruiting trip to the UK, interest is coming from other people in the UK who were aware we were there. The Department of State Growth has already indicated to us that number of UK nurses have approached them about visas to come to work in mental health here. A good and encouraging sign.

We have also been approached by people from other parts of the world. I understand it is still being finalised, but another psychiatrist in another part of the world has been successful and has been offered a position. I will give out more detail, once that person has accepted and it is publicly known.

We are encouraged, but also aware relying on people from other parts of the world is not necessarily the entire solution. We are looking at transition to practice programs that will support people who are in, or returning to, or are attracted to, the mental health workforce. We are looking at whether people who work in the private sector might find it more enticing to come back and work at least some part in the public sector.

We have a range of different initiatives in place at the moment.

Ms LOVELL - I will preface by saying I have been asked to ask you this question. Alcohol, Tobacco and other Drugs Council has been outspoken in its disappointment in not receiving the funding it sought through its budget admission. It has asked me to put to you the following question: what advice do you have for it and other non-profit organisations about what they can do in future to win support for projects, considering a modest request, collaborative partnership and leveraging federal government funding was not in this case enough?

Mr FERGUSON - I look forward to either myself or my office engaging with the organisation and discussing its submission with it. With our budget we had to be very careful about the priorities we peruse. We are major investor in alcohol and drug services in Tasmania.

We are already a major funder for the organisation; it's a predominated funder together with its member organisations and we have increased our treatment services to the sector by 50 per cent. Residential rehabilitation beds increased by 31 per cent in last year's budget, carrying across in these forward Estimates. I hold that sector in great respect, but would not be able to agree with any conclusion we are not providing really good support. To the last part of your question, we would always be happy to engage with the sector and its representatives.

CHAIR - Some questions from the AMA to close from that question. How many people are on the methadone program? How many people are waiting to be put on the methadone program? As comparison, what was the waitlist in 2018?

The other one goes to some of the questions about wait times in the ED which it would like included in the questions: what was the total number of mental health patients seen in the emergency departments who required patient admission? You may have that now or you may not. How many mental health patients identified for admission are waiting greater than whatever the time frames are, whether it's eight hours, 12 hours, 24 hours, 48 hours, 72 hours or 96 hours?

Mr FERGUSON - Given that I have already taken a more global question on notice, what if we supplemented that and answered the other question, including a subline on mental health?

CHAIR - That is fine, we will do that.

Ms WEBB - The Hussey initiative was funded for two years. Will an evaluation be done when it is complete, with a view to seeing it continuing?

Mr FERGUSON - That came across to us from the Department of Communities Tasmania. Do you have anything to offer?

Dr GROVES - Yes, minister, I have been working with Jeremy Harbottle to look at that with Colony 47. We intend to do an evaluation of the housing model, as long as the funding will stretch that far over the two years.

Ms WEBB - It's named in the budget paper as a highly successful model from New South Wales and there is a big evidence base behind it. It combines a housing component and a health component. It would be surprising if you didn't discover that it had delivered results here. I am hoping to see further funding or expansion of that initiative in years to come.

Mr FERGUSON - I will take your comment on board.

Ms WEBB - Sure.

Mr FERGUSON - I totally support the notion of evaluating as we go.

Ms WEBB - It would be disappointing if it wasn’t evaluated and dropped.

Mr FERGUSON - Colony 47 proposed it and we would be keen to see it is successful.

2.6 Forensic Medicine Service

Mr GAFFNEY - This is not a very large budget item but it's important to the people who need the service. I note the significant increase in the Budget in output group 2. What is the number of professional staff involved with the Community Forensic Mental Health Services and what is the current caseload of that group? Are you quite happy for me to continue with questions? You can table them later because I am aware of the time.

Mr FERGUSON - Can I offer to take that on notice? I don't have that information to hand.

Mr GAFFNEY - Okay. What is the current ratio and specific numbers of forensic mental health and high-risk civil patients in the three regions, the north, north-west and the south? That was provided in 2017, so you have those figures somewhere. The current patient caseload at the Wilfred Lopes Centre would be appreciated.

Mr FERGUSON - Yes, I will put that on notice.

Mr GAFFNEY - Do these figures illustrate a trend of an increased, decreased or steady demand for forensic medicine services? How many patients are under supervision orders in each

of the three parts of the state, north, north-west and south? How many child or adolescent patients received input and diagnosis during or on release from the Ashleigh Youth Detention Centre, and what follow-up services are provided? I can give these questions to somebody who might be able to follow them up.

During the 2018 Estimates hearing, Mr Valentine was informed by the secretary that the Chief Forensic Pathologist had noted the demand on those services was, 'increasing somewhat, but very gradually'. Are the figures for the past 12 months consistent with that observation? I am aware that autopsies are performed in Tasmania by the State Forensic Pathologist with a proportion conducted by other pathologists. What is the number of externally conducted autopsies and why does this occur? Is the SFP unable to meet demand?

Mr FERGUSON - This one we can answer.

Mr PERVAN - Where it says that they are externally provided, they are provided by pathologists at the Launceston General Hospital.

Mr GAFFNEY - Okay. So, it's not outsourced?

Mr PERVAN - No, it's not outsourced.

Mr GAFFNEY - Can you provide us with the numbers of those -

Mr PERVAN - Only the minister can take a question on those, but we can find those for you.

Mr GAFFNEY - Okay.

Mr FERGUSON - I am totally respectful of that range of questions and more than happy to take them as a job lot, on notice. There is some disaggregation that we will need to do in terms of the difference between the forensic mental health services provided through the mental health and the forensic psychology services. We are more than happy to take all of those questions.

Mr GAFFNEY - Particularly with the forensic mental health and the high-risk civil patients, there is separation there. Basically we just want to see the figures for those to see what is happening within the Budget and whether it covers the increase or otherwise of that service.

Mr FERGUSON - I have some answers for you. In rapid response, staffing numbers for the Community Rapid Response Service in the north as at 31 March 2019 are 8.1 FTEs and it is a headcount of 11, taking account of some part-timers. I will table a general piece of advice about waste management and stewardship of plastics and recycling.

CHAIR - Thank you.

Mr FERGUSON - In relation to the North West Integrated Maternity Services, I will add some information to the record and table the advice. I confirm that in my correspondence in April to the acute health services inquiry, I provided a copy of the recommendations arising from the review, with a summary of some of the comments and assessments made. I understand the subcommittee received that. It was always my intention to provide the inquiry with the same level of information provided to the ANMF. I have since discovered that this has not been the case and the ANMF had been given further information than I had provided to the inquiry. Today I table the letter from the

secretary to me that accompanied the report, the executive summary of that report and, for the benefit of this committee, also those recommendations.

CHAIR - Thank you. We might pass it on to the committee.

Ms WEBB - Can I have a quick question on that answer you gave? Were these just the Launceston numbers so there aren't confirmed numbers for the rollout in the other regions as yet?

Mr FERGUSON - Yes, that is right, but it is modelled on the same principles and the budget allocation was very similar.

CHAIR - We will go to 3.1 now; the head of the ambulance is off the ramp.

3.1 Ambulance Service

Mr FERGUSON - First of all, can I please introduce Neil Kirby, Chief Executive Officer of Ambulance Tasmania.

Ms LOVELL - Minister, being mindful of the time, I'm happy for you to take some of these questions on notice because there probably is some information that will need to be sourced. My first question is: how many vehicles are there in the Ambulance Tasmania fleet, and how many of those are ambulance trucks?

Mr FERGUSON - Ambulance Tasmania utilises quite a range of vehicles to meet the needs of the service. Currently Ambulance Tasmania utilises the following operational vehicles: 93 type 1 ambulances; five Volkswagen all-wheel drive ambulances; 12 four-wheel drive troop carrier vehicles; three special operations bariatric vehicles; four community emergency response units; two Mercedes Vito for our ECPs; and 34 light fleet operational support vehicles.

Ms LOVELL - Thank you. Minister, can you confirm that all Ambulance Tasmania vehicles are up-to-date on their service schedules and safe to be on the road, considering they are often driven at higher than normal speeds and in difficult circumstances and environments?

Mr KIRBY - I haven't every individual vehicle access with me. There is a regime of maintenance and a routine service is planned in the program of vehicles, and they are rotated through that. It's only the status of each individual vehicle I haven't available to me at this time.

Ms LOVELL - Can we get that?

Mr FERGUSON - No, we are not going to table every vehicle's individual service history. But what would help you?

Ms LOVELL - Not service history, just whether they are up to date on their service schedule.

Mr FERGUSON - What would help the committee here?

Ms LOVELL - What?

Mr FERGUSON - What information are we looking for that would help allay any concern?

Ms LOVELL - I'm looking for information. I'm looking for you to confirm whether all the Ambulance Tasmania vehicles are up-to-date on their service schedules.

Mr FERGUSON - Yes, okay. Well, I will take that on notice in that case.

Ms LOVELL - Thank you. How many Ambulance Tasmania staff claimed workers compensation during this financial year, and how many of those claims have been for stress or stress-related injury?

Mr FERGUSON - All right, I've got some information here, Ms Lovell. As at 31 March 2019 Ambulance Tasmania saw a 31 per cent decrease in overall claim numbers when compared to 2017-18, which is reflected by a 43 per cent decrease on a preceding three financial year average. Downward trends are attributed to a significant decrease of aggression and muscular stress-related claims, with a moderate increase of stress-related claims, and a 19 per cent increase of stress-related claim costs in 2018-19 for the partial year, nine months, compared with 2017-18.

Ms LOVELL - Do you have numbers there, minister, rather than percentages?

Mr FERGUSON - I do. I have Ambulance Tasmania claims for the nine-month period: 37 claims.

Ms LOVELL - How many of those were stress-related?

Mr FERGUSON - Of those, 19 were stress-related. I'd like to give you the other numbers for the previous year. That compares with previous years: 63 overall and 14 overall for stress-related claims.

Ms LOVELL - Thank you. I'm not sure about this one, but do you have the number of the claims made for injuries sustained from use of Ambulance Tasmania equipment, including vehicles?

Mr FERGUSON - I don't think we have a specific breakdown, do we? They would fit in that first category I gave you, which was the more global trend, which was well down and showed a significant decrease in those physical injuries due to muscular stress.

Ms LOVELL - Okay. How many Ambulance Tasmania employees are currently absent from work due to workers compensation claims or work-related injury?

Mr FERGUSON - I don't have that information to hand. Do you?

Ms LOVELL - I'm happy for you to take that on notice.

Mr FERGUSON - I might need to take that one on notice.

Ms LOVELL - Yes, and while you're taking that on notice also, could we get a breakdown of how many of those employees have been absent for more than three months, more than six months, or even 12 months?

Mr FERGUSON - We might take that as a single question on notice and provide you with the level at which we can responsibly provide you with that information.

Mr VALENTINE - Could that include the number of employees who are ambulance officers?

Mr FERGUSON - I can provide that now. For the sake of time, I will add that to my response.

Ms LOVELL - Minister, can you tell the committee - and I hope you have tracked this in some way - how many hours were spent by paramedics on the ramp at each of the four major hospitals in the last financial year? By that, I mean at the hospital, with a patient they were unable to transfer into the care of the emergency department staff.

Mr FERGUSON - I would need to take that on notice. I am pretty sure the Auditor-General had some of those figures, but I will inquire.

Ms LOVELL - How many overtime hours were worked by paramedics in the last financial year in each region?

Mr FERGUSON - I will have to take that on notice. I will refer you to yesterday's *Hansard* and I will take any further details you asking.

Ms LOVELL - My last question relates to a letter I have here from the mayor of Dorset Council, Greg Howard, which was sent to the Leader of the Opposition, Rebecca White. In relation to the health system and in particular ambulance ramping, Mr Howard says -

> The issue of ambulance ramping would easily be solved by introducing a fee for calling an ambulance. This would cut out ambulances being used for minor injuries and ailments. Tasmania is the only state that provides free ambulance services, but these are obviously being abused by the public.

Minister, do you agree with the mayor of Dorset Council that Tasmanians are abusing our ambulance services?

Mr FERGUSON - I do not believe I have seen that letter and the Government will not be introducing a fee for ambulances.

Ms LOVELL - Do you agree with that comment?

Mr FERGUSON - I have just given you the Government's position and that is my position.

Ms LOVELL - You are not willing to say whether you agree with the comment or not?

Mr FERGUSON - I have not seen the letter and the Government will not be introducing a fee for ambulances, nor does it want to, nor do I.

CHAIR - I remember the last time a former member of the Labor Party wanted to do that when he was minister. He would have had real challenges in this place.

Mr FERGUSON - Our investment of $125 million into Ambulance Tasmania is a very clear indication of the Government's sense of priority. Supporting Ambulance Tasmania from the top down and from the ground up, including significant capital infrastructure. We have already employed 90 more staff in Ambulance Tasmania and are currently budgeted to provide a further 42

paramedics in the regions. Our record on ambulances is second to nobody's, but we do not intend nor do we want to introduce any fees for Tasmanians to use our service.

CHAIR - Can I clarify a comment was made earlier in the day about some of the health demand funding going to ambulance services out of the Health allocation, not Finance-General. How much was that?

Mr FERGUSON - There is $5 million per year, which is in the Budget and not in Finance-General allocated to Ambulance Tasmania per annum.

CHAIR - That is where the $20 million covers the whole period. I thought you had said $5 million and wanted to clarify.

Ms LOVELL - The $5 million for the financial year we are about to enter is for ambulances to cope with the increase in demand. Do you have any advice about how the funding will be used in this coming financial year and the impact it will have on Ambulance Tasmania and what measures will it be used towards?

Mr FERGUSON - The impact is to support Ambulance Tasmania. I will ask the chief executive to respond to how it will be used in practise.

Mr REYNOLDS - We were asked this question yesterday in the other House and, as I said, the money has not been identified or targeted for a particular expense item. and has gone into the global budget for Ambulance Tasmania to use for its operational purposes.

Ms LOVELL - So there are no specific plans at the moment as to that particular $5 million?

Mr REYNOLDS - If the chief executive requires to spend it to make his operational requirements.

3.2 Public Health Services

Mr FERGUSON - I introduce to the table Mr Mark Veicht, Director of Public Health, and Mr Peter Boyles, Chief Pharmacist.

Ms WEBB - I am particularly interested to have some clarity on, the Healthy Tasmania policy and the Tasmania Community Health Fund. Let's start with the Healthy Tasmania policy. There seems to be different figures on how that is being funded, what is additional and not. When I look at page 102, there appears not to be anything allocated, then there is 1.1. Can you explain the funding of that and the function of it?

Mr FERGUSON - I can. Mike Reynolds might be able to assist in the accounting treatments. This money was allocated in last year's budget across the forward Estimates. Our first term commitment was a $6.4 million commitment over four years from 2016-17. The Government has also committed further funding of $1.1 million per year for 2020-21 to enable the continued delivery of Health in Tasmania actions.

Ms WEBB - There was a gap between the two.

Mr FERGUSON - It is not a gap. You can see on page 102 where it refers to the initiative or the deliverable of health in Tasmania, that is continued funding that sits over and above previous allocations.

Ms WEBB - In addition to other amounts?

Mr FERGUSON - Correct.

Mr REYNOLDS - We have the funds for this item sitting in output 1.1, which is the Health Management System. It is not reflected in the allocation you see for 3.2.

Mr FERGUSON - I was wondering why we had not seen that in the same heading. I hope that assists.

Ms WEBB - Yes, thank you.

Mr FERGUSON - There has been a view that the name of our fund could be improved and it is to be known as the Healthy Tasmania Fund.

Ms WEBB - We are not talking about the Healthy Tasmania policy, or are we talking about the Tasmanian Community Health Fund?

Mr FERGUSON - Some people felt the Tasmanian Community Health Fund sounded like another fund, so we will be referring to it as the Healthy Tasmania Fund.

Ms WEBB - Okay. That separate item was funded across two years but it has been rolled into one by the sounds of it, because it was not expended in the first year it was funded.

Mr REYNOLDS - Yes, that is correct.

Ms WEBB - That is correct. During this budgeted year, will the whole allocation be expended in that fund to groups that apply for it? Is that what the arrangement will be?

Mr FERGUSON - The $1.4 million fund will be available in 2019-20 and we expect to open that grant round in a small number of months and allow people and organisations to apply. We are particularly targeting those areas of greatest concern listed in the strategic plan, which include tobacco, overweight and obesity, physical activity and nutrition.

Ms WEBB - That is the $1.4 million?

Mr FERGUSON - Yes.

Ms WEBB - The $6.6 million over two years you dedicated to the Tasmanian Community Health Fund has become $1.4 million?

Mr FERGUSON - The $6.4 million is not for funding to be applied for. That funded a range of initiatives. I will seek some advice and come back to the committee with a decent breakdown of that $6.6 million, and provide a simple view of the different initiatives funded through that. There will be a fund of $1.4 million in 2019-20 available for community groups and organisations to apply for, for the purpose of grassroots actions in local communities. We want to see championship

thinking, so that people can rally around a cause that is important to them in their local area, noting that each community is different.

Ms WEBB - Indeed. The quantum of funding into preventative health as a proportion of the Health budget is going down over time. If you still have an aspiration that we become the healthiest state by 2025, how do you expect to deliver on that goal with preventative health spending going down, given that we know from international evidence it needs to be at or around 5 per cent of our total health spend? It's currently down to 1.2 per cent in this Budget, I believe.

Mr FERGUSON - It would be very challenging for us to carve out 5 per cent of our precious Health funds. With the way we are managing our current budget priorities and the challenges we are facing, 5 per cent of our $8.1 billion would be a significant carve-out that would have to be diverted to non-treatment and non-care services. I respect the philosophy of wanting to do everything we can to support preventive measures.

Ms WEBB - Have you abandoned our goal of being the healthiest state by 2025 by acknowledging you won't be spending 5 per cent?

Mr FERGUSON - No, it's the only goal to have. Nobody can mathematically guarantee any outcome on a percentage basis. We have to work with the community and that's the philosophy we pursue as we go through this. It's not a top-down approach or a command centre from my office or the Department of Health to tell people what they must do. We want to partner with local communities at the grassroots level, as close as we can get to where people live their lives.

Ms WEBB - What do you think would be the right proportion of the Health budget to spend on preventative health to assist us in reaching that goal?

Mr FERGUSON - I can't nominate a figure but we're having to manage such a large number of competing priorities for the health dollar and we are doing our best to engage with community. We want to use the money we have purposefully and obtain better outcomes for people. I particularly want to see more people quitting smoking, fewer people taking it up and more people finding fresh ways to get active in their community.

Ms WEBB - You might take this question on notice. You have said we spend $70 million on preventative health. Could you provide a breakdown of what that $70 million is spent on?

Mr FERGUSON - Yes and no. That advice was provided to me when we launched our plan a number of years ago. The central agency from the Department of Premier and Cabinet did a desktop assessment. I would be very happy to share that in any level of detail I have access to. It looks across all of government and GBEs and there was a best estimate of the level of activities in respective agencies and GBEs that are preventative in nature.

Ms LOVELL - Minister, it's not $70 million the Health budget has funded. That’s $70 million across all government departments, is that correct?

Mr FERGUSON - Correct, yes. We've always said that. That’s never been in any doubt.

CHAIR - Minister, you’ve talked about the goal of the healthiest population by 2025.

Mr FERGUSON - That’s right.

CHAIR - This output group says that it aims to protect and improve the health of Tasmanians by enabling Tasmanians to make positive health choices and live in safe environments. You would've seen the recent study on smoking rates in Tasmania. A media article talked about people with high rates of smoking, particularly in Bridgewater and Risdon Vale, with Bridgewater people more than 3.5 times more likely to die from preventable smoking-related illness than people in the average Australian suburb. Victoria's smoking rates dropped as low as 10.7 per cent in 2018. We are not comparable communities across the board but that's a lot of difference. What extra actions are you taking?

I'm aware of a great program the midwives at the Royal Hobart Hospital brought in and that's fabulous. Maybe we should go out into the malls and offer it to all people to understand what their carbon monoxide levels are? Maybe there's a way to expand that beyond pregnant women? I'm interested to know what you think what you could do.

Mr FERGUSON - This will be a brief canvas of what is included and will come back to my earlier answer about how this $6.4 million worked. We are investing in additional marketing at the levels the evidence told us would reduce smoking in Tasmania as well as highly targeted Quit campaigns, supporting women to quit smoking through the multi-strategy approach, and undertaking additional enforcement and targeted education. That's been supported because the Government has tripled the cost to tobacco sellers for their tobacco sellers licence.

We have targeted smoking uptake by young people by hiring more compliance and education officers to undertake additional enforcement activity. This includes increasing penalties for supplying a tobacco product to someone under age to match the highest penalties in Australia. We are controlling the sale, use and promotion of electronic cigarettes, so we're not renormalising smoking. We are taking action to target the illicit tobacco trade, which works in hand with the Commonwealth at the border. There will be more to say about this in the near future because we'll be undertaking some pilots of point-of-sale information in some targeted communities in Tasmania, but I'm not able to announce that today.

CHAIR - Okay. Maybe the carbon monoxide monitoring is another option?

Mr FERGUSON - I hadn't thought of that.

CHAIR - It's pretty low cost.

Mr FERGUSON - I hadn't thought of that, that's worth having a look at.

CHAIR - Yes. Anyway, moving on because we are running out of time. Recently, there was a large controversy about some research relied upon for the anti-vaccination crowd and people are drawn in to that. It has taken 10 years or more to recover from the falsehoods perpetuated that research suggested links with ADHD, autism and other things. Our immunisation rates are pretty good but do you think it's necessary to do a public education campaign to make sure people are aware of the true facts of the matter?

Mr FERGUSON - I'd defer to the Director of Public Health on this as the state's authority on the best way to engage. A big part of me doesn't want to give too much attention to the other side of that debate but I'd be open to ideas. Generally, the disposition is to strongly encourage the view that vaccination is safe and effective and the best way to deal with disease. I know the committee

will know that as soon as national stocks return to normal levels, the Tasmanian Government will be funding mumps, measles and rubella vaccine for all Tasmanians born between 1966 and 1994 because we're concerned that a large number of those people are not fully immunised. That's a major announcement we're making today which is about supporting the health of the Tasmanian community, noting that we've seen about 100 preventable cases of measles around the country. That is something the Government is doing, as we did with meningococcal and influenza, on the advice of our expert here. I'd ask Dr Veitch to address the question of how we combat fake news in regard to anti-vaccination claims?

Dr VEITCH - Thanks, minister, and thank you for the question. Over the years, we have tended not to engage too vociferously with the people who would use non-evidence based stances to oppose vaccination. It has always been my practice in any public discourse to emphasise the widespread acceptance of vaccines by Tasmanians as a whole. The proportion of people or children who are incompletely vaccinated as a result of locked-on objection by their parents is very small; it's really only 1 per cent or so of people. It's probably important to emphasise the positive in this.

Chair you made a point about the harm done by the controversy about measles still lingering in some parts of the world. The United States had an experience recently in which misinformation about measles led to a very widespread outbreak. It's very welcome to be able to provide a program to catch up and completely vaccinate adults with the measles vaccine. It's unfortunate there's a national shortage of MMR vaccine, other than for the infant supply. We have been fairly fortunate in Tasmania in that we've only had an average of one case of measles in the state each year and very little ongoing transmission. That reflects a pretty reasonable level of protection in the community and some good performance by my colleagues in Public Health to contact trace cases of measles to limit the further spread. It would be advantageous to provide a booster dose to young to middle-aged adults whose immunity may be uncertain. I look forward to that.

CHAIR - Okay. Minister, with regard to additional funding you've provided to the Stroke Foundation. Can you outline what this funding of $440 000 over two years? I know I asked some time ago - and the subcommittee on acute health was also looking at access to telemedicine to link with Victoria to do some thrombolysis treatment for acute stroke victims - can you give us a bit more detail around this that.

Mr FERGUSON - Do you have any follow-up questions about this? I only have brief information here. I am more than happy to receive an email from you or to take it on notice, whatever you like. We have committed funding of $220 000 per year for two years to implement a range of initiatives, including the establishment of the Tasmanian community of practice. I believe we might have kicked that off late last year with the foundation. The new Tasmanian Stroke Patient Follow-Up Service is about insuring that stroke survivors and their families are connected with the services and information that they need. While the community will be more aware of stroke responses through the promotion of FAST and StrokeSafe, we are not going to leave it there though because we are still exploring other possibilities. There is significant interest around our neurologists at the moment who are exploring in what other ways we can improve services in our regions.

CHAIR - Thanks, minister. Any other questions on output group 3.2?

Mr FERGUSON - I have an answer to a previous question. Ms Lovell, you may have asked for the number of patients who have received treatment by Mental Health Hospital in the Home. The number is 29.

Ms LOVELL - Thank you.

Capital Investment Program

CHAIR - One question from me, minister, on the Capital Investment Program. We discussed the upgrade to the North West Maternity Services antenatal clinic. I don't believe you gave me a time frame for when you expect it to be completed. You said it hadn't started and that there was a great expectation it would be. When do you expect it to be completed?

Mr FERGUSON - Since we commenced funding of this, the project is aiming to complete construction in 2020 and my advice is that has not changed.

CHAIR - Early or late 2020?

Mr FERGUSON - The year 2020, but I don't have a date. I am telling you what the department is providing with me, but the stage that it is at right now is this: an initial options analysis and stakeholder consultation has commenced. The client-preferred location is presenting difficulties as it has the potential to impede future expansion and development. I don't have to tell you, do I, that it is a very space-constrained site.

CHAIR - Basically, in a broom cupboard.

Mr FERGUSON - No, I'm talking about the overall campus. The campus is very space-constrained. I have seen some of that initial work and I know that further work needs to be done on the location and the scope of works. That work will be occurring in coming months to identify the best solution. It was intended to finish the design phase in 2019. It seems to me that might need some extra time. I hasten to add at this point that very fortunately, the federal government that was re-elected has committed $10 million to that campus. Our Government will be seeking to work very rapidly with the Commonwealth on the best way that we can apply those funds across the campus to get the best outcomes.

Ms LOVELL - There are two businesses in particular, but there are others I am aware of, Tasmanian companies that have been working on the Royal Hobart Hospital redevelopment in a subcontractor capacity: Lifters Hire, a Cambridge-based business, and C2 Plumbing and Gas, a plumbing business in the northern suburbs.

Due to breakdowns between John Holland and AMS Hydraulics, these businesses have been left out of pocket. Lifters Hire has been left $15 000 out of pocket, and C2 Plumbing and Gas has been left more than $100 000 out of pocket, which, for a small Tasmanian business, is having a devastating impact. What steps will the Government take to ensure these Tasmanian small businesses are paid for the work they have done on this project of great significance to our state?

Mr FERGUSON - I introduce to the table Ben Moloney, Project Director of the Royal Hobart Hospital Redevelopment team. This state is extremely lucky to have him and his services; working as he has been, he is doing an exceptional job and we are very grateful for it.

I will ask him to respond on this matter, noting there are commercial matters at play that make it quite difficult for the Government to make public commentary on it, but I invite Mr Moloney to respond as best he can.

Mr MOLONEY - On the matter you are referring to, as I understand it we are referring to a subcontractor to the main contractor we have engaged. Essentially, in this space it is not appropriate for us to comment on commercial dealings between those two parties, but there is certainly no commercial relationship between the state Government or our managing contractor.

We understand that when a company goes into liquidation there are appropriate processes to follow, and we would encourage Tasmanian businesses that are owed money to follow those correct processes.

Ms LOVELL - Thank you. That answers my question.

Mr VALENTINE - Can you outline why there has been a 30.8 per cent reduction in the appropriation for 2019-20 compared to last year's budget papers?

Mr FERGUSON - Could you point me where you see that, please?

Mr VALENTINE - For 2019-20, in last year's budget papers, $108.299 million; this year, it's $93.322 million. If we look at 2019-20, it's $138.691 million, and yet this year, it's $95.993 million.

CHAIR - Where are you looking, Rob?

Mr VALENTINE - Last year's budget paper on page 140, you will see that there was an Estimate going forward to 2019-20 of $138.691 million; if you go to this year's budget papers, 2019-20, it's $95 993 million, so it is a very significant difference.

Mr REYNOLDS - Without looking into detail at this stage, I suggest that reflects the changes in the cashflows associated with the various projects, which, as the committee has seen in the past, have been quite variable, and the numbers we have there at the moment would be our best estimate of when we anticipate the cashflows associated with each of the projects to be spent.

Mr FERGUSON - That said, I would like to satisfy the question in a mathematical way and take it on notice, and we will provide you with a reconciliation of that.

Mr VALENTINE - I appreciate that. Can the minister please outline why the expected completion of the redevelopment of the Launceston General Hospital has been pushed out an additional year beyond what was suggested in last year's budget?

CHAIR - The redevelopment or the car park? There are two.

Mr FERGUSON - I don't feel that it has been, Mr Valentine; if you could point me to where you feel that is suggested, I will take it on board. Maybe what has happened here is that we did provide it in last year's Budget. It was a six-year project and so the extra year that has come into the forward Estimates only adds to what is actually budgeted - I'm getting nods around the room - but I am not aware of any delays. In terms of process, earlier you met the chair of Clinical Planning Taskforce, Dr Lawler, who is leading that process for LGH just as he did for the Royal. As far as I am aware, there is no change to the time frames and no reason to think that. Second, some of the early stage works, including air-conditioning and the 4K women's and children's building, are already underway, and the two additional levels on the multistorey car park are currently in the market.

Mr VALENTINE - I will take answer on board.

Mr FERGUSON - I will provide the committee with a reconciliation of the earlier question.

Mr VALENTINE - I appreciate that. I note that over the period of the forward Estimates, you expect to see a wide range of capital project within the Health portfolio largely complete and operational, as indicated by the low level of investment by 2022-23. Does this completion of existing capital project signal a period where capital investment in health services across Tasmania will continue at a level 85 per cent less than at present?

Mr FERGUSON - It indicates we are currently not funded for more advanced projects than we have currently committed to. Included in this Budget for the first time is funding to fully fund stage 2 of the Royal Hobart Hospital Redevelopment. There is funding for the north-west hospitals and LGH. Any future major capital projects will need to go through the appropriate process, including relevant business cases to be considered by Government through a very robust Cabinet process.

Mr VALENTINE - Looking at strategic planning, when you are going forward with capital infrastructure? What strategic planning process are used within the health system for capital infrastructure, given that over the past two budget cycles two significant projects - stage 2 of the RHH and LGH redevelopment - have appeared without being flagged in the budget only one year earlier.

Mr FERGUSON - I am sorry I did not quite catch the last.

Mr VALENTINE - It is the lead time with these major projects, they are being flagged in the previous year, with one year's lead time. You would think if you are doing it strategically, there would be a much longer lead time.

Mr PERVAN - Partly because of that reason and partly because we were developing a longer range plan in terms of developing our sites and assets to meet demand. Part of the Government's commitment at the last election was the establishment of the Clinical Planning Taskforce chaired by Professor Lawler. The task force is doing master plans for both LGH and the Royal sites that envisage the next 10 to 20 years of possible development on those sites and what will be needed to maximise the value of those locations and deliver to those services.

Following that process, there is the Treasury process for capital works, where we will join the queue along with all the other Government projects and work our way through and obtain funding as Government prioritises it.

Mr FERGUSON - We were very clear in our election policy, which was extremely substantial in terms of new capital, that we would not attempt to spend that money - for example, at LGH - without also going through a master planning process so it was controlled and took account of the needs of the next 30 years, just as we have done at the Royal, before proceeding with any future stages.

Mr VALENTINE - I am hearing it will be more strategic in future.

Mr FERGUSON - Absolutely, in fact at this table one year ago - not picking on anyone at all; please do not accuse me - I was being asked to do certain things at K Block, and redesign it. The most prudent way to work through these competing ideas is to take a step back to the master plan and process. The great thing about it is not only the scholarly approach but also the engagement with many stakeholders. Dr Lawler is another person we should be grateful to for his work, because he has actually been able to bring a lot of consensus to this process, which has assisted us to crack on with the Royal works and move onto stage 2 in a fantastic way. The Government wants to see this at the LGH.

CHAIR - I am going to wrap it up now. Thank you, minister, and thank you, team from Health. We will not commence again until 4pm.

DIVISION 8
(Department of Police, Fire and Emergency Management)

CHAIR - Welcome back, minister, we now have your Police team. I invite you to introduce the members of your team at the table for the benefit of Hansard, and then to make an opening statement if you wish.

Mr FERGUSON - Thank you, Chair. I introduce Darren Hine, Commissioner of Police and Secretary of the Department of Police, Fire and Emergency Management; Scott Tilyard, Deputy Commissioner of Police; Donna Adams, Deputy Secretary, Business and Executive Services, DPFEM; and Todd Crawford, Director of Business Services. I will introduce other guests as we go through the outputs.

I will give a short overview, please.

CHAIR - Yes.

Mr FERGUSON - In 2018-19 the department has continued to provide valuable police and emergency management services to our community through Tasmania Police, the Tasmania Fire Service, the Tasmania State Emergency Service and the Forensic Science Service Tasmania with corporate support provided by BES.

Our police service does an exceptional job. It is a huge credit to the serving men and women of Tasmania Police that local communities recognise and value their hard work and commitment. Tasmania Police repeatedly records the nation's highest public satisfaction levels in their performance and should be extremely proud of this achievement. I certainly am. We are continuing to deliver on our commitment to support police and boost frontline numbers by a further 125 to help keep Tasmanian communities safe. We have reversed the previous cuts, built up service numbers and now have 1254 FTE police officers serving with distinction.

The Government has committed to provide a core full-time special operations group over this term of office and this Budget takes the first step towards establishing that by investing funds into capital and for specialist equipment.

Important infrastructure developments will be progressed this year, including funds for New Norfolk and the new emergency services hub at Sorrel. We have also allocated $10.7 million to replace the replace the police vessels *Dauntless* and *Van Dieman* to continue the Government's progressive police vessel procurement program.

The health and wellbeing of our emergency responders is a key priority for the Hodgman Liberal Government. Police, firefighters and other emergency service workers are more susceptible to mental health issues due to the severity of incidents they attend and the cumulative effect of incidents attended over a long period of time. That is why I was delighted only yesterday to announce not only the funding, but the successful tenderer for our $1.5 million per year proactive preventative program in relation to both physical and mental health, providing intervention and support as necessary.

In the Tasmania Fire Service, I am sure everybody here will agree they served our state with great distinction and bravery over the recent summer months. Our solid investment in the Tasmania Fire Service shows continued support for the great work it does. The Budget provides more than $13 million for new medium tankers, heavy pumpers and aerial appliances, plus more than $3 million for the replacement and refurbishment of fire stations. Of course, $9 million each year will continue our nation-leading strategic Fuel Reduction Program. Our career emergency service personnel were supported in the recent fires to an outstanding degree by volunteers, and they are also recognised in this Budget with funding continued for our innovative volunteer grants for the Tasmanian Volunteer Fire Brigades Association and SES units.

Local government authorities will also be receiving emergency management planning and education support with $1.5 million over four years to allow our SES to employ regional emergency management planning and development offices, which has been warmly received.

This portfolio provides a critical service to our Tasmanian community to ensure a safe, secure and resilient Tasmania. I thank all members and volunteers of the department for their continued dedication and professionalism.

CHAIR - Thank you, minister. I think most of us would echo your words on the great work of the police, fire and emergency service and the high regard in which they are held. That is not universal around the country, or it has not been historically. We acknowledge that. In broad terms, it seems that Police, Fire and Emergency Management is one department within the Government that tends to come in on budget every year. Are we likely to see that again this year overall?

Mr FERGUSON - Yes.

CHAIR - I don't know if you have the estimated outcomes for the various line items in this portfolio area?

Mr FERGUSON - I would be happy to obtain it for you; I don't have it to hand.

Mr HINE - Basically we have done a budget analysis, which the deputy chairs from the police side of things and also Mr Crawford are on, and we will come in on budget again this year.

CHAIR - That is to be commended. We will get to this more in some of the output groups, but notionally there are increased rates of some crimes and things like that. Is that putting, in a broad sense, more pressure on the budget or is it being managed within current resources?

Mr HINE - We have always had the philosophy that we want to be a responsible government citizen and operate with the budget and that is the budget we have operated within. Obviously, there are fluctuations in crime. We are going from a 15-year when [inaudible] crimes and offences

were committed. We are sort of averaging between 24 000 and 30 000 now, so we have brought it down significantly. But it's always like a balloon, they pop out in various areas, whether it's in a traffic area or a crime area or a public order area. Some areas have different issues to others, but I have to say that, as a whole, the DPFEM has worked really hard to maintain a good fiscal strategic plan and every agency within the DPFEM has worked really hard to get good results as well. We want to provide a quality service to the community within the budget allocated to us.

CHAIR - In broad terms, minister, if you want someone to ask under a particular line item I am happy to do that. Because it covers quite a few areas, I am interested in the number of members of the police service who are on workers compensation and sick leave, and a breakdown of those numbers related to stress leave or stress-related leave.

Mr FERGUSON - We would be quite comfortable dealing with output groups as the committee would see fit because I think the personnel are unlikely to change.

CHAIR - If we ask that question under 1.1 perhaps, we might move to 1.1 and ask it there - acknowledging that with people involved in traffic policing we are picking up the whole gamut with that question.

Output group 1
Public safety

1.1 Support to the Community -

Mr FERGUSON - What was the particular data?

CHAIR - The number of members in the police service who are on sick leave or workers compensation leave where it is stress-related.

Mr FERGUSON - Where it is stress-related?

CHAIR - Yes - the total number and then the proportion that is stress-related, which is more meaningful.

Mr FERGUSON - I've some information here that relates to the whole of the department, excluding TFS, and then I can report TFS separately. That doesn't just mean police, but it does mean sworn police and people in the department. So we have a total number in the financial year to the end of March, a total number of 90 individual claims. The cost of those claims equates to $2 409 551. Of the psychological category subset, of those 116 claims, the cost of eight was $499 122. We discussed in another Estimates committee the main reported cause of injury to police officers is contact with offenders. Nonetheless, each one of those eight people is very important to us and deserves to be supported.

CHAIR - So, incidents of contact with offenders is rising?

Mr FERGUSON - I think so. Commissioner?

Mr HINE - It is maintaining relatively steady, but with extra training and some of the claims in certain areas, like down at the academy, for example, with new recruits when they exercise. We have reviewed some of the ways they exercise to make sure we reduce injuries there. We have new

training in relation to OC spray, handcuffing - all of those things - to try to reduce injury to police officers. It is fair to say we are remaining reasonably steady in relation to contact with offenders. But as we know psychological injury is certainly really important to us and we are putting considerable time and effort. As the minister announced, we have a new contractor to help us manage there. Any injury to a police officer is one injury too much. We are doing a lot of work in relation to psychological injury and want police officers well to do their work and live life. While it is relatively steady, we are seeing more psychological injuries coming forward, which is a good thing because I would much rather police officers -

CHAIR - So, they are not hidden and are being spoken about?

Mr HINE - Yes, that is right. They are coming forward and whether through the TFS or the State Service, I would much rather them come forward to get the help they need. One of our messages is it is okay to be not okay, and let's treat this as an injury; whether it's a broken arm or a broken leg or a psychological injury, we need to address the injury so people come forward. We're selling the message that we have all to work together right across the organisation.

CHAIR - So, do you think, commissioner, raising awareness about it being okay not to be okay is actually the reason you may be getting more reports of psychological injury?

Mr HINE - One of the reasons is that people are actually prepared to reach out and get the help they need. I have had personal experiences when I have reached out to someone and they quite rightly stopped, had a think about it and reached out to get the help they needed. I think that is a good thing. Males are the hardest to get through, the male culture is 'I will tough it out and be okay'.

CHAIR - Not only in the police service.

Mr HINE - Yes, in society also. We have worked really hard and have a long way to go. I won't shirk from the issue that we have a long way to go and need to work really hard to make sure we have the results our members deserve. Through the Government's allocation of $6 million over four years, we voted to sign off a new contract, which I am excited about. It is going to provide great services to everyone in the organisation, to give them the support they deserve. It will not only be leading in Tasmania, but some of the things we will rollout will be nation-leading. Exciting, but am not going to shirk from some issues, and we will continue to work with them to make sure we get better and better.

Mr GAFFNEY - You talk about physical and a psychological injury or illness. Any person applying for a position with the police force must meet certain criteria, certain physical attributes are needed, for example, as in a lot of forces. Due to the changing nature of the pressure that's placed on people in the police force, what psychological assessments are you doing? Has a case been made to look further into that to make certain the person who puts their hand up for the job is in the right career, whether they should be in the external workforce or inside doing some other work? Has that changed in the time you've been there and what can you do to minimise psychological harm felt by some of our police officers?

Mr HINE - That's a really good question, Mr Gaffney. We've worked hard over many years. We utilise a SafeSelect program for the recruits coming through because a lot of emergency service workers are exposed to trauma and we want to make sure people coming into the organisation are ready for that and we do the right tests to make sure they are ready. We don't get it right all the time but I'd much rather tell the person before they come into the organisation and say that you're

not psychologically ready or able to handle the job. We do SafeSelect testing to make sure they are ready and if we need to do further work with them, we'll have the psychologist interview them as well. I'd rather screen them out for the right reasons and we continue to work on that. It is much better to prevent it rather than deal with the person when they come into the organisation.

Mr GAFFNEY - If 100 people applied to the last intake and 15 or so might not make it because they don't have the physical skills required, how many does the department say, 'Sorry, we don't believe this career is for you from a psychological assessment point of view?' I'm interested in the differences.

Mr HINE - Yes, we do, as you rightly point out. There is an exam they undertake; there is SafeSelect and the job suitability test; they go through interviews and they go through physical fitness testing, and then they go through an interview. It is an onerous process - we want the best of the best and we make no apology for that. In relation to how many are screened out psychologically, I don't think we capture that data. They say that sometimes out of 100, only 10 will be selected.

A lot are screened out at that initial point, whether it is a criminal history check, not passing the exam, not passing the job suitability test, the interview or the physical fitness. Those who make it through have gone through a rigorous test - we don't want to bring someone in and damage them or have them damaged through the process if they are not suitable for the job. It's no reflection on them; sometimes this is not the job for them. The fire service is going through that process as well.

Mr GAFFNEY - Thank you.

Ms WEBB - Does it happen in any systematic way throughout people's career, as part of performance supervision or management process, that you recheck those elements to proactively pick up on things people might not be coming forward with?

Mr HINE - Yes, and it's another really good question. We are working hard on what we have been doing and what we can do into the future. There are several things we have in place now - for example, we have a Critical Incident Stress Management Team. If someone goes to a critical incident, they are later called by a peer to check on them to make sure they're okay, whether it be ambulance, police or fire. We have wellbeing officers in place and we've recently doubled those numbers - we had two but we now have four. They could be contacted if there's an issue going on. In certain critical areas, for example, where they were exposed a lot of trauma we have a regular check-up with them. We have also trained some managers and supervisors in mental health awareness. I and all the senior executives have been through that and we want to bring it down through the ambulance, fire service and police so the supervisors and managers recognise the signs if someone is struggling - themselves and other people.

Through our recruits, we are doing mental health first aid so that they can help work colleagues and members of the community. We are doing what we call 'ready for response', we pay for a three-month gym membership for people with this money the Government gave us for ambulance, fire, police and our State Service personnel. This is the second year and we are in the process now because we know there is a strong correlation between physical fitness and mental health. Last time we did it it was really successful. We are doing it again to put people into the mindset to say, okay, I am enjoying this. They can go along to a gym we pay for but they can do it online if they don't have access to that gym. We have an online program they can join as well. We want people to start to move and recognise the need for physical fitness - we don't want them to run marathons - we

simply want to get them to move and to be healthier. It helps their mental health and takes the burden off the health system. You will be aware of those benefits.

I can talk about the tender we have joined up with. It will take us even further in doing online self-assessments. We are dealing with an internationally recognised company and they are going to support us through that. You can do a mental health screening assessment and a physical screening, the fire service has a presumptive cancer screening they can do as well, and there is a hub that will be available for people to go in. There are a lot of things we are doing. It is comprehensive and we need to do more. People are our business and we have to look after our own people and we are really passionate about making sure we continue to do that. I know it was a longwinded answer, but we have a lot going on.

Ms WEBB - No, that was a good answer. It was very comprehensive, thank you. We might go back to numbers, I suppose.

Mr FERGUSON - I will provide this to the committee; it is on record from our announcement yesterday. The tender has been awarded to Gallagher Bassett. There is a lot of detail about who in our teams can access what kinds of extra services and support. I hasten to add that it includes Ambulance Tasmania personnel, as part of the design project.

CHAIR - Does it apply to volunteers for the fire service and SES?

Mr FERGUSON - Yes.

Mr HINE - There are different components for the salaried staff compared to the volunteers because there are now over 6000 volunteers. The TFS has access because of the presumptive cancer legislation.

Mr FERGUSON - It is outlined in it.

Mr HINE - Yes, exactly. It is really exciting and I am looking forward to rolling it out and giving people access to it.

Ms WEBB - Looking at the revenue from appropriation of this output on page 193, it goes up over the forward Estimates and the footnote talks about that increase relating to additional funding for a 'First-Class, Next Generation Police Service policy, and Police Salaries - Additional Funding'. I assume the police salaries additional funding element is the extra numbers of police officers that are being put in place. What proportion of that increase is for those elements?

Mr FERGUSON - To answer the question directly, it is the full amount required to achieve the Government's policy of employing 125 additional police officers. It is entirely funded.

Ms WEBB - Is that the police salaries additional funding element?

Mr FERGUSON - Yes, that is right.

Ms WEBB - The other element, the First-Class, Next Generation Police Service policy -

Mr FERGUSON - That's the lion's share of the cost of the $125 million. On further advice, Government recognised we needed to provide a small amount extra to ensure it was fully funded.

Ms WEBB - Right. Was that included?

Mr FERGUSON - It is included. That's in this year's Budget.

Ms WEBB - Right, and does it also explain the increase across the forward Estimates?

Mr FERGUSON - It certainly does.

Ms WEBB - Are there any other explanations for that increase?

Mr FERGUSON - We are recruiting. We are keeping the academy very busy at the moment. They are taking 10 courses through, the second for this calendar year are coming in shortly.

CHAIR - Ten this year?

Mr FERGUSON - Not 10 this year but 10 courses over the four years. Maybe we can do two a year?

Mr HINE - It's two to three a year, minister. We also have a fast-track course, with 11 people from other jurisdictions. We have a shortened course for them and they are graduating later this month.

Ms WEBB - To clarify, I notice for some performance measures we have actual figures for 2016-17 and 2017-18 and targets looking ahead are equal to or greater than the national average, say, satisfaction with police services. Can you tell me whether the actual figures for 2016-17 and 2017-18 are reflective of that target of equal to or greater than the national average? I don't know what the national average is on those figures. Are we sitting at that level at the present time?

Mr HINE - I can go through each individual target we are at or above as at 31 March for this financial year, if that helps?

Ms WEBB - Sure. Are we sitting at that level now, are we behind on some of them, how are we doing?

Mr HINE - In relation to the national averages for satisfaction with policing services, for example, at 31 March this year the target was 79 per cent, which was the national average, and we were 85 per cent so we were well above that.

Ms WEBB - Maybe for the sake of not having to go through a list of numbers, are there any we are sitting below that we would need to look at?

Mr HINE - In relation to the national averages?

Ms WEBB - Those we've pegged as our target for 2018-19.

Mr HINE - On the survey's perception of safety in public places during the day and night, we are above the national average. We are doing better in some than others for the family violence indicators we have set targets for, and in some we are below. Under this output group 1, we are doing are better than the national average in the satisfaction surveys.

Ms WEBB - In terms of the cost of policing per capita in that performance table, is there national benchmarking or some way we benchmark ourselves against similar jurisdictions?

Mr FERGUSON - We are increasing the cost of policing per capita because we are increasing our police force by 230 or more.

Ms WEBB - I am not asking about the increase; I am asking whether we -

Mr HINE - Have a target?

Ms WEBB - Yes, and whether we look at it in relation to benchmarked figures from somewhere.

Mr HINE - Under the RoGS, we don't benchmark ourselves against other jurisdictions.

Ms WEBB - In terms of the family violence incidents, looking at the targets for 2018-19 we have at or above the three-year average. There will be natural ups and downs and looking at a three-year average gives you a smoother picture of where we are sitting. Does that indicate that you think where we are sitting, with sort of relatively consistent number, is about what we would expect as a community or do you have an expectation as to where that number will go in future?

Mr HINE - Thank you for that question. Family violence is a strong priority and it has been for a number of years. We are sitting above the target we set by 243, but again I know there has been some interest here in relation to family violence. I want that figure to be zero, to be honest with you, but we have to be realistic. I still expect that figure to go up for various reasons which we can discuss now or later.

Ms WEBB - I do not necessarily believe it is a bad thing if it goes up, it does not necessarily indicate worsening of actual incidents in the community.

Mr HINE - You are exactly right and the surveys are telling there is unreporting. Up to 80 per cent are still not reported. We use a rast, a safety instrument, to say where is it on the scale we use. The incidents of high are coming down, the incidents of low where we have actually categorised a low are going up. Those high ones are coming down which is really good where there is significant violence involved. It indicates people are prepared to report minor matters which people in a family violence situation should report. There are a lot of surveys telling us this is significant.

Ms WEBB - With the movements you are observing in those figures and in the different proportions of severity, is there a consistent statewide picture, or are there regional differences to the way those figures move or you are observing them to move?

Mr HINE - The family violence matters actually does move across the state. I would not say there is a significant difference across the state, various areas will go up and down. The ones we are looking about family violence include the very issue it can happen anytime, anywhere in any suburb and in any area. We have discussed at length with this committee before about family violence not happening an influential community, well, I can tell you it does. It does not only happen in a lower socioeconomic area. It is one of those conversations we had about mental health. It happens everywhere, anywhere and we are certainly alive to that. I do not like to put a target about where it is going to happen as it fluctuates anywhere. The Government has certainly invested

significant money for a whole-of-government plan and police have a role to play to help, especially women to get out of violent situations and also hold men to account. I am seeing it going up - am I concerned about that? Yes, of course I am concerned because I do not want to see anyone put up with family violence. The personal safety surveys we are seeing conducted still tell us one in three Australian women experiences physical violence.

CHAIR - And one woman a week is killed at the hands of an intimate partner.

Mr HINE - Horrible statistics we keep seeing. While I am in this job, I will keep making sure we have a really high focus on this. It takes up a significant of policing and time, but for the right reasons. Hopefully, I have answered your question.

CHAIR - I might just invite Ivan to the table, he is on Committee B as you are probably aware and has a question in this area.

Mr DEAN - Hopefully it fits in this area.

CHAIR - I will pull you up if it does not.

Mr DEAN - Yes, you will. It relates to a question asked yesterday by MP Shane Broad and the question was: does Tasmania Police have any policies, processes and practices within its disciplinary system when interacting with a police officer after a disciplinary matter, who is known to be treated by a mental health practitioner and/or is in a mental health hospital? Is there a systematic referral to seek that health practitioner's professional guidance as to the implications and the wellbeing of that officer prior to that interaction occurring or immediate release being promulgated concerning that matter? The commissioner answered that question and simply said no and unfortunately my advice is it does occur. Not only has it occurred once, but it has occurred a number of times.

If I can add this to it: currently officers are taken out of mental health institutions for interviewing and charging without such health guidance. I need to be careful here because I don't want to identify the officer. In the most recent case only a few weeks ago, an officer was removed from a mental health area, interviewed, arrested, charged, bailed by the court and returned to the hospital post-bailing from the court by police.

This occurred without consulting the treating mental health practitioner. Tasmania Police would not do this to a member of the public. This is the advice I am getting. Adopting a process of seeking guidance would ensure that the police officer who is under investigation and suffering a mental health issue remains safe and appropriate section is undertaken within mental health considerations.

CHAIR - On this, before we keep going, member for Windermere, I'm a bit concerned we may be dealing with an individual case here. I am happy for you to address this question broadly in terms of process, but not to address a particular case.

Mr DEAN - I don't have to address a particular case to simply to say that has happened within the organisation, where police have been removed in these circumstances for the purposes of interviewing without taking the right advice and the right process.

That was contrary to the answer provided by the commissioner yesterday, on my advice, and I am repeating that here now.

The Police Association is asking for the minister to give them some undertaking that will no longer occur.

Mr FERGUSON - I suggest, Chair, that we take this in a couple of stages. First, I support Mr Dean's right to ask the policy question here at the table, but, without in any way disrespecting the question, I throw some caution on a suggestion of a particular recent case. You would understand, we won't be responding on that basis. We might consider what further work we might be able to do to satisfy the concerns.

I first turn to the commissioner to respond in general terms, listening to Mr Dean's question and supplementing your answer to yesterday.

Mr HINE - I appreciate the question and I answered the question yesterday to the best of my knowledge. The association hasn't approached me recently to ask that question, and I am a little surprised they haven't actually come to me to ask that question.

Mr DEAN - They would have heard it yesterday. They were obviously listening in to proceedings yesterday and that's why they now want clarification on this whole process.

Mr HINE - Sorry, I thought the question came through the association to Mr Broad, not to you.

Mr DEAN - No.

Mr HINE - I am surprised I haven't had any contact from the Police Association in relation to this matter to actually ask this directly because I certainly wouldn't want to discuss any case.

Mr DEAN - I am not asking you to discuss a case. I am asking whether there has been some clarification given in relation to the information and evidence provided yesterday as to what is currently occurring within the organisation.

CHAIR - What is the policy surrounding police officers in mental health care when they need to perhaps be interviewed and what is the defined process? I am sure you have processes around that, commissioner and minister. If you could identify what they are.

Mr HINE - I think that is certainly the question you are trying to ask. Again, I would much rather the association came to us and discussed this issue, but I will go to the deputy commissioner to talk about our protocols around this.

Mr DEAN - Minister, this was raised yesterday in the Estimates process, and they felt the best way to clarify it was to ask the question and further raise the issue with the commissioner.

CHAIR - So let's get the policy position on it.

Mr FERGUSON - To be clear, no problem. Let's continue.

Mr TILYARD - We have a policy in relation to this and that is if one of our officers is under some form of treatment for a mental health condition, we would normally consult with their treating doctor or practitioner and seek that person's advice as to whether they can be spoken to in relation to disciplinary matters.

Fundamentally though, we treat our police officers who are subject to allegations of misconduct or perhaps they have committed an offence under the law, the same as we do any other member of the public. That underpins our thinking in our approach in all of these cases.

Yes, we do seek appropriate health advice if the circumstances warrant it but, fundamentally, we don't see why police officers should be treated any differently from anybody else if we are investigating a serious breach of the law.

Mr DEAN - What the Police Association is saying is that their people should be treated exactly the same as a member of the public.

Mr TILYARD - That's exactly right, that's my point. In the commissioner's response yesterday, the question was specific about a person being removed from a mental health facility to be interviewed. To my knowledge, that hasn't occurred and it would be very rare if it had occurred. I can't categorically say that it might not have occurred, and it certainly wouldn't have occurred without the authority of the treating practitioner, I'm sure. We can certainly inquire into that further and see if that was the situation. If it was, I'm confident that our people would have acted in accordance with how they would have responded had it been a member of the public, for example, in the same situation.

CHAIR - Okay. So we have the policy position of how it does work, or is supposed to work; is there a further question?

Mr DEAN - No, that's all thanks, Chair, as long as it will be pursued.

Mr FERGUSON - Before Mr Dean leaves, thank you for bringing it to our notice. I think the commissioner has expressed that he would have preferred the association to use the open access it has to address it to the commissioner, but I support your right to bring a question to the table, Mr Dean. If I can undertake to provide to the committee further information to elaborate on our policy position in a way that doesn't disclose information about an individual, I would be prepared to undertake to do that, but I need to take some further advice.

Mr DEAN - The commissioner has stated this publicly yesterday; that's why the association just wanted a clear position on it.

CHAIR - We have a clear position now on the policy.

Mr DEAN - That's what they want.

Mr HINE - Every [inaudible] we have a regular meeting with the association and if they want to discuss policy issues, that is the place to discuss it.

CHAIR - I'm sure they know how to get hold of you, don't they?

Mr HINE - They do.

Mr DEAN - It came out yesterday in Estimates.

Mr FERGUSON - All right, thanks Mr Dean.

Mr GAFFNEY - On support to the community, I notice in the preamble it's about the provision of safety initiatives and the system of developing safe, secure and resilient community; I'd like to talk about the colleges and get some information. One of the programs that is very successful in colleges, years 11 and 12, is the presence of a police officer on campus. I'm interested, over the last four years, if you could provide information at some stage on notice about which colleges have taken up that opportunity, how it's funded and for how long? I'd like the break-up between government and non-government colleges.

One of the things I'm concerned about in the next four or five years is that if there has to be a saving of 75 cents in every $100, schools will have to decide what support services they have in their college. On all accounts, I've heard the connecting with the youth at a particular time in their life where they might need some guidance and the relations of being dealt with the police is really important for our 17- and 18-year-olds. You can either make a comment or provide me with that information. I'm interested to know who actually funds that. I know it says here it's in consultation with the department; I just want to know who foots the bill for the police officers being on campus, and are they going to be retained?

Mr HINE - Thanks, Mr Gaffney. Again, I think we have discussed this around this table as well. Yes, we have a number of police in colleges at the moment and there is a funding arrangement with the colleges that they pay for the majority of a police officer's time to be there. I can supply you with a list of where we are doing that. We are actually reviewing the program. I hear what you're saying in relation to the police officers in colleges and making sure that intervention is there, but we are also looking at how we can intervene earlier with children around schools. Is it the right allocation of resources in colleges, or do we need to intervene, from a policing point of view, earlier on?

CHAIR - Do you still have the Adopt-a-Cop program?

Mr HINE - Yes, which is basically a police officer volunteering but through Assistant Commissioner Cowling we are looking at a totality of the Youth Strategy, including police in schools. There was one in Launceston where they put the police officers in primary schools around the catchment area and it worked well. They had some metrics around offending around the schools and better interaction with the school. They are looking any totalities of the best use of our resources in colleges, or do we actually need to intervene at an earlier age, around primary school? We are developing a youth strategy.

At the moment, yes, we are continuing with the colleges, but reviewing to make sure of the best interaction with the children. Some of the evidence is that it pays to intervene at the primary school and the younger age.

Ms WEBB - It would be great to do both.

Mr GAFFNEY - Obviously, from a community point of view, there are some areas in the state which are traditionally suspect of the relationships between the police and the community, and these are gradually broken down. It is important to have police part of the community. I would hate to

see any funding cuts with frontline staff, that service or see that opportunity get pushed to the background because of uncertain funding initiatives that come up.

CHAIR - Efficiency measures.

Mr HINE - I agree with exactly what you are saying - prevention is much better than cure, and the earlier we can get into some of these schools, the better off we are going to be. We interact with the school and the family. Obviously we need to also look at it from a totality and government point of view, which we sit on the panel of Communities Tasmania.

We are investing more money. We have someone offline at the moment helping develop a high-risk youth offending strategy at various forums. We have been up to New South Wales to have a look at what they are doing and they are coming down to look at us. We are actually investing more to interact better with the youth at the right age. For example, in an area down south, six 14 or15-year-olds were charged with over 900 crimes, so that prompts us we have to do better in relation to the high-risk youth offending. We have to do better, we have to do more and that is why we are developing a strategy at the moment.

Mr FERGUSON - What if I come back with some schools and colleges involved?

Mr GAFFNEY - I would like to know the range.

Mr HINE - It is about five - Elizabeth College, Launceston, Newstead, Hellyer and Don, but I need to check.

Mr GAFFNEY - There aren't any non-government colleges involved?

Mr HINE - No, and there has not been in the program I have been aware of. It has always been the public-funded schools.

Mr FERGUSON - We will check and come back to you.

Mr GAFFNEY - Thank you.

CHAIR - Going back to safety of the police officers, physical and psychological. Has the use of body worn cameras had any impact on the physical injuries particularly, better than the psychological injuries? I do not know how you would measure, but you may have some information on body worn cameras.

Mr HINE - Thank you for that question. The body worn cameras - the Government again has given us some funding in relation to this and it has been really successful. It has been rolled out across the state. Anecdotally, we are seeing some of the complaints against police are being resolved quickly, which obviously causes less psychological stress to the police officer involved. I can give you a couple of examples where body worn cameras have proven straight away where someone has made an allegation of assault against the police officer, and within a short period of time, they could review it and say, 'Hang on, no. This is your behaviour', and it has been resolved really quickly. There are a couple of examples. That takes away the psychological stress for the police officer.

CHAIR - Also police time and potentially court time.

Mr HINE - Exactly. Unfortunately, we still have offences against police but they are coming down. Assaults against police are down 22 per cent up until the end of March.

CHAIR - Is that for the nine months? Comparable with last year's nine months? It is down 22 per cent?

Mr HINE - Yes, 22 per cent; the resist arrest is about 3.9 per cent; and obstruct police is down 13.3 per cent. It is coming down. The body worn camera has had a two-pronged approach. It is about improving behaviour of the people police are interacting with and it also keeps police accountable too. We are actually going to do a full review after a short time to make sure that we evaluate it because one of the things I am also expecting out of it is that it will reduce police officers' time doing paperwork.

CHAIR - That can be taken into evidence, can't it, the footage from that?

Mr FERGUSON - Yes.

Mr HINE - In fact it is what we call the best evidence in relation to presenting before the court and again there are a lot more things we can do and that is why we want to do a full evaluation.

CHAIR - How long do you want to see them in place before their full evaluation is done?

Mr HINE - I am trying to see when the evaluation is due.

Mr FERGUSON - While the commissioner is looking for that, the rollout is still underway so not everybody is yet equipped with their camera. We are up to about 400 of 700 yet to come so 300 yet to go.

CHAIR - The question is are you going to wait for a year of use or six months or two years before you actually review it?

Mr HINE - We definitely have the evaluation and we have the evaluation criteria. I just can't find the date but I think it's after the first 12 months so it's towards the end of this year.

CHAIR - Any criteria for the evaluation?

Mr HINE - Yes, criteria are being developed. I haven't got that in front of me but we want to do a full evaluation. We have informed the Police Association we are going to do a full evaluation because there are some really good things to come out of it.

CHAIR - In the description of this sports community line item, it talks about the highly visible target of patrols. Are these car patrols or on foot patrols?

Mr HINE - Both.

CHAIR - They do include traffic measures as well. What sort of measurement of the impact - and I know people tend to slow down when they see a marked car - I saw a car being pulled up the other day by an unmarked car that you wouldn't have thought was a police car. Anyway they got them.

Mr GAFFNEY - Output 3.1.

CHAIR - No, it's in here, highly visible targeted patrols. I just asked: does it relate to that as well?

Mr GAFFNEY - No, 3.1 is to do with that.

CHAIR - Yes, I know. I just asked that, Michael, but is it also in here?

Mr HINE - Yes, visibility of policing is really important whether it's police cars or walking around the street. Traffic is a different issue and we have just launched some new vehicles in relation to that which we can talk about if you would like now.

CHAIR - You can do that in traffic. I am just talking about what it relates to here in this area, the visibility of the patrols.

Mr HINE - We certainly measure visibility of patrols in our corporate performance report but visibility is really important to a policing service. From a traffic point of view, unmarked cars are really important too. We use undercover people in street situations as well.

CHAIR - Again I think I have spoken about this before, minister. The benefit of having a uniformed police officer walking the street. I encouraged the Wynyard Police to come and walk up the street and have a coffee and to be seen. I still don't see it very often. Is it something that is not enough police out there to do it? They are too busy doing other things? Maybe I'm not in the street at the same time as the police.

Mr HINE - Sometimes that can occur. Down in Hobart you will see foot patrols around. Obviously in a place like Wynyard they will walk around down the shops and it is sometimes you can miss them by about 20 seconds and you won't see them. They have walked down the street and I have to say that at most stations that I visit the police officers are highly visible and a part of the community.

CHAIR - So they are encouraged to get out and be seen?

Mr HINE - Definitely. One of the things that I often say to the police officers when I visit the station is, I want to see you in coffee shops having a coffee with someone, have your meetings there. Many years ago it was frowned upon. Now we actually encourage it. People get out - it is community connection, whether they are doing their shopping, having a coffee, doing a walk through various entertainment areas. It is certainly encouraged down the entertainment precinct at Salamanca. The road and public order teams are often walking down. There are uniformed people walking around. We even walk around down to various meetings around Hobart as well.

I'm not sure I am as effective as a fully trained constable at the moment but I can normally talk my way out of a situation.

CHAIR - I hope you don't find yourself in too many of those situations.

Mr VALENTINE - I saw four of your constables last night doing their duty around the waterfront.

Mr HINE - Okay, that's good.

CHAIR - In uniform.

Mr VALENTINE - They were in uniform.

CHAIR - Yes.

Mr HINE - Yes. And again, I certainly encourage it. There's nothing to say that a police officer shouldn't be walking and interacting with the community. I was on Flinders Island just recently where you can't not be a part of the community; it was fantastic. But sometimes they like a bit of anonymity in getting away from that area as well. So, we can give them a break off the island. But, certainly we encourage it and we'll always encourage it, and the more they can get out of their cars and walk around. If they're a parent of a child, we'll encourage them to take the police car in uniform, and if they can get out there -

CHAIR - Drop a child at school.

Mr HINE - Drop the child off to school, go and watch sports, because unfortunately as police officers we miss out on a lot of the school events, as we all do through work. And if they can do it in a time when their supervisor allows them to do, great.

Mr VALENTINE - It improves connection.

MR HINES - It does.

CHAIR - So, in terms of the efficiency measures, which the Treasurer's got his knife out to try to find where he can cut, one of the areas he's targeting is travel and consultants. Do police have much of a budget, or what do they spend on travel? Someone driving around doing policing duties, we don't want you to cut that. I don't think the minister does either. But it's the additional travel at a more bureaucratic level. Also, do you use consultants?

Mr FERGUSON - There is certainly some use of travel and consultants and back office costs such as advertising, which certainly could be looked at. We're not even at the beginning of that process yet, so it's far too early to -

CHAIR - I know, but I'm asking what is spent currently in those areas?

Mr FERGUSON - Where would you like to start? Consultants?

CHAIR - Yes, consultants, travel, advertising.

Mr FERGUSON - All right. So, what about if I gave you the end of March 2019, so partial financial year. I'm going to ask Deputy Secretary Donna Adams if she would provide that information.

CHAIR - Just bring your microphone closer there, Donna.

Ms ADAMS - Thank you, minister. We actually have two categories in terms of how we actually record our consultancies. The first one is in relation to purely consultancies. Most of those relate to our major projects. We've got a number of communication projects at the moment; our SCAD; our whole-of-government radio network project, TasGRN; the Large Vessel Replacement Project; the Triple Zero Project. They are examples of the consultancies that we've paid over the last nine months. Just to give you a figure, the department has paid $7 705 485 from 1 July 2018 to 31 March 2019.

If you're interested in the State Fire Commission?

CHAIR - Might as well do that now then - yes.

Ms ADAMS - Yes. It was $513 334 . The actual building and equipment, again we have a separate category for those fees. They relate to the police housing, and also the infrastructure works that we do to our police stations. Again, from 1 July 2018 to 31 March 2019, $467 171; and for the State Fire Commission, $1186.

CHAIR - Thank you. Advertising?

Ms ADAMS - We don't have an investment in advertising, but we certainly do with travel. Again, for 1 July 2018 to 31 March, the department's travel bill was $604 902 and at the State Fire Commission, it was $1 344 924 with a significant allocation of travel for the wildfires for the State Fire Commission, which should be noted as being $1 188 063. That was a significant contribution.

CHAIR - Was that to fly people in to the fires? What was the purpose of that travel?

Ms ADAMS - That was travel associated with moving volunteers, firefighters and also interstate people to fight the various fires.

CHAIR - It is notionally operational - it is not like bureaucrats travelling for non-operational matters?

Ms ADAMS - It is purely operational.

Mr FERGUSON - That last figure includes accommodation.

CHAIR - That figure is pretty much all operational. Is any of that cost recoverable through the Australian Government financial support you get for natural disaster relief?

Mr HINE - There is a complicated formula involved in claiming from the Commonwealth in relation that process. I don't think it has been completed because all the costs are still coming in. Once it is sorted out where it fits in, that is when Treasury makes the call about what claims to make.

CHAIR - Some of that could be recovered by police?

Mr FERGUSON - On the global figures I have seen, and the Premier has also publicly stated, approximately half, and it may be more than half, of the anticipated costs of $60 million plus is expected to be compensated by the Commonwealth.

CHAIR - Will some of that money flow back to fire?

Mr FERGUSON - It is a reimbursement model so Treasury is providing full cost to the State Fire Commission for the recent fires and Treasury will seek reimbursement of the contribution from the Commonwealth.

CHAIR - Okay.

Mr HINE - Chair, if I may, the 12-month review of the body worn policy and guidelines is scheduled to commence on 2 August this year.

CHAIR - It will only just have been fully rolled out by that point.

Mr HINE - That will be the first 12 months.

CHAIR - That will be reported in next year's annual report?

Mr HINE - Yes. We can update this committee when we are back here next year. It will take some time to do the review, but it is starting in August this year.

Ms WEBB - I did have another question on one more area in the performance information table on page 186. In relation to the fuel reduction burns; this is not an area I know much about.

CHAIR - Do you want to do it under fire when we get to State Fire Commission?

Ms WEBB - Whatever suits best.

CHAIR - It is probably more suitable there.

Ms WEBB - Yes.

Output Group 2 -
Crime

2.1 Investigation of Crime -

Mr FERGUSON - I would be quite comfortable if you want to take Group 2 as a group and go through your questions as you request.

Mr GAFFNEY - I have a poppy one. Five quick questions on poppy security. Given the 2016-17 season was a bad year for capsule theft, there were 12 000, certainly an outlier statistically, in spite of the declining industry, plantings have been significantly reduced due to the decrease in demand, how do current season's figures for theft and recovery compare? For the last 12 months.

Mr FERGUSON - Thank you for the question. I am advised that in 2019 there was a significant decrease in the number of poppy interferences and thefts compared to the previous growing season. In the year 2018-19 to 31 March 2019, 124 were capsules stolen which, as you have noted, compares favourably with previous years. It is the lowest in the past four or five years. Last year was 1430 and the year before over 12 000. The capsules recovered amount to 1058.

Being a larger number than that number stolen, perhaps the commissioner can advise if that relates to earlier thefts or thefts that weren't detected. That is the record I have for you.

Mr GAFFNEY - Following on from that, it says crop interferences are down. How do you assess whether that has to do with the unfortunate death and subsequent education programs we had or is it more attributable to the decline in the industry, resulting in fewer farms, so fewer opportunities for people to steal heads? How do you measure that?

Mr HINE - It is really hard to judge. It could be a number of factors. It can kill you and we have had some unfortunate deaths over the years. I think what you have said is right, there are fewer opportunities for people and sometimes it's the popularity of different drugs. As we know, the biggest drug in use in our community is alcohol and cannabis is the next one. It is a different drug of choice, but opium poppies do have a risk. It seems to be less popular among those who are prone to use it as well.

CHAIR - People who know can read the language. It is often tourists. The most recent deaths were tourists, I think.

Mr GAFFNEY - There was a 17-year old boy.

CHAIR - Was there?

Mr GAFFNEY - Are crop interferences just deaths or does that include trespassing, or attempted theft? When you put down 'crop interferences' do you stipulate what that might be?

Mr HINE - It is normally theft, where someone has actually gone in and stolen the actual capsules. Just getting back to your question I think we are seeing it as less of a drug of choice in the community because of, as you said, the unfortunate 17-year-old.

Mr GAFFNEY - Seventeen years old.

Mr HINE - That was very sad and there are other unfortunate -

Mr GAFFNEY - There was a 26-year-old Danish backpacker in 2014 and a 17-year-old Hobart boy in 2012 and a 50-year-old Launceston man in 2011. To the last question because I think we will go to the hemp one with the minister tomorrow. How do the poppy security figures in Tasmania compare to those in other Australian states now that some of the other states also have poppies as a crop? New South Wales came on a couple of years ago. Do you compare? How do we do in comparison with the other states?

Mr HINE - It is a fair question, but I don't have the figures in relation to that. Maybe we can take that on notice and do some comparisons.

Mr GAFFNEY - Could be a KPI.

Mr HINE - I think that is a reasonable question to ask.

CHAIR - Just a couple of questions on information on the investigation of crime performance measures, on page 188. Even when you look at some of the others in our previous output groups, and even with the traffic policing, there seems to be a reduction in a lot of these offences even

though our population has grown. Is the reduction we are seeing greater per capita? What do you put that down to?

Mr HINE - When you say the reduction of the actual crimes committed?

CHAIR - The numbers. The total offences. The actual in 2016-17 is 27 439 then in 2017-18, 26 174. I am not sure how the figures are tracking for this year. They could go up again. Are they going up again?

Mr HINE - Yes, unfortunately there is about a 5 per cent increase on total of crimes and offences right across the state. I think it is fair to say we bottomed out at about 24 000 and we now seem to be bobbing between 24 000 and 28 000. We have had a 10 per cent decrease and a 9 per cent increase and now we are going to a 5 per cent increase. There seems to be a bobbing around of the figures.

CHAIR - This is total number of offences as opposed to per capita?

Mr HINE - Exactly.

CHAIR - It is like some of the road safety statistics, you have to look at the number of kilometres travelled and make a comparison that way.

Mr HINE - We do some of those comparisons per 100 000 but we just seem to be bobbing around in relation to crime at the moment. We have had some significant inroads in the northern district at the moment with various people being charged. There is an operation up there called Raptor. They have had some issues with their crime figures up there, with at least 12 firearms taken off the streets and a number of charges made a month ago. One gentleman was charged with over 50 crimes. They were working really hard in the northern districts.

CHAIR - Some individuals are responsible for quite a few of those.

Mr HINE - Unfortunately, we see that figure of a small number of youths committing a large number of crimes and we are finding that in Launceston as well.

CHAIR - What about the introduction of the bikies' colours legislation? Has that led to reduction in the crime in that area that you can identify or is it a bit too early?

Mr HINE - That legislation is in the process of being enacted. Anecdotally, it is a great concern. We don't back away; they are our major organised criminals in the state and we will do anything we can to disrupt them. It is too early to say how much of a disruption it has been. The other day, I saw a report in relation to some of their violent activities.

CHAIR - In Tasmania?

Mr HINE - Yes. We haven't had a national run for some years. I have openly said they are not welcome here in Tasmania because they disrupt the harmony we have in our community. You might have read in the media recently that an international group was set up in Victoria and they said that they were coming to Tasmania or were in Tasmania. Our intelligence says they are not here yet. They are a group that is banned internationally and we don't want them here. I make no apology and we will continue to work with the legislation the Government has given us - we need

to enact that and we are working hard on it. When we briefed the House here, we were talking about targeting five major groups and now there six.

CHAIR - The regulations haven't come through yet, have they, minister?

Mr FERGUSON - The commissioner has given a very good summary. I will clarify one point only - the consorting legislation is fully operational now. I don't know if you are prepared to name the number of orders that have been presented? You can do that if you are comfortable to do that. The police advice is that is underway in relation to colours or insignia.

CHAIR - The organisations are going to be named in the regulations.

Mr FERGUSON - I am being careful how I express it. Police are currently working with intelligence files presented for government to consider.

CHAIR - To make the regulations, which haven't been made yet.

Mr FERGUSON - Correct.

Mr HINE - In relation to consorting, as the minister quite rightly pointed out, there are eight people with 56 notices because it is on one. There might be eight people but there several different notices we have to serve amongst these people. Most of those have been appealed, which is under the legislation, and those appeals are being sorted. Under the legislation they can appeal to a magistrate. While the notice still stands, they have all these appeal mechanisms and they can go to the magistrate if they desire.

CHAIR - None have been to the Magistrates Court yet.

Mr HINE - Not that I am aware of. They have only sorted out where a senior officer commander has reviewed the notices that have come in.

CHAIR - That has been upheld, each of those?

Mr HINE - Yes, they have been upheld and now have the option under the legislation to take it to the magistrate.

CHAIR - No-one is surprised about that.

2.3 Fisheries security -

Mr VALENTINE - I note the forward Estimates show no significant increases in resources to the fisheries security activity, yet there is a possible expectation if you look at the performance information that more offenders will be detected. That is on page 188. Can you please provide details as to how the marine police group are improving the efficiency of detection? One would expect the trend is up. In 2015-16 there were 1277, and it was 1412 in last year's budget papers, but it is 1408 in this. It is a bit over 10 per cent increase. In 2017-18, there is a 5 per cent increase to 1479. The numbers are trending up in picking up offenders. Is there any reason for that? Do they have some fancy gear that is giving them the edge?

Mr HINE - You picked up a really good point; yes, every police officer is trained in marine enforcement. We have specialist marine police and they are picking up an increase in offences in this area but they have been working really hard. It has increased and we expect it will start to level out. They can only pick up the offences that are there. They have done a really good job and it is unfortunate that they continue to see offences. We want to protect our marine industry. The other concerning aspect is that we have had some unfortunate drownings and the coroner has to present their findings. One of the other things that has come online through the Government funding is PV *Cape Wickham*, which has given us greater capability to enforce marine laws. The minister can talk about his personal experience of that vessel and its capabilities.

Mr VALENTINE - He wasn't caught, was he?

Mr FERGUSON - I was assisting police. I wish - I haven't been able to go fishing for a long time. The Government is making a big investment to enable Tasmania Police to upgrade police vessels. We have already spent $8.5 million on phase 1, which is the replacement of -

CHAIR - Minister, we don't have a quorum. We need to wait for one member to come back.

Quorum formed.

CHAIR - Sorry to interrupt, minister.

Mr FERGUSON - I will wrap it up but we have seen a wonderful new commissioned vessel in PV *Cape Wickham* and its fantastic capability, making such a difference on the water, able to do search and rescue and maritime enforcement. We look forward to commencing the next phases of the $10.7 million to replace PVs *Dauntless* and *Van Diemen*. Those projects are going to help us modernise our police vessels.

Mr VALENTINE - Can you provide numbers in recent offence data, the seriousness of the offences, fines levied or prison sentences achieved? What trends are expected across the various classes of fishery offences?

Mr FERGUSON - We have some information we can provide you with now, which may be what you are looking for. I don't know about convictions -

Mr HINE - If I can give some enforcement activities, minister?

Mr FERGUSON - Yes.

Mr HINE - Vessel inspections at sea, in 2017-18, there were 5100; until March there were 3100 marine offenders detected; 2017-18, 542; up until March this financial year it was 539. Looking at some of the patrol hours marine and rescue services - in 2017-18, 5700; this year, it's 3300. District marine services in relation to vessel control hours - 669 in 2017-18, and up until March this year, 676. Those district services are obviously doing more and more hours as well.

Mr VALENTINE - It's interesting the marine offenders are 500 and something by March. That's nine months of operation, yet here we are looking at 1479 for the full year, so there's only three months to go. The detection rate might be going downhill.

Mr FERGUSON - I think the detection rate is up. I'm not sure if you got the same figure I did, 542 for 2017-18 compared to 539 for the nine months of this financial year, so actually the marine offenders detected is already in nine months more than the previous full year.

Mr VALENTINE - Okay. It's just that the performance information says marine offenders, 1479 for 2017-18.

Mr HINE - Our corporate performance report tells us a different number as well. On our corporate performance report up until the end of March, it tells us that 1195 is the performance in relation to marine offenders, so I'm not sure what that was; this is offenders. We will probably take it on notice so we can just clarify that, if it's okay.

Mr FERGUSON - You might have to reconcile that for the committee.

Mr VALENTINE - So the question on notice is that -

Mr HINE - The number of marine offenders detected.

CHAIR - Would you get a number of convictions? Have you got that information, commissioner?

Mr HINE -No. We'd have to go through the Justice department in relation to that.

Mr VALENTINE - Number of marine offences detected for the past two financial years.

CHAIR - Any other questions?

Mr VALENTINE - Is the offence activity increasing, or is the detection efficiency increasing, but I'll get those figures and we'll have a look at that.

2.4 Support to judicial services -

CHAIR - Minister, this has been discussed lots of times: whether the police should be involved in doing judicial services rather than other suitably trained people. Is your view unchanging in this?

Mr FERGUSON - Yes, it certainly is unchanged because -

CHAIR - And unchanging? Not likely to change your view? You can respond; I'm sure it will become apparent as you do.

Mr FERGUSON - Certainly through working with my colleague, the Minister for Justice and Corrections, there's certainly a body of work being done and continued to ensure that where we are able to take police out of courts ,this happens; it has been implemented in Launceston. The Government is happy to restate our commitment to extending that project to the north-west. The Department of Justice is investigating options, so I am speaking in this respect somewhat on behalf of the minister, Ms Archer, but the Department of Justice is investigating options for correctional officers to take over prisoner transfers, transport and court security from police in the north-west, so that more police officers can return to frontline duties. I don't have a date for you at this point in time, but it's under active consideration by Government.

CHAIR - One would assume, then, that the cost associated with this would then transfer to Justice?

Mr FERGUSON - I think I would need to allow the other minister, my colleague, to answer that, but the experience so far has been that it resulted in a net increase of frontline policing to Tasmania Police, if Corrections picked up the cost version of the new workload.

CHAIR - The non-sworn officers in Courts?

Mr FERGUSON - Correct.

CHAIR - So you would expect, if it is fully rolled out, that this money be transferred to Justice, the majority of it.

Mr FERGUSON - No, I am not saying that. I would like the other minister to be able to speak for herself, but the intention is not that there be a transfer of resource. It would be a net gain for Tasmania Police resource.

CHAIR - Then the allocation of these funds, would that go into other areas of policing?

Mr FERGUSON - It is not so much money as people, so how would you like to answer that?

Mr HINE - In relation to the Launceston situation, where the duty work transferred across to Justice, there was a transfer of some money as well. There was a little bit of money but it certainly was not the total. As the minister said, there was certainly a net gain for Tasmania Police, and let's hope those discussions will continue on. When the Government - actually I think it was an extra five or six police officers who were taken out of court - they were put back into operational duties.

CHAIR - Next year's budget, near enough $11 million, would that be then spread across all other areas, or it is likely that they are going to go into 1.1, Public safety, and perhaps 2.1 or 3.1?

Mr HINE - If we look at the money in relation to the point of judicial services about prosecutions -

CHAIR - So there is still some money that would need to be spent there?

Mr HINE - The prosecutor would still be responsible for the prosecution.

CHAIR - And that would come out of there?

Mr HINE - Yes and the coronial matters as well. That would come out of that money, and that is the majority certainly of the money. It is more the operational area where the police officers would be freed up to be able to do operational area tasks.

CHAIR - The DPP office has a separate allocation, though.

Mr HINE - Yes. Through the Justice department.

Output group 3 -
Traffic policing

3.1 Traffic policing

Ms LOVELL - I have one question on the performance information for output group 3, related to the targets for 2018-19: I assume we do not have the actual yet because the year is not finished, but if we got a year to date, that would be great. Maybe we will start with that.

Mr HINE - If we go down the number of high-risk traffic offenders, the targets until 31 March were 19 000, and we exceeded that target - it's 23 557. The speeding offences police-issued infringement: the target was 31 000, the number is 30 900, so that's down by 591; random breath tests conducted: the target was 330 000 and the actual is 327 000, so that is less 2661.

Can I indicate some of the reasons we are down in some of those issues is because of the fires, where police had to be taken off normal duties to be able to assist during the fires, which went for 85 days, I think, in total, so that had a significant impact. In relation to the number of drink-driving offenders, the target was 1900; and again up to 31 March, the number achieved so far is 1393, so that's down 521. Oral fluid testing: the target was, up until 31 March, 2440; we exceeded that at 3329.

Ms LOVELL - That is good, thank you.

Mr HINE - Number of drug-driving offenders: the target was 1276 [inaudible]; up until that date there's 1793. Fatal and serious crashes: the target was 202; unfortunately there was 227, so 25 above, that is including fatal and serious.

Ms LOVELL - Okay, thank you for that, commissioner. On a couple of those, it's interesting that you've actually exceeded the target for the entire year by March already. My question then is about the targets for 2019-20: some of them seem to be quite low compared to what has been achieved in those areas, and in actual outcomes for previous financial years. Why is that, minister?

Mr FERGUSON - It is a good question and I will answer it in two parts. Some of it is that you can only represent numbers in terms of offenders detected on the basis of what level of misbehaviour is actually occurring in the community. The other is that while it would seem very reasonable to be able to more or less target levels of activity, for example testing or the number of random breath tests or the number of oral fluid tests, much as we would have, for example, an ideal target of zero deaths on the roads, it is a difficult conversation to state what the ideal target is for the number of drug-driving offenders.

Apart from the commissioner's explanation about how busy our people have been over the period of the summer fires, some of those indicators are up in activity, and I think that helps explain why some of the drug-driving offences are up. It is concerning nonetheless.

Mr HINE - We are rolling out what we call a new system that's called Unify. We know that is going to have a significant training component and that is why we've revised some of those figures. As the minister quite rightly pointed out, we would much rather not detect, we would rather detect less.

Ms LOVELL - Yes, I guess we would like to see the offenders target lower.

Mr HINE - Yes, we would; in the notes we have indicated, it will actually be impacted by the training component we have. We have obviously got fatigue management issues and we want to address those, so we have adjusted that down to get the police officers through in relation to this new system. Again, the Government is giving us funding to roll that new system out.

Mr FERGUSON - I will add to that answer as well; I have some advice that while it remains random breath testing since 2014, police have adjusted the balance between high volume static testing and more targeted random breath testing. I think that indicates you have seen a decrease in the operational performance target for the total number of random breath tests to 440 000. Back in 2013-14, that number was 580 000. It is a statistically significant reduction in the targeted number of RBTs to occur, but a more sophisticated and nonetheless random process so far as the driver is concerned. So far as police are concerned, however, it is more strategic and targeted.

CHAIR - What are the unit costs per test for the random breath test and the oral fluid test?

Mr FERGUSON - You mean, for example, for consumables or for the service?

CHAIR - Well, more for the consumables.

Mr TILYARD - The cost of the mouthpiece that fits into the breath-testing device is minimal. There is a cost associated with it but it is a few cents per item. The roadside drug tests are far more substantial; I think it is around $35 per test and takes about 10 minutes to do on the side of the road. You can imagine if you are trying to put thousands of people through that, you would have a 10-kilometre traffic jam.

CHAIR - It always has been more expensive and that is why it has been more targeted; that is what we have been told.

Mr HINE - The legislation that recently passed allows where police officers do drug driving tests. We don't have to take it to the hospital anymore. That eases the burden on the hospital to take blood tests. Now we can do it through saliva. It is a win/win for us.

CHAIR - Self-interest for the minister.

Mr HINE - It is one of those advantages where we're not only saving policing time and for Health, but there is still a cost for the Forensic Science Service Tasmania to analyse these tests as well.

Output group 4 -
Emergency management

4.1 State Emergency Services
4.2 State security and rescue operations -

Ms WEBB - Looking at 4.1, State Emergency Services, and the revenue from appropriation table on page 193, that increase has been substantial across this year's and the forward Estimates. It is explained as reflecting the Regional Emergency Management Planning and Development Initiative. Can you provide some detail on the magnitude of that increase under that?

Mr FERGUSON - Yes, I can. Can you give me a page number quickly, please.

Ms WEBB - Page 193.

Mr FERGUSON - First of all, I will introduce to the table Mr Matthew Brocklehurst, who is Acting Director of the State Emergency Service, Tasmania. In so doing, I ask you, Matt, to please again to please pass on our thanks to your team for the fantastic work they do every day and particularly during last summer's bushfire season and the extreme weather event the year before.

CHAIR - And all the volunteers.

Mr BROCKLEHURST - These were our outcomes from the Department of Justice review a few years ago and the intent there was to address the recommendation where we provided greatest assistance to the three regions and the creation of three additional positions - one person per region to support the Minister for Police, Fire and Emergency Management's committees with the development of that. That funding is principally for three salaries.

Ms WEBB - Three salaries, which is about $300 000. Okay, thank you.

I note that under 4.1, there isn't really any performance information noted. Am I not finding it, or do we not have a table with any performance information for the State Emergency Service? When I look on page 189, for example, we have it there for the next one.

Mr FERGUSON - They are on page 189, but you are quite right that the selection of performance indicators is not direct.

Ms WEBB - This is my first Estimates hearing. Is that something that is typical or did we have performance indicators and then remove them?

Mr FERGUSON - It is always a conversation about selecting out the best performance indicators for any of the output groups. You are quite right to point that in this case the performance indicators haven't referenced output 4.1 specifically.

Ms WEBB - Would there have been some in the past perhaps?

Mr FERGUSON - There would have been over different budgets and different governments, I suppose. You might have, for example, said a performance measure might have been the number of hours that the SES and its volunteers were called out on jobs. We are very much subject to weather so it is not a very helpful performance measure for our budget.

Ms WEBB - Sure. Can I ask a couple of questions about the volunteers? I am interested in your volunteer workforce. How many volunteers are involved in the SES at the moment?

Mr BROCKLEHURST - At the moment we are tracking around about 600. That is a fluctuating number and we have seen a fairly steady increase over recent years. I would have to dig up the data for you.

Ms WEBB - Is that a deliberate increase, as in you have been actively recruiting a higher number, or has it been a natural increase that has happened because people have been keen?

Mr BROCKLEHURST - It is a bit of both. The reality is that in the urban areas we are actually well supplied for numbers and we actually have waiting lists, for example, in the southern regional unit. In some of the more rural units, it is a bit of a struggle, and it's a similar experience with TFS as well.

Ms WEBB - I would be interested, and you might not have it to hand, in a regional breakdown of the numbers of volunteers and even an urban/rural breakdown.

Mr FERGUSON - We can do that.

Mr BROCKLEHURST - I can do that. In fact, that data was provided yesterday at the other Estimates hearing. I don't have it at hand with me at the moment.

Ms WEBB - If you could send it through to us, that would be really good. I was interested in trend over time and you mentioned that it is increasing.

Mr BROCKLEHURST - It's a slight increase. I have only been with the organisation for two years but we have probably increased by about 50 or so across the state over that time. As I have said, the challenge we have is it's the rural areas where we struggle for people and that is a common issue.

Ms WEBB - Is that where you target your recruitment efforts?

Mr BROCKLEHURST - Yes. For example, this year and we have a future strategy to improve our recruitment strategies around events such as Agfest because that is focused on that community.

Ms WEBB - How about the age profile of your volunteers?

Mr BROCKLEHURST - It is ageing and again that was a similar question to one that was asked last night; we are still gathering the data for that over the three years.

Ms WEBB - I will be interested to see it.

Mr FERGUSON - What if we bring it back to this committee as well?

CHAIR - And gender mix.

Ms WEBB - That was my next one, thank you.

Mr BROCKLEHURST - The gender mix I can happily say from an SES perspective, we are definitely improving and we are at about 30 per cent female. Certainly the SES, as with the TFS, is an active member of the Male Champions of Change initiative that's been taken up to the emergency services sector. There is work to be done but I am happy to say from an SES perspective we are tracking pretty well. It's always good to have a mixed gender and an inclusive environment.

Ms WEBB - Do you do satisfaction measures or some sort of culture measures with your volunteers?

Mr BROCKLEHURST - We do a four-yearly survey. We are actually due to do one this year.

Ms WEBB - That could be a performance indicator for next year.

Mr BROCKLEHURST - Yes. We are going to get some support from the University of Tasmania for that. Previously we have done it ourselves but Andrew Lee who is the substantive director has had some discussions with the University of Tasmania which have an active interest in doing some research in this space. So, we are going to help each other out with that scenario.

Ms WEBB - I am interested in the training and equipment budget for your volunteers, particularly the training budget. Is that a static number or does it grow over time as your quantum of volunteers grows, or how does that work?

Mr BROCKLEHURST - We do have a bit of a challenge with our budget and the fact that we don't have a sustainable funding model and that is something under consideration as part of the review of the state Fire Service Act 1979. It does ebb and flow but it is something in that area where do need to get some consistency.

Mr FERGUSON - I will just briefly add to that, particularly for you, Ms Webb, as a newer member. The Government has already commissioned an independent review into the Fire Service Act 1979. It is a very old act and it needs contemporising. It also needs to help government and help parliament find the best way forward so that we have a sustainable funding model for the State Emergency Service as part of those arrangements, which at the moment are rather outdated and fragmented. That work has already commenced. We have had a change in chair due to Mike Harris taking the position interstate. It's now being led by Mike Black.

Mr GAFFNEY - It comes up in the Tasmanian Fire Commission, there was $500 000 for volunteer units from the Tasmanian Fire Service and State Emergency Services each year for the last four years, starting last year. From the SES, it says -

> To enable all volunteer units from the Tasmanian Fire Service and State Emergency Service to apply for upgrades to equipment.

Over the last 12 months, what upgrades have you requested and what money has been spent for your volunteers and what is predicted for this year? The money is there. What part of that money has gone to you as part of the SES and your volunteers?

Mr BROCKLEHURST - We have run a grant program in conjunction with the TFS. Ours is a little bit different. I haven't been an active part of the review process for those applications that I mentioned but we are doing eight units per year over the four years in order to share the load a little bit differently to the way the fire service is delivered. Effectively, it is the same amount of money per unit or brigade. My understanding is that it is an increase for things such as AV equipment to facilitate training and some unit upgrades to enhance the experience for the volunteers in their particular units.

Mr GAFFNEY - I will ask the fire commission when you get to that line item about what is the possibility of that funding continuing for volunteers in the future? You've had four years of $500 000 and there's nothing in the line item for 2023, so obviously that's another budget item. So, I'll ask that when you get to the fire commission.

Mr FERGUSON - I'm just happy to grab that now. So, just so we're clear, the fund as you've correctly identified is a $2 million fund the Government established and to provide that in equal disbursements of half a million dollars per year for four years. We're still in the first year, and I'll just give you a quick snapshot.

In the first grant round that was opened up over summer, and you can just imagine how busy our fire brigades and SES units were then. So, even though it was a really positive response we recognise that quite a number of brigades and SES units were busy and didn't put their mind to a funding application. So, we actually opened up a second round, an extra round, which is currently under consideration. We'll continue to provide this over the next three financial years as well. Volunteer brigades and SES units absolutely love it because they've never had this before.

The only emphasis I'd place on all of this is that while we're really proud of doing it, it's a first. No Tasmanian government has ever provided direct grants to the brigades and units in this way before. So, we'll certainly be monitoring to see how it goes but my early feedback is what I warmly received - I'll just give you a quick snapshot: defibrillators, some AV equipment has been a common theme. Some brigades have been buying communications, for example, CB or UHF radios. They can also use it for facilities improvements as well. The only key point we want to emphasise is that this sits above what the Service would regard as core or essential equipment services and safety. Equipment PPE, for example. So, we don't expect - that's our burden of responsibility to provide those. The Emergency Volunteer Fund grants are for the extras.

Mr GAFFNEY - Okay. A question, minister, on - you might have to think about this one. If the $500 000 is not expended by June 30, which is budgeted for, say $400 000 goes: does the extra $100 000 go into the next budget so there'd be $600 000 available for the next 12 months?

Mr FERGUSON - We expect to milk it dry each financial year. But in the unlikely event that there was any underspend, we would absolutely carry that over.

Mr GAFFNEY - Okay, Thank you.

CHAIR - So, no further questions on either of 4.1 or 4.2? Okay. We'll move to the Capital Investment Program. Minister, just on this one, I thought this was where I would ask you, but it doesn't appear to be here, is the whole-of-government radio network. I didn't discuss it with the Treasurer yesterday. He said it really was a matter for you. So, can we have an update on this?

Mr FERGUSON - Yes.

CHAIR - It's been such a long time coming, and I really would like to know when it's going to be delivered basically. I understand it went out to tender quite recently.

Mr FERGUSON - So I'm here, and the subject experts are here as well.

CHAIR - That's why we're asking you.

Mr FERGUSON - Yes. The project itself is funded out of Treasury; that's why it doesn't appear in our chapter. I'm sure you'll find it in Finance-General.

CHAIR - It is there, yes, it is.

Mr FERGUSON - We're implementing it, and so we can speak to that. I'll ask the deputy commissioner to give you the answers you're looking for, noting that we're currently assessing tenders, as the tender round has closed.

Mr TILYARD - Thanks, minister. You're correct in saying that the tender for the new network did go out recently. It went out in November. It closed last Friday, and we're going through the process now. The project team is in standard procurement process of evaluating the tenders that were received against the specifications and requirements of the tender from a compliance perspective. Once we complete that process over the next few weeks, we will then transition into the actual tender evaluation process proper, which is comparing the tenders against each other in terms of who the preferred vendor is.

CHAIR - What is the time frame for that process?

Mr TILYARD - It is planned at this stage that the selection process should be completed by around about August and a number of months have been set aside for contract negotiations with the preferred tenderer. We will commence the build of the new network next calendar year.

CHAIR - All the funding available for that hasn't dried up somewhere?

Mr TILYARD - There is funding into the forward Estimates as well as contributions from by the agencies that use the various networks around the state. That forms part of the ongoing funding. Until we sit down and negotiate a contract with the preferred vendor, the precise costings won't be known.

Mr HINE - We are really excited about having a new radio network with a P25 capability, which gives us greater encryption and a whole-of-government radio network. We understand that radio networks need to be refreshed and this is a significant investment made by the Government. It will make things a lot smoother in that we have further interoperability with our emergency service workers. They can do it now through another system, but it is really exciting that we get greater encryption and greater coverage right across the state.

CHAIR - There is great interest from my constituency on the west coast in communication during fires. They had the recent fires in Zeehan and there was a problem with consistency of communication about whether to evacuate and those sorts of things. They are looking forward to this being up and running. The tender isn't finalised, but is there an expected time frame for delivery? Is a delivery time frame part of the tender?

Mr HINE - Yes, there is definitely a delivery time frame but we also reach the stage where you have to run two networks side-by-side. Mr Tilyard will be able to explain that further. While you are decommissioning one, you have to keep that going until you have the new one.

Mr TILYARD - You may be aware, because we have discussed it during previous Estimates, that a number of different networks operate around the state now. The Trunk Mobile Radio Network, which is the network the police, the Tasmanian electricity supply industry, Hydro and TasNetworks and, to some extent, the SES operate on, is a digital capable network and it is used in both digital and analog mode.

The other networks used by Tasmania Fire Service, Ambulance Tasmania, Parks and Wildlife and Sustainable Timber Tasmania, are old analogue networks introduced after the 1967 bushfires. You can see the need for the new network that picks everybody up. Some work has already been completed as part of the Tasmanian sharing project, and that is installing what is known as an interoperability gateway. For the last few years we have had the capability to connect all these different networks together when our frontline people need to talk to each other. That has been used on a number of occasions and was used very successfully during the significant fire event we had over the past summer.

CHAIR - It must have been used more effectively down in the Huon.

Mr TILYARD - Yes, it was certainly used in the Huon.

CHAIR - It didn't appear too effective in the west.

Mr TILYARD - Radio networks are strange things, there are always issues. The topography of Tasmania makes it one of the most challenging places in the world to have a radio network. There is a range of factors like weather, conditions and smoke that affect it.

CHAIR - I understand that from a west coast point of view.

Mr TILYARD - It does affect it. You will never get 100 per cent coverage 100 per cent of the time. It is not capable of -

Mr VALENTINE - Even if it is satellite, I suppose.

Mr TILYARD - That is right, well, we won't go into too much detail but even low-orbiting satellites wouldn't give us coverage right to the bottom of every gully in Tasmania. You can spend as much money as you like but you are not going to get 100 per cent coverage, 100 per cent of the time.

Mr HINE - Sometimes it is not the radio networks, it is what put over the radio network, the messages. In really busy emergency situations, sometimes getting the correct message out -

CHAIR - To the right place.

Mr HINE - can be difficult. When you are comparing what is on the ground, someone else will have a different perception. It can be the radio network and it can be the messages.

CHAIR - What is the expected delivery according to the tender process?

Mr HINE - The build starts in 2020 and we are hoping to start transitioning some of the users onto the new network toward the end of 2020 and 2021. There will be transitional phase of bringing the various users on over the next couple of years. In the interim, what we have been and will continue to do is the maintenance of the existing networks to the extent they need to be maintained to allow that transition to occur. You don't switch one off and switch another one on straight away. There is an overlapping period where you make sure the units have the coverage you need. You decommission your old networks after that.

What we have been mindful of is reducing the cost of the new network to the public, and utilising the existing infrastructure, already owned by government or government entities, to the fullest extent we can. That includes a significant number of towers around the state and rationalising some of those towers. It includes TasNetworks towers, towers that we own and towers that Tasmania Fire Service owns, in various locations around the state. We will continue to maximise the reuse of those with the successful vendor.

CHAIR - Can we expect it to be complete and operational at the end of 2023?

Mr TILYARD - No, 2023-24 is the time frame we are working to. When we sit down and work through the contractual arrangements with the vendor we will be able to firm up the time frames for the transitions. It will be over the next few years.

Mr VALENTINE - Make sure they dig their tower lines down greater than a metre because the lines at Dunalley melted a metre underground. Unbelievable.

CHAIR - With the body worn video, there is no budget allocation this year but more in 2021. I thought you were still rolling it out. Why is there no budget allocation for this year? It is under capital investment on page 190, budget paper 2.

Mr CRAWFORD - The funding was provided as capital in two injections. The equipment has been effectively bought as a managed service, paying for all that equipment. That funding relates to a refresh of that equipment in two years. It was anticipated that we would be rolling it out a quicker than we were.

CHAIR - All the cameras you need are currently being purchased, is this right? It is not that we are having wait for those who don't have it yet. Okay.

Mr VALENTINE - You are renovating New Norfolk, Longford and Sorell stations. What are the next regional centres to be targeted for upgrades?

Mr FERGUSON - There are none at the moment. Any other future capital requests need to go through a process of government to determine that is justified and, if so, how you would cost that out. We would submit that through the Cabinet process on the advice of Treasury, which is known as the SERT process. That would be for major infrastructure but you will note in the Budget that we have a continued commitment to upgrading police housing. It is something the Police Association has been very strong on but so have the people alongside me. We need to do better and support our people in the field. The projects we have on are keeping us quite busy and occupied in New Norfolk, Longford, and Sorell. As government is able to do more, I am sure we will.

Mr VALENTINE - How many upgrades to facilities like that have you done in the last four years?

CHAIR - Are you talking about police housing?

Mr VALENTINE - No, I am talking the police stations, emergency services facilities.

Mr HINE - The major police stations we have renovated over the last number of years were Bellerive, Devonport and Glenorchy. Glenorchy was the last major station that was done. Through

the government grants, we are do the other hubs. We have spent some money on other stations to a minor degree and we have also had some -

Mr VALENTINE - When you say stations, you are talking about police stations?

Mr HINE - Police stations.

Mr VALENTINE - What about emergency services facilities?

Mr HINE - As in SES and Fire?

Mr VALENTINE - Yes.

Mr HINE - That is a different category and probably brings me back to why we have no performance indicators to SES, because they are actually not out of government appropriation and under of the fire service commission.

CHAIR - We will go there in a moment.

Mr HINE- Remind me to answer the question in relation to the fire service and the SES; maybe Mr Crawford would have the information about the number for infrastructure.

Mr CRAWFORD - Not here, commissioner [inaudible]

Mr VALENTINE - That is okay, I was trying to get an indication not after the hard and fast.

CHAIR - I will move to State Fire Commission.

State Fire Commission

CHAIR - When you are ready, minister, you can introduce your new team members.

Mr FERGUSON - I would like introduce to the committee Chris Arnold, Chief Officer of Tasmania Fire Service, and Mr Bruce Bryatt, Deputy Chief Officer, TFS.

Mr GAFFNEY - In the outline it said further information on the commission can be found at www.firetasgov.au. I went to the annual report and I congratulate the commissioner on that report. There are some questions associated with that which reflects onto the fire commission.

I noted in the annual report the UFU and the LGAT were vacant. Have these positions been filled and if so, by whom? It was on page five of the annual report from 2017-18 -

> At the time of preparing this report the vacant position for United Firefighters Union rep had not been finalised, as is the case of vacant position of Local Government Association of Tasmania

I am wondering if that has been filled.

Mr FERGUSON - We are working through vacancies. The current vacancies been filled are in regard to LGAT and the two people who have been appointed are Chris Hughes and Graham Brown.

Mr GAFFNEY - Nobody from the UFU?

Mr FERGUSON - Not at this time.

Mr GAFFNEY - In reading some of the recent *Hansard*, could you provide the sources and amount of revenue for the State Fire Commission, as it often comes from different revenue sources and I would like that on the record where the money is coming from.

Mr FERGUSON - Can I ask Todd to advise the committee of the various sources for funding.

Mr CRAWFORD - I will use 2019-20 Budget figures: the fire service contribution with a budget of $48 145 000; Insurance Fire Levy, $20 million; state government contribution, $3 451 000; Motor Vehicle Levy, $9 million, fire prevention charges, $6 361 000; sundry income $10 552 000; interest, $250 000; Commonwealth Government, $1 450 000, with a total revenue of $99 209 000.

Mr GAFFNEY - It is significant and the reason I raise it, in independent chair Rod Sweetman last year noted there was budget surplus of $4 million or so. He said -

> The unexpected increase in variable revenue streams had assisted the organisation to ensure the cash division was better than predicted.

He also warned -

> This cannot be relied on to continue in future years. There continues to be a need to keep expenditure within budget to manage any unforeseen expenditures that may impact on planned expenditure.

So notwithstanding the complexities of the commission and its funding stream, what measures has the State Fire Commission employed to maintain tight control over its 2019-20 budget? How do you keep control over the budget? How does that work?

Mr ARNOL - Thank you, Mr Gaffney, thank you, minister.

To go back to the revenue, there is a bit of volatility, particularly in the insurance revenue, which is about 20 per cent of our revenue. It could very easily move into $2 million difference but there are some issues around that.

There are also some ups and downs with the other side of that with our workers compensation and things associated with that. However, to keep control of or to manage our finances, we have had a review, and our finances are under Wise Lord and Ferguson. Taking stock of that review, we are or have implemented all recommendations. Some are ongoing because we have a monthly expenditure review committee, a budget oversight committee. We have established the budget oversight committee just prior to the review, but post the review, we have an expenditure review committee that looks at all our budget centres to make sure that we stay on track with the various cost codes within those budget centres, particularly the ones that have some movement in them.

Mr GAFFNEY - Thank you for that. The review you were talking about is not the independent review by Mike Blake that was started in August-September? It started with Mr Harris I think. That is a different process?

Mr ARNOL - Correct. It is an independent review by an internal auditor we've asked through the department. It was completed, it was done. Wise Lord and Ferguson is an auditing company. We use their services fairly regularly. And, yes, it is a different review to the Blake review which is now continuing.

Mr GAFFNEY - Interesting, and that is my next question. The Blake review, we will call it that now. Comment on the issues paper was completed by 7 September 2018. What is the process now? What is the timeline? When do you expect that review to be completed and to improve the service or take [inaudible] with what Mr Blake is assessing?

Mr ARNOL - It might be problematic to call it the 'Blake review' given the Blake review into the recent floods.

He is a great servant of our state and I am glad that he was able to pick up the work by Mike Harris.

Mr Gaffney, I am happy to take further questions.

I will go back a step. The steering committee for the review developed a project plan to meet the work required to undertake the review. This included identifying problems, developing options and making recommendations. An issues paper was prepared for public consultation to inform the content of this work. As you have said, submissions closed on 7 September 2018, and the draft options paper was prepared for feedback from the steering committee. With the departure of Mr Harris, the appointment of a new chair and the recent fires, a revision of that timetable and budget for the review has been necessary. Mr Blake is drafting proposals in this regard. We need to wait a little while to resolve that.

The next steps in the process will be for the steering committee to provide the chair with a draft report.

We feel it is important that there would be a further period of consultation. That would be before a final report is presented for consideration by the Government. There will be a second look at it.

Mr GAFFNEY - There is a detailed four-year plan for the firefighting appliance replacement program. I note the program includes the purchase or fabrication of medium tankers, heavy pumpers and aerial appliances. Could you explain to the committee what type of aerial appliances this program will cover? Is this the first time this concept has been tried in Tasmania? Are these appliances in use in other states or jurisdictions?

Mr ARNOL - To put it into context, heavy pumpers are urban machines that are for house fires. They go into our cities, they are a Scania type truck. They usually carry a career crew. We have an ongoing program where we replace one of those every year. We are about to get two in the new financial year. That will keep their life down to about 15 years, as we only have 15 of them. The medium tankers are more for our tanker-based firefighting in bushland. We have light, medium

and heavy tankers. We are into the medium tanker build at the moment and we will be rolling those out predominantly to volunteer fire brigades. Occasionally they'll go to our permanent paid staff as well.

The aerials that you speak of are what we have received $3.75 million for two years ago to procure. They are what we call aerial apparatus, not to be confused with aircraft. They are basically a ladder or a boom appliance that you can elevate so firefighters can fight fires from an elevated position. They are used for other things such as observation and a number of purposes but that's essentially what they are. There are all sorts of types. There are even combination pumper aerials. There's a range of things you can buy or purchase off the shelf.

At the moment we have gone through a process and identified a preferred supplier. We haven't gone into consultation with what the exact design will be, although we have an aerial strategy because the current aerials we have are what we call Simon Snorkels. They are based in Hobart, Launceston and between Burnie and Devonport, we vary where we locate there. There are three of these unique apparatus around the state. It's our intention to replace those because they are fast running out of life or out of compliance. We will need an extension on our compliance for the first two. We'll probably need to replace a few hoses to make sure they're still compliant, that sort of thing. We will get an extension on compliance so that we can have them replaced in a seamless way. The type of apparatus we might procure is not determined yet but we are considering both the ladder, which is just an extension ladder that could go 40 metres, or an articulated boom. So there are a couple of options. They have different attributes. Some can go below ground level and others can't, there are restrictions on how they're used.

Mr GAFFNEY - Just a quick one on the build of your medium tankers. Is that manufacturing happening here in Tasmania?

Mr ARNOL - Yes, I'm very proud of the fact that we manufacture all our tanker fleet. That's now under our business and executive services arm. That's still at Cambridge. We build our light, medium and heavy tankers. We fabricate some of our specialist units like our rescue units. Others, like the pumpers and these aerials, we won't do much. We'll buy them off the shelf, but we will have them built to our own specifications. The pumpers will come off the ship onto Tasmanian soil and they'll be all ready to go and equipped.

Mr GAFFNEY - With regard to the employment of SES regional planning and development officers over the next four years, has a strategy for the officers working with municipal authorities been developed? Working with committee of local government reps, SES, meeting regularly as required, briefing, there is funding there for those positions. I am wondering how those positions will be managed and how will they relate to the different communities?

Mr BROCKLEHURST - At the moment the three regional managers for SES have a dual hat of responsibility in looking after emergency management and also response. As I mentioned before, one of the key findings and recommendations out of the Department of Justice review was that we improve our resourcing to supporting the municipal emergency management committees. These three positions are going to do that.

There is a bit of a change process to manage that relationship. We are going through that process of bringing those people on board and clarifying roles and responsibilities as it will affect other positions as well that we need to work through.

Mr GAFFNEY - I thought that one of the duties for that was education support. How do you see educating whom and what?

Mr BROCKLEHURST - Okay, that would be providing assistance to the emergency management coordinators within each municipal area to help upskill other staff that might come on board. For example, we would provide assistance with the risk assessment process that they go through and providing education in that case; also assisting with their skill sets for emergency management and how that works; for example, introducing the AIIMS process, which is a standard tool that we use across that sector and how that would be applied within the municipal areas. This is that person who will get out and run workshops, supporting and facilitating that training.

Mr GAFFNEY - That is important because each of the areas are obviously markedly different. The commission's annual report describes the previous investments and predictive modelling for bushfire risk. It appears that this focus was extremely useful in forecasting danger levels.

Mr FERGUSON - Let me introduce Chris Collins to the committee, the Acting Director of Community Fire Safety.

Mr GAFFNEY - Thanks, Chris. It is about the predictive modelling for bushfire risk. It appears this focus was extremely useful in forecasting danger levels and implementing the appropriate fire bans and rapid weighted response strategy over the summer of 2016-17. Was the modelling effective over the 2017-18 season? There was some comment that it was effective in 2016-17, but are there inadequacies or areas for improvement?

Mr ARNOL - In a word, yes, it is the same modelling we used. We were able to identify what fires were our priority. There is quite a process by which we do that. We weight certain elements of wish to the community, whether it's life, property or the environment. We gauge what our priority fires will be through the predictive modelling and the impact it can have.

As far as the detail of the modelling we use, I am happy to refer to my colleague and Acting Director of Community Fire Safety if you need any further information on that. By and large we have a very robust process. We are advancing that somewhat with the Bureau of Meteorology to make it even better into the future.

Mr COLLINS - I would add that this last season posed challenges in predictive modelling, that is for sure. All of these events are learning opportunities and as the chief has rightly pointed out, we are actively engaged with the Bureau of Meteorology and the Australasian Fire Authorities Council across the industry to build capability at the national level.

This season we saw our counterparts from across the country coming to assist us, building additional capability nationally in that space.

Mr GAFFNEY - We have discussed the $500 000 and how that is going to work over the next three years, but I was also pleased to read about the remote area teams training initiative. There is no allocation in 2022-23. Has this program been undertaken in Tasmania before? How many volunteers are expected to undertake the training and how long do the courses take? Is the training a one-off or will regular requalification be required? What is the background to this training and how will it be introduced into the area?

Mr FERGUSON - I welcome back Mr Bruce Bryatt.

Mr ARNOL - There are a number of points in your question. The current remote area capability in Tasmania consists of our career firefighters as an opt-in. We have approximately 80 out of our approximately 320 firefighters who are able to deal with the fitness elements to do this arduous work in remote firefighting, and Parks has approximately 89. That is about the capacity, and I can't tell you how many Sustainable Timber has.

That is the land management agencies' firefighters' primary function. Firefighting in those respects are classified in fitness as well, whether it be arduous or not, but the arduous requirement is there.

The AFAT [?] review of 2016 recommended that we consider using volunteer firefighters to do similar work. Our volunteers are tanker-based trained so we can access fires with bushfire tankers but we haven't got other types of training, perhaps that are more adventurous where we are putting people in place through helicopter transportation and so on.

We received $535 000 over a four-year period to implement remote area firefighting as a subsequence of that recommendation. We will shortly appoint a person who is under the State Operations Centre to do that and a couple of other tasks. We have done the planning for what that might look like.

I can also inform you that over summer, whilst we had support from interstate to fill a void in our capacity, we only at one time needed to have 70 remote area firefighters in addition to the Tasmanian remote area firefighters that were deployed. The quantum was 70 additional at any one time in the state from interstate or New Zealand. The plan at the moment with our volunteer remote area teams is to build that to 80. They will be only teams of eight at a time. We haven't tested the waters to see if we just do some fairly quickly through recognition because I am sure there will be some capable people in our volunteer ranks that have already done this perhaps in another life and so on. The program will be supported by good collaboration we have got from New South Wales so that if we need to, we are able to access instructors there. We are assigning an individual station officer to take charge of that particular program that we will kick off.

Mr GAFFNEY - Thank you. The next quick questions you can take on notice and provide us with the answers because they are from the annual report - some clarification of some things.

On page 15, figure 3 of your annual report, there is no figure or graph for the number of accidental fire injuries per 100 000 residents for the 2017-18 period. Every other graph and table has a 2017-18 number. I am wondering if there is a reason for that. The 2015-16 number was very high and that is on page 15.

On that same page it also says: 'Due to the unavailability of the data, we are unable to supply figures for house fire insurance claims for this year's annual report.' Is that going to be in every annual report or is there only a problem getting those figures for this annual report? That might need to be explained.

On page 50 in the Auditor-General's report, I was interested in his assessment of the State Fire Commission. In 2017 there was $4 043 000 for reimbursement for Fuel Reduction Unit expenditure, but in 2018 there was $6 682 000. It says that the Tasmanian Government funded the fuel reduction program via the Department of Police, Fire and Emergency Management.

What is the figure allocated or expected to be for 2019 for fuel reduction? There was a significant increase from 2017 to 2018, I would imagine in light of some circumstances we have had. What is the likelihood of fuel reduction cost for the 2019 season? I am not sure if you want to provide that now. If you can, that would be helpful, minister.

Mr FERGUSON - I certainly can, in part, and let us tag team again. We are certainly providing ongoing funding for the fuel reduction program. It has been singularly successful. I do not have the brief in my hand but when I went through this it has actually reduced Tasmania's bushfire risk exposure by approximately 5 per cent, which is a really significant statewide average. In certain localities it has been much more than 5 per cent. In some cases, it has been 15 per cent. It has been a singularly successful program with large numbers of burns that have occurred and that is in the realm of 68 000 hectares, I recall.

That is going to continue, I do not know about the cost, let's say your language was the unit cost for burns? I don't have -

Mr GAFFNEY - It has the reimbursement for fuel reduction unit expenditure, according to the Auditor-General's report audit, was $4 000 043 in 2017 and $6 682 000, which is a big increase. I was wondering what it is intended for in the next -

Mr FERGUSON - The chief has the answer.

Mr ARNOL - This is a new initiative and in the first year we did not need to spend the money so we have hit our maximum now with $9 million which, we are delighted, is funded in perpetuity now. For the first couple of years we had to do our planning, so we could not do the burns and we could not expend the funding. Then we did a little bit more, hence the increase and we got more active in our burns. We ended up with about four times as many burns planned at we actually do because it depends on the vagaries of the weather as to whether you can get to them, the windows of opportunity.

That is what has created that difference as we have progressed through. That has been growing the program to get to its maximum. Now we are quite confident that other than the vagaries of the weather that we can now mount a solid program and make sure that we use the resources that are given by government to implement these burn programs.

CHAIR - Just on that point, if I might. Does the cost vary with the location of the burns, some are more remote and more difficult to get to?

Mr ARNOL - Yes, there is a variance depending on whether they are in an urban setting or whether they are in a remote setting. What we have been focusing on at the moment we need to get to landscape-scale burns eventually. At the moment we might do a small burn at Tolmans Hill that may only be 25 hectares because we want to make sure that the urban interface is safe first and then we will move it out to landscape scale.

In those first couple of years, we did a review and I think that gave the Government confidence. The review gave us good information about how solid the program was and how well it was working, I think that gave the Government confidence that that was underway.

CHAIR - They gave you some more money then.

Mr ARNOL - That was done by Mr Ewan Waller from Victoria. No, we were confident we were there but it was only funded for the out years so we only had about four years of funding then. So that locked that in for us, which I thought was so good. And we now have a program that I am proud to say is the best in the country.

Mr GAFFNEY - And just one last little question here. Somebody has had a review but there is no footnote on it I can understand. In 2017 there was $1000 spent on long service leave for employee-related expenses. In the following year there was $882 000 so something, (inaudible) or get some of these people to take long service leave. You can come back to me where that recommendation came from because it had to come from somewhere for that to occur.

And my last one is, is there anything I had to ask you that I haven't?

Mr ARNOL - The 2017-18 fire deaths (?)is probably because we had none. We have been very good with our fire(inaudible). You are the first party to ask the question. The other one was the annual report, which had the caveat on the annual report. We will have to try to find that information for you as with the Auditor-General's information. We certainly have a legal liability that we have to manage, long service and annual leave that we - I will try to get you an answer on that.

Mr FERGUSON - Would you like us to take it on notice?

Mr GAFFNEY - It is nice to see if somebody has recommended you do something about your long service leave and you have, I think that is good.

Mr ARNOL - We monitor the executive leadership team of the TFS and the SES through exception reporting each month. In fact, we had it out this morning. So long service and our annual leave and the plans to get that leave liability down. We do that every month.

CHAIR - What the Attorney-General was suggesting.

Mr ARNOL - Yes. So, it's part of that expenditure issue that you asked earlier about.

Mr GAFFNEY - Okay, thank you.

Mr VALENTINE - What do you do with your old stock, your trucks and the like? Do you ship them out to the west coast maybe where they don't have something like that, larger trucks? How do you deal with them?

Mr ARNOL - Thank you, Mr Valentine. When we have finished with our fire appliances and they are not suitable then we will sell them. People use them for firefighting but we do have a sale at our engineering services at an appropriate juncture. We just had one recently and it gives us an additional revenue sometimes, say $300 000 occasionally, depending on how we go with the sales.

That is how old light tanker fleet and medium tankers often just taking a chassis and used in the farming community and that's what we do with them. We do sell them with a caveat on them about the quality of the vehicle that they are purchasing and to be mindful of that. Whether they register them or not register them and how they use them thereafter, it resides with the purchaser and they take it as is.

Mr VALENTINE - I don't think this question was asked but with respect to interaction with other states and the possibility of resourcing from the Commonwealth for major aerial services for fighting fires coming from the central unit that the Commonwealth might fund. Is that something that has ever been discussed between the states, through you, minister?

Mr ARNOL - Do you mean aircraft?

Mr VALENTINE - Yes, I am talking about heavy water-bombing aircraft for something like the wilderness fires that we had, for instance. If they had got on top of that with heavy water-bombing aircraft they may well have saved a lot of the damage that was done. I know you can't always tell that something going to escape but if there was a central availability of fire equipment that the Commonwealth maintained, it could work well between the states. I was wondering if that has ever been discussed as a possibility?

Mr ARNOL - In short it certainly has been discussed as a possibility. Let me firstly make the point that aircraft are not the silver bullet. Aircraft are one mechanism that we use. Aircraft are very important and expensive. You will be able to see in our price suppression costs that they were the majority of the costs this year.

We use aircraft to hold the fire until we can get the boots on the ground to suppress the fire totally. That said, one of the things that I have implemented since being appointed is what I call rapid (inaudible) of response, that everyone knows that we will do (inaudible) response on the ground and with the air and it has worked beautifully. We put 36 fires out of all new starts that we got this summer using that weighted response. That is not to say we didn't have lots of other fires too.

Mr VALENTINE - Where do you get your aerial essentials?

Mr ARNOL - Coming to what the national aerial firefighting centre and that is coordinated nationally. We have jurisdictional representation. A healthy trial in Tasmania. So, we have a joint state and Commonwealth arrangement for contracts that we set up in Tasmania. We reviewed that recently and the aircraft that we use in Tasmania are five fixed-wing aircraft and two suppression rotary wing choppers and two fixed-wing aircraft. That is our complement in Tasmania. The report I asked for which recently gave us that as the ideal component for those set contracts that come on at different times during the summer and go out different times during the summer. That said, the experiences over summer may mean that we might revisit that, although that has been set out for about five years.

There are available to us through this national aviation fire centre or national aerial fire centre an additional 70-odd aircraft which we can access and particularly you would have seen large air tankers that come from New South Wales and Victoria. We did access them and we even based them here in Tasmania over the summer so that is available to us. If you like it is a federal arrangement, although it supported through the fire services coordinated through the National Aerial Firefighting Centre. It is predominantly supported by Commonwealth funding, but each jurisdiction has a component and ours is about $1.1 million. The state provides partial funding to have a static component in place over the summer.

Recently, however, I note New South Wales has purchased its own large new tanker, there are different arrangements in different states.

Mr VALENTINE - With the Commonwealth coming in, does that mean it is going to be cheaper in the long-term to have those sorts of assets flying around or not?

Mr ARNOL - I do not know, that is quite a speculative question whether we are leasing or purchasing. In New South Wales, as I said, has decided they think it is better to purchase. They have already purchased other helicopters in the state. The general model is a lease arrangement over the summer, but we have been finding the summer seem to be extending and we have trouble getting the use. It has always been northern hemisphere aircraft come to the south for the summer and they go back to the north for their summer and we are finding we are having difficulty getting some of those things to work.

Mr VALENTINE - Thank you for the fulsome response.

CHAIR - There being no other questions, minister, we will let this part of your team go and we will have a five-minute break to bring your last group to the table in relation to Information Technology and Digital Services Strategy and Policy Development.

The committee suspended at 6.37 p.m. to 6.42 p.m.

DIVISION 9
(Department of Science and Technology)

Output group 3
Electronic services for Government agencies and the community

3.1 Information, technology and digital services strategy and policy development

CHAIR - Minister, if you would like to introduce your team at the table for *Hansard*, please.

Mr FERGUSON - Chair, I don't have an opening statement. We are happy to go immediately to questions. I am supported today and I am very grateful for these people who do a great job, Deputy Secretary Ruth McArdle, to my right Glenn Lewis, Chief Information Officer for the Tasmanian Government. David Briggs to my left, Director of Service Delivery and Operations.

CHAIR - Thank you.

Mr VALENTINE - I am interested what the forward focus is of this unit, and exactly what new initiatives there are in the wind when it comes to science and technology. E-government is in this, isn't it?

Mr FERGUSON - Yes, it is. Mr Valentine, you may not have caught the news. We have amalgamated the functions of the Office of E-Government and PMD, now known as Digital Strategy and Services. We are working together. Both Dr Lewis and David Briggs are in their respective roles within that unit. I will ask each of them to speak in answer to that question about how the unified approach supports Government cyber efforts, and digital transformation as well, together with the engagement with agencies to ensure that they are continuously improving on some of the antiquated systems that have needed a lot of close-the-gate activities, and modernise it to protect the security of it.

LEWIS - In terms of DSS, or Digital Strategy Services, it was formed really to develop a more cohesive and strategic approach, delivering digital services across the government. We are committed to leading digital transformation and we understand that there are significant opportunities for digital transformation across government, to improve both the services within government, the services government provide, and also the lives of Tasmanians.

We also recognise that there are risks and challenges with delivering digital technology and digital services, so we are taking a considered, evidence-based and measured approach, a fiscally responsible approach to delivering that. As part we are developing a digital transformation strategy for government which includes a number of initiatives some the minister has referenced, including cyber security and improving the cyber security maturity of the Tasmanian Government agencies, developing and improving project management and project management approaches and frameworks across government.

Mr VALENTINE - Still there?

Dr LEWIS - Indeed. That is a key part of what we are doing. Developing and improving information management and using evidence-base for information and data management delivering better, more integrated services across government, forming policy based on data and evidence and also developing and building digital capability. We are developing more skills across government for delivering digital services. They are the key aspects of what we are focusing on.

Mr VALENTINE - What about centralisation of back office-type functions in departments these days? Is that still fragmented or gradually coming together?

Mr BRIGGS - It is still quite fragmented. That is an area we are starting to do some initial investigation and see what opportunities exist. In areas HR systems for example, we have a project combining smaller agencies' systems into a single HR system. Most of that work is related to getting common processes in those smaller agencies and the easy bit technically is bringing the separate databases together. That is a start in the right direction. They are the kind of activities we are on.

Mr VALENTINE - You mentioned you are still doing project management guidelines. What is the traction like in all of the agencies? Is everybody following these processes and providing the various levels of reporting in their projects to make sure the projects are on track and those sorts of things or is there still a bit of reticence to engage?

Mr FERGUSON - It would not be Science and Technology Budget Estimates without you asking me that question.

Mr VALENTINE - I will keep asking that question and always interested in the answer.

Mr FERGUSON - Now I know it is real and not a dream. I am very happy to pick up that. There has been increased focus on this, all agencies undertake project work and the DPAC's Digital Strategy and Service division is working closely with agencies s we promised to you in previous years to building strong consistency and capability in project management.

Mr VALENTINE - I am interested in whether it is happening.

Mr FERGUSON - It is happening. I would put the point respectfully to you in the Estimates we have just been through with Police and Emergency Management. you are seeing that. The point about facilitating whole-of-government project management framework and that would lead to value for money, better managed risks and deliver results. I feel quite satisfied that commitment we made to you in previous years is being honoured. I will ask Dr Lewis to add to what I have had to say, from his perspective who is more in the central role observing and supporting best practice in agencies.

Dr LEWIS - We have adopted a new project management framework and in the process of rolling that out and gaining adoption across agencies. That project management framework was originally developed by DPIPWE, in the spirit of not reinventing the wheel, we have engaged with DPIPWE and all agencies to agree to that being the project management framework for all of government.

Mr VALENTINE - What is that called?

Dr LEWIS - We are referring to is as the Tasmanian Government Project Management Framework. It goes through all the standard phases of project management, from initiation right through to the post implementation review and benefits analysis. In particular, we are focusing on the project initiation and making sure people understand what the project will deliver and why it is being done, what problem it is going solve. We are trying to focus on this, then driving through the adoption of project delivery and ensuring we are getting the outcomes the project is intended to deliver.

Mr VALENTINE - Do you still have staff go out to departments and project manage for them because they do not have the resources to do that?

Mr LEWIS - No, there is not that pool of resources that go out to agencies but we have developed a community of practice. We have a good community across government to facilitate and drive project management.

Mr VALENTINE - They look at the guidelines and refine them as necessary?

Mr LEWIS - Yes, to refine, work through and facilitate that adoption on a whole-of-government perspective.

Mr VALENTINE - You can't say much about digital security. I don't know what I can ask you about that without putting myself in hot water.

Mr FERGUSON - That's enough to go on with. Dr Lewis and I will take you through some updates on that. It has been an area of concern to us and I appreciate the way you have asked the question because we are often reluctant to talk about known risk. It is a real issue for every government. We established the Tasmanian Government Cybersecurity Program through a previous budget, which is $300 000 per annum to coordinate and mature our cybersecurity capability. The aim of this program is to mitigate cyber-risks and improve cyber-resilience of our infrastructure and services.

As much as anything, there is the other work of promoting cybersecurity awareness among agencies to cascade through their agency to their staff. I speak from a central advisory and policy development point of view. Nothing changes that each agency has responsibility to invest in and

establish their own cybersecurity capability and resilience within their individual businesses. They do that with Dr Lewis' and the unit's support.

I can tell you a couple of things you will find of value. Since last Estimates, we have developed the cybersecurity policy, which Dr Lewis will be well-positioned to go into if you want. That has been developed in setting out roles, responsibilities and expectations for agencies to manage cybersecurity. A working group of agency cyber-professionals is developing cyber-standards to ensure government systems are resilient to threat. Agencies are establishing cybersecurity teams to plan and implement preventative measures and these teams also increase the government's ability to detect and respond to threats.

You may have heard about the Australian Cyber Security Centre's Essential Eight. Work is progressing on implementing that, which is helpful advice from our national counterparts. As a part of this, agencies are implementing things including application whitelisting, restricting use of administrative privileges, increasing patching frequency and deploying multi-factor authentication. Agency cyber-teams are implementing data backup, business continuity and physical access controls for IT equipment rooms, which is simple and obvious, yet overlooked in the past.

Feeds from a range of threat intelligence services focus effort on potential weaknesses and action required to prevent these causing harm. We have a very high level of intergovernmental support and information-sharing. Agencies are receiving training on cyber-risk management, analysing threats, information management systems and exercising cyber-incident plans.

The government is also participating in the Australian Government Cybersecurity Programs to exchange cybersecurity knowledge with other Australian governments and industries. The best update I can give you is one that tells you we have responded to a threat and came out of it extremely well.

On 7 February, you would be well aware there was a significant state actor who had gained unauthorised access to the Australian Government's Department of Parliamentary Services network. Significant concern was expressed between governments that it may have affected other state and territory systems. The Australian Cyber Security Centre provided a scanning tool to the Tasmanian government, every other government and our parliament, which we were able to use to scan all of our servers across every agency and within the parliamentary networks for signs of the same incident. There was a bit of a concern that that might have occurred.

CHAIR - When was that, minister?

Mr FERGUSON - In the first half of this year. That was an extensive period of intensive scanning using a tool provided to us. I'm pleased to advise that we sent the scanning results back to the Australian Cyber Security Centre for analysis and I am advised it has not detected signs of this intrusion in Tasmania. We wondered for a little while, but I'm pleased to give you that report.

Mr VALENTINE - Thank you. That is comforting.

Mr FERGUSON - It has been an excellent exercise, if nothing else, to encourage people to think along the right lines, being vigilant about cybersecurity.

Mr VALENTINE - Enough said about all that. What are we doing as a government to encourage good digital innovation? Do you work with the university in looking to provide

opportunities for individuals to work in digital innovation? Do you encourage graduates to work in this area? Are there any projects or opportunities you provide or is that not something you see as -

Mr FERGUSON - I don't know if I'd specifically single out university engagement but we are working with industry via the portfolio of State Growth. Work is currently underway through partnership between government, TasICT and the Australian Computer Society to develop an updated work force development plan. We want it to be less word and more action-oriented and it is with that in mind that work has recently commenced. We are looking for that to be a pragmatic approach to how each of us in our relevant sectors can ensure we are training the next generation of ICT professionals in a fit for purpose way. There is a role for government, for the government owned-provider, TAFE, for example, and the University of Tasmania.

I might ask Dr Lewis to come back to the digital transformation, which is outside your area of responsibility but we keep a tab on what agencies are doing to transfer services to be digitally ready. The Co-ordinator-General has been assisting government and we are currently in the market for an accelerator program, which is about supporting growth-driven companies in our agri-tech, marine-tech, smart cities and internet of things sectors at the earliest possible stages. I don't have the dollar amount to hand but it is about $900 000 currently in the market. We are looking for that potential organisation to step up to be part of supporting our industry to be exactly as you've asked; taking innovation to market rather than simply building cool things.

Mr VALENTINE - What are your science and technology centres, your enterprise hubs, at $370 000 over four years, specifically aimed at achieving?

Mr FERGUSON - Mr Valentine, the enterprise hubs we've established in Hobart and Launceston are ongoing. The fund you've specifically named is in addition to that. When the accelerator initiative is completed it will work in tandem with the enterprise hubs because they are centres were people are gathering. The budget commits the $360 000 you refer to -

Mr VALENTINE - It's $370 000, I think.

Mr FERGUSON - I have $360 000.

Mr VALENTINE - No, go on. It might be my mistake.

Mr FERGUSON - If you're thinking of something different, please let me know. Budget commits the $360 000 for a broader scope of activities under the Science and Technology portfolio. That consists of enhanced STEMM engagement, highlighting career paths, building Tasmania's science and technology profile and brand, increasing knowledge, awareness and foresight of future industry trends and addressing critical science and technology infrastructure investment priorities. We're not yet in a position to release that but we're working on it right now and we look forward to saying more about it later in the year.

Mr VALENTINE - Okay, thank you for that.

CHAIR - Thank you, minister, we can wrap up. We've all had a long day. It is an interesting area, and there's a lot of potential and opportunity, thank you.

Mr FERGUSON - You're most welcome and thank you to the committee. I look forward to your letter and we'll respond to your questions in a prompt manner.

CHAIR - Yes, we'll have a brief meeting to make sure we have all of them and remove any you've answered.

Mr FERGUSON - Okay.

CHAIR - Yes, thank you.

The committee adjourned at 7.02 p.m.