PARLIAMENT OF TASMANIA

TRANSCRIPT

LEGISLATIVE COUNCIL

ESTIMATES COMMITTEE A

Hon. Bridget Archer MP

Wednesday 19 November 2025

MEMBERS

Hon Ruth Forrest MLC (Chair)
Hon Dean Harris MLC
Hon Sarah Lovell
Hon Cassy O'Connor MLC
Hon Bec Thomas MLC

OTHER PARTICIPATING MEMBERS

IN ATTENDANCE

HON. BRIDGET ARCHER MP
Minister for Health, Mental Health, and Wellbeing, Minister for Ageing, Minister for Aboriginal Affairs.

Ministerial Office Representatives

Chris Medhurst
Chief of Staff

Megan O'Brien
Senior Adviser, Health

Jill Maxwell
Senior Adviser, Aboriginal Affairs

Ben Davidson
Senior Advisor Health

Georgia Virgona
Clinical Adviser, Health

Melissa Snadden
Senior Adviser, Health

Melita Griffin
Senior Adviser, Mental Health and Wellbeing

Jorden Gunteon
Adviser, Ageing

Aboriginal Affairs Portfolio

Mellissa Gray
Deputy Secretary, Policy, and Reform, DPAC

Rebecca Pinto
Executive Director, Community Partnerships and Priorities, DPAC

Caroline Spotswood
Director, Aboriginal Partnerships

Jason Jacobi
Secretary, NRE

Louise Wilson
Deputy Secretary, Environment, Heritage and Land, NRE

Will Jocelyne
General Manager (Heritage) NRE

Steve Gall
Director (Aboriginal Heritage Tasmania), NRE

Deidre Wilson
A/Chief Operations Officer, NRE

Anita Yan
Deputy Chief Operations Officer, NRE

Adrian Pearce
Manager (Finance), NRE

Health, Mental Health and Wellbeing Portfolio

Dale Webster
Secretary, Department of Health

Sally Badcock
Associate Secretary, Department of Health

Prof Dinesh Arya
Deputy Secretary CQRA, Chief Medical Officer and Chief Psychiatrist

Anita Planchon
Executive Director, Office of the Secretary

Brendan Docherty
Deputy Secretary Hospitals and Primary Care

Jen Duncan
Deputy Secretary Hospitals and Primary Care

Craig Jeffrey
Chief Financial Officer

Kyle Lowe
A/Deputy Secretary Systems Management and Reform

Andrew Hargrave
Deputy Secretary Infrastructure Services

Michelle Baxter
A/Chief Executive Ambulance Tasmania

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Kim Ford
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Craig Jeffrey
Chief Financial Officer, DOH

Kristy Broomhall
Assistant Director, Community Services

The Government Budget Estimates Committee A met in the Legislative Council at 9 a.m.

CHAIR (Ms Forrest) - Thank you, minister, for appearing before the Legislative Council Estimates committees in your portfolios of Minister for Health, Mental Health and Wellbeing, Minister for Ageing, and Minister for Aboriginal Affairs. We will start off with Health. We did have a question: when you look at the systems management, did you want to do systems management for Health and then go on to the Health portfolios and then do systems management for Mental Health?

Mrs ARCHER - Whatever you would like to do is fine.

CHAIR - All right. We thought it would be better to follow all the Health ones and then do the Mental Health ones.

Mrs ARCHER - Whatever you like.

CHAIR - All right. You will have the same people at the table?

Mrs ARCHER - Yes, I think so.

CHAIR - Okay. If you would like to introduce your team at the table and then I invite you to make some opening comments and then we will go to questions. We will have a break about 11 a.m., just a short break, and then break at lunch, obviously.

Mrs ARCHER - Thank you, Chair. At the table I have the Secretary of the Department of Health, Dale Webster; the Associate Secretary of the Department of Health, Sally Badcock; and the Deputy Secretary CQRA, Chief Medical Officer and Chief Psychiatrist, Professor Dinesh Arya.

It's my pleasure to speak to the committee today about our strong investments into the vital, important areas of Health, Mental Health and Wellbeing in the 2025-26 state Budget. The health and wellbeing of Tasmanian families and communities is our number one priority and this budget reflects that with record investment of nearly $10 million every day into our health system. Health makes up more than a third, 34 per cent, of the entire state Budget, which is ensuring that we can continue to deliver better care to Tasmanians when and where they need it most, while responding to rising demand, especially in our hospitals.

Specific investments in this Budget include over $70 million to implement our new four-year elective surgery plan which was launched in June. This follows our first four-year plan which saw a record number of elective surgeries delivered for three years in a row. Over 22,500 elective surgeries were performed in 2024-25, more than 61 surgeries each day, and there has been a 46.1 per cent increase in the volume of elective surgeries conducted each year compared to the level delivered prior to the first elective surgery plan.

We're also investing in more care options in the community. For example, applications for postgraduate scholarships are now open to help Tasmanian pharmacists gain full scope of practice credentials, which means that once trained, pharmacists will be able to access and manage more common health conditions such as ear infections, reflux, rhinitis and skin conditions including shingles, eczema and wounds.

In Mental Health, we continue to make significant investments to support the mental health and wellbeing of Tasmanians. Over the past decade we've invested $564 million to shift the focus on services from hospital-based care to community-based support, and this Budget investor further $62 million over four years for mental health, alcohol and drug services.

I'd like to take the opportunity to thank our workforce, the nurses, doctors, paramedics, allied health professionals and countless support staff who serve Tasmanians each day, and this Budget continues our investment into our health system to ensure that they can continue to deliver world-class care for Tasmanians.

Output Group 1 - System Management
1.1 System Management - Health

Ms LOVELL - We're going straight to 1.1?

CHAIR - Yes. Systems management.

Ms LOVELL - Thank you, minister, and just to flag, I will be asking this for all of the line items really, but the line item for systems management - System Management 1.1 has the budgeted line item for the 2024-25 Budget, 145,082. What was the actual amount spent under that line item in the last financial year?

Mrs ARCHER - It was $123,671,000.

Ms LOVELL - An underspend then, on the budget amount? Where did that come from? How was that?

Mrs ARCHER - I will ask the secretary to make some comments.

Mr WEBSTER - The reason for the underspend there would have been the shifting of dollars across our portfolios, across the outputs, to balance it. Systems management includes our grants program but also includes new initiatives we're doing. If the initiative was delivered in part of the agency, we would have moved it to that part of the agency. It results in an underspend here, but the money is actually spent elsewhere in the output.

Ms LOVELL - In terms of a global figure - because obviously that's broken down across a number of output lines - do you have a global figure for the amount spent in the Health budget compared to the total amount budgeted for Health in the last financial year and for this year.

Mr WEBSTER - The global actual figure is $3,350,422,000.

Ms LOVELL - The actual is $3,350,422,000.

Mr WEBSTER - Excluding capital.

Ms LOVELL -What was the budgeted amount for 2024-25?

Mr WEBSTER - Budgeted amount - that's a good question. My team is going to hand it to me. The 2024-2025 budget was $3,130,735,000.

CHAIR - That's across mental health and wellbeing too. Is that what you're after Sarah?

Mr WEBSTER - Yes, it's the total for the department. Of course, there was a supplementary appropriation of $345 million in February of 2025 that needs to be added to that. So, the budget figure is not what was actually appropriated because of the supplementary appropriation.

Ms LOVELL - Yes, I understand that. Do you have the global total amount budgeted for this financial year?

Mr WEBSTER - The 2025-2026 total is $3,552,780,000.

Ms LOVELL - Is that including capital?

Mr WEBSTER - That includes capital, yes.

Ms LOVELL - The other figures you gave me before, did they include capital? I thought you said they excluded capital.

Mr WEBSTER - The budget figure I gave you included capital and I can give you the total actual, including capital, which is $3,578,682,000.

Ms LOVELL - So, $3,578,682,000 was the total actual, including capital.

Ms THOMAS - Including the supplementary appropriation?

Mr WEBSTER - In the actual figure, that includes the supplementary appropriation.

CHAIR - If I can confirm, the supplementary appropriation was all operational, wasn't it? There was no capital in that.

Mr WEBSTER -Through you chair, yes.

CHAIR - So, no extra capital, just operating. Sorry Sarah, back to you.

Ms LOVELL - That's okay. Just so I can be clear, then the total actual amount including capital - the amount spent is higher than the total amount budgeted for this year, including capital. Is that correct? 3578,682 total actual including capital for 2024-25, and the 2025-26 total budget including capital is 355,2780.

Mr WEBSTER - It doesn't exactly work like that, because the capital figure obviously goes up and down depending on what buildings we're doing, et cetera. So, there is an increase in OpEx between the two years and -

Ms LOVELL - Budget to budget, or action to budget?

Mr WEBSTER - When you include the Commonwealth money, et cetera. Table 6.5 on page 105 gives you a more breakdown of where the money comes from, et cetera.

Ms LOVELL - I appreciate it's complicated; it's a complicated funding model and it's not easy to explain, but it's a critical part of what we're talking about so people can understand it in the simplest terms possible. Take the capital expenditure out, just talking about operating expenses, do you have a figure then for operating expenses for actual spent in 2024-25 compared to what's budgeted for this year -

CHAIR - Across all Health and Mental Health and Wellbeing?

Ms LOVELL - Yes.

Mr WEBSTER - The total operational actual for 2024-25 is $3,000,350,422.

CHAIR - And then the budget for this year?

Ms LOVELL - Thank you - yes, and then the budget for this year?

CHAIR - Just for OpEx.

Mr WEBSTER - The budget for 2025-26, excluding OpEx -

CHAIR - No, excluding CapEx.

Mr WEBSTER - Sorry, CapEx. $3,315,814,000.

Ms LOVELL - Okay. So, that's quite a bit lower.

CHAIR - I will do the maths for you, if you'd like.

Ms LOVELL - Yes, thank you.

Mr HARRISS - If my writing is correct $34,608,000.

CHAIR - Dean's on it, I will check it with a calculator.

Ms LOVELL - So, $34 million less budgeted compared to what was actually spent last year. Where will you find that and what cuts will there be?

Mrs ARCHER - I would reject the notion, you're suggesting that would mean there are cuts. Health is demand-driven and will respond accordingly to the demand, but I will ask the secretary to make some more comments in relation to that.

Ms LOVELL - Well, I guess my question is that's what's in the budget. We see this every year; we see a budgeted amount that we end up topping up through the year. We all understand how health demand works. But you're planning to spend $34 million less this year than you did last year. How do you plan to do that?

CHAIR - Dean, I've confirmed your figure of $34.6 million.

Ms LOVELL - It is $34.6. Thank you. Thank you, Dean.

Mr WEBSTER - Our planned expenditure is the figure I've just given you, if you go to table 6.5 and our planned income is in fact $3,552,780,000.

Ms LOVELL - Sorry, where's that?

Mr WEBSTER - In table 6.5 -

Ms LOVELL - Sorry, I'm looking at the table - where in the table is that 3.3 -

Mr WEBSTER - Sorry. That's the total expenses after CapEx. And the total income, if you look at the top of the table -

Ms LOVELL - Sorry, Dale. $3,552,780,000 - that's the figure you just -

Mr WEBSTER - That's including CapEx of our expenditure. Our revenue, if you go up to the income side, is $3,675,377,000.

There is flexibility within the budget in terms of our expenses is what I'm saying because table 6.5 takes in all our sources of revenue, including income that's generated through insurance claims and income from the Commonwealth Government, income from federation funding agreements, private patients, et cetera, so 6.5 is the total envelope, whereas the preparations, et cetera early in the table at state budget and smaller amounts.

Ms LOVELL - What was the total revenue for last year then?

Mr WEBSTER - The total actual revenue $3,572,018,000.

CHAIR - What was it? $3,572-

Mr WEBSTER - Million, and $18,000.

Ms LOVELL - That was higher than was expected?

Mr WEBSTER - Because it also includes the extra $345 million that was in the supplementary appropriation; the actual figure does rather than the budget figure doesn't because the budget figure comes from the 24-25 budget and doesn't take in the supplementary appropriation.

Ms LOVELL - You can see why this is hard for people to understand. That's kind of the point of what I'm trying to get to here is drill down as much as possible so we can get a clear picture of what's actually happening with the health budget. So $675,377 million is the expected total revenue for this financial year, which gives you a little bit of room on top of the total expected operational expenditure.

But you're still budgeting to spend less than last year and that's reality across all agencies. We understand that there are efficiency dividends in place.

Mr WEBSTER - Yes, we are through a number of activities.

Ms LOVELL - Can you talk through some of that, what sort of savings you're expecting to see from where?

CHAIR - Particularly, if I might just come behind that why this is really important, the Treasurer basically told us the chance of having a supplementary appropriation this year is probably nil, which I don't believe. But just having said that, you stay within in your budget and that's it.

Ms LOVELL - The other question I've got related while you're looking at it, just trying to save you a bit of turning papers, what the quantum of savings is that you're expected to find. Again, it's complicated, it's hard for people to follow because there's been efficiency dividends on top of efficiency dividends on top of, for the last few budgets. In terms of this financial year, what is the total efficiencies that you're expected by the Treasurer to find in the Health budget?

Mr WEBSTER - I will start with the total, which is $44.95 million, and then work through where we're finding that. The first thing we're doing is looking at our leases and for instance, we're consolidating across Hobart. We've moved people from 50 Elizabeth Street, which had a lease ending into 22 Elizabeth -

Ms LOVELL - Admin staff, are they specialists, clinicians, what sort of accommodation was that?

Mr WEBSTER - Health and ICT staff are in 50 Elizabeth and they've moved into 22 Elizabeth. I highlight that one because the lease costs are incredibly high in Hobart, but for those sorts of spaces. Close to a million-dollar saving just in consolidating there. Doing a lease consolidation right across the state is firstly, one of our initiatives.

The second area is looking at our how we contract across our regions to where there is efficiency in and savings to be made from statewide contracts. We're moving to that and in fact through that process we've already identified $8 million of savings.

In terms of our contracting, in particular in items that have short or very defined use-by dates or best-before dates, whatever you want to call them, is in fact through our leasing or our contract arrangements moving from large amounts stored within the Department of Health and within the THS to just-in-time delivery type of contracts, so that we're storing less. Which reduces the risk of it becoming out of date and not being able to be used. There are several millions of dollars already identified in savings across that, particularly in pharmaceuticals.

Other examples, I'm just trying to bring them all to mind.

Ms LOVELL - Do you have a written plan? Do you have something, Minister, that you could table potentially?

Mrs ARCHER - We can take that on notice and come back.

Mr WEBSTER - Through the minister, our plan is actually called our financial sustainability plan, which we you'll see on our website where there's a number of references to it. On the other side of it, and this is reflected in that 6.5, is that there's a drive to increase revenue. Where we haven't been getting, for instance, our coding right. We put in a code that results in, say, one type of thing, but if we put in a different code and actually, we get far higher

revenue. We're making sure that we're actually doing reviews of coding, et cetera, to make sure we're maximising the revenue, getting our billing right as well for the private sector and insurance companies. That's actually driving revenue up as well; so there's an increase.

Ms LOVELL - To be clear, Minister, what I'm asking for on notice is if you have a table that will identify you've talked about $44.95 million worth of savings, whether you've got a table that would identify where those savings will come from with dollar amounts attached.

Mrs ARCHER - Will take the question on notice and come back with that information.

CHAIR - Can I just say on that last point, Sarah, just going back to ancient history when I was working in the hospital system. This was being talked about then, about proper coding, about making sure that your coded the patients correctly. This is 20 years later, we're still talking about it?

Mr WEBSTER - One of the issues we have is, literally, the doctor's writing and can you interpret into the code? Part of our Bluegum digital health strategy is in fact to put in an EMR that will pick up some of the coding things automatically by putting it in typed rather than handwritten notes. But secondly, clinical coders is actually a health profession and there's a massive shortage of clinical coders.

Having people actually interpret what's coming from the doctors into an MBS code or a, a private health insurance code is actually, it's a three-year degree course. Trying to actually get those people on board is also part of our issue.

Mrs ARCHER - They change over time, as well, the codes.

CHAIR - It just seems that this has been a measure to try and increase revenues for a very long time. Central transformation necessary.

Ms LOVELL - I was going to move on to another topic, if anyone had any questions on funding.

Ms O'CONNOR - Funding generally? I wouldn't mind exploring the key deliverables statement and the blank lines in the out-years while we're in systems management.

CHAIR - You still in systems management?

Ms O'CONNOR - It's a feature of this state Budget that there's these extensive areas of gap in the out-years. There's been an extra investment for example in the diagnostic breast screening, but there seems to be an assumption that there won't be the level of need that there is now or a greater need in 2028-29.

Apparently, we've finished ensuring that the Healthy Tasmania strategy is doing what it was intended to do -

CHAIR - Can I stop you, some of these things were picked up in other output groups.

Ms O'CONNOR - Sure. Thank you. There's a holistic picture that we need to establish -

CHAIR - I can just ask you to focus on systems management rather than financial because we will ask questions about these later on.

Ms O'CONNOR - I understand that. I just don't want there to be a different set of standards for me at the table. I'd like you to explain, minister, what the government's plan is in those areas of need, given what we've just heard about the need to find savings in a portfolio that's never been able to because the demand always increases, then the costs of meeting that demand always increase. What's the plan, in the out years, and including for home and community care?

Mrs ARCHER - Thank you. I might ask the secretary to talk more globally as you are asking for in this question, but we can look at those individual types of examples as well, if you like, like preventative health and the change in the Preventive Health Strategy. I'll just ask the secretary to make those.

Mr WEBSTER - I will start with the Healthy Tasmania strategy, we are doing the 20-year preventive strategy. That will actually reset what we're doing in this space. The Healthy Tasmania strategy has been a series of grant programs over the life of Healthy Tasmania, which is what this funding is for, the last year of those grant programs; but the Preventive Health Strategy, which the minister launched the consultation document for two days ago, we're looking at the longer-term strategy and how we actually do that in the long term. Healthy Tasmania is actually embedded within the Department of Health budget, so this one is the last year of the time-limited grants for Healthy Tasmania.

Ms O'CONNOR - Thank you, Mr Webster. I guess the question here is: in an agency that's told us the level of savings it's expected to deliver in this year, how do you rationally plan for what is going to be unmet need and increased levels of need? I'm glad to hear there's extra work happening in preventative health, because we've never invested enough in that and that shows in our chronic disease outcomes; but how can you rationally expect to meet extra demand given that you've got to find savings?

Mrs ARCHER - As I said, health is demand-driven and that fluctuates from time to time. What we have heard already today is really more around what I suppose you would call those administrative efficiencies. But at the same time as that - and I would use preventative health as an example - what we need to move towards is a reform in relation to the way that we address preventative health, for example: moving beyond - and they've been fantastic, the Healthy Tasmania grants have had measurable, evidence-based results that have given us an evidence base to work off for the Preventive Health Strategy, which has also had a very high engagement from Tasmanians in the draft consultation that's about to be released, but that is looking to move to a more whole-of-government approach to preventative health and actually having that focus, not just within the health budget, but also across portfolio areas as well; in much the same way, for example, as we would look to deliver on our Closing the Gap targets as well.

Ms O'CONNOR - Thank you, minister. Given what the Treasurer's really clear message was at the table this week, it's going to be an enormous struggle for you as minister, and the agency you administer, to be able to come close to meeting demand, let alone investing in such things as a whole-of-government preventative health strategy. Have you had a chat with the Treasurer about the reality of the portfolio?

Mrs ARCHER - Look, I think the Treasurer understands that, and that's reflected in the Budget continuing to heavily invest in Health, prioritise Health within the Tasmanian Budget. The secretary spoke earlier about the revenue side as well, and you would have heard me talking a bit recently about the National Health Reform Agreement, both in terms of maximising the revenue from the Commonwealth government but importantly, recognising that that is a reform agreement - the clue is in the name - and we would like to work more closely as part of these negotiations with the federal government around some of those reforms as well. Looking at these issues that we're having with stranded patients, for example, how can we be working more closely together to overcome these challenges which are creating challenges within our system, both in terms of access to hospitals in that case and consequently meeting demand. Did you want to make some more comments?

Ms O'CONNOR - I'm quite comfortable with that answer. Minister, obviously one of the pressures on the system is in elective surgeries and we can see in the Budget there has been an extra investment in trying to clear that wait list to alleviate some of the suffering that it embodies. In a media release on 7 August this year about elective surgeries -

CHAIR - Can we do this under 2.1, which is admitted services?

Ms O'CONNOR - We can, but there's a couple of questions I do need to pick up in the system -

CHAIR - I will go back to Sarah, and then come back to you.

Ms O'CONNOR - With respect, Sarah had a very long period of questioning before I was able to ask some questions, and there's some I'd like to get through.

CHAIR - We will get through them.

Ms O'CONNOR - Again, a slightly different set of standards.

Ms LOVELL - Minister, I've got one question about something that you just said, and then I'm happy for you to go back to Cassy for another question. I just noticed that you used the term 'stranded patients'; the Treasurer has used a different term. He's used the term 'bed blockers', and he used that in parliament. He also used it in the hearing on Monday on a number of occasions. When he was challenged on why that term is problematic, he showed zero willingness to consider not using that term or any understanding, really, of why it's problematic.

My question is, you've obviously used a different term. I'm going to assume that was a deliberate choice, but I ask you, do you understand why the term 'bed blockers' is problematic and will you commit to speaking to the Treasurer and the Cabinet, if it's required, about not using that term any longer?

Mrs ARCHER - I would speak to everybody, in fact it would be my message to all of Tasmanians, and it is one of the important issues in relation to the portfolio for Ageing as well is to not just reflect on ageing as a health issue, but also to look at positive ageing for Tasmanians to highlight positive ageing and to reduce stigma around ageing as well.

I can't be responsible for what other people say. I can be responsible for what I say. We collectively, have a responsibility to where we find the opportunity, as you have done, as I

would do now, to continue to talk to our community, to everyone in our community about reducing stigma and using inclusive language. That's something that I try to do, be responsible for my own conduct.

Ms LOVELL - You've talked about the community and the message to the community; do you agree that the Treasurer shouldn't be using that term?

Mrs ARCHER - I wouldn't use that term; I would encourage everybody to think about the words that they use, but as I said, I can be responsible for what I say and the message - and I'm very happy to promote that positive ageing message and the positive messaging and the inclusive language that we use. Sometimes in this place and probably in other parts of the community, but certainly in this place, from time to time, people can all maybe do better, but that's an important part of a sort of a continuous education.

It's important to not lose sight of the fact that we do have stranded patients in our hospitals and people that are through no fault of their own, unable to be in a home environment or with their family and friends or elsewhere. Of course, I would encourage all Tasmanians to be inclusive in the language that they use.

Ms LOVELL - We all acknowledge that has been a problem for a very long time. Specifically, though, again, you've talked about community and using the right language, but will you raise this with the Treasurer?

Mrs ARCHER - I'm raising it now.

Ms LOVELL - No. Will you raise it personally?

Mrs ARCHER - Certainly happy to raise it with the Treasurer, but I think it is a message for all Tasmanians.

Ms O'CONNOR - I'm interested in getting a picture of the health of the Health workforce. This is a question I asked last year, Mr Webster will recall. It would be helpful to have a picture of how many healthcare workers across Tas Health are on sick leave this year? How many are on workers' compensation? And the long-term absence data?

Mrs ARCHER - I can give you some general information. Paid personal leave - is that the information that you're seeking? Paid personal leave taken as a percentage of paid FTE was 5.33 per cent, which is an increase of 0.09 percentage points since June 2024.

Ms O'CONNOR - Do you have what it was at June 2019?

Mrs ARCHER - 2019? We might have to take that one on notice, Ms O'Connor.

Ms O'CONNOR - And do you have - does that cover workers' compensation and the workers' compensation costs to Tas Health?

Mrs ARCHER - The total number of new workers' compensation claims received for the 2024-25 financial year was 727. New claims for 2024-25 have increased by 16.3 per cent, compared to the previous financial year when 625 new claims were received; 72 per cent or

527 of new claims in 2024-25 were for physical injuries; 28 per cent or 200 of new claims were for psychological injuries, in that same period.

At the end of the first quarter of the 2025-26 financial year, 192 new claims had been received - which is slightly lower than the same time last year, which was 198 claims last year in that period; 67 per cent or 128 of new claims for the first quarter of 2025-26 year were for physical injuries, and 33 per cent or 64 were for psychological injuries. Those proportions are broadly in line with 2024-25. The cost of physical claims in 2024-25 increased 38 per cent and the cost of psychological claims increased 44 per cent compared to the previous financial year.

Ms O'CONNOR - Is it possible also, as with the last question, to have that data from 2019?

Mrs ARCHER - Yes, I think so. We will have to take it out on notice, though.

Ms O'CONNOR - And to assist our staff, is it possible to have some written record of the metrics you used, in order that we get the equivalent metrics for 2019?

Mrs ARCHER - I think so.

Ms O'CONNOR - It sounds like the hospitals are becoming less safe places if you've got claims for physical injuries soaring at that level. What's that about? What do the system managers understand that to be about, and how do you mitigate it?

Mrs ARCHER - Well, certainly there has been an independent review for Tasmanian emergency departments to identify opportunities to improve staff safety and security, including: considering the current security model and existing security and safety protocols as well as staff training and induction, and current physical security including CCTV, duress alarms, access control, and protective clothing. And, a safety and security steering committee was established to take immediate action and develop a long-term strategy.

From this work, a 10-point plan was created, which extends beyond emergency departments to cover all four major hospitals and hopefully, over time, all health services. The 10-point plan was launched in January this year, and key actions include:

- reviewing the hospital's safety and security model,
- including established, dedicated and highly-trained security teams in each region,
- introducing a new audit framework to identify priorities,
- developing a critical incident response model to ensure that staff get timely and appropriate support,
- updating security policies in managing challenging behaviours,
- enhancing training and education for staff,
- strengthening governance to oversee ongoing security improvements and ongoing engagement with union representatives and key stakeholders, and to support this new emergency department with further training underway.

There are regional project support officers working in the south, north and northwest to assist with the roll out of the 10-point plan.

A contemporary audit process is also now in place measuring performance against 50 security principles with the current focus on CCTV, duress alarms, facility access and security of pharmaceuticals.

A new security handbook has been developed to support staff with education and local risk-management, and there are additional initiatives including a communications campaign which you may have seen to promote respect for healthcare workers, encouragement of incident reporting, and installation of new CCTV cameras at the Northwest Regional Hospital, and also engagement with Work Safe to ensure that workplace safety remains front of mind.

Then there over the next three months the immediate priority areas include: developing a new specialised internal security model based on a proactive safety and support ethos; continuing close engagement with unions and key stakeholders; identifying and implementing a new accredited training model for occupational violence prevention which is scalable, adaptable and suited to all areas of health; establishing a statewide training delivery structure; developing a new support strategy for staff affected by critical incidents; completing a statewide policy gap analysis to ensure consistency across regions; and progressing work on requirements under the security of critical incident act and the protective security policy framework.

Ms O'CONNOR - Thank you, Minister. To get to the bottom of what these injuries are. From your answer, it's strongly implied that a significant proportion of those in injuries are about healthcare worker-to-patient interactions. Are you able to - Mr Webster's frowning - but I wouldn't mind getting some more granular detail on what kind of injuries we're talking about here. Are they - given that the focus seems to be in the plan on security measures and no other system measures to prevent injury. It would be good to have a more granular understanding of what those are.

Mrs ARCHER - Yes, and obviously they run across the full spectrum, both these types of injuries, but also workplace injuries in relation to obviously what can be quite physical work as well, and also at times a psychologically difficult working environment as well. I will ask the secretary if you can provide some greater detail.

Ms O'CONNOR - In that, is what we're seeing an increase in violence within our hospital system?

Mrs ARCHER - We're also seeing more - just to jump in before I hand to you - you're also seeing some more complex patient presentations, which is partly linked, I think, to that stranded-patient issue as well, for example.

Ms O'CONNOR - Frustration.

Mrs ARCHER - And just complex aged care patients, for example, with more complex behaviour, but I will ask the secretary.

Ms O'CONNOR - Certainly, I think it would be good to understand whether what we're dealing with here is an issue of increased violence towards healthcare workers within health settings.

Mr WEBSTER - Yes, we are and that's been an increasing trend over a number of years across Australia and in fact, you know a number of countries where we're seeing that. A response to that needs to build infrastructure that, if you like, mitigate some of that. An example from a previous workplace is, in fact, where a workplace that actually removed huge physical barriers between consumers and the workers and instead put wider front desks in so that the reach was the factor rather than a physical barrier, actually saw a drop in physical aggression towards staff. It's things like that revisiting, so the minister -

CHAIR - As long as they're not armed.

Mr WEBSTER - The minister talked about our safety and security program, but in addition to that we have running alongside that our workplace health and safety team constantly doing reviews of what else is in there. That can be everything from slips - our physical claims can be anything from slips-and-falls to the weight of trolleys being pushed. Our psychological claims tend to be more of the reaction to aggression and things like that. We have programs across all of that -

Ms O'CONNOR - Sorry to interrupt, but is there some data that breaks down the nature of the injuries?

Mr WEBSTER - There is, and I thought we had it with us, but we will be able to provide that.

Ms O'CONNOR - We can put that on notice. One of the measures you've talked about is around personal protective equipment. Could you please let us know what the PPE budget is today, because you can't see that within the budget papers and what it was on 30 June 2019?

Mrs ARCHER - While he's having a look for that, I can also give you a little bit of information about a couple of the initiatives the department has also enacted on well-being and staff well-being.

Ms O'CONNOR - Thank you, minister. With all due respect, we have limited time at the table. The question wasn't about well-being, it's trying to get to the bottom of the data on what's being invested in personal protective equipment to protect the health, not only of healthcare workers, but also of patients.

Mr WEBSTER - I am advised we can't break that down in the way that you're suggesting because obviously, PPE for us is a massive expenditure in ward-by-ward basis, and getting that data on what we're spending on everything, from masks through to -

CHAIR - Do you have a global figure?

Ms O'CONNOR - Mr Webster, you will recall last year in the other estimates committee, I asked you this question and there was a data set that told us what the investment in PPE was at that time, relative to 2019. Therefore, I am sure there is some information that would satisfy the question broadly.

CHAIR - What can be provided, minister?

Mr WEBSTER - I am advised by my chief financial officer that we were tracking it as part of our COVID activity, but it's not an ongoing tracking.

Ms O'CONNOR - On what basis would you stop understanding how much is being spent on personal protective equipment in order to protect your health workforce? Is it because questions are being asked about it? Or is it because it's too hard?

Mr WEBSTER - Because it's too hard. PPE is almost a standard item for us because of how much we use across every ward, every service, et cetera. We will endeavour to get as much as we can, but it is embedded in lots of cost centres and there is an ability to order it. Whereas during COVID, because of the amounts that we're getting and sharing with public and aged care, et cetera.

CHAIR - Let us finish this. We have other matters we want go to.

Ms O'CONNOR - Yes, I understand that. To try and get to the bottom of this question. Last year when I asked for this information, there had been a significant drop in investment in personal protective equipment for healthcare workers. Given the discussion that we've just had about injuries, and long-term workers compensation, can you confirm or give any indication whether or not the decline in PPE spending has continued. Whether the decline in PPE investment has continued, or whether, as a consequence of what we're seeing in injuries, the hospital has indeed upped its expenditure on protecting its workforce and its patients from, for example, infectious diseases like COVID?

Mr WEBSTER - Through the COVID emergency, there were a number of orders issued by the Director of Public Health right across health services, as well as the population. Our expenditure on PPE through that period was much higher than the needs of just the THS because we were supplying into aged carers as they needed it, and into disability services. We were providing PPE, in fact, through Service Tasmania to the public, as well. You would expect that at the end of the emergency, there would be a reduction in what we're spending on PPE. There is no strategy to limit PPE within our hospitals or health services. It is a standard stock item and we want to keep it available to staff and on wards where it's required. They're still using masks, et cetera as required, but there's no deliberate strategy to reduce -

Ms O'CONNOR - surgical masks.

Mr WEBSTER - well, again, depending on the ward -

CHAIR - I think we need to move on from this, we've spent a lot of time on this. I'm going to go back to Sarah.

Ms LOVELL - Minister, just back to workforce, how many Revised Employment Direction 5 have been underway this financial year, and can you give us information about the outcomes? Obviously, not identifying anyone, and we may need to be a little careful around how we ask and answer these questions, but what are the outcomes of those ED5s?

Mrs ARCHER - I will ask the secretary to give you the information he's able.

Mr WEBSTER - Keeping it at a high-level, in the year to 30 June 2025, we had 42 ED5 investigations in progress, of which thirty were suspended from work by under ED4.

Ms LOVELL - The staff member was stood down or suspended from work?

Mr WEBSTER - Suspended from work, so not attending work because of ED4. I am sorry, I'm just looking for the number I determined, which I believe was 13 - in fact, it's 18 that I determined during that period or the Associate Secretary may have determined. Of those 13 resulted in a breach, two resulted in no breach, and in three cases the investigation ceased without an outcome due to me deciding it was insufficient to proceed further.

Ms LOVELL - Insufficient in terms of evidence or insufficient grounds?

Mr WEBSTER - If there's insufficient grounds, that's no breach; but under ED5, if as the process proceeds, it's apparent the evidence isn't there to proceed to a finding either way, or we've started the process but it should be finished because what we've found says there's actually nothing there, then that's counted as us ceasing the action, rather than proceeding to a formal outcome of the secretary.

Ms LOVELL - You wouldn't proceed to a 'no breach' in the situation you've just described?

Mr WEBSTER - It's insufficient evidence for me to decide either way, but there's insufficient to even proceed further. That's usually at a much lower level of breach, when we proceed that way, but that is one of the options under ED5.

Ms LOVELL - Okay, so there are still a number in progress. Of the ED5s that you still have in progress, how long have they been in progress for?

Mr WEBSTER - I don't have the exact number of days, but it it would vary across many of those. We do have a number that extend over a long period of time. Particularly, where there are separate external investigations. I make the decision to pause what we're doing so that we're not interfering in those other investigations. That extends our timeline quite considerably while while those other activities -

Ms LOVELL - Would you be able to take that on notice, minister, so we can find out how long those investigations have been in progress for?

Mrs ARCHER - Yes, noting that it will vary, obviously, between individuals.

Ms LOVELL - Yes, that's what I'm after, is for each of the ED5s that are still underway, how long have they been in progress for?

Mrs ARCHER - That's fine.

Ms LOVELL - Thank you.

Again, I'm careful about how I ask this because I obviously am not wanting to identify any individual, but have there been any occasions, and how many in the last financial year where services have not been available because somebody has been stood down under an ED4?

Mr WEBSTER - Yes, there have bene, and part of my consideration under ED4 is, can I mitigate against further breaches or mitigate against the risk of having the person in the

workplace? I take it very seriously, but one of the inevitable outcomes of that in the small health services that we run is there will occasionally be impact, and there has been in this year.

Ms LOVELL - On how many occasions has that been the case and for how long?

Mr WEBSTER - Because of the small number here, it was one and had been going on for some months before we were able to actually recruit sufficiently to overcome that.

Ms LOVELL - Is that still the case?

Mr WEBSTER - We have actually recruited to overcome that at the moment. It isn't still the case, but it was some months before we were able to do that.

Ms LOVELL - Some months, three, nine, twelve?

Mr WEBSTER - I'm adding it up in my mind. I think it was a total of five months before we were able to fill the gap, give or take some days.

Ms LOVELL - I wanted to go to the annual report now. We heard from the Auditor-General earlier in the week and he had pointed out that in the health annual report, it shows that the health department is only meeting 152 out of 403 KPIs. That is not addressed in the annual report anywhere. What accountability measures are in place for meeting or not meeting those KPIs and what's being done to address that?

Mrs ARCHER - First of all, I would say we take those recommendations from the Auditor-General very seriously and have accepted those recommendations. I will ask the secretary to provide some more information on how that accountability is being achieved.

Ms LOVELL - Well, if I may, I'm asking you because the secretary, as head of agency, is responsible for meeting those KPIs. I would have thought it might be more appropriate for you as minister to talk about the accountability measures, given that it's really the heads of agency that are accountable.

Mrs ARCHER - Yes, I know. I will ask the head of agency to give you some information.

Mr WEBSTER - Separate to our annual report that's tabled in parliament, we actually table our annual service plan in parliament as well as required under the *Tasmanian Health Service Act*. There is a separate accountability mechanism in terms of separate reporting around the KPIs through the service plan, which is how we report on those.

Ms LOVELL - So what is that accountability measure?

Mr WEBSTER - With due respect to the Auditor-General it would be putting the same information in two documents, and we've chosen not to do that given the length of our annual report already. We separately table that and it's required to be tabled each year in so many sitting days after 30 June of each year.

Ms LOVELL - Can you outline the accountability measures that are in place in the service plan then?

Mr WEBSTER - In terms of the service plan, a number of the KPIs are actually published on our daily dashboard and our monthly dashboard so the public can actually see our performance on those key measures. In terms of the service plan and the KPIs, the Tasmanian Health Service revisits them with the secretary and I then revisit them with the minister every year as part of developing the service plan. What you will find is over the last five years, the number of KPIs within the service plan has actually increased markedly as we need to be more accountable to our public, we need to have KPIs that are relevant to the public. We've actually been increasing the number of KPIs and then making it transparent what are the measures on some of those key ones and in terms of the the annual reporting of that.

Internally, we have what are called our monthly accountability meetings, which is actually a meeting of the key service delivery leads in each of our areas with the secretary and associate secretary where they work through the KPIs, risk, budget, people issues, et cetera, directly with me and the associate secretary. In addition to that, under the new reformation of the THS and the Department of Health, we have a meeting once a month that's chaired by our Deputy Secretary Community, Mental Health and Wellbeing, which is the Tasmanian Health Service executive service performance review, where the systems management reform team collect the data. Then the service leads are accountable through the executive to are we meeting, and what are our strategies for improving our performance against those KPIs.

There are a number of mechanisms and the THS executive minutes then are available across the agency. Also, importantly for me is that systems management reform which sits within the Department of Health acts as, if you like, a semi-independent reviewer of this is how we're going and the THS executive then tell us what they're doing to improve performance against that. I am not a member of the THS executive, but I actually attend as an observer for each of those meetings. I am getting direct feedback from those meetings on service performance.

In addition to that, we produce a monthly update on the KPIs, that's provided across the THS, but importantly to me, so that I can actually then issue the please explains about what these are the things I want you to focus on, what are you doing about that? It builds into the annual report to the parliament.

Ms LOVELL - There's a lot of information there about how they're monitored and the work you're doing throughout the year, but my question is ultimately, the KPI's are not being met. I don't know if you have anything you can give us at the table about how they're tracking year on year, but it doesn't look good to be honest. We are not meeting those KPI's and delivering good health outcomes.

Minister, what are the accountability measures? We have heads of department. With all due respect to Mr Webster, paid a very generous salary to be overseeing this health department. We're seeing 30 something per cent achievement rate of KPI's. What happens next if those KPIs are not being met? As minister, what do you do?

Mrs ARCHER - As I've said, we're responding through the budget to both to that demand and to address those issues. Certainly, I take those things very seriously. I also take accountability and transparency very seriously. The issue that we have is demand. That is overwhelmingly the biggest issue that we have and to manage across all of these things, we need to do more to meet that demand.

I am not shying away from that or recognising that there's not a challenge and there's more work to do. As we've already heard, there's work underway and a whole range of areas to be able to do that. In addition to what Mr Webster has said of accountability to to me and of me as well, we are also obviously meeting weekly and more often to look at this specific issue.

Ms LOVELL - Could I ask then what conversations have you had about what improvement you want to see across those KPIs? What could we expect to see next year in the annual report?

Mrs ARCHER - We want to see improvement across all of those areas. That is always what we seek to do. We seek to have continuous improvement across all of those areas and one of those issues as we keep hearing about is demand. We are investing for example in elective surgery, additional funding for elective surgery for exactly that reason to try and meet that demand for elective surgeries and to be able to improve outcomes for Tasmanians.

We are accountable through various mechanisms, including this one, the parliament and that is as it should be. There is always more work to do.

CHAIR - On another accountability and potential cost saving area, the Auditor-General recently reported on the community service organisation grants. Quite an unfortunate report for the department. Minister, clearly there's massive problems here and obviously efficiencies need to be gained, and money can be saved. What is your response to that?

Mrs ARCHER - Several things is my my response to that. I might ask the Secretary to make some more comments. Again, as I said, acknowledging the Auditor-General's report and noting that the department has made significant improvements in the administration of grants over the past year.

CHAIR - In response to the report.

Mrs ARCHER - In response to the report, including the establishment of a central grants team in March 2025, which is resourced with 9.5 FTE positions, participation in whole of government work to improve the CSA funding arrangements in collaboration with DPAC. This is a particular area of interest for me, and we spoke earlier about whole-of-government systems approaches, which is certainly something I favour. A commencement of development of a whole-of-agency procurement framework and a whole-of-agency contract management framework.

Changes implemented to improve planning, oversight and governance of internal audits as part of broader work on enhanced risk management, which is being led by the department's chief risk officer. As I've said, we are committed to further improvement, to continuous improvement, and have accepted the recommendations in the report to improve the management of those community service organisation funding arrangements.

CHAIR - How will we know when we get there? Obviously, we can do - nine people working on this. One could argue they're not frontline stuff. I don't know what the definition is. It seems like an important body, but nine people working on it. When will we know it's done? How will we see the outcome?

Mrs ARCHER - I suspect you might see it in the next Tasmanian audit report, but if it hasn't been successful.

CHAIR - No, just on those performance audits, the Auditor General doesn't necessarily follow up, PAC follows up some of these and the audit office does some. It may be two or three years before that. I would hope we'd see some real action on that before that. How will we know, how will the people of Tasmania know that their money and the money provided to community service organisations is actually being done correctly?

Mrs ARCHER - I think there are several parts to that - I will ask the secretary to make small comments in a minute - but several parts to that. Including, what is being done internally in terms of centralising those programs, which is the 9.5 FTE, that whole-of-government work is the other side of that. I think that there are both parts, because I think ideally, we're looking to move to a more integrated approach over time as well, but I will ask the secretary to make some further commentary.

Mr WEBSTER - All Tasmanian Audit Office reports are actually - we submit them through our audit and risk committee, which is independently chaired and in fact has more independent members than internal members on it, to make sure that we have that. There is reporting through that committee to me of what we're doing in this space.

In this space, we started the changes that we're putting in prior to the Auditor-General's report and that's important. There was a recognition, particularly coming out of the COVID emergency and the number of grants that we did very, very quickly through the COVID emergency, that we needed to re-engineer what we were doing around grants and commissioning of grants. One of the major parts of the Auditor-General's report was: what's a grant and what's a service contract? And so we're auditing all new programs, but also existing programs as they come up for renewal about - and making a rational decision based on the interpretation of what's a grant, what's a service contract to make sure that they're in the right category.

Importantly, I want to reassure community service organisations, that we're not going to just pull the rug out from under them because we're doing this this work, we're working with them, to actually have built into new contracts, KPIs and things like that. There is reporting on that and, as I outlined in the other place, we've reinstated the quality and safety review processes -

CHAIR - That's good news.

Mr WEBSTER - That we're in place previously. Some of them were there but they were scattered because grants and commissioning was scattered across the agency, those programs were. Part of this bringing it together, we've reinstated that, and we are working directly with DPAC. We influence the whole-of-government and that's the move to a longer-term contracts as well to give greater certainty to CSOs. I want to reassure that, in addition to that, as part of putting this together in the Auditor-General's report, we have set timelines through an implementation plan that again we will report through our audit and risk committee to say this is this is our progress against the Auditor-General's recommendations, which we did accept, although -

CHAIR - You will report this in your annual report? The Auditor-General would like that I think.

Mr WEBSTER - The Auditor-General's office is actually present at every one of our audit and risk committees, by the way. They get this reporting at every meeting, so -

CHAIR - But we're not at those meetings. To report how you're tracking against any recommendations from the Auditor-General, or other bodies that do work in the Department of Health space, to adopt, reject - whatever - the recommendations - Surely, reporting against those in the annual report would be an appropriate place to put it.

Mrs ARCHER - I don't have any issue with that, Chair. It's no problem.

Ms O'CONNOR - Can I ask about Milo?

CHAIR - No, not at the moment.

Ms O'CONNOR - That's in systems management and how workers are treated. I think it's a reasonable question.

CHAIR - Just something quickly, then.

Ms O'CONNOR - Thank you, Chair.

There's been a number put on the savings that the system will need to find in the next year, which we know is aspirational at best, but there's some sign that some of the savings that have been made in the system are kind of silly and self-defeating. If you want to look after doctors, nurses, pharmacists, other allied healthcare workers, who are sometimes doing double shifts or extra long shifts, why would you take the Milo and the cheese out of the kitchen, and is that still the case?

Mrs ARCHER - I have heard about the Milo. I'll ask the secretary to -

Ms O'CONNOR - Yes. I've heard from some grumpy healthcare workers who can't leave the building to get lunch and so that's been a staple to get through the shift.

CHAIR - Has the Milo been removed?

Ms O'CONNOR - Is it still gone?

Mr WEBSTER - The Milo hasn't been removed.

CHAIR - Just locked in a cupboard, no?

Mr WEBSTER - No. There has been a review in one of our hospitals of the ordering processes and the volumes of product going into staff tearoom areas, but if you go to those staff tearooms - as I have since that's occurred - there are stocks of things like tea, coffee, Milo.

I would say that a number of dietitians have written to me saying that Milo shouldn't be in the tearooms, just to balance that.

Ms O'CONNOR - Sure, but - I mean, it has been appreciated by staff for a long time, so to take something like that away seems very self-defeating.

Mr WEBSTER - I appreciate that. It hasn't been taken away. It is about the ordering processes; it's about the interpretation of those. We revisited those. If you visit tearooms across the network, you will find there is stocks of the product they need.

My most recent visit was to the emergency department's tearoom at the Royal. In fact, there -

Ms O'CONNOR - What was in the kitchen?

Mr WEBSTER - There was a container full of cheese, there was a drawer full of crackers, there was Milo, there was T2, there was a drawer of bread. So, there are product still going into tearooms. It's just that what we're doing is trying to remind people that excessive ordering and throwing-out of product and things like that just isn't appropriate in this day and age. But, there has not been a service-wide determination that we're not supplying product into our tearooms.

CHAIR - Can I move to a much bigger expenditure item? The digital transformation piece, which is critical. I'm just trying to understand what's happening with the program. I know that [inaudible] long-suffering - well, everyone's long suffering in that - has been transferred to DPAC. What's been done in Health in the digital transformation space?

Mrs ARCHER - The government continues to invest in revolutionising the state's health system through the Digital Transformation Strategy. That's set to deliver a suite of digital initiatives by June 2032 to enhance operational efficiency and improve patient outcomes. As you've mentioned, it's called Bluegum digital health transformation. A core part of bluegum is implementing a statewide electronic medical record and an ambulance electronic patient care record.

A comprehensive procurement process was undertaken for the electronic medical record. In May 2025, Epic Systems was named the preferred vendor, and the program is currently engaged in contract negotiations. The program is also replacing the existing Ambulance Tasmania patient record system with a modern solution that streamlines handover processes and information-sharing capabilities between Ambulance Tasmania and receiving hospitals, nursing homes and other facilities, as well as clinicians. The program is ensuring that paramedics are also equipped with new laptops and improved connectivity to enhance the user experience of their current digital solution while the new patient record system is rolled out.

The Digital Solutions Design Governance Framework, which was approved in July 2025, ensures that the digital solutions used in our hospitals and health services are co-designed with the right people, and design working groups and a statewide design community are being established to enable meaningful community participation. The expressions of interest for that will open in late 2025 and implementation activities commencing shortly thereafter.

An electronic meal-management system project is underway. Once implemented, this solution will ensure that patients receive the correct meals for their dietary restrictions and allergies and also reduce the risk of errors that can occur with handwritten orders. Wi-fi network upgrades are ongoing at health locations across the state, enabling staff to perform

their duties more efficiently, but also providing patients and visitors with reliable public wi-fi. Infrastructure upgrades to allow the use of an enhanced mobile duress service are also ongoing at nominated sites, enabling real-time staff monitoring and duress alerts, improving safety. Mobile duress uplifts -

CHAIR - Who has those devices? Where are those devices going to be placed?

Mrs ARCHER - They have been completed at the Clarence Integrated Care Centre, the Kingston Community Health Centre, and are expected to be completed in early 2026 at Millbrook Rise, the Peacock Centre, and Glenorchy Health Centre. We are continuing to see the benefits of the electronic referral system with more than 173,800 e-referrals now received.

CHAIR - Are we still using faxes at all?

Mr WEBSTER - Yes, there are small number of practices, and in fact we did a small grant round through Primary Health Tasmania to try and get those last few practices upgraded in their electronics so they can communicate.

CHAIR - Have you succeeded?

Mr WEBSTER - We still have a handful that are resisting.

CHAIR - Right.

Mrs ARCHER - We also have rapid-access tap-on, tap-off technology live in major hospital pharmacies with more than 12,000 weekly authentications and 350 users enrolled. The TOTO saves time by removing the need to manually type login details, and that pilot is being evaluated in the Royal Hobart Hospital Emergency Department to progress to a full rollout in early 2026. Did you want to provide some more information about digital health transformation, Bluegum? I also recently attended the Tasmanian Health Senate where there was a two-day conversation there around digital transformation as well.

CHAIR - I'm concerned the rollout of some of the electronic patient records - do you want to go there, Bec?

Ms THOMAS - You can talk about it first if you like.

CHAIR - I'm just interested in how that's being rolled out. These can be disastrous rollouts and then end up costing a whole heap more. What measures are being put in place to learn from lessons of the past perhaps and not see what some other entities have seen with their cost blowouts in digital transformation pieces?

Mrs ARCHER - Thank you. Partly as you've identified, it is complex and important to sort of work through it systematically as well so that it's talking to each other and to itself along the way. I will ask the Secretary to make some more comments.

Mr WEBSTER - The first thing is to make sure that we get the co-design right with our clinicians and our community, which is -

CHAIR - Are all the clinicians on board?

Mr WEBSTER - I wouldn't say all, but the vast majority. In fact, there's a very large community of clinicians that are helping with the Bluegum transformation and directly inputting into it. We are building those design teams so that we actually deliver what our clinicians and our consumers want. The second part is making sure that we're working with the Australian Digital Health Agency to make sure that what we're building will upload into the My Health Record, Medicare, and MyMedicare, or whatever it's called these days, in the future. Importantly, and I take your point about learning the lessons of the past, is that large parts of NSW and the ACT have implemented Epic. As part of our governance, we've had people that went through that process on our steering committee so that we're learning from them. We also have as an observer in our steering committee someone from Western Australia, because Western Australia are behind us in terms of implementation, so they will learn from our process.

In addition to that, the former director-general of Queensland Health, who brought in electronic medical record in Queensland but was formerly the head of eHealth NSW when it brought in electronic medical record, he actually attends our steering committee and advises me directly on the governance and the process for this rollout.

This is a long project, so we're not expecting to go live with electronic medical record until 2028. In addition to the capital investment, there is an enormous operational investment across our Health ICT as we migrate many of our systems across into the electronic medical record. It will actually mean that we're able to migrate the staffing of that across as well, which it mitigates the op-ex. At the moment I think we have 472 individual systems across the department and the THS; this will replace the majority of those, so it's important that we get this right.

CHAIR - I will go to Bec.

Ms THOMAS - Thank you. Continuing talking about the electronic medical record, minister, earlier you mentioned that the biggest issue is demand. When Sarah asked about how you are responding to not meeting the KPIs, you said that that you're responding through the Budget; but if the biggest issue is demand, I'm interested to hear how you turn your mind to reducing demand across all areas of Health, including from a systems perspective, and whether that's been something you've considered as part of these systems changes, with particular reference to the electronic medical record and its capacity to factor in social prescribing and social determinants of health?

Clearly, more focus on prevention and early intervention, which we see the budget going down for significantly in the forward Estimates - and we can talk about that when we come to public health - but is part of the electronic medical record considering those system changes or additions that can be made to bring in more focus on prevention and early intervention?

Mrs ARCHER - Yes. The government is looking across a range of areas, as identified earlier, in relation to helping to drive down that demand, including in elective surgeries, investing in pharmacies and primary care, and specifically as well, as you've mentioned, through the Preventive Health Strategy. We're looking at that being a whole-of-government shift, if you like, or reform. In relation to specifically how Bluegum might be able to do some of that work, I will ask the secretary to make some more comments.

Mr WEBSTER - Importantly, just by way of a few examples of the change from electronic medical record: if you have a pathology test through your GP, it won't necessarily be available for a few days until it's actually uploaded into My Health Record and those sorts of things. That's the same in terms of some of our systems; so you have a test done at the Mersey, you're then transferred to the Royal, it's highly likely that we have to retest you once you arrive at the Royal. Electronic medical record will start putting these things into the record in real time, and as you do that, that retesting won't need to occur. Similarly on discharge, we will be making information available in real time back to the GP. That sharing information is a really important part of what Bluegum gives us.

As to the other thing you talked about, with preventative, et cetera; at the moment our immunisation records and our vaccination records are kept in a system called Maven, which sits under our public health. That then goes up to what's called the Australian Immunisation Records system, which is a federal system and eventually that will appear in your My Health record. With the electronic medical record, we will actually have the vaccinations, immunisations in real-time in the electronic medical record and that upload can occur automatically. That's another example of the improvements we will see.

One of the digital health strategy, or the total Bluegum strategy outcomes is in Horizon 3. Once we've rolled this across all of our Tasmanian health system is we then work with the primary health sector about rolling the interfaces - the switches, I think, it's the technical term they use - so we can actually transfer the information into their GP practise information in real-time and seamlessly. Because again, at the moment discharge summaries tend to be quite a manual transfer to our GPs. The sharing of information is really important in terms of better outcomes for individual consumers.

You then talked about preventative et cetera, but again things like being able to quickly see what allergies someone has and things like that in real-time across not just the health service, but across the health system is what Bluegum or the health strategy that's called Bluegum is aimed at achieving over the next few years and that will actually add quite a bit of saving to the system in terms of demand because we won't be duplicating across primary care as well as the tertiary care sectors.

Ms LOVELL - To be a bit more specific in terms of the capability of the Bluegum system, will it be able to support healthcare professionals in linking health consumers with social, therapeutic and practical support that's provided by volunteer and community organisations? The example that I'm aware of is the Kaleidoscope model in Gippsland in Victoria. Will this system have that capability and how far away would it be from being rolled out?

Mr WEBSTER - We call that Horizon 3, that broader connection across primary health, including the community sector. That is post-2028 we've got to get this working within the health service before we can start building, and I called them interfaces or switches so you can switch the information across. In terms of things like the socio-economic indicators and social determinants of health, et cetera, that's all part of the 'dashboard'. This is why we're working with community sector and community in terms of how we build this, because what information appears in the patient dashboard? Is it an important thing because that then tells us these are the features that consumers want us to know about them.

Ms LOVELL - Thank you.

Mrs ARCHER - Sorry, the secretary and his team have got the information taken on notice regarding workers compensation in terms of the injury breakdown, if you would like that.

CHAIR - Yep.

Mr WEBSTER - In terms of major injury categories to start with: mental disorder, 200; musculoskeletal and connective tissue diseases, 115; traumatic joint, ligament and muscle tendon injury, 260; wounds, lacerations, amputations, and internal organ damage, 65. I can break them down a bit further. There were: 22 fractures; in the compensation claims; 11 burns; there were 11 intercranial injuries; there were five nervous system injuries; there were four respiratory systems -

CHAIR - Separate to psychological injury?

Mr WEBSTER - That would probably be a subset of psychological.

CHAIR - There would be some nerve injuries. Yes, sure.

Mr WEBSTER -Skin and subcutaneous tissue diseases, two; infectious and parasitic diseases, two; and digestive system diseases, one.

Ms O'CONNOR - It's a hard and stressful job, isn't it?

Mr WEBSTER -That's right.

Ms O'CONNOR - Working in the health system

CHAIR - Just one other thing on the digital, is yours in the digital space or not?

Ms O'CONNOR - Mine's on system pressures space, but I mean, sure.

CHAIR - I want to ask one in the digital space, and you will know where this has come from. The voluntary assisted dying portal. There is evidence that some of the doctors are walking away because of the cumbersome nature of the paperwork, the problems with some of the paperwork, et cetera. There was, I understand, a commitment that a portal would be implemented and other jurisdictions all have one. Can you just update the committee on what your plan is there to avoid doctors walking away?

Mrs ARCHER - Absolutely. Thank you. Yes, thank you to Mr Gaffney for his ongoing advocacy in this area.

CHAIR - It couldn't possibly have come from him.

Mrs ARCHER - I have had a number of conversations with Mr Gaffney, and I will just note his ongoing commitment to this issue and I'm thankful to him for the opportunity to meet with some of those doctors as well. I have made a commitment to Mr Gaffney that we will deliver a portal, and I will just ask the secretary to provide some more information about that.

CHAIR - Before you got to that, I assume it will fit into the digital piece?

Mr WEBSTER - It will sit separate for a period of time because of the nature of it being a portal for the commission which has to be separate and independent of the department. In recent days, a matter of a few days ago, I signed off on a procurement process to have someone build that portal for us.

CHAIR - There's no funding for that in the Budget though, or is there?

Mr WEBSTER - It is funded.

Ms O'CONNOR - Minister, I want to take you to the health impacts of accelerating climate change, and you would be aware that both Tasmanian and the Australian governments have released national climate risk assessments which paint a really frightening picture of the future. Within the national climate risk assessment, in risks to people, it says that:

> Extreme heat, floods, bushfires, poor air quality and communicable diseases will escalate health risks. Those with pre-existing health conditions, including mental ill health, are most at risk. This includes the very young and our older populations. People who work outdoors will also be increased risk.

Has Tas Health undertaken any work on the health risks posed by climate change and is Tas Health incorporating the understandings that have come through the state and Commonwealth climate risk assessments?

Mrs ARCHER - Thank you, Ms O'Connor. We did come prepared for this question as your colleague did raise this the other day. The government recognises that climate change is a significant and increasing threat to physical and mental health, wellbeing and healthcare services in Tasmania.

We know that climate change affects the natural environment and the social and economic systems that underpin the health of the community. A change in climate has the potential to undermine decades of health progress by increasing the risk of mental health disorders, non-communicable diseases, emergence and spread of infectious diseases and health emergencies, as you've mentioned.

The Department of Health is committed to addressing the effects that climate change can have on health and create a financially sustainable and environmentally responsible health system that recognises, acts on, and measures its impact on climate change and also uses advances in technology and research to drive high-value care. The department's climate and health activity is currently guided by the responsibilities and commitments in the Long-Term Plan for Healthcare in Tasmania 2040 and Tasmania's Climate Change Action Plan 2023-2025, which does have some health-led actions and is supported by actions under the National Health and Climate Strategy.

Our Long-Term Plan for Healthcare in Tasmania 2040 includes three priority initiatives for environmentally sustainable healthcare, which are:

(1) A net zero health service by 2030.

(2) A strategic approach to cleaner health services, which includes a commitment to develop and implement a comprehensive environmental sustainability strategy for the department; and also

(3) Progressing the global green and health hospital goals.

Under Tasmania's Climate Change Action Plan 2023-25, the Department of Health-led responsibilities and commitments are to raise awareness about the links between climate change and health and the ways that communities can take action and respond to climate change. Support actions that protect vulnerable Tasmanians from the impacts of climate change such as bushfires, extreme heat and cold weather events. Support community action on climate change and our health through the Healthy Tasmania Fund, the Healthy Focus grants and this will obviously also be a continued focus under our preventive health strategy.

Ms O'CONNOR - What I'm trying to understand is Tasmania Health's assessment of risk in the decades ahead, in terms of system management, what are we likely to see change given that it's a fact in the event of extreme weather events, big climatic shocks, it's the health system that sits there to deal with it in many ways with the human fallout.

That will place increasing pressure on the system, so how does the system itself, and it might be too big a question to answer now, how does the system itself make sure it's ready to deal with that?

Mrs ARCHER - In part it is a bigger question, because there are many complex parts as you, well recognise, but I will ask the secretary to talk about some specific system approaches.

Ms O'CONNOR - Also is it Tasmania Health's understanding that these impacts are not to be considered to be in the far-off future? It's happening now. We're seeing those extreme events now, deaths and injuries from it.

Mrs ARCHER - This goes to the point I made earlier to on that 20-year preventive health strategy being a whole of government reform and looking at infrastructure development, for example, or food security or greening spaces, all of those sorts of things. Also, those social determinants of health that we were talking about rather than just looking at health specifically. But I will ask the secretary to make some health specific -

Ms O'CONNOR - Thank you minister and acknowledging that it's some of our most disadvantaged people and communities who will suffer the most.

Mr WEBSTER - A number of things is in terms of the immediate, we've revisited our entire emergency response activities. We now have exercises internally in the department about how we're going to respond. For instance, most recent exercises around if there is a fire event that threatens one of our district hospitals or one that surrounds Hobart, how do we actually respond to that at each of our hospitals.

Ms O'CONNOR - I am glad to hear you're thinking about that Mr Webster.

Mr WEBSTER - We have a what's called the Emergency Planning Response Unit whose whole role is to make sure that we've got the plans for each of these types of emergencies, and we are practising how we respond so that when it happens, it's seamless, hopefully. In line with

that we have part of 22 Elizabeth Street that easily converts to an emergency centre should we need to, learning from the COVID emergency and what we had to do to at the start of that.

Second part of it is and whilst we were subject to some derision in other parts of Australia, we revisited how we're doing warnings around heat waves, for instance. We don't use a high level as you would in Melbourne, Sydney, et cetera three days of above average temperatures where we will issue warnings around heat, et cetera because Tasmania is right-

Ms O'CONNOR - No, but that would be via text. How do you let people know?

Mr WEBSTER - We put out social media releases, et cetera, when that event is occurring so that we have the messages out there last year. It was a little bit easier because of the amount of derision we were getting for having put out warnings and temperatures like 25-26°.

CHAIR - It is hotter here when it's that.

Mr WEBSTER - But it's also that Tasmanians are acclimatised to lower temperatures and so these late 20s temperatures can have the same effect as maybe a 35° in far North Queensland. We need to adjust what we're doing to our climate, not to use Australia wide standards as it would apply.

Ms O'CONNOR - Do you work with emergency services on that sort of thing? What is the structure?

Mr WEBSTER - There is the Tasmanian Emergency Management - I can't remember what the 'A' stands for - the TEMA arrangement - which creates a statewide structure and then under that we then build our structure. Those structures are both regional and then statewide within health. We work very closely with State Emergency Service coordination around the State Emergency Management Centre, who work closely with the regional emergency coordinators, who are generally the commanders of police, in terms of what we're doing. It is under that, under the TEMA and the subordinate documents that exist, that creates the coordination right across government in how we respond to the emergency but also how we recover from the emergency.

CHAIR - Anything else on systems management? If no, we'll move to 2.1 admitted services.

Output Group 2 - Health Services
2.1 Admitted Services

Ms LOVELL - Minister, I tried to have a quick look at some of the conversations you had in the lower House committee on Monday. I know one of the things that came up on admitted services was Care@home, and that's certainly in the budget papers under the key deliverables. Can you tell us what the targets have been for Care@home and what numbers have been - I guess you say 'admitted'. Is it 'admitted', through Care@home?

Also, are Care@home and Hospital in the Home, are they same thing now, or still different things?

Mr WEBSTER - They are separate but sit underneath the one umbrella.

Ms LOVELL - Okay. Can you maybe outline the difference between Care@home and Hospital in the Home briefly?

Mr WEBSTER - Care@home describes our virtual and telephone nursing and GP support for Tasmanians, while Hospital in the Home is very specific to someone who is at an intermediate level of care. They don't need to stay in hospital, but they need additional support at home or indeed can be supported at home with additional nursing support, et cetera in the actual home. The difference really is that one is virtual whereas one is very much physical, but there is incredible overlap between the programmes, which is why we sit them together.

Ms LOVELL - When did Care@home commence?

Mr WEBSTER - Care@home commenced on the day that we opened the borders during the COVID emergency -

CHAIR - 15 December 2022.

Mr WEBSTER - 15 December 2022.

CHAIR - It's still etched in my mind.

Mr WEBSTER - As part of our response for knowing we'd see increasing cases of COVID, it was originally put in -

CHAIR - Was it 2021?

Mr WEBSTER - It was 2022.

CHAIR - No, it was 2021, because we opened the schools in 2022.

Mr WEBSTER - Yes; 15 December 2021 was when it commenced.

Ms LOVELL - This might not be something you have available at the table, but if you're willing to take it on notice, could we get a breakdown of the number of patients that have been admitted through Care@home over that time.

Mrs ARCHER - Yes, I think we can take that on notice and provide that.

Ms LOVELL - Thank you.

Mrs ARCHER - It has continued to expand.

CHAIR - Before you move on from that, Sarah -

Ms LOVELL - If I could just add to that, can we also get the numbers of patients admitted but also the targets that were set around Care@home.

CHAIR - On that, and maybe you can answer this at the table, but how do you measure outcomes from patient care? It's a great service and I'm not criticising the service, but how do you actually measure the outcomes?

Mrs ARCHER - Secretary?

Mr WEBSTER - In terms of Care@home, it is around avoiding admission, there's that side of it. We get feedback from surveying of the individual consumers and patients about their experience with the program. There are also timelines. If we're doing virtual monitoring for respiratory et cetera, we have equipment that needs to arrive at the person's home, so there's the timelines of does it arrive in time? A third part of it, again just focusing on respiratory and particularly viral respiratory - there is a timeline in terms of things like Tamiflu, et cetera, where the validity of the use of them is 48 hours from symptoms, so again, getting the scripts out within a period of time so they actually have access to the antivirals, all of those things are how we measure whether we are performing in Care@home, and Hospital in the Home has a different set of performance criteria, as well.

CHAIR - How many of those patients ended up being admitted to hospital? It could have been that something else happened, they fell over broke their leg; how many patients have been admitted from Hospital in the Home?

Mrs ARCHER - From Hospital in the Home or Care@home?

CHAIR - Well, either of them. I imagine you measure them separately, don't you?

Mr WEBSTER - From any of our home and community care programs, really, as we need to measure are we are still having admissions. For instance, if I take one of those, PACER, which is in the mental health space, if we measure how many there, we would measure the opposite, that is, how many hospitalisations we avoid through that program. It sits at around 75 per cent.

CHAIR - Which is the same thing, if they stay in Hospital@home, or whatever they are calling it now, do you actually have a number of patients who are in that system, but those who are in that care program -

Mrs ARCHER - And avoided a hospital -

CHAIR - end up being admitted for the condition they are in Hospital@home for?

Mr WEBSTER - I've just been reminded that we actually publish this as part of our dashboard as well, so it is available through our dashboards, but we will get the -

CHAIR - The admissions are?

Mr WEBSTER - The number of admissions to Care@home is actually -

CHAIR - No, to the hospital from Care@home?

Mr WEBSTER - Sorry, no, that isn't on there.

CHAIR - Can you provide that? You can?

Mr WEBSTER - Yes.

Ms LOVELL - On that, would that include all of those community care services? Could we get a breakdown of Care@home and - I mean Hospital in the Home is a little different though, isn't it? Often, those patients have been in hospital and then transferred back to Hospital in the Home.

Mrs ARCHER - Transferred back to home.

Mr WEBSTER - Yes, each of them has different measures. There's actually a suite of this. There is rapid access within the Older Persons Mental Health Services, which is about supporting people to stay in a residential aged-care home. There's a program - the name escapes me - within Ambulance Tasmania that supports residential aged care and people staying in residential aged care. There is secondary triage, PACER in the south, which is Mental Health Emergency Response in the north and north-west. Each of these programs has a number of measures, either about admission to hospital or about avoiding admission to hospital. There isn't one collective of them; each has their own measures, if you like.

CHAIR - See what measures you can provide in terms of - we're just talking about hospital avoidance here.

Mr WEBSTER - Yes.

Ms LOVELL - Maybe the question is: all of those programs that are about hospital avoidance, not necessarily shortening a stay in hospital, it would be good to know what measures and what outcomes you're delivering from those.

Mrs ARCHER - We certainly have some figures here around the number of patients treated each month, but that's not necessarily going to get to the level of detail around whether they may have avoided a hospital presentation.

Ms LOVELL - Minister, I know particularly in Tasmania we have a number of partnerships with private providers that are critical to being able to provide services. Can you tell us how many occasions of care or procedures have been provided through private hospitals for public patients throughout the last financial year?

Mr WEBSTER - At Calvary St John's, we contract there to have up to 10 beds plus a two-surge during peak periods. Over the period from the start of that contract to September 2025, we've used them 14,001 patient days, a very unique health measure -

CHAIR - Point one -

Ms LOVELL - When was the start -

Mr WEBSTER - 14,001. Sorry.

CHAIR - And one, sorry. I thought you said point one.

Ms LOVELL - You said 'since the start of the contract'. Is that from the start of the financial year?

Mr WEBSTER - 6 December 2021, the contract started to September 2025, which would be 30 September. Calvary St Vincent's, again in Launceston -

Ms LOVELL - Sorry, secretary. Do you have a breakdown of whether that's - I mean, that's quite a lengthy period of time - whether that's been increasing in recent months, or decreasing, or are we doing that more often or less often than we did at the start?

Mr WEBSTER - I don't have it as a breakdown, but I can say though that in terms of the 10 rehabilitation beds, we were using low numbers of them and that has increased as demand has increased in the public system. Similarly, with Calvary St Vincent's - I should say that Calvary St John's, the bed type is rehabilitation. Calvary St Vincent's, Launceston: these are medical beds. We contract for 14 of those. The contract started on 15 November 2021. To the end of September we've used 15,879 patient days at that facility.

Ms LOVELL - Is that increasing as well?

Mr WEBSTER - Again, that has increased over time as demand has increased or the use of those has increased. North West Private, we have a contract starting there on 1 December 2021 for up to three beds. We've used 3,472 from then to September 2025. With that one, that's been fairly steady across - and as you can appreciate, that's a low number. And Hobart -

Ms LOVELL - And what bed types are those?

Mr WEBSTER - That's medical. Hobart Private - we started a contract there on 30 June 2024. These are what we call 'maintenance beds', so these are longer-term stays. There are up to 10 in that contract, and since the start of the contract, we've used 4229 patient days to the end of September. In total, we have the ability to use 39 beds across the private sector, and we've used them 37,581. The second part of your question, I think, was around presentations around surgery within private?

Ms LOVELL - Yes.

Mr WEBSTER - I can go through those as well. I can break down by financial year. Number of admissions for elective surgery in private hospitals: in Launceston, 1,983.

CHAIR - Is that in the last financial year, or what time period?

Mr WEBSTER - No, that's total number in our system.

CHAIR - We've done more than that.

Mr WEBSTER - Sorry, that's in the private sector. We've done 1,983 elective surgeries -

Ms LOVELL - In Launceston?

Ms O'CONNOR - In the financial year that's just passed, in Launceston.

Mr WEBSTER - In Launceston, in the financial year 2024-25. Outsourced from the Mersey are 894 to private providers.

CHAIR - So they could have gone to Launceston or Burnie, either way?

Mr WEBSTER - They could have gone to North West Private, or yes, to Launceston. North West Regional, and these will be mainly to the North West Private: 386.

CHAIR - That doesn't count caesareans, does it? That's other surgery.

Mr WEBSTER - No, it doesn't. That doesn't include the maternity -

CHAIR - Public elective caesareans.

Mr WEBSTER - Yes, that's right. This is surgeries through our elective surgery list. The Royal Hobart Hospital have outsourced 1,892 in the south in that financial year, which is 5,155 for the financial year.

Ms LOVELL - You said you could give us a breakdown over a time period. Have you got maybe just the previous year?

Mr WEBSTER - Yes. 2023-24, Launceston: 2,177; the Mersey: 983; the North West Regional: 355; and the Royal Hobart: 2896 - for a total of 6411.

Ms LOVELL - So, those numbers are coming down. Is that because we're doing less surgeries overall or more surgeries in the public system or what explains that trend and is that a trend that's continued over a number of years or is it just an anomaly in the last year?

Mr WEBSTER - It does jump around a bit with private, but the total number of elective surgeries, I think the minister's already said, was at a record level last financial year. We did more in the public sector and less in the private sector in the financial year, but the numbers jump around each year.

CHAIR - I know Cassy had a question on elective surgery.

Ms O'CONNOR - What's the elective surgery wait-list as at this date?

Mr WEBSTER - It's on our dashboard and I'm just logging in.

Ms O'CONNOR - Is the dashboard - just remind me - is it real time?

Mr WEBSTER - The elective surgery dashboard is as at the end of the previous month.

Ms O'CONNOR - Alright, so while you're looking for the most recent figure. In a media release on 7 August this year about elective surgeries, Minister, you seem to blame COVID for driving up the elective surgery waiting list, which at that point was at 12,286.

I'm interested to know why and on what evidence the decision was made to blame COVID. We can agree it has had an impact and a negative impact, not only on individuals but on the system. Who advised you that COVID was to blame for the wait list reaching this peak?

Mrs ARCHER - Certainly, the advice that I have had is that it did have, as you identified, a significant impact on elective surgery, as it had a significant impact right across the health system. I don't know that it would be reasonable to necessarily - I know it probably generally terms not blame, or not seek to place blame, but really to provide explanation for some of the change in those figures.

Ms O'CONNOR - I could have said you attributed the rise to COVID and where that advice came from on the basis of what evidence?

Mr WEBSTER - The advice came from the department. I was around in those days, and it was due to a number of times where, due to COVID outbreaks within hospitals, et cetera, we actually reduced our elective surgery through COVID to protect consumers and the hospital from further outbreaks. That's why -

Ms O'CONNOR - Including in the past year, because the 12 August statement suggests that that impact on the system has persisted.

Mr WEBSTER - It peaked at that level and has come down since.

Ms O'CONNOR - When? Sorry, I'm just trying to get this.

Mrs ARCHER - When did it peak?

Mr WEBSTER - My team will let me know that, but the peak was somewhere in 2022.

Ms O'CONNOR - So are you blaming - are you attributing events of 2022 to the waiting list being driven up to 12,286, or is the advice that the system impacts are ongoing and that is why, to this date - so on a contemporary measure if you like - the wait-list problems are being attributed in significant part to COVID?

Mrs ARCHER - The COVID peak of 12,286 was in January 2021, but we've also noted that the elective surgery waiting list continues to decrease and is 36 per cent less than that COVID-driven peak in January 2021. That's in part being driven by the statewide Elective Surgery Four-Year Plan and again that's what we are seeking to do with our next elective surgery four-year plan, as well.

There are, I think, and Dale may add more to this, but I think there are a range of reasons that drive elective surgery, including screening programs. For example, we've seen screening programs contribute to increased demand for elective procedures like endoscopies and the like as well. Did you want to add anymore comments to that?

Mr WEBSTER - Just to give the figure, this is the end of September from the dashboard. The Launceston or Energy Age figure is 3276; Mersey is 652; Northwest Regional is 912; and the Royal Hobart Hospital is 4435. A total at the end of September of 9275. The peak was 12,000. We've come down to that figure.

Ms O'CONNOR - In July of 2017, the elective surgery waiting list was at 5403 by March 2020, when COVID hit Tasmania, that number had more than doubled and reached 11,307. In other words, 86 per cent of the waiting-list growth occurred prior to the start of the pandemic. Given that, do you think it was reasonable to attribute the peak being reached to COVID? And

are those impacts of COVID still being felt in the system in terms of, and I'm sure they are, in terms of being able to deliver elective surgeries?

Mrs ARCHER - I would just note that also the Australian Institute of Health and Welfare has noted earlier this year that since early 2020, elective surgeries across the country have been affected by disruptions to hospital services that arise from the COVID pandemic. And just to go back to what you indicated, I am not sure we were on the same page there. COVID-driven peak, 12,286 in January 2021.

Mr WEBSTER - A number of factors drive the wait-list - so we're delivering record number of surgeries, but the wait-list is quite stubborn.

CHAIR - Open the door and they keep coming in.

Mr WEBSTER - The other side of it is that, it is demand driven, but e-referrals has increased the number of outpatient referrals, you know, convenience because we've made it easier to actually refer to us, but we've delivered a record number of outpatient appointments but that means that the number of patients coming from outpatient appointments onto the surgery list has gone up. As we meet demand, we're creating demand, is one of the factors.

CHAIR - Can I just indicate that it's 11:00, we were going to have a break at this time and if people are expecting that we might break and come back to this. We will take a 15 minute break there and be back just after 11:15.

The committee suspended from 11.02 p.m. to 11.17 a.m.

CHAIR - I think you were about to ask another question on 2.1.

Ms O'CONNOR - Elective surgery, that's right. Thank you, Chair. We were talking earlier about the impact of COVID and potentially other infectious diseases on the system, on admitted services. In the past year, how many outbreaks of infectious diseases, and which diseases, have occurred in each hospital that required a response?

CHAIR - Well, everything requires a response.

Ms O'CONNOR - That required, for example, a new PPE arrangement being put in place. When there's an outbreak in any health system, there's a response. How many times did that happen in each hospital in the past year?

Mrs ARCHER - Thank you. Just to clarify that you're not speaking about disruption to services necessarily?

Ms O'CONNOR - No, because that's a given.

Mr WEBSTER - I'm just looking across - we don't have that with us, but we were actually talking about it during the break. This year was in fact a double peak in terms of respiratory disease through winter. We experienced a peak as normal in August and then we had another one in late September into October, so we actually had a large rate of infection across Tasmania, not just COVID -

Ms O'CONNOR - COVID, flu, RSV -

Mr WEBSTER - Yes, and we had a thing called parainfluenza that affected people as well that resulted in some hospitalisations. There were a lot of people who, even though immunised, picked up on that.

Mrs ARCHER - Those are all respiratory illnesses, but there would be presumably - potentially other infections as well.

Mr WEBSTER - We certainly had a number of outbreaks within hospitals, but we haven't actually collated that as a data set, how many times we had an outbreak in hospital in the last 12 months.

Ms O'CONNOR - Are there so many you can't count them, or is it simply not something that's recorded?

Mr WEBSTER - It's not something that's recorded directly, but it is actually reported because I get to know about every one of these situations.

Ms O'CONNOR - So it's recorded somewhere if it's reported?

Mr WEBSTER - Exactly. That's right.

Ms O'CONNOR - Where is it recorded?

Mr WEBSTER -Well, through our hospitals, it's one of the things they monitor. We just don't have it with us, but we will attempt to get it.

Ms O'CONNOR - You would be happy to take that on notice, would you?

Mrs ARCHER - We can take it on notice, yes.

Mr WEBSTER - Yes.

Ms O'CONNOR - And in terms of a response, if there's an outbreak on a ward - because let's face it, the PPE standards are not what they used to be - what is the response on that ward in the case of a highly-infectious disease?

Mr WEBSTER -There would be closure of that ward to externals, and again the PPE usage would increase within that ward -

Ms O'CONNOR - That's very reactive.

Mr WEBSTER - but we would then have a closure of that. You talk about reactive, but there is an ongoing assessment of where we use PPE and what level of PPE, related not just to outbreaks but to winter disease that we just spoke about, et cetera. There would be limited visitation, for instance, cohorting if the spread is across more than one location at the hospital. As part of our COVID response during the emergency, we also increase the number of negative-pressure rooms that are available across the network, in terms of infection -

Ms O'CONNOR - Isolate people.

Mr WEBSTER - so we can isolate, and in negative-pressure rooms so that there isn't spread beyond that room, and those sorts of things, so there are a number of initiatives that we put in place.

Ms O'CONNOR - Thank you. Can I ask, have admissions for tuberculosis increased, and what are they now because we're seeing an increase in tuberculosis around the world?

Mrs ARCHER - Australia has achieved and maintained good tuberculosis control since the mid-1980s, but challenges remain to progress towards pre-elimination. In Tasmania, the rate of TB is lower than observed in Australia, approximately 2.1 per 100,000 per annum, that's 2015 to 2024, compared to 5 to 6 per 100,000 per annum for the same period in wider Australia. While crude notification numbers in Tasmania are low, there has been a small increase in notifications in 2025 year to date. There have been 18 notifications in 2025 year to date, compared to a range of eight to 21 notifications per annum for 2015-2024; no cases in Tasmania year to date were among those who identify as Aboriginal or Torres Strait Islander, and the majority of TB notifications in Tasmania are among those born overseas in countries with high TB incidence, and among adults aged 15 to 44 years of age.

Ms O'CONNOR - Okay. Can I ask if a patient presents to the emergency department - and I know we will be dealing with emergency department matters soon - but if a patient presents and they are confirmed to have tuberculosis, what happens?

Mr WEBSTER - We might pass that to the Chief Medical Officer.

Prof. ARYA - We have a very rigorous contact-tracing procedure in our emergency departments, so if anyone who presents with TB or any infectious disease, the contact tracing kicks in immediately. We have a public health unit that then gets involved in tracing all those contacts or potential contacts.

Ms O'CONNOR - And the data that Mr Webster was talking about before, when outbreaks are reported, for example, that is recorded in that public health unit, is it?

Prof. ARYA -Yes. So, any infectious disease - and tuberculosis is a notifiable one - any infectious disease notification is recorded and monitored.

Ms O'CONNOR - Through you, minister, can I ask what other interesting and exotic -

CHAIR - Can we do this under public health?

Ms O'CONNOR - But this is -

CHAIR - Now we're moving into public health, we will do it there.

Ms O'CONNOR - Yes, we can. Sure.

Mrs ARCHER - Just further on your question about TB, the up-to-date and the past counts of rates of cases in Tasmania are also available on the national notifiable diseases dashboard.

Ms O'CONNOR - And just to confirm, if a patient comes in and is confirmed to have tuberculosis, are they isolated within the hospital?

Prof. ARYA - Yes.

CHAIR - Probably in a negative-pressure room.

Mrs ARCHER - We do have PPE information.

CHAIR - You are happy to table that?

Mrs ARCHER - Yes.

Mr WEBSTER - Yes.

Ms LOVELL - Minister, we know that with discharge out of hospital there are delays and we know there's delays at the moment that can be quite lengthy because of people waiting for aged care or NDIS supports and other services. Also, there are impacts from shorter term delays. I know in the past there's been services like pharmacy that don't operate over the weekend and that can contribute to delays in discharge. How many of those services are not operating over the weekends at the moment?

Mrs ARCHER - I am going to ask the secretary to provide that information. We did have some questioning on this Monday, but that was specifically in relation to transit lounges, but I will ask the secretary to provide some more information.

Mr WEBSTER - In fact, our pharmacies do operate on the weekend.

Ms LOVELL - Are they 24/7?

Mr WEBSTER - No, they're not 24/7, but they do operate seven days a week.

Ms LOVELL - What hours do they operate?

CHAIR - What are their hours on the weekend?

Mrs ARCHER - We will have to take that one on notice.

CHAIR - I assume that different hospitals have different hours.

Mrs ARCHER - Yes.

CHAIR - We can look at it.

Mrs ARCHER - We can get that information for you.

Ms LOVELL - Thank you. What I will put on notice then is hours of operation for pharmacy across the four hospitals. What about other -

Mr WEBSTER - In particular with pharmaceuticals, it doesn't need in every case to be discharged pharmaceuticals. It can be a script sent to a local pharmacy electronically and things like that. That can happen through the doctors, not just through pharmacists.

Mrs ARCHER - Secretary, can you talk to some of the other reasons for discharge delay?

Mr WEBSTER - One of the key issues is reductions in discharges on weekends and that tends to be around specialist medical practitioners. The majority of them are Monday to Friday. It will be a delay because the specialist believes he wants to see the patient prior to discharge. What we're doing there is we've pursued a program now over a period of time called criterion led discharge, where the specialist medical practitioner works with the staff on the ward and sets a set of criteria. If the person meets that criteria then that leads to the discharge and that improves discharge over the weekend.

We've been really successful with that, particularly in surgical areas, where the criteria can be well defined. In the medical spaces, it tends to be the criteria is more specific to each individual patient. We continue to work with doctors, nurses and particularly junior doctors, who are available over the weekend to make sure they're comfortable with that criterion led discharge.

Ms LOVELL - Can you give us some more information about the numbers of patients being discharged through those, I guess principles, I suppose you'd call it, across surgical and medical and how long has this been in practice for?

Mr WEBSTER - We can do that. It is information that we do collect. We don't have it with us at this particular point in time. This is a program, criterion led discharge has been around for probably a couple of decades in different forms as a strategy within the THS. We've been pursuing this actively for the last three years. Again, individual specialist medical practitioners have put it into their practice, probably in the THS as long ago as two decades. Again, as a strategy it's been around for about three years.

The second area is transit lounges, so again, a person not needing to wait on the ward for things to happen before they can go home, so we pursued transit lounges. That's highly successful, I have to say, at the LGH. At the Royal Hobart Hospital not as successful as a strategy, but we continue to analyse what we can do improve that.

Ms LOVELL - Why is that? What are you seeing through that analysis around why it's not as highly successful at the Royal?

Mr WEBSTER - Some of that will be on just the pure size of the Royal and the distance that doctors will need to travel if something goes wrong. Those sorts of things can contribute. There is, again, the distance between wards to the transit lounge and finding the orderlies to move people and things like that and some of the early things, but I have to say that given the amount of effort put into the transit lounges and we're achieving about a 20 per cent occupancy of them, part of our analysis is, is there a different model to the transit lounge? If it's not successful, don't just keep pursuing it. Can we change it?

The other thing I would say on that is that we're not certain of the data and how we calculate the transit lounges. The reason I say that is that the evidence of our own eyes that

LGH says it's a busy transit lounge, but they show it 20 or 30 per cent on a daily basis and that's about spread of hours and people remembering to log in that the patient's there in the system at the right time so all those sorts of data issues as well.

Usage probably is higher than we report, but again, I want to make sure it's working rather than just continue to pursue it if it's not working and it's a relatively new idea in the northwest.

Ms LOVELL - You mentioned things like orderlies and not having orderlies available to move patients between. Orderlies are a pretty critical part of the workforce, and I use them as an example. Is staffing one of the issues that's contributing to that low-occupancy rate in the transit lounge and delays in discharge, or is it if you don't have enough orderlies to move people around, that seems like a fairly basic solution would be put more orderlies in?

Mrs ARCHER - I think part of that issue is around the distances is what the secretary was saying, the distances that the orderly may be travelling to move between transit lounges and other parts of the hospital was what he was referring to there.

Mr WEBSTER - Yes, it was and also the busier times of the of the day in terms of moving patients around from wards down to imaging or wards to pathology, those sorts of things all happen at the same time as we're trying to discharge patients.

Ms LOVELL - Do you have a vacancy rate for orderlies at the moment?

Mr WEBSTER - I'm not saying it's because we've got a shortage of orderlies. I'm just saying that the busy times of the day, all of these activities we're trying to do at the one time across the network. But the staffing of the transit lounge is high, and we maintain it as a ward.

Ms LOVELL - They're fully staffed.

Mr WEBSTER - Yes.

CHAIR - You were talking about the registrar's residence, discharging patients on the weekend can send electronic script so they don't need to access pharmacy, they just send electronic strip to a pharmacist or to the patient. Where does it go?

Mr WEBSTER - There is a step through the pharmacy and pharmacists to get that across to the community pharmacy usually.

CHAIR - You still need a person in pharmacy to do that.

Mr WEBSTER - Yes, my understanding - and someone's going to check this in the background - but it still goes through pharmacy to that.

CHAIR - It does beg the question if you need a person to ask why they wouldn't dispense the medication. Bearing in mind that, like perhaps not such an issue down at the Royal, but certainly the Northwest Regional if they're going back to Queenstown: one thing they may not have that medication in stock ,with all due respect to the wonderful pharmacists we have down there, but also it's the hours aren't extensive and not on weekends.

Mr WEBSTER - There is the balance, so there will be discharge scripts, but there are also community scripts that that go out, and that may be because the medication has to go beyond an initial dispensing of them and things like that. There's still discharge scripts, but some people it's not - it's actually community - and it may be they've come in with medications and they're the same medications they're having, but they will run out a few days after discharge, so you're going to send a script off for those sorts of things. Or it may be that it's a highly specialised script and we want to warn the community pharmacy in terms of you need to get it in and things like that.

There's a whole lot of reasons why we do scripts as well as discharge medication.

Mrs ARCHER - And some of that is that individual - I think, going to the question - is the individual patient circumstance, obviously, as well. But, I think that's where - I don't think we can understate the number of those stranded patients as well, and that's why we are now reporting that information on the dashboard, because it's significant numbers, you know - I think around 90 currently at the moment, and I think up to about 111 in August - and I really don't think that can be understated in terms of the challenge that it does present in terms of access and flow.

Ms LOVELL - Yes, it's been the case for a long time.

Minister, I had some questions about TML as the pathology provider in the north-west. How long have TML been the provider?

Mrs ARCHER - It's a reasonably new contract, but I will ask - and again, I think we had some questions about this the other day, so I think the secretary will be able to provide you with some deeper information.

Mr WEBSTER - The TML took over the contact on 1 July this year.

Ms LOVELL - And since then - I understand there's been significant issues with the provision of that service - how many adverse events or incidences and notifications have been reported in relation to TML services?

CHAIR - Noting it's no longer on site either, at the hospital.

Mrs ARCHER - TML service is on site at the Mersey, but not the north-east.

CHAIR - Not at the North-West Regional, it's not.

Mr WEBSTER - We will get that figure for you. TML is not on site, but collection is still on site; it's just the laboratory is separated. It was a new contract and there were some initial teething problems around a different provider coming in overnight and those sorts of things.

Through our SLRS, we report all adverse things in terms of different levels of them, and to be fair, what we will get is the number of pathology-related reports last financial year before TML started - because again, there is always adverse events related to all of our services that we have to monitor. It's not just that suddenly we had zero and then we suddenly had some because TML came on board. But we do acknowledge there were teething problems, and we're

regularly meeting with TML and our clinicians are regularly meeting with TML to iron out those issues.

Ms LOVELL - That was going to be my next question. Have the issues been raised with TML and what have been the outcomes of those conversations? Specifically, have there been any breaches of contract involved in any of those notifications?

Mr WEBSTER - We initially were meeting with TML daily - and then it's moved out to a more regular pattern of that - and every time that something happened, it was raised with TML to make sure that was responsive.

In terms of breach of contracts, there were some timeliness issues initially that we put pressure on TML to overcome them. But again, I would say that across our outsourcing et cetera, these types of issues around timeliness and delivery under the contract et cetera, it's conversations we're having constantly with all of our providers, because as soon as they don't meet the timelines, we flag it. We don't wait for them to do it multiple times. We're flagging it all the time.

Ms LOVELL - Timeliness issues - can you elaborate a bit more specifically on what the issues were?

Mr WEBSTER - Some of the issues were with pathology. Reports can be reported electronically, and some of our doctors didn't have logins to TML because of the changeover, and so, TML reporting through that methodology but it not getting to the right person was the first thing - which is, again, we've overcome that with changes to the system. But secondly - because they're off-site, people are used to going down and sort of asking, but suddenly it's a report coming across from the lab to the hospital. So, there was timeliness in terms of that report coming into the hospital. All of those things - as I said - as soon as they occur, we address them with TML to overcome them.

Ms LOVELL - Where is the lab?

CHAIR - The old university building up in Mooreville Rd.

Mr WEBSTER - Mooreville Rd, which is, as the crow flies, a couple of hundred metres from the North West Regional, but by road it’s a few hundred metres -

CHAIR - A few roundabouts to go around. And if it's school time; there's a school up there.

Ms LOVELL - I'm going on to another issue. I don't know if anyone's got anything on TML or pathology while we're here?

CHAIR - No, that's alright.

Mrs ARCHER - Just back on pharmacy, Chair; the secretary has the pharmacy hours information that he can provide now, if you like?

CHAIR - Thank you.

Mr WEBSTER - As he does that, he hits something and can't read it!

At the Royal, the pharmacy operates from 8:30 a.m to 9:00 p.m. at night, seven days a week.

At the LGH, it's 8:00 a.m. to 6:00 p.m. seven days a week.

At the Northwest Regional and Mersey, it's 8:30 a.m. to 5 p.m., and it says it's open on the weekends, but the hours vary; I don't know what that means.

CHAIR - Not very helpful, really!

Mr WEBSTER - But it is open on the weekend is what it's saying.

CHAIR - They go home when they have other things to do.

Just on the TML, before we do go off that. Just to be clear, for the patients with haemophilia who require Factor VIII and other medications that are time-critical, they are now stored at the hospital, not up at TML?

Mrs ARCHER - As I understand it, that's right.

Mr WEBSTER - And just on the e-scripts, that's a recent thing; I was right, we do them, but it's a recent thing. Still a lot of doctors are working off a piece of paper, so handing it to the patient.

Ms LOVELL - Minister, I wanted to go to radiology now. I know that there's reports of images and results not being read for extended periods of time, up to 8 to 10 weeks. Can you confirm that that's the case? What is the length of time that it's taking to read these reports at the moment?

Mrs ARCHER - Do you mean in specific locations or just across the board?

Ms LOVELL - Maybe if you could give us information about what's happening across the board; I know particularly at the Royal, I think, it's taking a significant amount of time, but it would be interesting to know -

CHAIR - This is radiology for in-patients.

Mrs ARCHER - Radiology for in-patients, Mr Secretary?

Mr WEBSTER - There is a particular issue with - I can't remember the terminology - but it's physical X-rays rather than digital, not with reading them but reporting them. Reading and reporting are two different things. For some categories its actually up to 12 months that they've gone unreported, not unread; I keep emphasising the difference. This is a process identified by medical imaging and we're going through a process of triage of those to get to them - they are read - there is a recent upgrade to our storage of these which is called PACRIS [he means RIS PACS] - I haven't got a clue what that stands for, by the way - which is the storage methodology for them, and we're changing that storage. This has become a particularly urgent issue for us to address, and we're doing that through the Royal. As at the last report to me, there are around 24,000 of these unreported - I will call them X-Rays, but images.

Ms LOVELL - In terms of that work being done between the reading and reporting, would a radiologist do that work?

Mr WEBSTER - Radiologists would do the reporting, whereas the individual doctor - like if it's a an X-ray of a child's arm who has broken their arm, the X-ray might be shown to the ED doctor, who would then have done something and not need a report to do an action; but there still should be a report attached to it, so we're working our way through that.

Ms LOVELL - Okay. I understand that there was approval for the recruitment of two radiologists, but that has been withdrawn. Is that correct, that the approval has been withdrawn?

Mr WEBSTER - Not to my knowledge. I think I would know.

Ms LOVELL - Are being recruited or have been recruited? What's the update on that?

Mr WEBSTER - Being recruited.

Ms LOVELL - Being, OK. Thank you. You were looking for some data on length of time statewide.

Mrs ARCHER - Statewide information on reporting?

Ms LOVELL - Yes. Is this across the state or is it something that's specific to -

Mr WEBSTER - This is an issue at the Royal Harbour Hospital. There are no reports of this being an issue in the other two centres.

Ms LOVELL - Do you want me to keep going Chair.

Mrs ARCHER - If Ms Lovell would like to hear about increased investment in imaging?

Ms LOVELL - Is it going to fix the problem of reports taking 12 months? If you have something to add, sure.

Mrs ARCHER - Yes, I think it will assist.

Mr WEBSTER - We have done a number of reviews across medical imaging, in fact what I would call diagnostics, so both pathology and medical imaging. Demand has grown exponentially. It is more than just the general demand, because the number of diagnostic tests and imaging opportunities has actually increased with technology, et cetera. In line with that, the 2025-26 budget through the demand line will see an extra 0.6 or $600,000 in the northwest for imaging, $1.5 million in the north. In the south, $6.763 million has been provided to be split between imaging and pathology because of the demand.

Ms LOVELL - In the south?

Mr WEBSTER - In the south, yes. That funding is a permanent increase in funding.

Ms LOVELL - Is that for additional staff, equipment or what? Staffing?

Mr WEBSTER - That is just on staffing, just on operation associates.

Ms LOVELL - Great. Thank you. Do other people have one?

CHAIR - Yes, Cassy has one in this area.

Ms O'CONNOR - Yes, thanks Sarah.

Ms LOVELL - I am anxious of not taking over.

Ms O'CONNOR - Minister, nursing and allied health staff are entitled to leave and funding for professional learning and development. We have heard multiple reports of staff requests for study leave or professional development either being refused or the leave is approved, but no funding provided for course fees or travel. I know the budget's tied, but this is despite both being part of nursing and allied health awards.

Minister was the Professional Development Fund created as stipulated in the 2022 Allied Health Professional Public Sector Union Wages Agreement? If so, how much money was allocated to this fund in 2024-25?

Mrs ARCHER - Thank you. I will ask the secretary to make some remarks, obviously noting there may be specific individual circumstances.

Mr WEBSTER - The agreement you referred to is for allied health professionals. The funds created and administered through our chief allied health officer sitting in our Clinical Quality, Regulation and Accreditation unit, CQRA. The fund has been created, there's a certain amount per allied health professional. There are ongoing discussions about whether it remains as a fund as in the current agreement or whether it should be removed to individual as in other awards, like doctors. It is an individual allowance, but it has been created, and it is available, and they make the application through the Chief Allied Health Officers office for access to that fund.

Ms O'CONNOR - And for nurses? I am trying to get a picture here of how many allied health professionals and nurses have been approved for professional development under their respective awards in 2024-25.

Prof ARYA - For nurses, it is actually included in the award, very much like doctors, but for allied health it isn't. That is the reason why there is a separate fund.

Ms O'CONNOR - I see, so nurses have a specific provision in their award; allied healthcare workers don't, so it wasn't established. My understanding is it was stipulated in the 2022 Allied Health Professionals Public Sector Unions Wages Agreement.

Mr WEBSTER - That sets up the fund arrangement, so they have to make an application, whereas with the nurses and doctors it's actually part of their entitlements.

Ms O'CONNOR - Thank you. Is there data available on how many approvals there have been for professional development for allied healthcare workers and nurses in the past financial year? Does the data include how many were refused?

Mrs ARCHER - We can take it on notice.

Ms O'CONNOR - Okay. Can you provide any data on the status of nurse and midwifery employer-assisted study leave by division, classification and region in 2024-25 or is there a global figure that we could see?

Mr WEBSTER - We will pursue the study leave, which is a particular provision that people can apply for, but a lot of the time, for instance, with midwifery, it isn't done as a study leave provision. It's done as -

Ms O'CONNOR - A training add-on.

Mr WEBSTER - Yeah, as part of -

Ms O'CONNOR - Professional development.

Mr WEBSTER - professional development, but not just professional development, maybe a scholarship because we're pursuing that upgrade.

Ms O'CONNOR - Okay.

Mr WEBSTER - For instance, we're bringing in graduate nurses. We put them in mental health, and we put them through the postgraduate in mental health, but it's actually not treated as study leave per se. They're doing their on-the-job learning and we support them to do their course. We can get you a figure on study leave, but it would be almost meaningless in nursing because of these other approaches that we take.

Ms O'CONNOR - Study leave is not the response in nursing generally.

Mr WEBSTER - Yep.

Ms O'CONNOR - Okay. So, could we have some information on professional development of nursing and midwifery staff. And is it usual that staff, whether they're an allied health worker or a nurse who applied for professional development legal funding would be responded to. Because we're getting some feedback that some staff are putting in their applications and not hearing anything back, which sounds like a systems problem.

Mr WEBSTER - Nursing CPD would be very localised, so I couldn't answer that one.

Ms O'CONNOR - Localised to each hospital?

Mr WEBSTER - No, to each nurse unit manager that's managing rosters and things like that.

Ms O'CONNOR - Would they approve that kind of professional development?

Mr WEBSTER - That's right.

Ms O'CONNOR - Within the small unit in the hospital?

Mr WEBSTER - Yes, except where it might be an interstate conference. Though in those circumstances it would in fact be escalated to my level to approve the interstate travel along with the CPD.

Ms O'CONNOR - Okay. Do you have any information on the budget that's provided for professional development or is that something that's not recorded?

Mrs ARCHER - Across the whole workforce?

Ms O'CONNOR - If there's a global figure for professional development, that would be most more useful.

Mr WEBSTER -Because some of its allowances -

Ms O'CONNOR - Okay.

Mr WEBSTER - we subsidise it because it's an interstate conference and some of it is -

CHAIR - Some of it's mandatory.

Mr WEBSTER - through the fund, some of it's mandatory training so they actually do it through their workday.

Ms O'CONNOR - Okay.

Mr WEBSTER -There are a whole lot of categories and there's mandatory training such as CPR.

CHAIR - CPR. Keep people alive.

Mr WEBSTER - Those sorts of things. But there's also mandatory training that's prescribed by me as the secretary, for instance, child safety training.

Ms O'CONNOR - There's no actual allocation within the health budget for professional development that you could point to?

Mr WEBSTER - No. there's not. Because of the different ways it's administered for each profession in the area we just don't account for it in that way.

Ms O'CONNOR - As part of the savings that health has been asked to achieve, can you see that there would be any impact on professional development opportunities?

Mrs ARCHER - No, I wouldn't because some of those things are mandatory, but also as part of workforce development and retention it's necessary. We were talking with midwives the other day about ensuring that for upskilling midwives or re-entering midwives, for example, it's important for them to have those opportunities. No, but recognising that it's accounted for in different ways. I would be interested. As I said, I can't comment on specific individual circumstances and environments, but I would certainly encourage people if they feel that there's something amiss there to get in touch.

Ms O'CONNOR - I think it's just getting timely responses and hopefully approval for worthwhile professional development and training opportunities.

CHAIR - I will go back to Sarah for one more on this line item and then we will move to the next one.

Ms LOVELL - Thank you. I had some questions about maternity and birth services, specifically. Minister, if somebody wanted to access data about maternity and birth services in Tasmania, such as caesarean rate, epidural rate, or rate of vaginal births, where would they find that information?

Mrs ARCHER - That's a good question. As opposed to information requests or something, whether there is something publicly accessible available?

Ms LOVELL - Yes.

Mr WEBSTER - It's not on the dashboard, but we do collect it and I see it fairly regularly. Maybe we report it in a national data set.

Ms LOVELL - The Institute of Health and Welfare have a national mothers and babies report, but there doesn't seem to be a statewide report for Tasmania like there is in other states. Is this something that the government would consider? Is there a reason why we don't report that data?

Mrs ARCHER - I certainly see no reason not to.

Mr WEBSTER - Certainly, as the minister said, I see no reason not to. We've been increasing the amount of data we're putting on our dashboards over the last few years. We've been increasing the amount on a monthly basis but increasing the daily and that real-time stuff as well, so as I said, we certainly collect it, and certainly we can consider getting it put up there, particularly because we're reporting it through the national data set.

Mrs ARCHER - I'm also interested in speaking further to you if have a particular view of how you think that would be meaningfully reported as well. I'm sort of conscious because sometimes we put things on the dashboard, but what are we trying to achieve? In terms of maternity services that information is instructive. I'm keen to talk more about it.

CHAIR - On that point - and I'm sure you understand this - you can have a larger maternity ward with a number of obstetricians, and some may have a very low caesarean birth rate, while for some it may be very high, so a global figure, it doesn't really necessarily point to that. I think there are some jurisdictions which actually do take it down, regarding the actual caesarean section rate of a particular health professional. Am I right on that?

Mrs ARCHER - I think this is the point we make to Ms Lovell. The data is important and instructive, but how do we report that in that meaningful way? For example, perhaps the annual report as well, maybe, is a more meaningful way to deliver the information?

Ms LOVELL - Thank you. I'm aware there's a parliamentary inquiry obviously into maternity and maternal health services at the moment, but I understand as part of that evidence presented to that inquiry, the College of Obstetricians and Gynaecologists have identified that

obstetricians do not receive consent training, specifically as part of their studies. It's learn on the job, essentially. What assistance and training is the Tasmanian Health Service proactively providing to obstetricians on consent to make sure that we're in line with current legal standards of consent.

Mrs ARCHER - I might ask Dale to make some comments, or Dinesh?

Prof ARYA - I will need to look into the specific issue with obstetricians, but we do have very clear policy guidelines and protocols across the service that apply to obstetricians as well. As part of orientation induction, we do make sure that we are talking about consent, but for what is specific to obstetricians, I will need to look into what the concern is and what is not happening.

Ms LOVELL - What I'm asking for is there specific training or upskilling in that area for obstetricians to ensure that we are keeping in line with legal guidelines for consent for maternity and birth services, in particular?

Mrs ARCHER - I might take the question on notice because I think, as Dinesh has indicated, there might be policy positions, but I guess the question is are they being -

Ms LOVELL - You can have a policy position, but if you're not training people properly, then -

Ms LOVELL - I might take that on notice and come back with those.

CHAIR - On that, have there been any complaints from women accessing maternity services in regard to a lack of consent?

Mr WEBSTER - Yes there have; and in fact, in the review of maternity services in the north-west, and the reason why we took the decision to bring maternity services back into the public system in the north-west, is that there were a number of reports of that within that review. I think Ms Lovell referred to the evidence given by individual mothers to the maternity -

CHAIR - Maternal Health -

Mr WEBSTER - Select Committee in the Lower House in 2024, so there are reports through that as well, which resulted in us doing a maternity service review for the Royal, some of those the issues raised in the Select Committee, and heightening this issue as well.

CHAIR - It's been raised and obviously identified as an issue, and it is a pretty serious issue; an extremely serious issue. Have you tracked that since then? Has there been any improvement?

Mr WEBSTER - The level of reports has plummeted. Again, we continue to do surveys of mothers to make sure that after they've left the service we can get that feedback, because that was one of the outcomes of both that north-west review and the southern review was making sure the lived experience voice was being listened to.

Mrs ARCHER - Also I think that that information is provided to patients, to mothers -

CHAIR - Proactively?

Mrs ARCHER - Yes, proactively. There's a maternity information package that's given to women that talks about maternity care management pathways -

CHAIR - When they check in?

Mrs ARCHER - Yes. So making sure that patients understand their rights as well is an important part of that, ensuring that that's embedded across the service.

CHAIR - We might then move on to 2.2.

Mr WEBSTER - Regarding the stats that were reported around maternity services and different birth levels, there is actually the Council of Obstetrics and Paediatrics Mortality and Morbidity Tasmania Annual Report

CHAIR - Which is attached to the end of yours?

Mr WEBSTER - And also available on the Libraries Tasmania website.

CHAIR - It is tabled.

Mr WEBSTER - That's reported annually, through that annual report.

Ms LOVELL - For the state; for Tasmania specifically?

Mr WEBSTER - Yes

Mrs ARCHER - Again, I reiterate the point of the meaningfulness of that.

The secretary has some further information about TML safety.

Mr WEBSTER - In July we had 109 safety reports around pathology in the north-west; in August 69; in September, 71; and in October 35.

CHAIR - Do you rate them? Some of them would be relatively minor and some of them could be quite serious. Do you rank them?

Mr WEBSTER - Not in what's just been handed to me -

CHAIR - No, I appreciate that -

Mr WEBSTER - Through our SLRS or safety learning reporting system, we have a rating system of SAC 1 to 4; 1 being life-threatening or death -

CHAIR - Very bad.

Mr WEBSTER - Yes, through to 4, which can be addressed at a very local level with a tweak.

Ms LOVELL - Can we get that breakdown?

CHAIR - Is it possible to get the SAC 1-4 levels for those?

Mrs ARCHER - Yes

Ms LOVELL - Thank you.

CHAIR - We will put that on notice, then, and see how we go. That's it for your response at this stage, Minister?

Mrs ARCHER - Yes.

CHAIR - We will move to 2.2, which is non-admitted services, which includes the outpatient clinic, et cetera.

Output Group 2 - Health Services
2.2 Non-admitted Services

CHAIR - Minister, I note that the amount of money that was spent in this portfolio - or this output group - is greater than the budget. On the dashboard, the monthly one for the last year, the shining light North West Regional Hospital was the only one who actually wasn't continuing to increase in their wait times for outpatients. What is the plan to try and reduce these? Not only the numbers of people waiting, but the length of time they're waiting. I mean, North West Regional Hospital wasn't necessarily a shining light; there's still a lot of people there, but they weren't getting worse.

Mrs ARCHER - Right. Thank you, Chair.

The Outpatient Transformation Program forms part of the four-year outpatients transformation strategy, which is part of the long-term plan for healthcare in Tasmania. To address increasing demand and improve outcomes for patients, we are committed to improving access to public outpatient services. They include a range of specialist, procedural, surgical, medical, diagnostic, allied health and nursing consultations and interventions.

In the 2024-25 financial year, there were 575,753 outpatient attendances, which is a 10 per cent increase or over 52,000 more than a year earlier. There were 120,890 people added to the outpatient waiting list during the 2024-25 financial year. This is 9,456 more, but despite this, the outpatient waiting list grew by 8,096. The waiting list at the end of September is sitting at 67,967.

The department is providing ongoing funding to transform the way we deliver those outpatient services, to ensure efficient and effective services and enhanced access, but also reduced wait times. That's to allow us to see more people within clinically recommended timeframes and deliver improved outcomes for individuals and broaden community access.

Some of those investments are in:

- service delivery redesign to change the way we provide services, using new and innovative models of care including early intervention,
- alternative pathways,
- adapting clinician scope and considering any multidisciplinary nature of these services,
- information technology - which we have spoken about earlier - to modernise and simplify referral processes and to help improve communications between consumers and providers,
- business process redesign to streamline and standardise administrative processes, making it easier and more efficient for clinicians, clinic staff and referring providers, including extending the utilisation of SMS appointment notifications and reminder messages, and electronic patient waitlist audit survey. Some of that around filling cancelled appointments or reducing the number of patients.

CHAIR - Do not attend.

Mrs ARCHER - Yes, do not attend.

That is in addition to the investment that we've already made on digital technology with e-referrals, which has been implemented statewide since 2023. We are also publishing outpatient waiting list information on the Health system dashboard.

The percentage of patients who didn't attend an outpatient appointment was recorded at 6.6 per cent in June and that remains below the target set. That's indicating that more Tasmanians are attending their schedule appointment, which is obviously very welcome.

CHAIR - I was going to comment on that; the measures seem to be having an effect. But when you look at the actual numbers of people who do not attend, there's still over 3000 every month type of thing. So, where they don't turn up, do you actually contact them to understand why that is?

Mrs ARCHER- Yes. I will let the secretary make some more comments.

Mr WEBSTER - We do a couple of things. We are now doing a program where we randomly ring people if they don't arrive, to say, what was your experience around that? They might give us feedback that we didn't understand your text message or your letter or whatever. We're doing that type of surveying, but each person that doesn't arrive also gets contact in terms of why they didn't arrive. It may be that they didn't arrive because they've already, through their GP, accessed a different service so we can remove them.

CHAIR - Forgot to cancel.

Mr WEBSTER - Exactly.

CHAIR - But they do all get reminders, don't they?

Mr WEBSTER - It does vary across some of our specialities still, unfortunately, and we're standardising that so they do get reminders. There is an issue with Australia Post not delivering every day of the week anymore, or every day of the business week anymore across Tasmania, so there are circumstances where people are getting their letters after their

appointment. There are also circumstances where, in some of our specialities, we're booking quite a length of time ahead, where the person gets the letter, puts it away -

CHAIR - There's a balance there.

Mr WEBSTER - Yes. There's those sorts of things, but yes, we follow them up, but we also follow a sample of them up around are our processes right, rather than a 'can I rebook you' type of approach.

CHAIR - What percentage of the 6 or 7 per cent of patients that don't turn up would not have a mobile phone? Do you know that? Obviously, a text message the day before is one of the best ways. We all get them for any appointment we've got, pretty much. I know you're dealing with - particularly up my way - a lot of older people, some of them struggle with mobile technology. Is this one of the issues, are you relying on Australia Post, which is terribly fraught?

Mr WEBSTER - Some of it is. Most people have a mobile phone or access to someone with a mobile phone, but it's whether or not they respond to the text or believe it's from us and how people react to that is what we're getting feedback on. Also, there is technology - and we are investigating the rollout of this as part of our suite - where you can actually pick up that someone hasn't read the text message. That could then flag us to make a phone call to remind them to come. We are looking at those types of technologies as well, and that's part of this outpatient transformation. I did want to comment on your comment about the north-west being better than the rest of the state, remembering of course that a number of north-west clients on outpatients actually are on the LGH or the Royal Hobart Hospital wait list, not the north-west -

CHAIR - You didn't have to mention that. The member for Launceston will be on my case now you've said that.

Mr WEBSTER -The reason for that is that some of our specialities, because of the delineation across hospitals, we do have specialisations in Launceston and Hobart that don't - aren't in the north-west. Equally, to be fair to the member for Launceston, there are some specialities that we don't deliver in Launceston where the people are just on the roll in the hospital.

CHAIR - Can't whinge too loudly: I will pass it on to her. I'm sure she will be pleased with that. Unless anyone else has really got any questions, we might keep moving.

Ms LOVELL - I'm not sure if it's on this one, I wasn't really sure where this actually fits in terms of output groups, but it was about the commitment for GPs to be able to diagnose and prescribe for ADHD. Is that not admitted? I don't know really where that -

CHAIR - Where does that fit? Public health? No? I didn't know. Community health?

Mrs ARCHER - These are your rules, so you can ask whatever you like.

CHAIR - We will put it in here.

Ms LOVELL - Okay, great. Thank you. Now I've got to find it, sorry. My questions were around the training - sorry. This is in relation to the election commitment to allow GPs to

diagnose and treat ADHD. What will the training requirements be for this and who will provide the training? How many hours will it involve? What's the cost and who will pay for it?

Mrs ARCHER - I will provide you with a little bit of detail and then Dale might be able to provide you with some more. I probably don't need to go into the reasons why we are doing it. Obviously, there are increasing presentations and people having to travel interstate to - I might add as part of that, reducing some of those barriers through the interstate prescribing, there's also obviously part of that as well, so the pilot ADHD clinic for children was established in 2025 to provide a specific service for neurodevelopmental assessment and management, with a joint model of care between paediatrics and the Child and Youth Mental Health Service. That is one part of the suite of initiatives to respond to ADHD.

In relation to the election commitment for GPs to diagnose, treat and manage ADHD, that work is underway and it does include obviously ensuring that appropriate training is provided to GPs. It will enable general practitioners to specifically refer at the moment as well. In terms of cost, I'm just looking for cost details there, sorry -

Ms LOVELL - Sorry, specifically refer -

Mrs ARCHER - Into the ADHD clinic, which is not what you're asking me about because you're asking me about GP clinics. I might just ask Dale to give you the updated information about where we are at in relation to those ongoing - or Dinesh might like to actually respond to that - rollout of that election commitment, and I have met recently with both with GPs but also with other specialists around ensuring that there's appropriate frameworks in place for that as it rolls out.

Mr WEBSTER - I will start; Dinesh will fill in any blanks that I leave. The first thing is that we're working with the Royal Australian College of General Practitioners to define what needs to be in the program, to define how it will be delivered and then working out the ongoing supervision required that attaches to that. We've started those discussions. It's hard for me to actually say to you, 'It's going to be this number of hours, et cetera, and this will be the cost,' because really we need to make sure the college are on this journey and will be part of the delivery of this.

If I give you the example in terms of hours and supervision in WA, who went slightly earlier than us, they're looking at 13 hours upfront, and then supervision from either a psychiatrist or paediatrician over a six-month period to reinforce that training over that period, and that would be one hour per month under their model. We will work with the college - so I'm not saying we will pick up the WA model, I'm just using that as an example of one of the models that's in the market already, but we're working with the college to define it for Tasmania.

Mrs ARCHER - And of course, Queensland has also just implemented this, and the other wider point is there's been discussions at national level as well around a desire over time to have a harmonisation across the country, but also with a view that we don't want to stop individual states from continuing to be able to step in and do that.

Ms LOVELL - In terms of the supervision requirements, you said you're talking with the College of GPs. Presumably you'll also be talking to the colleges for those specialists as well to make sure we've got that workforce to be able to do that supervision that's required.

Mrs ARCHER - Yes.

Mr WEBSTER - Yes, of course, but primarily we started with the college of GPs because that's where the delivery will come from.

Ms LOVELL - I understand too, in terms of the capacity constraints that exist at the moment, that one of the obstacles is around co-prescribing that I believe used to be available, and then there was a change, and now it's not available and there's a requirement for review of prescriptions regularly that causes quite a backlog, particularly where you've got a situation that's not complex and maybe doesn't need -

CHAIR - Medication reviews.

Ms LOVELL - Yes, medication reviews. Is there any thought into amending - I think it's the *Poisons Act* that would need to be amended to allow that co-prescribing model again so that there's not that additional review requirement that maybe isn't as necessary?

Mr WEBSTER - We have a review of the *Poisons Act* underway. All of these things will be reviewed as part of that. The co-prescribing review period also overlaps into federal regulation, so we're working with the the federal government on that side of it.

CHAIR - It would be good if you talked to the federal government about allowing Telehealth for subsequent medication review appointments. Not the first appointment, which is when they should go to the patient's home, but the subsequent ones to help our more rural pharmacists undertaking this role.

Mrs ARCHER - There is more that can be done in relation to Telehealth and notwithstanding that - we were talking about COVID earlier - the work that was done to develop Telehealth from zero to 100 in a pretty short amount of time. There are a lot of opportunities and still some things to work through, but still a lot of opportunities ahead as well for Telehealth.

CHAIR - It avoids taking a single pharmacist out of their practice for some time if they're flying to one of our islands. I am happy to get you to talk to someone about that if you need to understand it more fully.

Ms THOMAS - Thank you. I know Sarah touched on pathology services earlier, but if you didn't already, can you tell us how many patients are currently waiting for an anatomical pathology report on their biopsy?

Mrs ARCHER - We talked about radiology earlier.

CHAIR - Equally important.

Mr WEBSTER - We are not aware of any wait list for those reports.

Ms THOMAS - I have heard reports the capacity of the public radiology and pathology departments are a critical issue. There is something in the order of 1521 biopsies and a wait time of 12 weeks for people getting results. That's not something you're aware of, minister?

Mrs ARCHER - Not that I'm aware of, no.

Mr WEBSTER - We did outline this slightly earlier, but there is increasing demand for pathology and radiology. I outlined earlier that at the Royal, for instance, there is $6.7 million ongoing to uplift both pathology and radiology. There are increases in pathology at the Launceston General and of course in the north-west it is outsourced. In addition to that, Deloitte did a major review of pathology and reported in 2022, which has resulted in us creating an implementation plan to create a statewide pathology service. That will leverage all of our pathology arms into one service similar to what we did with pharmacy 12 or 13 years ago. If there is a need to use resources from a different area, we can so that we can actually structure our pathology and be responsive to individual demand. That is funded as part of our uplift for meeting demand in pathology. If there is a backlog in pathology, there is funding through the health demand line in the budget to increase the number of pathologists, medical scientists, doctors, et cetera, in those areas.

Ms THOMAS - Minister, is that something you would take on notice to come back with if there is zero results waiting for anatomical pathology results?

CHAIR - Reports or results?

Mr WEBSTER -Yes.

Ms THOMAS - Maybe both then?

Mrs ARCHER - We can go away and see what else we can find out.

CHAIR - It is probably the reports that are critical.

Ms THOMAS - The concern that has been reported to me is the long waits can be the difference between living or dying. When you're talking about someone being diagnosed with cancer, if it's not caught soon enough to treat or not able to be precisely located because it's moved in the time between testing and result or report.

Mrs ARCHER - We can take it on notice, but also, I previously mentioned if certainly there are individuals with specific concerns, I would encourage you to share that information.

Ms THOMAS - This may be part of the $6.7 million uplift package, but, minister, are you aware as to whether all of the public health radiology equipment is current and serviced and eligible for Australian Government rebates?

Mrs ARCHER - I'm wondering whether the secretary might have an update in relation to this? We did have a question on Monday in relation to an MRI machine at the Royal. Did you have any further update on that at this stage, Dale? Otherwise, I think had to have taken that on notice the other day.

Mr WEBSTER - No, I'm just looking to my Deputy Secretary of Hospitals to get that update. He's not looking at me. We might have to take that on notice.

Mrs ARCHER - Dinesh can provide an update.

Prof ARYA - I think licencing of MRI machines for Medicare is a little bit complex because the licencing arrangement changed on 1 July. Until 1 July it used to be an equipment-based licence. Only equipment that was licenced you could use to bill Medicare, but from 1 July it is now a practise-based licence. Any practice that is approved for billing can then bill Medicare. In fact, from 1 July 2027, this licence actually will be removed completely. The Medicare reimbursement will become automatic for any practise that is approved for this licence.

The other complexity we probably need to understand is the difference between in-patient imaging and out-patient imaging. In-patient imaging is covered by the state-funded medical imaging services anyway.

CHAIR - The wonderful cost-shifting arrangement we have.

Prof ARYA - Yes, but for out-patient imaging, there we can bill to Medicare.

Ms LOVELL - Has that been an issue? I have heard you say that the licencing system is changing, but has, Minister, are you aware whether that's been an issue that has prevented the Tasmanian government from getting rebates, not being eligible for rebates, over recent years because our machinery and equipment has been out of date?

Mrs ARCHER - Do you have any further information in relation to this?

Mr WEBSTER - No, I don't.

Mrs ARCHER - We will take that on notice, Ms Thomas. Which as I understand, we did on Monday take that on notice from the other committee as well. We will provide that to you as well.

Ms THOMAS - I do have some others on this line or do we need to move on?

CHAIR - Probably need to move on fairly soon. Do you have anything you want to pick at specifically?

Ms THOMAS - Further to this similar topic, I guess, around cancer services. There's been concerns expressed that the current provision of chemotherapy chairs is not sufficient to meet current demand, let alone increasing demand as cancer rates we know are expected to continue to rise. Has there been any modelling done on the number of chemo beds required? If so, what does it say? And is there any budget allocation over the forward estimates for increased chemo beds, including for furniture and pharmacological services?

Mrs ARCHER - Thank you. I will ask the secretary to speak to that.

Mr WEBSTER - In terms of how we project future demand, we have the long-term health plan and then sitting beneath that the clinical services profile that tells us what we need to increase. In terms of medical equipment, through the Budget, we have the medical equipment fund. If is a need for specific equipment that can be applied to all through there.

In terms of pharmacological, we have in fact increased. There is actually an allocation to the state-wide hospital pharmacies to increase the pharmacists within our compounding area.

The capital spend on a new pharmacy at the Royal Hobart Hospital included a new sterile compounding suite and increased capacity there.

CHAIR - To prepare the pharmaceutical treatments?

Mr WEBSTER - To prepare the pharmaceutical treatments for chemotherapy, et cetera, if required. In addition to that, we have a contract with Slade pharmaceuticals, where they actually fly in some of our pharmaceuticals related to cancer treatment and to radioisotopes on a daily basis.

Ms THOMAS - Minister, are you satisfied that the current provision of 17 beds is sufficient to meet current demand?

Mrs ARCHER - Look, I think it's always going to keep an eye on those things. I'm comfortable with the advice provided by the secretary at the moment, noting that there's a range of other upgrades, treatments and others associated with that.

Just possibly linked, but to your previous question as well under that medical equipment, the medical residence imaging upgrades at the Royal is one of those pieces of equipment that procurement has commenced for at a cost of $1.2 million, and I note that in that provision of those medical equipment that does also include in that list some services specifically for cancer services as well like echocardiograph machine as well at a glance.

CHAIR - We might move on to 2.3 Emergency Department. Sarah, if you can lead on that?

Output Group 2 - Health Services
2.3 Emergency Department Services

Ms LOVELL - Minister, I wanted to talk about the transfer of care protocol. I know there was some discussion about this on Monday as well. I refer also to an ABC report from earlier in the week, that was Monday as well, 17 November, so I understand that there's a bit of a push to go to the next step and reduce the transfer of care timeframes to 45 minutes this year.

You gave some data to the committee on Monday, I believe, around the transfer of patients from ambulance to Emergency Department, I don't know if you might want to recap that just for this committee's benefit.

Mrs ARCHER - As you noted, the performance of the transfer of care delay procedure is closely monitored and reported by Ambulance Tasmania. In September 2025, 82 percent of ambulance arrivals statewide were released within 60 minutes. Ambulance Tasmania is now progressing the second phase of the transfer of care protocol to reduce the target from 60 to 45 minutes by the end of 2025.

In 2024-25, 86 percent of patients were transferred to the care of ED clinicians within 60 minutes.

Ms LOVELL - Sorry, 84 percent?

Mrs ARCHER - 86 percent.

Ms LOVELL - 86 per cent. That was over the whole financial year? In September it was at 82 per cent, was that for the month?

Mrs ARCHER - 82 per cent for the month, yes, so that's the reported data on the dashboard. In 2023-24, which is following commencement of the procedure on the 22 April 2024, 86 per cent of Ambulance Tasmania arrivals statewide were released within 60 minutes of arrival. In the 17 months since the procedure was implemented, there have been 15,779 hours of transfer of care delay. In 2024-25 there were 9920 hours of transfer of care delay, which is the lowest level since 2016-17 and is 17,478 fewer hours or reduction of 63.8 per cent compared with 23-24.

Ms LOVELL - Just on those statistics that you've given at that 82 per cent in September, 86 per cent in the financial year, they're statewide figures. Have you got a breakdown across the state at the four hospitals?

Mrs ARCHER - Yes, I understand that the secretary does have a breakdown.

Mr WEBSTER - We will get that quickly. It's actually on the dashboard, but I can't get my hands on it. Maybe if we move on to the next thing and I will come back to it in a few minutes.

Ms LOVELL - Yes, no problem.

Mr WEBSTER - I apologise for that; it's incredibly small writing. The September figures are: the Royal Hobart Hospital, 79 per cent; Launceston General Hospital, 83 per cent; the Mersey Community Hospital, 83 per cent; and the North West Regional Hospital, 89 per cent. I don't have the full financial year 2024-25 broken by hospital.

Ms LOVELL - Okay, that's fine. Can we get that?

Mrs ARCHER - Yes.

Ms LOVELL - Thank you. The key with this policy is that it affects a number of areas, it's not just about that transfer of care. What is the protocol achieving in terms of ambulance response times? No, we will come to that. Can we do it all here?

CHAIR - Maybe leave that to ambulance response times, just stick with the emergency department.

Ms LOVELL - Okay. Coming back to ambulance response times, what is it showing you of the wait times in the emergency department? Once somebody is transferred out of the care of the ambulance service into the care of the emergency department, what's the data showing you on access to care within clinically recommended time frames?

Mrs ARCHER - I will just ask the secretary to find the very small numbers on that. While he's doing that, I will make the point that the transfer of care protocols, as we've seen, are having a significant impact on those times. That is important. I acknowledge though that also has consequences in terms of the emergency department. Data will give me some figures.

Ms LOVELL - The ultimate goal is about getting access to health care faster for people, so is this protocol actually achieving that or is it just achieving a reduction in numbers, that's really just about time spent on the ramp.

Mrs ARCHER - Well, it gets ambulances back out on the road quicker, so that is also important -

Ms LOVELL - We will come to ambulance response times in a later output group, but in terms of access to care?

Mrs ARCHER - Yes, and I know I've made the point before, but that's also got to be viewed in the context of demand. It is important we note those hours saved because that does get ambulances out in the community quicker. I think the secretary has found some information now.

Mr WEBSTER - In 2024-25, the percentage of patients that had a length of stay of less than four hours in our hospitals was 47.5. In the previous financial year, it was 50.4 per cent so it actually decreased. However, the context is that the number of presentations in 2023-24 was 52,152, but the number of presentations in 2024-25 was 55,040, almost 3000 extra.

CHAIR - Can I just question those figures? That's not what's in your annual report. You say additional presentations or presentations all up? Because the number in your annual report says ED presentations in 2023-24 are 177,639 and it does go up in 2024-25 to 183,120.

Mr WEBSTER - That's presentations that resulted in an admission to the hospital, sorry, the one I just read out. That's the total number of people coming to our EDs.

Ms LOVELL - Minister, your secretary just said the percentage of people with a stay of less than four hours in the hospital, is that within the hospital or the emergency department?

Mr WEBSTER - In the emergency department.

Ms LOVELL - So they may have been admitted into hospital?

Mr WEBSTER -No that's - yes, they may subsequently have been admitted.

Ms LOVELL - Come to the emergency department and gone home or they've come to the emergency department and been admitted to hospital.

Mr WEBSTER - The total stay is less than four hours. That may be that they're admitted within that four hours, or they may have gone home within those four hours or moved.

Ms LOVELL - Yes, total stay within the emergency department, not within the hospital,

Mrs ARCHER - No, within the emergency department.

CHAIR - That doesn't cover any time in EMU, does it?

Mr WEBSTER - No, it doesn't, because EMU is the short-stay unit.

CHAIR - No, that's considered as admitted to the EMU.

Mr WEBSTER - That's right.

Ms LOVELL - 47.5 per cent of patients have a stay of less than four hours or a process through the emergency department in less than four hours. What about beyond that? I mean, that's less than half of the patients that are presenting. How long are the rest of those patients waiting in the emergency department?

Mr WEBSTER - We track it to eight hours. Again, this is actually admitted rather than - I'd probably have to take - rather than give you the wrong stat because we go through admitted and some are not admitted and things like that. We will get that for you, if that's alright.

Ms LOVELL - We ask for this stat every year, so I'm a bit surprised that we don't have it.

Mr WEBSTER - Me too.

Ms LOVELL - Anyway, we can take that on notice. I know there's - and this again, annual report - and there's the dashboard. There's clinically-recommended timeframes for different triage categories; are those statistics improving since the introduction of the transfer-of-care protocol?

Mr WEBSTER - If I look at category 1, they've always sat very close to 100 per cent anyway, but there is a slight improvement of 0.2 per cent at the LGH because they've dropped to 99.8 per cent in the 2023-24 financial year. Category 1 sits up there.

Ms LOVELL - Category 2?

Mr WEBSTER - Category 2, again, I'm going to have to take that on notice to go down into the categories.

Ms LOVELL - If we can get a breakdown of the percentage of patients seen within clinically recommended times at each of the categories at the four hospitals, that would be helpful. Have any additional resources been provided to the emergency department to deal with the increased pressure as a result of increased demands? I mean, it is increased demand generally. We all understand that.

Mrs ARCHER - Increased demand.

Ms LOVELL - Of course, but it's just particularly in relation to this protocol, that's increasing demand also. I mean, the demand will be there obviously anyway, but there's is significantly increased demand.

Mrs ARCHER - Yes and as you've heard, it is significantly increased demand.

Ms LOVELL - Perhaps I will rephrase that: putting aside the transfer-of-care protocol, there is increased demand on the emergency departments. What additional resources are being provided to help deal with that?

Mr WEBSTER - Specific to the Royal Harbour Hospital, there was a $22 million lift in last year's state Budget. For the LGH -

CHAIR - For the Royal?

Ms LOVELL - The 2023-24 state Budget? Oh sorry, 2024-25.

Mr WEBSTER - 2024-25, yes. You will see in the state Budget that there is in fact a lift of - I'm doing this sum in my head - about $48 million in allocation to the emergency department output which matches to demand; that's in addition to the $22 million.

Ms LOVELL - An uplift: that's by comparison to the budgeted amount from last year? What about the actual amount that was spent?

Mr WEBSTER - It has remained steady.

Ms LOVELL - The actual amount spent in the ED in 2024-25 is?

Mr WEBSTER - Steady in 2025-26 on those figures. So the same amount -

Ms LOVELL - Sorry, that's the same amount that's budgeted, so the actual spent in 2024-25 is the same as that budgeted amount in 2025-26: one eighty-six three eight six?

Mr WEBSTER - That's it, yes.

Ms LOVELL - So there's no additional resources, but we're seeing increasing demand?

Mrs ARCHER - We're also seeing increasing demand despite the introduction of urgent care clinics as well, and we've seen good statistics around presentation at Medicare urgent care clinics, and that is diverting people from hospital, but we are still seeing those high levels of demand. I have -

Ms LOVELL - How will the ED manage that increase in demand without increasing resources?

Mrs ARCHER - It goes to why I continue to talk in recent days around the national health reform agreement, because in the next 5 years, that $673 million - that's 1.2 million emergency department presentations, for example; 128,000 elective surgeries - and this is on top of those discharge delays that we were talking about. I've said it a lot of times in recent weeks, and I've been very clear to say it's not about blame, but we have this increasing demand and we are also having the federal government linking that funding arrangement to driving down demand.

Ms LOVELL - I understand that the reform agreement is underway, the negotiations are underway, but the state government has a responsibility here as well. Presumably, if there's a dual-funding model and demand is increasing, both funders should be increasing their funding or their resources. How is the state government explaining not increasing emergency department funding at all by comparison to what was spent last year, when we know and have known for a very long time, that demand is always increasing?

Mrs ARCHER - We're also looking to meet that demand across a whole range of other areas to try and stop emergency department presentations, for example: some $50 million into primary care and other hospital avoidance initiatives like Care@home which we talked about earlier, or the mental health emergency response. We're looking right across the health system, that health ecosystem, to look at ways that we can drive down emergency department presentations. Whilst looking at are we meeting demand within the emergency room, it's also about looking at the whole range of initiatives across the system to avoid those presentations in the first place.

Ms LOVELL - Increased investment in primary care and preventative health is commendable and that's something that I've advocated for a long time; but the impacts of that in terms of hospital presentations will be years down the track. That's not going to have any great impact on a reduction in demand in this financial year.

Mrs ARCHER - Preventative health, yes, but I think not necessarily in relation to primary health. Again, this is the state stepping into an area that is not the state's responsibility.

Ms LOVELL - Primary care presentations to emergency department are not sitting in category 1 or category 2.

Mrs ARCHER - Correct.

Ms LOVELL - In fact, they're probably not even being admitted to the emergency department; they're probably either sitting in the waiting room and going home, or they're treated very quickly and discharged, so they're not really having a great deal of impact on the real demand in terms of care that's needed in the emergency department. Again, it's a good thing to invest more in primary care, but we're not going to see an impact of that on demand in any significant way in this financial year. It comes back to that question about how the emergency department will cope with an increase in demand without an increase in funding.

Mrs ARCHER - Exactly: that's the point I have just made. We do need an increase in funding, and we need that funding to come from the federal government. We still had over 7000 category 5 presentations at emergency departments.

Ms LOVELL - Is your argument that the state government should not have to increase its funding despite increased demand?

Mrs ARCHER - The state government continues to invest a record amount of funding in our health system, and we have increased that funding, but as you have pointed out, this is a shared responsibility. We are meeting our responsibility -

Ms LOVELL - But you haven't increased the funding.

Mrs ARCHER - - in relation to both hospital care, and also in relation to primary care and other areas that are not areas of state government responsibility. We are doing that because we care about the health of Tasmanians, but we do need your federal colleagues, and I think that you could join us in asking for that, because -

Ms LOVELL - You haven't increased the funding, though, minister. You just said you've increased the funding, minister, but you haven’t.

Mrs ARCHER - We have increased the funding in the health system -

Ms LOVELL - The secretary just told me that the funding for emergency department services is the same as the funding that was spent in the emergency department -

Mrs ARCHER - and I have just explained to you -

Mr HARRISS - Sarah, just on that, when the secretary says it's the same, correct me if I'm wrong, it's actually $6.2 million less from last year's actual that's in this year's budget. It's similar, but it is actually less so, it's not going up. That's what I understand, anyway.

CHAIR - When you count inflation costs.

Mr HARRISS - Yes, so it's 6.2 less than the actual from last year.

Mrs ARCHER - We talked earlier about the difference between the actual and the budget. I will ask the secretary to make some more comments.

Mr WEBSTER - I was just looking over my shoulder as you saw as I did that so if I've got it slightly wrong, I apologise for that, but what I would say is that we significantly increased it to match demand and including at the Royal the $22 million investment to make sure we can uplift the number of doctors and nurses.

We continue to to staff the LGH above the calculation of nursing because of the pressures there. We do have additional staffing in our EDs to match with demand. It might not be reflected in a headline budget figure, but we do match the demand because it's coming through the door. Your point about fours and fives don't cause the blockage, but they still have to be seen.

Ms LOVELL - Some of them are not being seen, they go home.

Mr WEBSTER - The number that leave is very small.

CHAIR - What is the number for the do not waits?

Mr WEBSTER - The do not waits is 4.6 per cent.

Ms LOVELL - Do you track how many could be seen like GP level?

Mr WEBSTER - The category fives are basically all GP level and category fours are mostly GP level. If you take four and five it's around between 35 and 40 per cent of all patients coming into the ED are in those two categories and that continues to be there. It has declined slightly with the urgent care clinic coming online, particularly where they're close to the hospital.

But it continues to be a demand item because people can't afford to go to a GP because of our bulk billing rates or indeed because of the hours of GPs, because of the the areas where GPs are they don't have access etcetera.

Ms LOVELL - When you, and I'm sure you do too, when you talk to staff in the emergency department, they would argue that number of people who should be seen by GP is actually very low and that most of the patients that are in the emergency department need to be there. But again, coming back to this funding, you have less in the budget for this year for emergency department than was spent last year, that then increases by a tiny amount for the next year-

CHAIR - By 5.2 per cent over the forward Estimates.

Ms LOVELL - But then it decreases, so you're projecting to spend less in the Emergency Department than was spent in the last financial year in the out years of this budget.

CHAIR - That's only 5.2 per cent over forward Estimates too.

Ms LOVELL - And when you take into account inflation?

CHAIR - Health inflation.

Ms LOVELL - Health inflation and increase in demand, which I know there's some measures underway.

CHAIR - So your question?

Ms LOVELL - How do you expect the emergency department to cope and for things not to get worse when they're already some of the worst statistics in the country?

CHAIR - Let's go back to the question.

Mrs ARCHER - I would reiterate the two things I have previously said. One, obviously demand driven system. Secondly, revenue is an important part of that, and we do need the Federal Government to play their part in this as well. But I would also note that Tasmania has more healthcare workers than any other state.

CHAIR - Per population.

Mrs ARCHER - Per head of population, and we have increased the number of hospital beds to more than twice the national average and we have increased healthcare spending and we are taking those measures, to try and drive down demand to the best of your ability both in the short and medium term and in the longer term with preventive health strategies.

But this is a shared responsibility, and everybody needs to play their part in that. Tasmania is not alone in calling for that. All states and territories are united in calling for a better deal from the federal government so that we can do more. But we reiterate, we spend 34 per cent of the state budget in health, we're continuing to invest in our healthcare systems, including in areas that are not the responsibility of the state government because we are trying to drive down that demand and provide better access to Tasmanians where they live.

CHAIR - Can I give Cassy this one?

Ms LOVELL - I have one more on the transfer of care and then I'm happy to go to Cassy.

Going back to the transfer of care protocol, I just had a question about what happens when patients come in. Say, a patient presents to the hospital themselves, they have someone drive themselves in and somebody presents via ambulance, triaged at the same category, both requiring the same level of care as urgently as each other. With that transfer of care protocol, what happens in terms of who takes precedence in that situation?

Mrs ARCHER - I will hand to Dale; it would be a triage situation.

Mr WEBSTER - That's correct. You can say they're the same category level, but other factors will be factored into that. If they're both category 1, then they're both seen immediately. If they're category 4 or 5 then the person coming in by ambulance may be transferred to the wait room of the hospital.

Ms LOVELL - What I'm talking about is, say you have - let's use category 2, as an example. You might have someone with chest pain or something in the waiting room. Equal. They do an assessment, I know, and make a determination, and this is something that I hear happens quite frequently. There are patients who need care equally as urgently. If they come in via ambulance, is there pressure on the Emergency Department to transfer those patients - say there's only one bed available or one treatment spot, whatever you call it, available in the ED - is there pressure to take the patient from the ambulance service more quickly because of the transfer of care protocol?

Mr WEBSTER - The short answer is no, there's not. It is around the triaging and it's not as blunt as everyone is category 2. There would be an assessment of which of these patients -

Ms LOVELL - I understand, what I'm talking about is where there are two patients.

Mr WEBSTER - This is why we would never achieve 100 per cent on any of these categories of transfer of care. It is because you've got to allow for the fact that there will be circumstances where, in fact, the person coming through the door who is not in the care of a health professional, will be prioritised over the person that's coming by ambulance who is in the care of a health professional.

Ms LOVELL - Of course, the staff do a very good job.

CHAIR - Surely, it's based on clinical need.

Mr WEBSTER - But that's a clinical decision, not the protocol.

Ms LOVELL - Of course, and the staff do an excellent job of that, but what I've been told is there are circumstances where that might not be. There might be some pressure. One last question on the transfer of care -

CHAIR - No, I will go to Cassy.

Mrs ARCHER - I think the situation could equally occur that you have two patients present through the emergency room or two patients arrive by ambulance at the same time. They will be assessed on their clinical need and triaged accordingly, regardless of how they arrive at the hospital.

Ms O'CONNOR - Minister, during Monday's discussions on health in the Lower House, there was a lot of talk about transfer of care delays and ambulance ramping. In discussing the issue of patients arriving at the hospital, and that interface with the Emergency Department and transfer of care occurring from paramedics to hospital staff, the secretary said:

> The reality is that the first 14 to 15 minutes is the usual handover period. We want them transferred within 15 minutes.

That's a view that reflects the Australian College of Emergency Medicine's advice that for clinical safety, handover should routinely occur within 15 minutes. I just want to confirm with you as minister, for the avoidance of doubt, that the transfer of care within 15 minutes remains the government's best practice goal for ambulance arrivals.

Mr WEBSTER - It is and that's why we continue to report that category. It's important that we actually do achieve that. As I said, there are clinical - the reason we use transfer of care delay as the sort of terminology is that they're in the care of a health professional. Ideally they should be transferred, but there were, as in the answer the previous question as I was saying, it may better to actually leave them in the care of a health professional because someone's come in the door that isn't the care of health professional.

There are always balances between them, which is why you'll never achieve 100 per cent, but ideally, with that's what we need to be going for.

Mrs ARCHER - And as quickly as possible.

Ms O'CONNOR - Thank you, Mr Webster and minister. In an ABC story published on Monday, the secretary is quoted as saying:

> Ambulances spent nearly 17.5 thousand fewer hours ramped in 2024-25 than the year before.

We want to confirm the data behind this statement. When you say ramped, are you using the commonly understood definition that the department, previous ministers and previous secretaries all use - that is, that 'ramped' or 'transfer of care delay' patients - are those subject to transfer of care delays greater than 15 minutes? What's the measure?

Mr WEBSTER - I've just had someone nod at me. That's how the data's derived.

Ms O'CONNOR - Okay.

Minister, the government, in quite an interesting election announcement that preceded you, announced a ban on ambulance ramping - which I hope you agree is just not only unrealistic but ridiculous - which was slapped down by the Industrial Commission last year when it ruled that transfer time frames couldn't be mandated. After that decision, the Premier and the former minister changed their language and instead talked about the 'goal to end ambulance ramping'. Is 'ending' ambulance ramping still the government's goal?

I know these might sound like very basic questions, but we're just trying to get to the bottom of what the policy is, the practice, and the evidence underneath it.

Mrs ARCHER - From my point of view, we want to see patients transferred to hospital as quickly as possible. We want to minimise the transfer of care delay that occurs. These figures that I spoke to you about earlier demonstrate that having those targets is resulting in fewer transfer of care delays. That is a good outcome, but that doesn't mean that you sort of 'set and forget' or you don't do any more. I think it's a continuous improvement situation, both in terms of transfer of care delays, ambulance response times - noting, of course, everything that we've already said about demand, and also recognising then that there are access and flow issues to overcome as well. We've also spoken about some of the issues -

CHAIR - We are getting a bit repetitive here. We spent a lot of time on this earlier.

Mrs ARCHER - Yes. I mean, I think it is part of a wider situation, but it is about minimising those transfer of care delays, getting ambulances back out on the road in the community as quickly as possible, and importantly, ensuring that patients are being able to be cared for and are being able to be attended to in the community as well.

Ms O'CONNOR - I'm sure that's true. We understand that so far the department has laid out a plan to gradually transition to transfer of care protocols at 45 minutes and then 30 minutes. Are you then planning to go to a 15-minute transfer protocol? What's the plan to reach the goal we talked about in terms of routine transfers within 15 minutes, and when do you think we might get there?

Mrs ARCHER - I will ask the secretary to make some more comments, but as I said, we can see that data is improving with the transfer of care protocols. That's what we want to see, that continuous improvement, and that has been achieved by setting that protocol, so I would say that that has been successful in that respect.

But I will ask the secretary to give some more information about phasing that approach, and recognising that - which I think Ms Lovell sort of indicated - it doesn't act in isolation as well. You can't just have that one part.

Ms O'CONNOR - It's all intimately connected, yes.

Mrs ARCHER - Correct.

Mr WEBSTER - I'd note - and again, we publish this data - that the percentage that are being transferred within 15 minutes and within 30 minutes has also increased as a result of this focus on transfer of care occurring quicker. So, in terms of 'will we be getting down to 15 minutes,' I think at that target, we will have that in there continuing. We're doing this in steps to make sure that the protocols meet what we're requiring. Some time in 2027, we will continue to report the 15 and 30 minutes, but we would hope that we're getting to the maximising 15 minutes once we've actually got these focus coming down.

Will we ever say our only benchmark is 15? I don't think we will; we will still have a 30-minute one because we will track the people in between, but it's about getting the focus right. As I said, by focusing on transfer of care and saying, 'we have to achieve it within 60 minutes as much as possible,' it's actually had a positive impact on what we're achieving in 15 and 30 across the network. Those sorts of improvements are what we're tracking in the background. I am hoping by getting the 30, we will be maximising the 15 to get there.

Ms O'CONNOR - I want to ask about the data around the extended transfer-of-care delays. I am not sure if this was passed on to Ms Lovell in her questioning. For 2024-25, what's the 90th percentile figure for length of delay for ramp patients? Is it possible to provide this statewide and for each hospital?

CHAIR - Do you have that data?

Mr WEBSTER - Yes, we have got to find it.

If you bear with me, I will do 50th, 75th and 90th, which is actually what we've been asked in previous years.

Ms O'CONNOR - Sure.

Mr WEBSTER - At Launceston General Hospital, the 50th percentile is 29, the 75th percentile is 41.2, and the 90th is 60.4.

At the Mersey, it's 25.4, 33.9 and 48.1.

At the North West Regional, it's 25.9, 37.3 and 53.4.

The Royal Hobart Hospital is 36.5, 55.2 and 81.5.

Ms O'CONNOR - From that data, where do you see the greatest opportunity for improvement?

Mr WEBSTER - Obviously at the tertiary hospital, which is the Royal. They're getting the most complex cases. They're getting most of the higher-level trauma cases and those sorts of things, but we do need to drive performance there. I think the minister already mentioned this, but the rebuild of the ED at the Royal is essential to that. It's also essential in the North West and Launceston, but the rebuild of the ED - a more efficient flow of the ED, where we have greater access to different types of treatment bays and those sorts of things - will assist in that. In the meantime, our focus needs to be on on getting the Royal back to similar to the other three major hospitals.

Ms O'CONNOR - Is the ED redevelopment on track and on budget at this point?

Mr WEBSTER - Yes.

Mrs ARCHER - Yes.

Ms O'CONNOR - It is? I don't need the extra layering of detail on that, but if there's any update -

CHAIR - I would like to move on to 2.4, now. We've still got to get to mental health, etcetera.

Ms O'CONNOR - Can we just confirm before we do that the ED redevelopment is actually on track and on budget?

Mrs ARCHER - So far as I understand it. I'll ask the secretary.

Ms O'CONNOR - If there's any delays, let us know.

Mr WEBSTER - Yes and yes. I am getting a thumbs up from my Deputy Secretary of Infrastructure.

Ms O'CONNOR - Great, that is good to know. Thank you.

CHAIR - We will go to community health services. Sarah, you have the lead on that.

Output Group 2 - Health Services
2.4 Community Health Services

Ms LOVELL - Again, I'm not sure if this really falls into this category; I don't have a lot of questions on this one, Chair. I understand the rural medical services tender process has been withdrawn.

Mrs ARCHER - Yes.

Ms LOVELL - Can you provide us some more information about why that was withdrawn? I know it was to do with some feedback provided, but what was the feedback and what's happening with that now?

Mrs ARCHER - It's reasonable to say it was the feedback provided that prompted a review of the tender.

Ms LOVELL - What was the feedback?

Mrs ARCHER - I had some feedback that, amongst other things, it seemed like a short period and that there was some feeling that there hadn't been a lot of consultation. We spoke about that and the secretary consequently went in and had a look at the tender because it didn't -

Ms LOVELL - Do you mean too short a tender period when you say, 'too short a period?'

Mrs ARCHER - Yes. The secretary might want to give you some more granular detail about -

CHAIR - The contract was running out for some, too, so you might just like to address that too.

Mr WEBSTER - To answer both questions, in terms of the rural medical tender, the first feedback was we had made the timeline too short, particularly for smaller practices to participate -

Ms LOVELL - To be able to tender?

Mr WEBSTER - That's right. That could have been fixed by extending the tender period, and we initially did that, but then in response to some of the practitioners and the AMA meeting

with the minister, I did a very detailed consultation with rural medical practitioners that currently have contracts with us and got quite specific feedback about what the model should be and how it works on the ground.

It led me to conclude we were putting out a tender that whilst it encouraged - and the wording of it said that individual practises could tender - With the structure of the model we really disadvantaged those small practices. That was not the intent of the tender and after seeking legal and procurement advice - following that rather detailed session I had with doctors - I took the decision to say we should withdraw. We should go back out and consult more widely with the sector - particularly with rural doctors - and spend some time with those rural doctors to inform ourselves. To create a model that was going to meet, firstly, the needs of those rural communities, but secondly, was not going to disadvantage rural practices from putting in a tender against a corporate that might put in a tender that wanted the whole state.

I wanted to make sure there was a balanced approach to the tender and after consulting with the doctors, I concluded that the wording of the tender didn't provide the balance. I took advice and I was allowed to withdraw it.

Ms LOVELL - Thank you. Do you have a time frame for next steps?

Mr WEBSTER - To answer the Chair's question on that, I've taken initial procurement advice and signed off on extending current contracts by 12 months to allow us a few months to do that consultation and put it back out well in time. It will need to be back out in May-June of next year so we're not running into contract expiries again. It will be a much fairer process as a result of withdrawing the original tender.

Ms LOVELL - That's good. Thank you.

CHAIR - Maybe you can table this, but do you have a breakdown of rural hospital occupancy? We have the high levels, but I couldn't find on the dashboard easily the breakdown per regional hospital.

Mr WEBSTER - We do have it to hand, and I read it out in the the other place the other day. Someone's finding it for me.

Mrs ARCHER - You've been a little busy. You've got enough of your own going on, Chair.

CHAIR - While you're looking for that, minister, I do note that the overall occupancy rate has increased. Is that across the board or is it that certain hospitals have perhaps been better utilised?

Mrs ARCHER - I think it is across the board, but there are also some hospitals being better utilised. I am certainly aware of Beaconsfield where there have been some changes in-house.

CHAIR - Because this is an option for trying to reduce some of that demand pressure or the patients who are stranded may be able to be cared for in one of our rural regional hospitals as opposed to in a tertiary hospital. Is that an active -

Mrs ARCHER - Consideration,

CHAIR - Yes.

Mrs ARCHER - It would depend on individual patients, and suspect some of them are being cared for in that way, but the secretary will be able to give you some more details.

Mr WEBSTER - To answer that one, specifically Campbell Town is very good at actually drawing patients from the LGH.

Just to go through them quickly, overall, there's been an increase around 6 per cent across the board. Beaconsfield, for instance, is now 67.7 per cent. Campbell Town is 106.6 per cent.

CHAIR - They have topping and tailing going on?

Mr WEBSTER - They achieve that because if they've got an aged care vacancy, they will actually use one of their aged care rooms to do subacute for a period of time.

CHAIR - Unless someone needs the aged care bed, surely.

Mr WEBSTER - Unless someone needs the aged care. Yes. It's when there's a vacancy, but they do achieve 106.6 per cent, which is quite remarkable. Deloraine is at 58.7, Esperance at 56.1 - but Esperance is a small number of beds. Flinders Island is 30.5, George Town is 74.9, HealthWest or Queenstown is 43.2, King Island is 50.2, Longford is 55.2. May Shaw at Swansea is 65.0, Midlands or Oatlands is 78.5, New Norfolk is 92.1.

CHAIR - It's certainly better than the historical figures.

Mr WEBSTER - Yes, and that's drawing up from the Royal. Scottsdale at 32.8, Smithton at 46.6, St Helens at 30.2, St Marys at 44.4, and Tasman - with a very low number of beds - at 78.0. Overall, we're at 58 per cent of beds occupied, and that's up from 51.8 in the previous financial year.

CHAIR - Thank you. It is time for a lunch break that was scheduled at this time. Does anyone have any crucial questions? It would be good to move on if we can to ambulance services when we come back.

Ms THOMAS - I had one question about diagnostic breast imaging services.

CHAIR - We will come back and do that then. People might have commitments at lunchtime. Then we will move on to ambulance services.

The committee suspended from 1.16 p.m. to 2.00 p.m.

CHAIR - Thanks, minister, for actually coming back.

Mrs ARCHER - I wasn't aware that I had a choice.

CHAIR - I will hand back to Bec to finish off Community Health Services, then we will move to Ambulance Services after that.

Ms THOMAS - Thank you, Chair.

Minister, I just have a question about the diagnostic breast imaging and BreastScreen units and the fact that they've been increased to cater for increased demand. I'm just wondering if you can tell me about the budget for the operations of that facility. Obviously it's been a capital project, but in terms of the operation of the facility, can Tasmanians and the staff be assured that there will be sufficient resources in the budget to be able to operate it at the level that the increased infrastructure will enable?

Mrs ARCHER - Thank you. As you might be aware, I went recently just to have a look at progress on the capital works that are being undertaken there in relation to the new diagnostic breast imaging services at the Royal Hobart Hospital. It will have a phased implementation of the service to build the system capacity. Staffing and infrastructure has commenced, and currently the service is limited to referrals received from the Royal.

The 2025-26 budget includes $7.5 million over three years for additional diagnostic breast imaging clinics, to provide statewide public diagnostic mammography services to improve accessibility for Tasmanians. This is in addition to the $18.2 million committed in the 2024-25 Budget to build the new public diagnostic breast care centre in Hobart. That includes $15 million for infrastructure development and $3.2 million for facility operational costs.

Do you wish to make some further comments, secretary?

Mr WEBSTER - Thanks, Minister. In addition, this is an area of health demand; that's another area of imaging, so there is actually money in the health demand budget for operational costs as well.

From this financial year, the operational budget of diagnostic breast screening amounts to around $5.6 million, if I do the maths quickly in my head. [inaudible 2.03.26] demand, the $2.5 boost that's in the 2025-26 budget as a line item, and the ongoing $1.18, I think it was, from the previous 2024-25 Budget, which is an ongoing amount.

Ms THOMAS - Okay, and how does that compare to the budget allocated in previous years?

Mr WEBSTER - There wasn't a budget in previous years because we didn't have a diagnostic breast imaging service. We established that, I think, two years ago, initially as a pilot funded by the federal government, and the state government has now provided the money for it to continue to operate ongoing.

Mrs ARCHER - And it will expand its operations, importantly, too. At the moment it takes referrals from the hospital, but it will be able to take referrals from general practice as well.

Ms THOMAS - We're talking specifically here about the diagnostic breast imaging service. What about the BreastScreen service that will be co-located?

Mrs ARCHER - There will be, as you point out, co-located services in with that facility for screening as well as the diagnostic services. Did you want to ask specifically about that screening centre or screening across Tasmania?

Ms THOMAS - Both, but first of all, will there be adequate resources provided, because I believe the breast screening service will have increased capacity in the new centre as well, is that right? If so, will the operating budget be increased to be able to service that?

Mrs ARCHER - I will ask the secretary to make some more comments.

Mr WEBSTER - The National Breast Screening Program is actually a federal funding agreement, so there is funding both from the federal government and the state Budget for breast screening. Whilst the centre will have increased capacity, most of that capacity will be on the diagnostic side because that's the bit we're growing. Our strategy around BreastScreen is in fact to move to other centres, and that will see the transfer of resource resources to other centres so that we're actually delivering the service closer to the population rather than just centred in one spot.

Mrs ARCHER - That includes a range of new permanent breast screening sites across Tasmania as well; I think four new sites in addition to the -

CHAIR - Have you go the locations identified for those?

Mrs ARCHER - Yes. Kingston, Devonport, Triabunna, and Glenorchy.

Ms THOMAS - From a previous conversation I had with you, Devonport is first, right?

Mrs ARCHER - Yes. As we've previously said, that site is currently being established and that will be able to free up the mobile unit, Ida, to be able to travel more widely once that site is established as well.

Ms THOMAS - In terms of the breast screening budget, you mentioned it's federal and state funding towards that, so how does the budget for that service look this year compared to in previous years?

Mr WEBSTER - I don't actually have the exact breakdown for BreastScreen alone. Breast screen is part of a division called cancer prevention -

Mrs ARCHER - It's screening services and it also includes bowel and lung screening as well.

Mr WEBSTER - It's called Population Screening and Cancer Prevention, which includes cervical, bowel and lung cancer screening efforts as well as breast screening.

Ms THOMAS - Is that something you would take on notice, Minister, and provide the budget for this year and the forward Estimates and how that compares to previous years?

Mrs ARCHER - Yes. We can take that on notice.

Ms THOMAS - Thank you. You said the Devonport new facility is being worked on at the moment?

Mrs ARCHER - Yes.

Ms THOMAS - Do you have any indication of when the other three that were announced - Kingston, Glenorchy and Triabunna - will commence?

Mrs ARCHER - I will ask the secretary to give an update about where we're at with each of those sites, starting with Devonport.

Mr WEBSTER - We've prioritised Devonport because it frees up Ida to do some sessions on the east coast, in particular, which is a concern because Luna is offline. Kingston will align with a build that we're doing to extend at Kingston. Triabunna requires us to enter into some agreements with the local government area, because they run the Triabunna community health centre. I'm doing these in the order that they will actually happen. Glenorchy will see a reconfiguration of our health centre at Glenorchy, so we're expecting that Glenorchy will be 2027 or 2028.

Ms THOMAS - As to the bus that is to be replaced, is there any update on that process?

Mrs ARCHER - Possibly no update since the previous update that I've provided. I'm not sure if you were aware of that, but a new bus has been ordered; it has been through that procurement process. I don't think we have any updated timelines. We're still on track to deliver that within the previously advised time frame, which I think was by September next year.

Mr WEBSTER - Yes, that's right, and we're hoping, fingers crossed, to be able to borrow a bus from another state in advance of that to get us going, because we're mindful that each clinic that we've had to postpone puts us behind in terms of the program. The minister has already, I think, outlined in detail in the other place the transport processes we've put in place for the east coast to help them get to appointments.

Mrs ARCHER - There has been some buses provided, also patient transport scheme, and breast screen has been proactively contacting patients to schedule those appointments. Obviously if we can get the bus sooner, we will, but if there's an opportunity as well that we've been exploring to be able to get - to borrow one from another jurisdiction in the meantime, we will also do that.

Ms THOMAS - Thank you.

CHAIR - We will move on to 2.6. You want might to have a little change at the table, do you?

Output Group 2- Health Services 2.6 Ambulance Services

Mrs ARCHER - For *Hansard,* Michelle Baxter has joined us at the table from Ambulance Tasmania.

Mr HARRISS - Thanks Chair. Can I start - can we go to table 6.3, page 93, budget paper 2, volume 1. The 2025-26 Budget: $182,354,000, that's as I understand it, from the

actuals 2024-25, which was $186,467,000, that's $4.1 million less in total expenses budgeted for this year. Can I have some understanding of what that might do?

Mrs ARCHER - Thank you. Dale, did you want to make any responses or straight through to Michelle?

CHAIR - If I could just add to your question there, Dean, perhaps they could also identify in that what caused the cost increase necessity, what was it used for - cost overrun?

Mr WEBSTER - If I could commence, this financial year we're in - in fact, prior to the start of the financial year, we took the opportunity to - there'd been a number of announcements in terms of increased staffing for Ambulance Tasmania. We started that recruitment process early and got those people on board early, which is why this year was up. We passed the year, didn't we? 2024-25 was up. There are a number of things such as we've moved the state headquarters from Brisbane Street to Cambridge, and a number of other one-off type expenses in 2024-25 that won't continue into 2025-26.

I think the other thing is that the underlying budget of Ambulance Tasmania has actually increased across the forward Estimates and increases from last year's Budget. Indeed, there's money in there for the new fixed rotary-wing contracts and the increases required there. That's something that's shared with Taspol, the Department of Police, Fire and Emergency Management. It's one of those budget areas where, because of movements up and down, and again there's particular efforts in in Ambulance Tasmania in terms of billing around workers compensation, MAIB, private health, other states such as Queensland using ambulances and things like that, that we've focused on to increase the revenue of Ambulance Tasmania to balance off ongoing needs to increase the expenditure. We're growing the number of paramedics across the network as well.

Mr HARRISS - On the numbers then, can you give me some figures? Because I had a quick look, and it didn't look like it had changed too much from 23-24, 24-25. I could be wrong.

Ms O'CONNOR - We have a bit of a math savant at the table here: consistently on the numbers, on the money.

Mr WEBSTER - As, for instance, the recruit - because we knew there was a commitment in the election campaign in 2024 to increase paramedics in 24-25, so we took the opportunity to recruit early because we had gaps there and of course that didn't match the funding - was to recruit during the year, but we'd actually recruited prior to the year.

Mr HARRISS - Sorry, prior to?

Mr WEBSTER - The start of that financial year.

Mr HARRISS - 24-25?

Mr WEBSTER - We recruited in 23-24 in advance of 24-25, which meant we had a full-year effect, and effectively with turnover, et cetera, we went over establishment for a period of time knowing that we would adjust in around a financial year, but we've also taken opportunities because we have been able to actually bring in interstate paramedics who are already, if you like, registered but just require a short course for orientation so that we're

recruiting quicker. That's a quicker way to recruit if you like, but in addition to that, making sure that we're bringing in sufficient graduates to support the graduate programs through particularly the University of Tasmania so that we keep - you know, we've got a steady supply into the future.

All of those things are added to cost because they had a full-year effect when in fact, they were part-year funded, and with turnover, et cetera, we believe that we've returned almost back to establishment. We will recruit in this year as well, but we're confident that what we've got in terms of the Budget this year matches to our needs in Ambulance Tasmania, but we did have a couple of years where we were over establishment, and that was quite deliberate in terms of - I shouldn't say over establishment, on the ground you might still have gaps, but we put new graduates for a program, that means that they're actually on the board getting paid before they're on the road, and we've got to account for that and those sorts of things, and as I said one-off things like the move, et cetera.

Indeed, if you looked at last year's state Budget, we were funded for new ambulances across a number of years, but we actually decided to purchase all of those in advance in 24-25 because we've got a need to update our fleet. All of those things contribute to why the expenses were higher in 24-25.

Mr HARRISS - Thanks, secretary. On the numbers of paramedics, so the increase in that, has that been a steady increase? What I'm trying to do here is link it to - or relate it to responses, as in increase, we've had an increase in responses. Have we matched that increase in staffing, or - it's probably not as simple as that, obviously.

Mrs ARCHER - I can give you some staffing figures: in 2024-25 as of 30 June 2025, Ambulance Tasmania employed 682.83 FTE, which is 800 employees, 675 of which were employed under the Tasmanian Ambulance Award, including paramedics and communication centre staff. Ambulance Tasmania has increased its workforce from 759 to 800 employees total headcount from June 2024 to June 2025, equivalent to 5.4 per cent.

Since January this year, 31 graduate paramedics commenced with Ambulance Tasmania; 15 on 27 January and 16 on 28 April. In 2024-25 - that's really breaking it down to the specifics - 393 employees identified as male and 405 as female, and two employees is unknown. The 2025 Report on Government Services indicated that the total number of ambulance operatives increased from 292 in 2014-15 to 563 in 2023-24, and it's also currently supported by approximately 402 volunteer ambulance officers.

Mr HARRISS - Sorry, how many was that volunteering?

Mrs ARCHER - It was 402.

Mr HARRISS - We've touched on transfer of care a little bit. You've mentioned that there were some 17,000 hours saved - or however you want to put it - in 2024-25 due to that implementation. Is it fair to say that hasn't reduced response times? Or has it improved response times?

Mrs ARCHER - I will ask the secretary to make some further comments, but I think when I spoke about this earlier, I think you also have to look at it in terms of demand as well, but I will ask the secretary to make some further comments.

Mr WEBSTER - That's a fair statement. There hasn't been a direct correlation between that reduction and response times. As the minister said, demand has actually increased over that period, so we're trying to get more paramedics on the ground, upgrade our infrastructure, and get our fleet replenished so we have a good enough fleet to cope with the additional paramedics. All of those things feed into it. At this point, even having those extra 17,000 hours on the road hasn't actually resulted in an increase in response times.

Mrs ARCHER - I think it would be reasonable to say if you hadn't saved those 17,000 hours you would see a consequent response time issue.

Mr HARRISS - If I go back to 2021 to 2025, from what I can work out, there's been a 9 per cent increase in paramedics. In the same period, there's been a 7 per cent increase in responses. I'm trying to understand here what that looks like. When we say there's been increased demand, has that been matched with paramedics?

Mrs ARCHER - There has been an increase in the number of paramedics, as I just spoke about. The increase in demand last year, I think, was around 4 per cent.

Mr WEBSTER - You had a different period, I think.

Mrs ARCHER - Yes, it's a different period of time.

Mr WEBSTER - That was a correlation between the increase in staff and increase in demand, but we've also put in different programs like intensive care paramedics, which is a rapid response to, say, heart attacks. We put paramedics in that category. For PACER, we have paramedics that are doing hospital-avoidance as well through that. Secondary triage includes some paramedics. There are other programs that contribute in other ways to the total health system, not those that just respond to lights and sirens and ambulance-type activities. It is important to note that. There has also been an increase in our use of aeromedical, for instance, which means more resources have gone down there as well. With all of those things, the pure demand in responding to a job isn't matched. It is less than the increase in paramedics, but we've actually increased paramedics because we've got other programs running. Again, this means that the demand would have been much higher than 7 per cent if all of those PACER responses were coming to hospital via ambulance and things like that. It doesn't quite work - it's not apples and oranges.

Mr HARRISS - The rural areas median emergency response time for 2024-25 is 22 minutes, with a KPI target of 15 minutes. What has been done to try and get that down to the KPI?

Mr WEBSTER - The first thing is some of the rebuilds we're doing across our rural ambulance infrastructure will assist. The second part of that is we're increasing the number of double branch stations; I think that's what we call them, which is multiple paramedics at our branch stations rather than one paramedic with volunteers. Some of the issue, whilst we have 402 volunteers, the majority of our volunteers have other work lives, so they're not always available, and because we are calling on volunteers, there may be a delay in dispatch because we are waiting on the volunteer to be on board and those sorts of things. There is a complex thing that happens in rural and regional Tasmania around a dispatch that adds to that time.

CHAIR - Can I follow up on that particular point while we're on it; you know what I'm going to ask, don't you? How is King Island progressing, and what is the reason for delays? I assume the money is in that line item for $4.5 million this year.

Mrs ARCHER - I have some information. Obviously we are very committed to building a purpose-built ambulance station for King Island. There was a feasibility study of suitable locations which was completed, and the preferred location is 25 Edward St, which is located within the King Island District Hospital grounds. The Department of Health has consulted closely on the site chosen with the Council, Ambulance Tasmania volunteers, and the health service. Designs for the station have progressed and include: a training room, modern office and storage facilities, accommodation for on-call staff, and a two-bay garage capable of housing up to four vehicles with expansion capacity for the future.

Members of the public were invited to view the designs at the Council offices from 3-27 June and the development application for the new station was submitted to the King Island Council on 10 September. Obviously, construction will commence once those relevant approvals have been received and a tender for construction is awarded. It's expected that the station will be completed in 2027.

CHAIR - In terms of the community paramedic that was going to be appointed, is that going to wait until this is done or is the community paramedic coming on ahead of that?

Mr WEBSTER - The community paramedic programme aligns with our district hospitals rather than the station, so it is likely that it would come on in advance of that.

CHAIR - When?

Mr WEBSTER - I'm going to throw to Michelle for the timing of King Island, but the community paramedic program is over a number of years.

Mrs ARCHER - Sorry, Michelle. It does require a new service delivery model and that model is currently subject to consultation with key stakeholders the unions.

CHAIR - What's the timeline? That's what my people want to know.

Ms BAXTER - We're currently looking at the program itself, so the community paramedic program, and how we will deliver that in areas that are not within the metro. The recruitment for that has commenced, and once we deliver them through the program, then we will look at King Island and make sure the infrastructure is there ready for them to go.

CHAIR - So we don't know?

Ms BAXTER - We are still working on that date, yes. I've already been to King Island and talked with the hospital around what that might look like.

CHAIR - Did you talk to the volunteers while you were over there?

Ms BAXTER - Yes, I did.

CHAIR - Good, I'm pleased to hear that; relying entirely on volunteers -

Ms BAXTER - I even had dinner with them.

CHAIR - Chris took you out for dinner, did he?

Ms BAXTER - Yes.

CHAIR - That's nice of him. Back to you, Dean.

Mr HARRISS - I might stay there, Chair. Can we have an update on all four? We've just touched on King Island, but there's Cygnet, Legana and Snug. Where are they up to?

Mrs ARCHER - There's a couple there - we have Bicheno, which had community consultation in late 2022, and the process to acquire the preferred site, which is 60A Burgess St commenced, and the land was vested to the Crown. Following additional stakeholder consultation in November 2023, the department decided not to proceed with the construction of the station at that site and have selected a site at Lot 119 Sinclair St. That land was already owned by the Crown, and a development application was approved January 2025, and the tender was released on 29 March 2025.

The new Longford Ambulance Station will be at 20 Union St. That land was acquired by the Crown, and construction is expected to commence in late 2025 and be completed by the end of 2026.

King Island, we've talked about.

Legana: A preferred site for the new station has been identified at Lot 23, Legana Park Dr, and the department will commence the land acquisition process to secure the site. It's anticipated the tender will be released towards the end of 2027, and construction due to commence in 2028 to be completed by early 2029.

Cygnet: The department identified a preferred site at Mary St, Cygnet. The department and Ambulance Tasmania are currently working on best-fit plans and negotiating suitable lots of land with the landowner. At the landowner's request, the department is not releasing the physical address of the site. It's anticipated that the tender will be released towards the end of 2028, with construction due to commence in early 2029 to be completed by early 2030.

Snug: A preferred site for the new station in Snug was identified at 10 Wellbor Rd, Snug. The land is owned by the State Fire Commission and houses the Snug Fire Station. The State Fire Commission had provided in principle support for the new ambulance station, but they have now advised the department that they no longer support the new station at that location, so the department is now assessing other potential sites for the station in Snug. But, it's anticipated the tender for construction will be released towards the end of 2029, with construction due to commence in early 2030 and be completed by early 2031.

Mr HARRISS - Were those timeframes extended? Were they blown out? Were they always looking at 2029-2030, or were they programmed for earlier than that?

Mr WEBSTER - We didn't have a program of when each one was, but what we've tried to do here is - we're mindful of the fact that we do need long lead times in the regional areas. For instance, finding a builder for Oatlands took us some time. What we've done is try to do

this in a logical sequence that doesn't overload markets, and that's the same as across all of our Health infrastructure. We actually will see these now as the achievable timelines.

In the past, we may have spoken about other timelines; our experience is that if you don't allow a lot of time for the regional areas, then we don't achieve them. That is the reason. It maybe looks like we've extended them, but what we've done is the real work on an implementation plan.

Mr HARRISS - Chair, you might help me here. I have a couple of - the main capital, Glenorchy and Burnie ones -

CHAIR - Do the math. We're going to run out of time to get to all of them, so just do them under the relevant one here.

Ms O'CONNOR - I do have some ambulance questions. Not rushing you at all, just letting you know.

Mr HARRISS - No, I've only got a couple more.

The Burnie and Glenorchy stations - they were budgeted at $20.5 million first up and then increased to $28.9 million. Are they both completed, and do we have final costs?

Mr WEBSTER - They're definitely both completed and occupied, and we will get costs in the next hour or so.

Mr HARRISS - Can we also have costs for Oatlands?

Mr WEBSTER - Yes.

Mr HARRISS - Thank you, Chair.

CHAIR - Cassy, I will go to you.

Ms O'CONNOR - Thank you.

My first question is about management of Ambulance Tasmania. It's obviously a really hard job. In early 2020, Neil Kirby resigned from the CEO role at Ambulance Tasmania. Not long after, in early 2021, Matthew Eastman resigned from the CEO role. In March 2023, Joe Acker resigned from the CEO role. In April this year, Jordan Emery resigned from the CEO role. The organisation is now on its fifth CEO in just five years, albeit an interim CEO.

Minister, this rapid turnover of CEOs must worry you. Can you tell the committee what's being done to make sure the next person in this critical role lasts for more than a heartbeat?

Mrs ARCHER - I will make some initial comments, and then Dale might want to add to that. Obviously, senior executive health staff are in high demand across the nation and it's not surprising we see Tasmanian health leaders being recognised for that work. We also recognise the opportunity for fresh thinking and renewal, that new leaders can bring improving healthcare outcomes in Tasmania and note that staff have the right to progress their career wherever they choose to, so we wouldn't criticise anyone for making that decision. Over that

time, we have had continued leadership with temporary appointments during periods of leave and ongoing recruitment processes, but I will ask Dale to make some more comments on what we're doing.

Ms O'CONNOR - Yeah. It's very high turnover, most of them within a year of each other, which is unusual.

Mr WEBSTER - Yes. To correct that slightly, in fact Neil Kirby's resignation was not until 2021, he went on long-term sick leave and Matthew Eastham acted in the role when the job was advertised because Neil wasn't returning. Matt chose not to apply at that point. Matt had been acting through that period but didn't apply because he took up an opportunity with local government in the Northern Territory.

Joe was employed from February 2021. He chose to return to Canada in 2023. I don't think he would mind me saying, under pressure from his partner who wanted to return home, and Jordan, who we had recruited from New South Wales, stepped up into the role and won the job on merit. To Jordan's credit, he has now gone to a much larger, more complex and I would say -

CHAIR - Better paid.

Mr WEBSTER - better paid role in Victoria. Moving up from an 800 head-count ambulance service to a 6,500 thousand ambulance service. Perhaps we take credit for the fact we trained him ready for a bigger role.

We've gone through a recruitment process. We expect that the next person will be a long-term prospect - as we expected all the previous by the way - but the reason I went through the reason they left are because they've all left for very different reasons. Not necessarily because the job's a terrible job or whatever -

Ms O'CONNOR - I am sure it's not a terrible job, but I'm sure it's a very difficult job, and constant cost pressures and stresses within the system and a lot of public scrutiny of the performance of Ambulance Tasmania, for better or for worse.

Mr WEBSTER - That's right. But incredibly, Joe Acker coming in started us on a pathway of reform with Ambulance Tasmania, which Jordan has continued, which Michelle, to her credit, has continued in her period since Jordan left. We recruited Jordan from New South Wales as we recruited Michelle from Queensland to bring experience into our service. That's actually improved our service by bringing in that expertise from interstate to add to our local expertise.

Ms O'CONNOR - I want to wish you all the very best of luck with the next CEO and hope that next year at the table we meet that person, whoever they may be.

I would like to go now to the fixed and rotary-wing contracts for aero-medical services. There's been a 10-year extension of the Royal Flying Doctor Service with no tender. Perhaps you could provide some information to the committee on the value of the contract, noting that the original 10-year contract without tender was a consequence of an MOU signed between the Royal Flying Doctor Service and then Liberal premier, Peter Gutwein.

In the context of the Rotor-Lift contract, the government said the competitive open tender process has ensured the best aero-medical services being provided at competitive cost. Why wasn't there an open tender for the Royal Flying Doctor Service and why was Rotor-Lift treated differently?

Mrs ARCHER - Thank you. As you've noted, the Department of Health has contracts with aviation providers to deliver emergency rotary-wing or helicopter services for both Ambulance Tasmania and Tasmania Police and emergency fixed-wing or plane air ambulance services for Ambulance Tasmania.

The rotary-wing aircraft are currently provided by Rotor-Lift and operate at Hobart Airport, and these helicopters support essential aeromedical search and rescue and aerial law-enforcement functions. The Department of Health recently completed a competitive request for tender process for the new long-term rotary-wing contract. As we recently announced, following a rigorous open tender process, Australian Aviation provider StarFlight has been selected to provide these helicopter emergency services to commence on 12 January.

The reason why that process went to tender instead of the contract being renewed is that I'm advised around three years ago the premier and then minister for Health met with Rotor-Lift, at which time Rotor-Lift requested an open competitive tender. There is an expectation under the *Financial Management Act* and the Treasurer's instructions that from time-to-time contracts are opened to ensure the state is getting the best service and value for money. Rotor-Lift held the contract since 1 August 2000.

In relation to the difference in the procurement processes, that is because they requested an open tender. Also, the procurement approach, whether open or closed, reflects the specific market and the service delivery considerations relevant to each model. Both services differ significantly in their operational design, clinical scope, and logistical and infrastructure requirements. It's not really appropriate to compare the tender processes.

Ms O'CONNOR - Well, there wasn't a tender process for the RFDS.

Mrs ARCHER - That was, as I've previously stated, because it was Rotor-Lift themself who requested an open tender, as they have previously publicly acknowledged.

Mr WEBSTER - Minister, if I could correct that. There was a tender, it was a closed tender. RFTS actually did have to respond to the specification and satisfy us that they met the requirements of the TI in terms of an assessment of their tender. Including, value for money. Whilst they weren't assessed against other tenderers, they had to meet a tender specification including showing that they demonstrated value for money in their tender.

Ms O'CONNOR - I haven't often heard of closed tenders being used in government procurement processes. Particularly, for a contract of this length and value to the RFDS and cost to the taxpayers of Tasmania. The question still stands. Why didn't the RFDS - which has had favoured treatment and, acknowledging the good work they've done all over the country for many years, but favoured treatment from this government for a very long time - why didn't the RFDS have to go through what the Minister described as a rigorous open tender process, presumably in compliance with the *Financial Management Ac*t as well as Treasurer's instruction?

Mrs ARCHER - I would reiterate the fact that Rotor-Lift held the rotary-wing contract for 25 years, so also a long-term arrangement there. I will ask the secretary if he's got anything further to add, but still a closed tender process have to meet specifications in terms of capability required and that sort of thing as well as meet the value for money test.

Rotor-Lift asked for a competitive tender process to be conducted.

Ms O'CONNOR - Is it appropriate to go outside Treasurer's instructions about tenders on contracts of this size?

Mrs ARCHER - It hasn't gone outside the Treasurer's instructions.

Ms O'CONNOR - Is it appropriate to give such an extensive and expensive contract to a provider with no tender process?

Mrs ARCHER - There's a closed tender process, so it still has to meet our process.

Ms O'CONNOR - No open tender process, then.

Mrs ARCHER - Do you want to make some more comments about the circumstances under which you would have those different types of - perhaps - some other examples, if you have some.

Mr WEBSTER - The decision whether to go with a closed tender as we call it - or a limited tender is the more correct term - is because you can use it to say we only want one tender. Or you might use it in a circumstance where you would say we're going to approach three people or three different organisations as a way of doing it is available within the Treasurer's instructions and under the *Financial Management Act*. The reason why with the RFTS contract we went with a closed tender is, firstly, the specification was very clear what we needed. The type of aircraft that we needed was really clear and we had a long-term provider.

I took the decision and signed off on a decision that we would go with a limited tender, but it was made clear to the RFDS that they had to demonstrate all aspects of the tender and if they didn't then I would then open it up to the market more generally. Importantly, they had to meet the value for money provisions of the Treasurer's instruction as part of that assessment.

It was made very clear to them, failure on that specification would mean that I would then cancel the closed process and move to an open process. Then we got in market experts to help us assess that value for money to make sure that we're actually getting value for the taxpayer dollar. It also aligns with the fact that RFTS and Ambulance Tasmania are joint base and RFDS have a base at Launceston Airport.

In addition to that, commitments made by the federal government in terms of upgrades to the Launceston Airport to align with a new RFDS contract.

Ms O'CONNOR - We will get to that, but I need to clarify whether the in part, the decision not to go to an open tender for the fixed-wing contract was to do with the Memorandum of Understanding that had been signed, and it was in 2017 or 18, but correct me if I'm wrong, between the then Liberal premier, Treasurer, and the RFDS, because that's a very

clear agreement between a political party hoping to achieve government and a major provider of fixed aeromedical services.

Mr WEBSTER - There is a Memorandum of Understanding between the government and RFDS signed.

Ms O'CONNOR - That's between the Liberal Party.

Mr WEBSTER - No, sorry, I can only talk about what's between the government but there is actually an MOU sign between the government and the RFDS that was signed by the current Premier and then Minister for Health in July, and I could get this year wrong, 2022 which covers just more than aeromedical. It also looks at other services like oral health that are provided through RFDS.

As part of that, there was no guarantee to RFDS they would get a contract. There was a commitment that where under following the FMA and the Treasurer's instructors, we would look at what the long-term strategic relationship was with RFDS. It didn't actually oblige me to give them a contract.

Ms O'CONNOR - Probably not under law, but there would have been an understanding in your mind.

Mr WEBSTER - I took advice at that time from the then secretary of Treasury around that MOU, and also took advice from Crown Law around that MOU to make sure that it wasn't outside of the law.

Ms O'CONNOR - Is it possible for the committee to have a copy of that MOU? I don't think I've ever seen it, but it may be a public document.

Mr WEBSTER - Yes, it is a public document we released it at the RFDS base in July 2022.

Ms O'CONNOR - The Commonwealth has awarded the RFDS $15 million for a new purpose-built base at Launceston Airport, and the cost has since gone up, I understand it, to $21 million. The state has committed to a six $6 million funding injection towards that base. Is that enough given the cost of people asking for everything? And is the state going to be left to carry any overrun costs on that base?

Mr WEBSTER - We have no reason to suspect that's not enough, and in fact, it started as a $10 million base and has increased at 21.

Ms O'CONNOR - That's why I'm asking the question because the risk is.

Mr WEBSTER - That's because they went to the process of design and costing of the actual base. The commitment from both the federal and state government is capped at their current levels and RFDS, as the owners of the asset, would be drawing on their own funding beyond that.

Ms O'CONNOR - What's the latest budget for the new rotary-wing facility at Cambridge?

Mr WEBSTER - The rotary-wing base will be a leased base. We're not building it. It's a lease base and we are still in negotiations on the lease.

Ms O'CONNOR - Has there been any budget set aside or any understanding of what the budget might be for that lease and is it anywhere identifiable in the budget papers across the forward estimates? Or is this another unaccounted-for expenditure?

Mr WEBSTER - There is actually a key deliverable, which is actually related to increased expenses for aeromedical.

Ms O'CONNOR - What was that quantum of funding that's been projected?

Mr WEBSTER - In the budget document, $5.439 million this financial year, which is a part year given the contract starts on 12 January and then $11.7 million, rising to just under $12 million over the forward Estimates. That's for all aspects of aeromedical.

Ms O'CONNOR - My final question. Regarding the base at Cambridge that was being utilised by Rotor-Lift Aviation, which is already in place, is there any reason why government decided to spend another $17 million worth of public money replicating a facility or investing in the replication of a facility at Cambridge?

Mrs ARCHER - It was part of the new contract for the rotary-wing services. The department committed to developing a new southern air base that's independent of any operator, which provides the state with capacity to change operators either at the end of the contract term or if the Crown needed to terminate the agreement for any reason to ensure we were able to have continued delivery of an essential service.

Relevant to your last question, Rotor-Lift presently charges $234,497 per month or $2.8 million per annum for shared base costs.

Mr WEBSTER - I should correct the figures I gave you for the uplift in the Ambulance Tasmania budget for aeromedical, not just for the base -

Ms O'CONNOR - It's not specific to Cambridge.

Mr WEBSTER - That's right. Exactly.

Mr WEBSTER - The other thing is the Rotor-Lift base is actually owned by Hobart International Airport, and we did engage with them, as well as Cambridge, in a limited tender process to say -

Ms O'CONNOR - There are not many airport operators in the south of the state, are there?

Mr WEBSTER - Exactly. To say where would it be, et cetera, and the Rotor-Lift base was not put forward by Hobart International Airport.

CHAIR - Before we move on to public health. Minister, the secretary mentioned earlier about the decision to update the fleet as one hit. Was that more cost effective? Are there still vehicles in the fleet that need updating?

Mrs ARCHER - Of the Ambulance Tasmania fleet?

Ms O'CONNOR - Yes.

Mr WEBSTER - We have a target of 250,000 kilometres on our Sprinters. We therefore replace them on an ongoing basis. This was an uplift because we're getting a number of new paramedics. We actually had to increase the size of the fleet. There was money in the 2024-2025 budget -or it might have been the one before - which spread that money over a number of years. We decided we needed all of those in the fleet ordered immediately and we've done that. That's why the money was brought forward into that year. We will still have a replacement program going forward -

CHAIR - How much is allocated to the replacement program for the others that are currently in the fleet? Not the new ones, obviously.

Mr WEBSTER - I don't have the figure in my head, but I think it's -

Mrs ARCHER - It does say they have a lifespan of five years or 250,000 kilometers and that's consistent with other ambulance services across Australia.

CHAIR - Maybe if you could take that notice. If you get it back. The budget allocation for the best vehicle replacement. We will move then to 2.7 public health.

Output Group 2 - Health Services 2.7 Public Health Services

Mrs ARCHER - We have Professor Arya rejoining us at the table.

Ms O'CONNOR - As you be aware, minister, there's a lot of concern amongst coastal recreational users, recreational fishers, rock lobster fishers about the decision to allow the use of florfenicol at volume in fish farm operations. Particularly, in the south of the state.

Through the public health lens, are you able to advise the committee what advice public health provided to the Tasmanian Government or the EPA on the potential risks of allowing this very high strength antibiotic into the marine environment at scale?

Mrs ARCHER - Yes, thank you. I note that the advice provided by the Director of Public Health is that florfenicol is an antibiotic used in many countries for veterinary medicine, agriculture and aquaculture, including salmon farms. When farmed salmon are treated with florfenicol in medicated feed, wild fish nearby may also eat some of this feed. There are no reports of adverse human health effects from exposure to traces of florfenicol in meat or fish. However, recreational fishers may choose to avoid exposure to antibiotic residues, the traces of florfenicol in the fish that they catch and eat. There are no public health restrictions on recreational fishing within three kilometres of a treated lease. It is precautionary advice.

Ms O'CONNOR - Are we able to hear from public health directly, what advice was provided to government about any risks associated with florfenicol widespread in the marine environment?

Mr WEBSTER - Firstly, public health is not the regulator in this case, it's NRET and the decision to allow the use of florfenicol was in fact through the Australian Pesticides Veterinary Medicines Authority.

The application that was made to them by Abbey Laboratories was sent to the state regulator, so the EPA and National Resources and Environment Tasmania Department and they send it to the director of public health for comment. In his advice to me, he provided comments on several aspects of the application, including the nature of the product. That this was a substantial increase in its use within Tasmanian waters. He made reference in particular to antimicrobial resistance and that is a problem.

Ms O'CONNOR - That is a cause for concern.

Mr WEBSTER - His advice, which he issued on the same day as this was announced and made public and is available on our website - his advice to government is consistent with his advice to the public, which is that this antibiotic could be present in the wild fishery and as a result there should be an area around the salmon pens in the D'Entrecasteaux Channel where we should be advising people that fish caught in those areas may have the antibiotic residue within them and you may choose not to eat those in the same way as there is a 21-day exclusion, I think, for salmon being harvested from the pens. He was saying there should be the same sort of exclusion in that three-kilometre zone across there.

Ms O'CONNOR - That's interesting, because it counts on fish not travelling outside a notional line on a map that is drawn by government, and the advice doesn't seem to be particularly strong.

It's just that, you know, you might not want to eat the fish that had been dosed up with a very heavy-duty antibiotic which, in a peer-reviewed paper released last month, shows drastically changed sediment microbial communities, suppressed susceptible taxa, enriched antibiotic-resistant bacteria, and shifted core biogeochemical pathways, including reduced ecosystem resilience. Is Public Health in Tasmania confident that its advice, both to government and to consumers and users of the marine environment, is based on the latest science?

Mrs ARCHER - Well, that is the advice of the Director of Public Health, and he has confirmed that there is no evidence of harm to human health from consuming traces of florfenicol, but again, reiterating that to enable people to make informed choices and reduce their chance of consuming fish with trace amounts of florfenicol, he has issued that precautionary advice, as noted.

Ms O'CONNOR - Now, is that advice static or is it refreshed? I ask this because all of us at this table represent, to some extent or another, coastal communities, their level of concern about the safety of not only swimming but consuming, let alone the impact on the marine environment. Is that advice from Public Health just a static piece of advice? When you talk about consumers making informed decisions, how can they make an informed decision if there's a piece of advice at one point - they don't get told when this substance is being used in the waters. I mean, how often is Public Health re-examining that advice to consumers, to Tasmanians?

Mrs ARCHER - I think, firstly, there is advice when that product is currently being used in those environments. That information is available and publicly available, and there are maps also available for people, so that they can make those choices.

Ms O'CONNOR - If they go looking for it.

Mrs ARCHER - In relation to is the advice static or not, I think it would be generally true to say that all public health advice is a continuous process and is constantly re-evaluated. And of course, we take advice that is provided. If that advice changes, we obviously adjust to that as well. I will ask the secretary to make some specific comment around florfenicol.

Ms O'CONNOR - Where is the Director of Public Health? Where is the Director today?

Mrs ARCHER - Where is he? I don't know that he would normally -

CHAIR - Normally he does, but -

Mr WEBSTER - He hasn't for the last couple of years. During the COVID emergency he was always on the table, because obviously we had a lot going on in this space, but he does provide us with the briefs to use, and on this particular issue he's briefed me a number of times directly on it. As the minister said, his advice is not static, and as part of what is happening around the use of this particular antibiotic, there is monitoring going on in the zone around it. That monitoring and the outcomes of that monitoring will be fed to the Director of Public Health, who would then review his advice.

Ms O'CONNOR - Can I just say, for a committee that's established to scrutinise the Health budget, where there is a line item that says 'Public Health', for us not to be able to speak directly to the Director of Public Health, I don't think is really satisfactory, I really don't. I recall directors of Public Health in the past, as the Chair said, being at the table, and so I simply note that the absence of the Director this year is disappointing at best.

CHAIR - Have you got another question?

Ms O'CONNOR - Yes. I do.

Mrs ARCHER - I'm certainly happy to take that on board, and also obviously make the point that if there is specific advice that you would like to receive in relation to any of these matters from Public Health, we can also take that on notice for you.

Ms O'CONNOR - Sure, except I'm just one person and the committee's just five people. There's a whole constituency out there that wants answers to these questions.

Mrs ARCHER - Yes, I understand.

Ms O'CONNOR - Does Public Health capture data and assess data on disease rates and infectious disease rates? I will give you a couple of metrics and see if you've got any information on them, like other public health - like the National Health Service in the UK and Finland Public Health collect. Do we have data, for example, on E. coli infections and hospital episodes?

Mr WEBSTER - There are a number of infections, et cetera, that are notifiable diseases under our legislation.

Ms O'CONNOR - That's right.

Mr WEBSTER - And they're notified to them and they collect that data. There's then a level of collation of that at the national level as well, and just recently passed in the federal parliament is the legislation for the new centre for disease control, or CDC, for Australia which will enhance the ability to monitor these things not just at a state-by-state level, but at the national level as well.

Ms O'CONNOR - Thank you. That's for infectious diseases. There's another set of metrics that I want to explore. Who might hold this data? Does public health collect E. coli infection data, viral hepatitis infection data, cancer of the lymph nodes data? I'm happy to read this in, and whatever you can provide, and then we can move on. I'm happy to give you this list. I'm looking for data for all-ages hospital episodes on E. coli infections, viral hepatitis, sarcoidosis of lymph nodes, malignant mast cell tumours, blastic lymphomas, Kaposi's sarcomas of the lymph nodes, strep A sepsis.

In maternal health - and I don't know if that's a different dataset - I'm interested in information on premature births, congenital malformations and developmental disorders between 2019 and 2025; also, whether public health has identified any increase in the number of strokes and myocardial infarctions.

CHAIR - A lot of this doesn't sound like public health, does it?

Mrs ARCHER - Some of it would sit across health more broadly.

CHAIR - Some of that data is in the perinatal morbidity and mortality report, the maternal health stuff.

Mrs ARCHER - I think generally we can take it on notice.

Mr WEBSTER - Generally take it on notice.

Ms O'CONNOR - Some of that material around maternal health, would that be in the college of obstetrics annual report that you referenced earlier?

Mrs ARCHER - A mortality and morbidity report? Yes, which is what I tabled in the last session.

Ms O'CONNOR - [inaudible] obstetrics council before, so that's that one the Chair referred to?

Mr WEBSTER - The council of obstetrics and perinatal mortality and morbidity.

CHAIR - That's right, obstetrics and perinatal mortality and morbidity.

Mr WEBSTER - Which is a committee that reports through to the minister and the secretary. On the categories you had in maternity, some of it is collected and reported through the Tasmanian Health Service rather than Public Health, and some of it is Public Health.

Mrs ARCHER - And just to clarify, you're looking at hospital presentations of those conditions?

Ms O'CONNOR - Yes. All-ages hospital presentations.

Mrs ARCHER - We can take it on notice.

Mr WEBSTER - There's also the cancer registry that's in existence that would cover some of those categories as well, so we will get all that data together from the various sources.

Ms O'CONNOR - Thank you. It might actually help you form a picture too, so hopefully it's not just a make-work scheme for you.

CHAIR - You're done?

Ms THOMAS - Minister, you mentioned earlier today the 20-year Preventive Health Strategy is being drafted. I think you said the Healthy Tasmania strategy is coming to an end -

Mrs ARCHER - Yes.

Ms THOMAS - and we've got $1 million allocated to the final year of that existing strategy. Is there anything included in the public health services line item in the forward Estimates for the implementation of the new strategy once it is developed?

Mrs ARCHER - Yes. Well, I think you sort of point to part of the situation there is that it is currently being developed. That strategy currently has had some 5000 interactions in the initial consultation from Tasmanians, which is fantastic. That's been pulled together and will shortly go out as the draft consultation. This is with a view to developing action plans for consideration in next year's Budget; noting the point that I made earlier on moving from what Healthy Tasmania has been, essentially a grant-based program over five years to a more embedded program over time, including a sort of a whole-of-government approach. As I spoke about earlier, looking across portfolio areas as well, so infrastructure, for example, looking at food security, for example. Across a range of areas.

It's a reform, if you like, looking at a different way. In terms of the Budget, I anticipate that costs would be spread across a range of portfolios as well. We often hear people talking, for example, about allocating 5 per cent of the state budget, for example, to preventative health, we've been quite careful not to lock into a number.

We currently spend-

Mr WEBSTER - $3.13 of the Health budget and $270 million on top of that.

Mrs ARCHER - In preventative health, but really you would hope to increase that level by also recognising that it sits across whole-of-government as well. Did you want to make some further comments, Dale?

Mr WEBSTER - The reason why there isn't an allocation under Healthy Tasmania across the forward Estimates is we are generally out consulting and hearing from community about what should be in the new strategy and then we will cost and go to government in terms of costings and they may not sit within Public Health.

In fact, most of our preventative health effort doesn't sit under the Public Health banner, for instance; we have a large program within BreastScreen Tasmania as a universal screening program, is in fact a preventive health strategy, oral health run a program et cetera.

It doesn't sit in this line item, Healthy Tasmania sat there because it was a grant program and so we've funded the last year of grants in the Budget, but the new strategy will have ideas and implementation plans that will go across more than just Public Health.

Ms THOMAS - Is it reported anywhere that figure you reported of 3.1 per cent of the total Health budget, not state budget, the Health budget is what I assume you mean.

Ms O'CONNOR - Currently.

Ms THOMAS - Yes, 3.1 per cent of the total Health budget is invested in preventative health initiatives. Is that figure reported anywhere?

Mr WEBSTER - It's reported by the Australian Institute of Health and Welfare. That figure they have a method of calculating it based on our activities, et cetera, but it doesn't take in anything that's spent outside of the Health portfolio. For instance, the school lunch program in schools isn't actually counted within the AIHW any community activity isn't added and those sorts of things. That's why we say the 5 per cent is an artificial figure because if you worked it out, we'd actually be reducing our spend on preventative health to reach 5 per cent not increasing.

Ms THOMAS - I'm interested to know if you're aware of the Australian childhood maltreatment study and the findings that have come through from that, which is the first study looking at adverse childhood experiences and the impact on lifelong health outcomes for people, and whether that's something that you would consider factoring into what this next preventative health strategy looks like in terms of the importance of preventing and responding to trauma given the impacts that it has on lifelong health outcomes.

Mrs ARCHER - Absolutely, and certainly I have a long-standing and quite public personal commitment to this particular issue. It is a very serious public health issue and does have lifelong consequences. So yes, absolutely, and it is also one of those examples so if something that kind of sits across a range of areas, not only within Health, it has Health consequences, but if we're looking at prevention and early intervention that needs to happen at various other points; Health, yes, maternal health education, a range of areas and through to some of those other social determinants of health that you have previously identified, which often go hand-in-hand as well.

Ms THOMAS - I totally acknowledge that and pleased to hear you say that. It needs a champion though, so go be that champion.

Mrs ARCHER - Well, you can help me with that.

Ms THOMAS - I will, very happy to.

Output Group 1 - System Management 1.2 System Management - Mental Health and Wellbeing

CHAIR - We might move on. With regard to state-wide mental services, 1.2 we will go back into Output Group 1 System Management, state-wide mental health and wellbeing. I know that in the description here of what's delivered that the profile falls away, reflects the fixed-term funding provided for a number of measures including Tasmanian Lifeline, Speak Up Stay Chatty, and there's a few other Rural Alive and Well, et cetera. All really important programs, particularly in our rural communities. I'm sure you're aware, Minister.

Does this mean that that's the end of the funding or what is the plan there? If it's not reflected in the Budget now, when will it be?

Mrs ARCHER - Obviously, these are always - all of these programs form part of the normal budget submission processes as well. We continue to talk and in fact I've met with all of those organisations in recent weeks to talk about the work that they are doing, the work that they are wanting to continue to do. As well, this I think fits also within our re-think and beyond strategy as well in terms of the next mental health strategy for Tasmania, as well.

CHAIR - The way I read this - and if I was a person who relied on Rural Alive and Well for example, or any of the others - it seems to me that the funding stops. Is that right?

Mrs ARCHER - That wouldn't be how I would characterise it. No.

CHAIR - But it's not a funding allocation in the line item.

Mr WEBSTER - There are fixed-term programs as well as ongoing programs. This is an indication of some of the fixed-term programs. For instance, A Tasmanian Lifeline was established at the during COVID. We've continued it beyond that, but in the meantime, we've been putting together the Access Mental Health Phoneline and central intake and referral line; so there is one point of contact for anyone coming into the mental health system. There will be a transition from A Tasmanian Lifeline to the growing Access Mental Health Phoneline and central intake and referral, which is not a very good name for it, but it will come through the same number as Access Mental Health. That's what that one -

CHAIR - Is that program in the funding over the forward Estimates?

Mr WEBSTER - Yes, it is. That's part of the reform money that's been put into mental health. We've been establishing Access Mental Health and the central intake and referral line, which is in fact the - if you like - the federal government's bit of Access Mental Health. That's part of our federal funding agreement, the SIRS bit and Access Mental Health is funded through statewide mental health services and the money we've received there over time.

CHAIR - Would you be able to provide the committee, then, a list of those that are fixed-term and when their terms finish? With the Tasmanian lifeline, for example, just some description about - if it runs out and it's not going to be renewed - what the replacement is. We shouldn't just keep funding programs if you're not working. I'm not suggesting that about any of these, but I do expect that there needs to be a process around it.

Mrs ARCHER - I should say, there may be some confidentiality arrangements around funding agreements, but notwithstanding that -

CHAIR - I'm not asking for the agreement. I'm just asking for which ones are fixed-term and when did that term end? And if it is to be replaced with something that there's clearly a plan for that to identify that.

Mrs ARCHER - I think also important to note that, as I said, all of these organisations we're continuing to consult with. Particularly around the wider re-think and beyond and whilst there may be time-limited programs, it doesn't mean that there isn't other opportunities through the budget submission processes for where, in the case of this -

CHAIR - We keep hearing about how tight the budget is, we worry about these things.

Mrs ARCHER - That we're not duplicating things that we are already doing in other ways as well.

Ms LOVELL - Can I just clarify on that, with Tasmanian Lifeline, the intention is that that funding will cease, and Access Mental Health will be funded instead?

Mr WEBSTER - Access Mental Health already exists, so effectively there's a duplication of services between A Tasmanian Lifeline and Access Mental health.

Ms LOVELL - A Tasmanian Lifeline's demand is quite high though, so will there be an increase in resources to Access Mental Health?

Mr WEBSTER - Yes, and it grows in terms of it adds services. Access Mental Health will be the one-stop shop for mental health services; it'll allow you to be referred off to any of our community sector services and things like that. I want to emphasise that the A Tasmanian Lifeline, which is the 1 800 number is not as well used as the 1 3 number that most people know around Lifeline. There is a difference between the two lines.

Ms LOVELL - It is quite well used though.

Mr WEBSTER - We would be confident that Access Mental Health is able to pick up that load and with growing Access Mental Health and the services available through Access Mental Health will be much broader than what's available through A Tasmanian Lifeline.

Ms LOVELL - Would Access Mental Health be a support service in itself or is it just a referral service?

Mr WEBSTER - It's both in that it can be referred off and that's an important service that's provided, but it actually has mental health professionals there that can actually be part of that support service. But importantly, it makes sure that the service referred off to matches to the needs of the of the consumer that's making the phone call. It's a live referral off.

Mrs ARCHER - Recognising that sort of single door, that we've seen with, for example, the intention of the Medicare walk in mental health clinics, for example, that people know that there's one one stop shop and not having any confusion about where to go or that they're going to be assisted if they ring that number.

I want to reiterate I am committed to working with the Tasmanian Lifeline as well to see what role they are able to play and know, for example, talking about the work that they've been doing with other agencies on support and specific supports. Including recently, I am talking with Parkinson's Tasmania, for example, about the work they're doing with the Tasmanian Lifeline.

We will continue to talk with all of these community groups and also looking at not avoiding duplication and having a more streamlined process for people seeking support but also looking at where the gaps are that exist across. That's part of that rethinking and beyond, avoiding duplication, but also what what could we be doing differently or where are some of those gaps and seeing how we can match those up.

Output Group 2 - Health Services
2.5 Statewide and Mental Health Services

CHAIR - We are going to 2.5, which is the statewide mental health service that was the overarching systems management.

Ms THOMAS - I know we have only about 7 minutes left, so I'll keep it quite high level. You mentioned in your opening statement about the review of the Rethink mental health plan. Can you tell us a bit more about that and what the budget allocation is for that in this particular line?

Mrs ARCHER - The government's long-term plan for mental health Rethink 2020 has transformed Tasmania's mental health system and we are seeking to build a contemporary integrated model of mental health care so that people can get more holistic support. As I mentioned, we've invested over $564 million in the last decade.

Part of that is refocusing mental health services from mostly hospital-based settings to now deliver supports that reach out to Tasmanians in the communities where they live. Some of those initiatives that have made a difference today through Rethink 2020 are the Peacock Centre, which include co-located community-based services, Access Mental Health we've just mentioned and also working in collaboration with the Australian Government to create that network of Medicare, Mental Health Centres across Tasmania, including for children. Statewide roll out of the mental health emergency response service.

Youth Mental Health Hospital in the Home, which I'm not sure whether we spoke about that here, but certainly on Monday talking about the success of that program. We will be looking to see how we can continue to expand those services, launching the Mental Health Council's lived experience training hub and growing that lived experience, training pathways for people. Continuing to implement the statewide Tasmanian Eating Disorder Service, and a commencement of a rapid-in service for residential aged care facilities in the north and north-west.

The next stage of that is Rethink and Beyond. We've begun consultation on the Rethink and Beyond with a recent stakeholder roundtable, and that brought together those lived experience representatives, peak bodies and sector leaders. We will continue to have that statewide engagement so that the strategy reflects the needs of Tasmania, and it includes some of the stakeholders that we have, of course, just been talking about.

Dale is going to provide some more information about, I think you were asking about funding for Rethink and Beyond.

Mr WEBSTER - The funding for Rethink has always been part of our reform program, which does continue. So, the funding is part of our ongoing funding.

Ms THOMAS - Okay, great. And is that amount stable? Across the forward Estimates, is it the same or has it gone down?

Mr WEBSTER - There are a number of elements of reform - the forward Estimates - now it's built into the base of statewide mental health services. Increased as we switched on new reforms, as the minister with that list there. So, it does fluctuates and changes depending on the program, I believe.

Mrs ARCHER - And there are infrastructure initiatives connected to that, like mental health precincts, across all areas.

Ms THOMAS - Has there been any valuation of the peer workforce within the statewide mental health services, and is that funded to continue?

Mrs ARCHER - Yes. Dale?

Mr WEBSTER - The valuation is under way; we have a peer workforce strategy. We are committed to increasing our peer workforce. It's an incredibly important feature of our Peacock Centre. We will have a centre like that at St John's Park that will need peer workers, and the Devonport Centre we're currently working with Fairbrother to build in Devonport will include peer workers also. We will have an increased number.

Mrs ARCHER - The Mental Health Council's lived experience training hub I mentioned is an important part of that, providing those training pathways for people with lived experience across mental health, suicide, and drug and alcohol prevention.

Ms THOMAS - As well as the Mental Health Council of Tasmania, are the consumer and family and friends groups involved in the consultation?

Mrs ARCHER - Yes. In fact, the family and friends joined me for the launch of Rethink and Beyond the other week. They have already been engaged in that stakeholder roundtable and continue to be engaged throughout the important part of those stakeholders.

Mr WEBSTER - And Mental Health Lived Experience Tasmania.

Ms THOMAS - Great, thank you. I am conscious of time.

Mr WEBSTER - Chair, I have a number of things that are probably- in the interest of time, I can just table:

- The workers' comp claims back to 2019,
- the personal leave back to 2019 by award,
- the data for emergency departments seen on time by triage category,

- the emergency department time in ED, discharged across four hours, eight hours and 12 hours.

Ms O'CONNOR - Excellent.

CHAIR - People are working hard in the background.

Mrs ARCHER - I apologise to whoever must now collate what else we've taken on notice.

CHAIR - That's Jen's job, not yours.

Ms O'CONNOR - But in the department, there are a few jobs for your people.

Mr WEBSTER - Yes.

- And the outbreaks by location and type of infectious disease across the network.

Chair, the ED5s, the time: there are 42 in progress as at 30 June. Twenty are in the one to six months, 12 in the six to 12 months, and we have 10 that have gone beyond 12 months.

Ms O'CONNOR - Chair, was that your question or Sarah's?

CHAIR - That was Sarah's.

Mr WEBSTER - My apologies, Ms Lovell. Since 1 July we have reduced the number that have gone over 12 months to eight and we've finalised another 14.

CHAIR - Thank you, minister. We will be a bit pressed for time to do justice to our mental health services, which are pretty stretched. We will have other opportunities to discuss these matters. Thank you for your appearance today. We will have a five-minute break while we change over to your portfolio of Ageing.

The committee suspended from 3.30 p.m. to 3.35 p.m.

Minister for Ageing

CHAIR - Thank you, minister.

Mrs ARCHER - Thank you, Chair. At the table I have: Noelene Kelly, Deputy Secretary, Community and Government Services, DPAC; Corrina Smith, Director of Community Services, DPAC; and Dale Webster, Secretary, Department of Health. I have a few words about the Ageing portfolio to start with, particularly acknowledging that ageing is not just about growing older, but it's about living well, being valued, and staying engaged. Through this Budget, we're investing in services, infrastructure, and partnerships to enable older Tasmanians to thrive, and communities that respect and celebrate their contributions.

In January this year, we launched A Respectful, Age-Friendly Island: Older Tasmanians Action Plan 2025-2029, which is a comprehensive, forward-looking framework shaped

through extensive community consultation, outlining our vision for Tasmania where older people are valued, included, and supported to live well. The action plan responds directly to the voices of older Tasmanians and addresses key themes raised during the engagement, including tackling ageism, as we mentioned earlier, promoting social inclusion and enhancing safety, participation, and respect.

The Budget includes funding to support the implementation of the action plan, with priority actions already underway, including establishing a governance group to guide delivery. This work is further strengthened by Lifelong Respect: Tasmania's Strategy to end the abuse of older people 2023-2029, which reinforces our commitment to dignity, safety, and the prevention of elder abuse. Together, these frameworks guide our commitment to ensuring older Tasmanians are respected and supported to live well in their communities.

As part of the more than $3 million committed across the first two years of the action plan 2024-2025 and 2025-2026, the Tasmanian government is continuing to fund a suite of elder abuse prevention initiatives, including the Tasmanian Elder Abuse Helpline, the Elder Relationship Service, and community awareness programs delivered by COTA Tasmania, the Migrant Resource Centre and also Welcome Cultural Services.

Ms LOVELL - Thank you, minister. I appreciate your opening comments because it was a little bit hard to figure out how we scrutinise this portfolio with no budget allocated to it. What you've described there suggests that there is funding allocated to measures but not sitting under you as Minister for Ageing. They're under other ministers, is that how it works?

Mrs ARCHER - It mostly sits with DPAC at the moment and there are some ongoing conversations, certainly conversations I've had with stakeholders. It's important, for example, that it's not just health-focused, and stakeholders have indicated that they would prefer that it didn't sit with Health. At this stage, it sits with DPAC and we will continue -

CHAIR - Under what line item?

Ms LOVELL - Can I clarify? You're the Minister for Health, that's one portfolio, but you're the Minister for Ageing as a separate portfolio; is that right?

Mrs ARCHER - Yes.

Ms LOVELL - Are you responsible for this funding or does that sit with a different minister?

Mrs ARCHER - Yes, it sits with me.

Ms LOVELL - That's not identified in the Budget.

Ms KELLY - It's not broken down as to how much it is.

CHAIR - We have asked for a more thorough breakdown in a previous hearing on what is under this line item, because it's all one big -

Mrs ARCHER - Previously, and this may answer your question, the ministerial responsibility would have sat with communities for Ageing. That responsibility has transferred to a dedicated minister with -

Ms LOVELL - And the funding as well?

Mrs ARCHER - And the funding as well.

Ms LOVELL - Can you give us a breakdown of the allocation of the funding for this portfolio?

Mrs ARCHER - Yes. I might just ask - would you like to make some comments on it?

Ms KELLY - We have a breakdown here in terms of the funding that we provide to Council on the Ageing in terms of their peak funding and then one-off funding. We've also got a table here that provides information around funding that we provide to Advocacy Tasmania, and then also specific funding around elder abuse. We have a copy of that.

Ms LOVELL - That's funding provided to other organisations, but in terms of funding in the Budget that's allocated to this portfolio, where do we find that?

CHAIR - This is the Communities 3.3.

Ms LOVELL - Yes. So how much of that $31.48 million -

CHAIR - I think it's on the table isn't it, how much is on each line? If you're able to table that, Minister.

Ms LOVELL - But it's all going to other organisations?

Mrs ARCHER - There is the establishment of the governance committee that we were talking about as well.

Mr WEBSTER - In addition to that, there's the Aged Care portfolio that sits in the Health budget, which is split across admitted services, not-admitted services and community services.

Mrs ARCHER - Yes, so there is funding across health, but I was really at pains to make the point as well that we want to look at all of the things we talked earlier about inclusion.

Ms LOVELL - This total funding essentially is the amount that's in this Communities line item.

Mrs ARCHER - $3 million across the first two years, and the continuation of those initiatives that I mentioned in my statement.

Ms LOVELL - I had a question, too, and I appreciate this as something very recent, I know it's been a busy week for everyone, but I was just interested in the Law Reform Institute report that came out. It might have even been today or yesterday. The safeguarding against the abuse of older Tasmanians and the recommendations in that report. Again, appreciate that it's very recent, but wondering if you had any response to that yet?

Mrs ARCHER - Certainly, I've probably only seen the same reporting that you have at this stage, but I also was very interested in that, and it remains a very high priority for the Tasmanian government and for Tasmanians to address this very important issue.

That report was released on 18 November and the key recommendation to create a commissioner for older people, responsibility for that obviously sits with the Department of Justice and the Attorney-General in terms of any legislative changes and safeguarding arrangements. There will be a range of consultation in order to respond to that.

Ms LOVELL - I don't expect you to have this today, of course, but just in terms of whether we would expect to see a response from the government to that and when we might?

Mrs ARCHER - Certainly, I would have to come back to you with a time-frame. As you said, it's very new, but yes, I expect that there will be a range of consultation in relation to that and then there will be a response.

Ms O'CONNOR - The elder abuse prevention strategy, we've been presented with the table and just for the purposes of people who are maybe watching, in the out-years, there's a whole lot of gaps. I understand that's a feature of this budget. But the elder abuse awareness campaign and the elder abuse strategy funding runs out in 2026-27. I know, Minister, you will agree that's not because of the devastating consequences of elder abuse have been dealt with by a government or us as a broader society.

Two questions: what is the government's current understanding of the extent of elder abuse in the community? On previous data about 10 years ago, we thought there might be 3500 to 4000 older Tasmanians who are at risk of physical financial abuse, neglect and the like. What's the government's current understanding of the extent of the issue, and what is the plan for funding ongoing elder abuse prevention?

Mrs ARCHER - There's a range of services that are currently funded to address the issue. The issue that Ms Lovell referred to with Australian Law Reform report also points to that issue being persistent and actually asks for the creation of a commissioner to deal with it, which is pretty sad indictment of the situation. It's also - as part of this prevention of elder abuse, but it's also the importance of having a dedicated minister for Ageing, which has been a long advocated for position by advocates in this space, because we have to look at it not in isolation as well. Of course, continued funding to address the issue of elder abuse, but we need to turn that around as well, by destigmatizing AGME's whole range of positive ageing initiatives in addition to that, but I might just ask DPAC to make some more comments about it.

Ms O'CONNOR - So, the question of the trends and the data as we understand it and then back to you if possible, Minister, just to talk through that funding question in the out-years and what process we might go to there.

Ms KELLY - We don't actually have any up-to-date information around the current trends and statistics, but that's certainly something that we could work with (inaudible, 3.45.50) to bring through.

Ms O'CONNOR - I don't want to put any more work on an already overextended segment of an agency, but anything that's readily accessible that could help the committee understand the extent of the problem would be good and back to the Minister: funding.

Mrs ARCHER - Yes and look, all I can say is I remain committed to continue to address that, but we will also work in consultation with these agencies and through these governance groups as well, that we are establishing to look at future actions as well in relation to that, to unite that. There's programs delivered across a range of organisations, including in cold communities as well, and I am certain that there are some other areas that we could look to in taking some further action as well.

So, no, I remain committed to addressing this very serious issue and including from the conversation with Ms Lovell, around looking at these recommendations through the Attorney-General's department, around whether or not there's more that can be done in terms of having a commissioner for older persons or something of that like as well.

Ms O'CONNOR - Or, potentially, legislative change, there are jurisdictions that have a specific crime in their statutes of elder abuse, which certainly points to governments taking it seriously.

Mrs ARCHER - And I think that one of the challenges that we have identified is making sure that people in our community, across a whole range of areas, are able to recognise where elder abuse might be occurring and recognising that it occurs in a range of different ways, as well, whether that's financial abuse, physical - there's a whole range of things that would fall under that category. So, it's about people being able to recognise that so that they can also intervene.

Ms O'CONNOR - I mean, even though there's no funding in the out-years, it is clearly not government's intention to stop contributing towards Seniors Week, is it?

Mrs ARCHER - No.

Ms O'CONNOR - Thanks, Chair.

CHAIR - Well thanks, Minister. I know it was a brief amount of time. And I must apologise and I believe Sally's gone, but it is -

Mrs ARCHER - Well, we didn't sing happy birthday ...

CHAIR - Oh, she's up there. So, we mightn't do it while the camera is going, but I would like to thank her for spending her birthday with us. It's quite an achievement and someone on this table has a wedding anniversary this day, who's also spending it in public with his wife.

Mrs ARCHER - Congratulations.

CHAIR - But we all wish Sally a happy birthday. Sorry she had to spend it with us.

Mrs ARCHER - I think she is probably now sorry she had to spend it with us as well.

CHAIR - Well, thank you, Minister. We will change out to have a 15-minute break, change out to Aboriginal Affairs portfolio and we will help to let people go.

The committee suspended from 3.48 p.m. to 4.15 p.m.

Output Group 6 - Heritage
6.2 Aboriginal Heritage

CHAIR - Welcome back, minister. We're now onto your Aboriginal Affairs portfolio. I will invite you to introduce the people at the table. We will start with the NRE Aboriginal Heritage line item to start with and if you wish to make an opening statement, if you could do it across both areas, that would be helpful.

Mrs ARCHER - I have Steve Gall, Director (Aboriginal Heritage Tasmania), NRE; Louise Wilson, Deputy Secretary, Environment, Heritage and Land, NRE; and Will Joscelyne, General Manager (Heritage), NRE. Joshua Brown, Manager Budget Services is back there if we require him.

I will make a brief opening statement. Firstly, I'd like to acknowledge the Tasmanian Aboriginal people as the traditional and original owners and continuing custodians of the land on which we meet and pay my respects to Elders past and present and I acknowledge Aboriginal people here with us.

It's been an honour throughout my career and now as minister to meet with many Tasmanian Aboriginal people, communities and organisations. Our commitments in this budget are about ensuring the resources are there to create lasting change for Tasmanian Aboriginal people. For the first time, key Aboriginal organisations have been given funding certainty across the forward Estimates, allowing them to plan and act with confidence, including funding for the Tasmanian Aboriginal Centre, the Tasmanian Regional Aboriginal Communities Alliance, the Elders Council of Tasmania and the Palawa Business Hub.

There's also funding to begin the process towards truth-telling. With the funding there, we will work with Tasmanian Aboriginal people at their pace to begin the planning and establishment of truth-telling, noting that this process must be Aboriginal led. This work has been welcomed by Tasmanian Aboriginal people as a long overdue step towards justice and unity. As Elder and chair of the Elders Council, Delia Summers, said: 'History has been made and now we must deliver real outcomes', and I can assure this committee that that is exactly what we will do.

We are strengthening the Aboriginal Land Council of Tasmania with a 48 per cent increase in funding, recognising its vital work as guardian of country and culture, and there's also additional funding for cultural heritage assessments and the Aboriginal Heritage Register to ensure that development and cultural respect progress together.

There's no doubt that Aboriginal self-determination and leadership is a high priority for our government and through these commitments we're building new partnerships together where Aboriginal culture is supported, voices are heard, and the partnership guides our way forward. Thank you.

CHAIR - Thank you, minister. This is one line where there's actually been a legitimate and real increase. That's a positive and important indication of your seriousness about addressing these matters.

In terms of the Aboriginal heritage side of your portfolio, can you indicate to the committee what work has been done in that area and how you've engaged across the broader Aboriginal community?

Mrs ARCHER - Yes, through a range of of areas. Importantly, you will be aware that we have a commitment to a new *Aboriginal Heritage Act* that now has some quite specific timelines. Thank you to the advocacy of Mr Garland in the other place and we have committed to having a new *Aboriginal Heritage Act* out for draft consultation by March next year and in the parliament by the end of 2026.

That is obviously one of the most important aspects in relation to the protection of Aboriginal heritage. I might ask Steve to make some more comments about Aboriginal heritage more broadly, in relation to -

CHAIR - You must be getting some input into the consultation draft. I'm just interested in how you're doing that.

Mrs ARCHER - We have committed to have some pre-consultation, if you like, before Christmas, noting that it has been some time in the progression of this legislation, and it's been some time since there's been that formal consultation around it. We know that it is a high priority for Tasmanian Aboriginal people, but we will commence that initial pre-consultation, if you like, workshops in the lead up to the end of the year -

CHAIR - Who leads that work?

Mrs ARCHER - That work will be led by NRE. I am happy to ask Steve to talk more about that process, and Louise might like to add to that.

Mr GALL - The legislation program been going for some time, and there's been some delays based on a whole bunch of different things like elections and so forth, however, we've had a lot of conversations and engagement with the Aboriginal Heritage Council throughout the last few years in this space. We are constantly - it's on their set agenda to talk about heritage legislation and to actually unpack some of those cultural aspects, and to really unpack some of the changes that we're proposing.

For instance, we are moving from an advisory role to a decision-making role, and so trying to work with the council to understand the repercussions of that type of process, and the fact that it is a very different dynamic, actually making the decision in relation to impacts to Aboriginal heritage for the common good in the new legislation. It actually provides us with some real insight as to some of those issues that we need to capture in the drafting.

We have got to a fairly - draft 19, I think, at this point, so we're well on our way to being ready for March. A lot of that's been with the input from the Aboriginal Heritage Council in the design of that. The other is that we've also reached out and are having conversations with TAC now on that as well, so to talk about how we engage, and we're having conversations with TRACA as well about how they want to be engaged over the consultation process, and -

CHAIR - When I look at the fact that TAC don't recognise all the Aboriginal organisations in the state, so you won't just talk to them?

Mr GALL - No. We will be talking to TRACA as well, and as always there will be broad consultation and engagement. We will be going out to all those organisations and actually finding out how they want to be engaged in the process.

CHAIR - I'm sure Mr Garland will be on that too.

Mr GALL - Absolutely.

Mrs ARCHER - This has been **-** I think that I noted that before, that this is identified as a high priority across Aboriginal communities, which is very positive. I have, in the short time that I've been the minister, got around and talked to many stakeholders overwhelmingly raising this as a priority. We are very keen to progress that as a priority and recognising that that is an important part as well of building trust with the Aboriginal community as well, as we move through truth-telling as well.

CHAIR - I will hand over to you because it was your line item, but you just weren't here at the time.

Ms O'CONNOR - Thanks for covering for me. Thanks, minister, and congratulations on being trusted with the Aboriginal Affairs portfolio. I'm sure you realise now it's a really important and meaningful portfolio to administer. Are you able to provide the committee with an update on the process of establishing that truth-telling framework and how it will work out for Aboriginal people across the island?

CHAIR - Is this under the other line item under DPAC?

Ms O'CONNOR - Well, it's heritage as well. I guess the thing is, that heritage is part of the truth-telling as well.

Mrs ARCHER - I can talk in some broad terms around that and then we can revisit with DPAC as well, if you like. I think that goes to the point that I just made, and Steve may wish to add some more to this. Certainly, I think the Aboriginal community has identified several key priorities: two of those priorities are Aboriginal heritage and also land returns, and so consequently we are prioritising those two items. It is my strongly held view that both of those things are important, and you talked about trust and we often talk about moving at the pace of trust. I think those two things, and the progression of those two things are very important as we move towards truth-telling and, indeed, to sort of lay a foundation for truth-telling. We know, as I said, from talking across a range of stakeholders, that there is very broad agreement that these two things are very high priorities.

That to me seems like a good way to build those relationships and build that trust to be able to do the vitally important work of truth-telling and healing; but I think we have to move at the pace of trust and we have to build trust and relationships as well to be able to do that. Steve, did you want to make any particular comments around that? You don't have to, but I am conscious that I'm speaking.

Ms O'CONNOR - There's experts at the table, actual experts.

Mrs ARCHER - There's experts at the table.

Mr GALL - Look, as an Aboriginal man, land return is absolutely a large priority for us and certainly, the heritage act 1975 is a long time ago, absolutely. So from our area of responsibility, they are the major focus for us. We are very conscious of the Closing the Gap targets and we are having some in-earnest conversations about how to move forward with the land return.

We have an exhaustive list of land that has been provided to us through different organisations and individuals in the community, and we are focusing on a handful of those to at least get some assessment done and have a look at how we can start moving this forward, because the reality is land return.

Ms O'CONNOR - That's right, and we can talk a little bit more about land returns shortly in the next output. It is encouraging to hear that the new Aboriginal heritage legislation is in -

Mrs ARCHER - It's well-advanced.

Ms O'CONNOR - Well-advanced and in full development, and I heard you say that the structure is moving from one where Aboriginal people advise government on heritage protection to being able to make decisions over heritage. How will that work in practice? I mean, if it's well-advanced, there must be a reasonably clear idea of the structure that you would establish, the heritage body that you would establish, that has that decision-making capacity.

Mrs ARCHER - Yes, and I will ask Louise to make some more comments. That's correct. I suppose the caveat to that, which you may speak to as well, and Steve alluded to as well, is that that's not without complexity as well and cultural sensitivity. I think it's reasonable to say we already know that, and Heritage Council members reflect the difficulty of doing that job as it is, and so we are approaching that carefully to ensure that you're taking people along on that journey, and that it is culturally appropriate and safe for people to be able to engage in that process. That has been part of the process to date and will continue to be, but I will ask Louise to make some more comments.

Ms WILSON - Thank you. The new bill at the moment provides for a new Aboriginal Heritage Council. Currently under the current act -

Ms O'CONNOR - The relics act?

Ms WILSON - It's got a new name, but yes, basically the same with a few tweaks - the Aboriginal Heritage Council is an advisory body rather than a decision-making body and I know that can be very frustrating for the council at times. Under the new legislation we are proposing a decision-making body for the Aboriginal Heritage Council, and the council will be responsible for almost all the decision-making under the act, so that they will be the primary decision-maker rather than a minister, or purely being an advisory body, which is really important, and there will be some provisions for minister responsibility, but they will be the exceptions rather than the rule.

Ms O'CONNOR - Okay, and through you minister, that goes to what you said, Louise, that the council will be responsible for almost all decisions. What's the proposed threshold for the ministerial intervention?

Mrs ARCHER - One of the examples of that goes to what I just said, where there may be occasions where the council doesn't want to or, for whatever reason, determines that they are unable to make that decision or don't want to make that decision for some reason - some more examples of where that might if you don't mind - oh, that's it.

Ms O'CONNOR - Historically, for example, the Property Council has been resistant to Aboriginal heritage framework that provides decision-making, and therefore potentially a veto, over some developments that may have an adverse impact on Aboriginal heritage. I'm interested, Minister, to hear a little bit more about how you make sure there's integrity in the authority that you give to this council, so that it's not just, 'there's easy decisions over here we can leave to the council,' but if it came to, for example - contentious - if it came to a stadium on Macquarie Point that impacted on Aboriginal heritage values, how would that work for government?

Mr JOSCELYNE - One of the concepts which is included in the current drafting actually borrows from other jurisdictions. We're constrained in the current act insomuch as the only instrument available to make a decision in relation to is a permit. You know, it reflects the age of the act. It's a very crude, blunt instrument, and it doesn't provide - the act as it's currently drafted really provides very little guidance for a council in terms of how to consider decisions for an agency, how to support a council in relation to decisions. At the moment, that's all policy driven, and that reflects, I suppose, the experience and time of the council and the department.

In other jurisdictions, they've introduced and are introducing what's known as management plans. You'd still have permits in the act, but one of the instruments that is currently being considered is management plans, which will provide for more complex decision-making, potentially higher levels of -

Ms O'CONNOR - More complex projects?

Mr JOSCELYNE - More complex projects. That complexity could be in terms of scope, time, the complexity of the tenure, multiple dimensions. Interests, as well.

And so, the current thinking is that management planning process would allow for early assessment and consideration by the council in relation to a proponent coming forward with a proposal - similar, but it would obviously be different, from what might happen in environmental legislation at the moment with the NOI.

The council would then work with the proponent, and the proponent would also be required to work with Aboriginal people in relation to the conception and development of a management plan that would identify potential impacts, identify community concern, and then articulate how those matters are going to be addressed in a management plan, which is then ultimately considered by the council.

Now, as the minister has already identified, we're anticipating there could be situations where the decision-maker might wish to say, 'Actually we'd rather not contemplate this at all,' and that could be for that it's considered unsafe. And so therefore, we want to have a conversation through this engagement phase which we're about to enter into next year, to understand how we might deal with that. We want to seek, I suppose, a robust administrative decision-making piece of legislation, but we've got to have - underpinning all of that has to be that sensitivity around it - the design and the guide frames for decision-making.

Mrs ARCHER - And that has to be led by community. Will touched on it, but I think that all of that happening much earlier in the process than what we currently see now - which is one of the ongoing criticisms of the existing legislation, that it's ages before that sort of interaction, that assessment is taking place - that's one of the things that we will continue to work through with community as we move towards the draft being released as well.

Ms O'CONNOR - Can I ask a sort of threshold question of ownership of heritage? It's not a question that Palawa people ask themselves; they're very clear about who owns the heritage. Will that be addressed in the draft bill? And from memory there's an Aboriginal heritage register, and there's sometimes been question marks over who owns the heritage on the register, who is able to administer it, access it and that sort of thing. Are we resolving those thresholds ethical questions, if you like?

Mrs ARCHER - I hope so and I will ask Steve, obviously some kind of cultural experiences as well to respond.

Mr GALL - Yes, it's a tricky space. The Aboriginal heritage - one point just prior to that is just the other really important component for our average community to be decision-makers is that management plans will move into a space where we can ensure ongoing management of things. If we do have to have a compromise, some impact, and at the moment it is a permit, but there's no guarantee for anything else on that property, management plans ensure ongoing management that could be a negotiated outcome so that we do get something out of it for our community.

I just thought that was an important point for management plans. With the register, the register will be central, so it will be statutory register. That's the intention of it, and that's because we have to have one version of the truth, especially when it's interfering with everybody's lives, when you interact with Aboriginal heritage, and that's how we have to have accuracy, we have to have a good solid basis for imposing a process on somebody.

In my mind that is a government role to ensure that happens and that it is able to comply with compliance enforcement and all the other things that we need to deal with as administrators. The information itself, absolutely is Aboriginal community-owned information, or some of it, not all of it, because some of it will be business information it will be private information from people.

It is complex the information that's on the system, but certainly the Aboriginal heritage site information and location of that is Aboriginal-owned.

Ms O'CONNOR - Sorry to interrupt, but the site mapping of heritage, how protected is that information?

Mr GALL - Currently or into the future, it will be statutory, which means we will change - so at the moment the register doesn't exist in law. It is the memory [??] of the Director of National Parks and Wildlife because that's basically a person has to notify the Director of National Parks as soon as it's practical when they believe they've found Aboriginal heritage and so the register is basically being evolved out of that system.

It has no legal basis, and it has no protections other than the policy setting that we work in and that policy has been developed over the last 30 years. I've been in this role for 18 years

and we've been very strong on that, and we don't allow access to that information unless there's good, valid reasons.

We have three pathways into the register at the moment, which is for regulation, for Aboriginal community, and for research. Two of those things go to the council for consideration. The regulatory is obviously a process that people need to go through for the assessment and potential permitting process.

The register itself, at the moment, it doesn't have any legal basis, but it is captured and we've considered this and we work through this under RTI so there are safeguards under the RTI for the information that's in there. And so there are protections, it's just not in our legislation, but we are proposing that as a central register to the legislation and so we will have some rules around it.

But the system that we're creating at the moment will have access for Aboriginal community and that, how that works and we've got to work through that with community, about how the access is given, all that sort of stuff but we've got a lot of work to do in that space.

As for the actual system that's being replaced currently and will be live mid next year that will allow for consultants to have access to certain information to do the regulatory process, the Aboriginal community for their purposes will be able to access cultural information as well.

Mrs ARCHER - Just having that single source of truth is really important also for providing a common understanding, which is the other challenge that currently exists around just providing certainty for anybody in relation to it and having less uncertainty in regard to that. And part of that is also about making sure that where we land is something enduring as well, and I have spoken about this before, but we don't want to have a situation where we have legislation that's been repealed at some point in the future. We're working through those things.

CHAIR - Any other questions on Aboriginal heritage? I will let you change the people at the table, minister, for your Aboriginal affairs.

Mrs ARCHER - If you had any questions about land return -

CHAIR - Now?

Mrs ARCHER - Yes, because it would be with these people.

Ms O'CONNOR - I am happy if others go first.

CHAIR - No, you're right.

Ms O'CONNOR - Minister, as you know, I think it was 2005 that the last lands were returned under the act. A small island or two in Bass Strait, to our shame as a state really. What is the plan for the return of lands to the Palawa?

Mrs ARCHER - Yes. First of all, I agree with that assessment and most people would agree it has been far too long. It has not sat in the too-hard basket, I think it's fair to say. We are really committed to both improving outcomes for Aboriginal people and land return is part of that. It's part of our Closing the Gap commitments. As I've said, since becoming minister

and as I move around and talk to Aboriginal people, it is a very high priority and a shared priority for Tasmanian Aboriginal people. There's been a review into the model for returning land. That included three rounds of consultation, including on the exposure draft of the Aboriginal Lands Amendment Bill. It was clear from that consultation there are diverse views in relation to that legislation, both within the parliament and also amongst Tasmanian Aboriginal people. I know the former minister worked to try and build consensus on that. It's only when we secure that consensus, we would seek to to reintroduce that. We are looking at a whole range of opportunities; there's quite an extensive list of parcels of land.

Ms O'CONNOR - Of Crown lands that have been identified?

Mrs ARCHER - Yes. So, working through all of those proposals which Louise or Steve may speak about. There are complexities and there's a range of complexities depending on different parcels of land, but it's not to say you shouldn't try to work through them.

Ms O'CONNOR - Of course you should.

Mrs ARCHER - That's right. I might see if Louise wanted to add to that. It was a question that came the other day. We're looking at progressing land returns, but in addition, also looking at potential for leases and other arrangements, in parallel, not instead of.

Ms O'CONNOR - This might be a question for you, minister, or Louise. You wouldn't want to wait until there was a consensus over the *Aboriginal Lands Act* before taking some steps to return what land you can, would you?

Mrs ARCHER - No. You have to act in parallel. As I said, there's work to be done obviously, to build consensus in relation to that, but that's not to say you don't do the work required to progress that. I will let Louise speak about where that's at. Thank you.

Ms WILSON - There are a number of parcels that we've been looking at. We have a long list and if we try and address them all at the same time, it will take a long time. Some pieces of land are more complex and have more complex issues associated with them than others. We've been talking to Aboriginal people about what their priorities are and obviously there's a lot of different priorities. We really need to look at the parcels of land and what interests exist. For example, with Crown land and some types of reserve land there are existing non-Aboriginal interests, but really important values and land of important value to Aboriginal people. It's also working through with non-Aboriginal stakeholders, because if there are existing leases for example, then it's not a simple process of just deciding to return a certain parcel of land. There's a bit of a process to go through and we are - minister, you have given us pretty clear directions that this is a priority and that we will be working very hard. We have also to consider other portfolios involved.

Ms O'CONNOR - Yes and presumably that would include, for example, the minister for crown lands who you'd have to have a discussion with.

Mrs ARCHER - Sure, but it's important to note - and you asked the question about why you wouldn't wait - because there's clear -

Ms O'CONNOR - Why you would wait until the act was sorted out.

Mrs ARCHER - Why you wouldn't wait or why I am disinclined to wait.

Ms O'CONNOR - Oh, yes, okay.

Mrs ARCHER - Why I am disinclined to wait is because there's a direct obligation under our Closing the Gap targets that it clearly relates to land returns. That is why, in my view, we must progress land return.

Ms O'CONNOR - Under the process of returning lands through whatever mechanism you decide as a government to do so, are you looking at, for example, the return of some reserved lands to Aboriginal ownership and management? Are you looking at tenures like indigenous protected areas and those sorts of things so there's more capacity there to return culturally important areas of country.

Mrs ARCHER - Yes, is the short answer, but I will ask Louise to expand more on what what that looks like in practise.

Ms WILSON - The priorities will be the list we have. It's quite a long list and I might throw it to Steve in a moment, but nothing is off the table. We're listening to all proposals and looking at all options. In some cases, for example, there are some parcels that are probably going to be prioritised for land return, but there might be options for joint management.

The Aboriginal Land Council of Tasmania is the organisation established under the *Aboriginal Lands Act* to be the owner and manager of the land on behalf of Tasmanian Aboriginal people, but other groups might have an interest in the land. We're looking at all options to try and realise positive outcomes across the board as much as possible, but it really will depend on what Aboriginal people say as we progress this work and what they want. It's not without its complexities, but we're pretty determined to just keep pushing through.

Mrs ARCHER - And that's about identifying what are those barriers, what are the challenges or the complexities on that, and then looking at the ways we can work through them depending on the particular complexities of that situation. As we have said, obviously, ensuring that's Aboriginal land.

Ms O'CONNOR - I'm deliberately not going to ask you for a list of the areas of land that you're looking at because I think that could potentially be unhelpful, but Kooparoona niara - which is an area of country attached to the Greater Western Tiers and to the Tasmanian Wilderness World Heritage Area - is subject to what I think would be still an existent request and claim. A request to government to return an area of land that was set aside under a predecessor and the parliament, as a conservation area. Is that a specific area that's being examined, given that a formal request came through from - I'm pretty sure - the TAC and the Aboriginal Land Council of Tasmania for government to return that land to Aboriginal people as ownership and managers of the land?

Mrs ARCHER - I might ask Steve to comment.

Mr GALL - Yes, we've had several formal applications for things of interest from the community. Regarding Kooparoona niara, I guess the position we're taking is to try and find some of the lower hanging fruit to try and get the ball rolling I guess, to be quite crude about it. We are looking at some that are not as complex that we can start moving forward with as

soon as we can to meet these targets. Kooparoona niara is an interesting one in that when the request came in it was for an Aboriginal National Park and that isn't currently under any legislative framework. There's got to be some further conversations about what that looks like.

There are a couple of angles we could take. We could push it down the road and go, 'We're going to go for the legislative review and create something else under budget', but we can talk about that in 20-years' time. Or we can have some conversations once we get to this point with the TAC and that and have a look at what exactly it is that they want, what sort of tenure we're looking at: is it Aboriginal term land or is it some other lease agreement or something like that.

To work under the current program would be easier than to look at an Aboriginal National Park, I guess. That's the point of confusion, I guess, from the application was that it was something that was probably going to tie us up into legislative reform for several years. That's another conversation we have to have, but I guess at the moment we've got to build some faith and some strength in our relations with community. We have to get the ball rolling as well. The focus from our conversations, and the minister has driven this, is that we've got some parcels that we're at least exploring now that we can really to see happening sooner rather than later.

Mrs ARCHER - It's not to say no, it's really more that it speaks to the complexity across the whole range of parcels that have been identified. I think the easiest thing to do would be to just to keep kicking it down the road.

We can't do that. This goes back to the issue that I was talking about, about trust and building trust and building foundations of trust for the whole range of other conversations that are ahead of us that are really important, that are about truth-telling and healing and where we go from there. I think we have to build these foundations. I think it's low-hanging fruit, as Steve said, identifying amongst all of those parcels of land what can we progress more quickly and what might take longer, but not doing nothing in the meantime, I think.

Ms O'CONNOR - Do you have a question?

CHAIR - No, you're right.

Ms O'CONNOR - Oh, good. First of all, it sounds like there's lots of work and engagement happening, but is there a notional time-frame on any kind of land returns or a benchmark you've set yourself, Minister?

Mrs ARCHER - I think there is complexity to it, as I've said, and you've identified that some of it sits across portfolio areas as well. Notwithstanding that, like I have been very clear both publicly and certainly with the department, that Aboriginal heritage and land-return are high priorities for me. They are they are my two highest priorities in this space, along with truth-telling, as we have identified. I think it's important that we and - you will hear said often - that we don't rush it, that we get those things right, that they're enduring and importantly that again we're moving at the pace of trust with our Aboriginal communities as well.

Ms O'CONNOR - On Minjerribah/Stradbroke Island, the Quandamooka people were given land back and that land along the west coast of Minjerribah/Stradbroke Island is now the Quandamooka National Park, and it's owned and managed by Quandamooka people, and it provides them with an economic foundation.

Obviously, in Queensland there must be some tenure you can designate to an Indigenous protected area. Is the Tasmanian government looking at whether there's changes that you'd make to the *Nature Conversation Act* or whatever it is in order to create the opportunity for a specific tenure for Aboriginal land returns, in protected areas? It doesn't sound like it at the moment.

Mr JOSCELYNE - I think it's fair to say, and this was actually reflected in the other place the other day, is that it's certainly been identified that that is something that would need to happen. You're right, the *Nature Conservation Act*, *National Parks and Reserves Management Act* currently do not provide for that, and clearly this is a cross-portfolio matter. We wouldn't want to speak too much into that space other than to say that within the national parks act there are also some provisions that could be useful as a part of the pathway.

For example, section 29 provides for other managing authorities to be assigned to land that are not the Director of National Parks. Now again, I'm saying what's in another act because it's factual, but those are matters that are in of themselves complex in our current legislative arrangements.

Mrs ARCHER - And sit in other portfolio areas.

CHAIR - We might let you change, we will go to the DPAC output and go to Aboriginal Affairs.

Output Group 1 - Policy Reform and Government Priorities
1.6 Aboriginal Affairs

CHAIR - Thanks, Minister. We will get you to introduce the new people at your table and I'm sure you made all the comments you wanted to previously and then we will go to Mr Harriss for questions.

Mrs ARCHER - Okay, so at the table with me now, I have Mellissa Gray, Mel Gray, Deputy Secretary of Policy and Reform with DPAC, and also, Caroline Spotswood, who's Director of Aboriginal Partnerships.

CHAIR - Great. Dean.

Mr HARRISS - Thank you, Chair. Minister, I will start with the line item and just with the actuals from last budget or last year, 2024-25, being $2,810,000; that is the same as the current Budget allocation. I tried to have a look but I could not find it. Has that gone up over the last five years?

Ms GRAY - It's usual for the operating budget for Aboriginal Affairs to remain the same, but the overall funding fluctuates from year-to-year depending on what the government priorities are and, for instance, over the couple of years prior to that, we had $5.3 million in Closing the Gap Capacity Building grants and in this year's budget, there is $4.4 million over the forward Estimates over four years for Closing the Gap and Aboriginal projects.

Mr HARRISS - So, just on Closing the Gap and the work happening there, can you update us on what the Tasmanian government is doing there?

Mrs ARCHER - Broadly. So, as a signatory to the National Agreement on Closing the Gap, we are required to reduce the disparities in health, education, adult and youth justice and overall outcomes between Aboriginal people and the wider Tasmanian community. This is a long-term commitment requiring transformation, resources and genuine partnership with Tasmanian Aboriginal organisations and people.

Closing the Gap acknowledges that better outcomes are achieved when change is led by Aboriginal people, with Aboriginal people at the centre of decision-making about issues affecting them. The government works in partnership with its Closing the Gap Coalition of Peaks partner and the Tasmanian Aboriginal Centre and the government also works with other Aboriginal community-controlled organisations to ensure that their perspectives and priorities are considered within the Closing the Gap architecture.

The key message of the Productivity Commission Review report on Closing the Gap 2024 is that fundamental changes are required to deliver on the agreement. Caroline might like to speak some more to this, but I think the key word in there is 'transformation', and looking at the way- I probably referenced this earlier today, but for Closing the Gap to be successful it must be a whole-of-government, transformational approach. While we look at line items and funding items within Aboriginal Affairs, they are, I suppose, at a capacity-building level, but also seeking to drive transformation across whole of government. Caroline might like to speak more specifically about that.

Ms SPOTSWOOD - Thank you. We were pleased to announce that Tasmania's Plan for Closing the Gap 2025-2028 has been released and is now available on DPAC's website page. To get to the stage of that document being finalised was extensive engagement with Aboriginal people over a period of two years to inform the process and the actions in the plan. The document was endorsed by our Coalition of Peaks partner, who we work closely with, and also with other Aboriginal people and organisations.

Within the plan, it goes through a number of actions, 62 actions, with different lead agencies. Also embedded in our plan are our four priority reforms. Those four priority reforms are about access, and for community-controlled organisations, shared decision-making - I think I've got them back-to-front - transformation of government, and also Aboriginal people having access to their data. Following through those priority reforms that are embedded are our policy partnerships, that our jurisdiction is membership over those policy partnerships. That's very broad. Thank you.

Mr HARRISS - Since - I'm just trying to find - when it was announced that treaty process was not going to be progressed - it must have been May this year, was it? I'm just trying to find - anyway, can you talk me through the truth-telling aspect of that and how you see that working, albeit early stage?

Mrs ARCHER - Yes. I guess I alluded to some of this earlier in relation to some of the work that I think that we need to do even on the way to truth-telling, but I certainly understand the significance of truth-telling and treaty to Tasmanian Aboriginal people. I have had a lot of conversations about this, both in my previous role but also since coming to this role, and I know that there are mixed views amongst the community about what should come first or whether one should progress without the other.

The interim advice provided by the Aboriginal Advisory Group on Truth-Telling and Treaty, which was in October 2024, included the appointment of independent commissioners to guide a genuine, Aboriginal-led, truth-telling and healing process for Tasmanian Aboriginal people. Following this advice, and after extensive engagement with Tasmanian Aboriginal people by the former minister, as well as our commitment to Closing the Gap, we announced that we will focus our efforts on a healing journey for the whole Tasmanian community, walking together on a shared pathway.

Truth-telling is a necessary step which must run its course before any formalised agreements, and whilst I understand the importance and significance of treaty, I believe that an Aboriginal-led truth-telling process must happen for healing to truly take place in Tasmania. That's part of what I alluded to earlier, and why I believe that things like land return and the new *Aboriginal Heritage Act* are important steps along that journey as well.

That process was disrupted by the election, and we will continue to work with Tasmanian Aboriginal people on the next steps, including the process to appoint the commissioners, noting again that this will be led and driven by Tasmanian Aboriginal people. Mel, do you want to speak anymore to where we're currently at and the timelines that we foresee?

Ms GRAY - You've expressed it perfectly. Part of Closing the Gap is being Aboriginal led at every stage and taking the time that is necessary to co-design with Tasmanian Aboriginal people the way that they want these priorities to occur. So we will not be rushed, we will walk alongside our Coalition of Peaks partner. There is some funding, though, provided in this Budget, this financial year and next financial year, to initiate that process.

We've identified that some of that funding will be allocated to the elders council, for example. There is some soft work that we can undertake that we know that Aboriginal community-controlled organisations already want to do that fits within the truth-telling approach. Whilst we're continuing to consult and listen to Tasmanian Aboriginal community-controlled organisations and people, we may undertake some activity that we know will contribute to that process.

Mrs ARCHER - It's part of working through all of these issues that we've already been speaking about as well. It's important to recognise that truth-telling is a continuous process as well. I don't think it's we might start some truth telling at some defined point; there's the formal processes, but in all of the work that we do, we should be open to and listening to that truth as we move forward and creating space for that, and I think that's part of that Aboriginal-led approach, making space for that and making that culturally safe for people to participate in a continuous way as well.

CHAIR - Can I just pick up on one of those points, if I might. Mel, you said that there's funding available to deliver some of these; is this in the line item that is Aboriginal Affairs? As Dean pointed out, there was $2.8 million appropriated, in the end it was less than that in the Budget, but then it does drop away. I'm just interested, if the money's there, then what else is giving?

Ms GRAY - It's the specific line item which is Closing the Gap and other Aboriginal projects, so that's the $4.4 million over four years.

CHAIR - It sits under output group 1.6 in DPAC. I think there was nods from behind you.

Ms GRAY - Emphatic yeses from behind.

CHAIR - I could see that pretty clearly. In that, are you able to provide a breakdown of the allocation for the 2025-26 Budget of $2.810 million, as to what is to be delivered under that, and particularly new things, if you can identify new projects under that, because over the forward Estimates it does drop away.

Ms GRAY - The base funding is 1.323. The Closing the Gap and other Aboriginal projects, that's the 4.4 that I've been referring to over the forward Estimates. In this 25-26 year it's 1.4, so the allocation is 1.4, 1.4 and then it drops in 2027-28 and 28-29 to 800 and 800.

CHAIR - Why does it drop then? I don't think we will have closed the gap by then, I'm just saying.

Ms GRAY - No. That is the funding in the first two years for the truth-telling commissioners **CHAIR** - (cont) wingman over here.

Ms THOMAS - Who finds the extra missing zeros.

Mr HARRISS - Thank you, Chair.

CHAIR - Did you have questions on this area?

Ms O'CONNOR - No.

CHAIR - It was helpful to get that breakdown, but it is apparent that there is funding for things that will inevitably need to continue in the out-years that aren't in the budget papers. That's a clear statement and factual. There are no other programs under this; obviously you've outlined them all and we've touched on what each one of them does. I don't have any more questions and I'm happy to complete early if other members don't have questions.

Ms O'CONNOR - Are there other things that you'd like to share with us about your work in the portfolio, Minister?

Mrs ARCHER - As I said, I have not been in the portfolio for very long. It's been an absolute pleasure and privilege today to be able to travel around and talk to all kinds of stakeholders, and indeed, the expertise and knowledge that we have within the department, as well. I feel very positive about the opportunities for Tasmanian Aboriginal people. I think there are very clear priorities and pathways to achieving some of those priorities.

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Some other very important information is that we are of course hosting Joint Council in Tasmania this week on Friday at Piyura Kitina. The welcome reception is tomorrow night. That is an exciting opportunity for Tasmania to showcase some of the work that we have been doing.

I think there has been some very positive things to showcase; for example, the Palawa Business Hub and the work that they have been undertaking. I'm excited for that opportunity, as well.

Ms O'CONNOR - Is this the first time we've hosted Joint Council?

Mrs ARCHER - Yes.

Ms O'CONNOR - I have a final, broad question. We're entering a period of accelerating global heating, damage to Country, and damage to ecosystems. I'm sure you agree that there is a lot we could learn from Palawa people about how to better look after the place. That's the first point and respect for Country, but there's also a lot we could learn in practice about how to mitigate some of the consequences of climate change that are coming down the line. I wonder if that is part of your conversation, because Aboriginal land-management principles are something we haven't really endorsed or adopted in the way we treat this island and we could do better. I'd like to hear your observations on what is possible.

Mrs ARCHER - I think that you're correct. I think there's been a growing recognition of that. Certainly, with the Indigenous Ranger Program, we're seeing a real uptick in activity in that area and an understanding that that is the case. Also, some of the work that is being undertaken - it's sort of a bit outside of my portfolio - but work has been undertaken with Parks generally and burning for fire management, for example. I visited Lungtalanana probably more than 18 months ago and it's fantastic to see what's happening there with both cat management and hopefully cat eradication. Also, weed management and restoration of native pastures. We're seeing the benefits of restoring that knowledge and amplifying that knowledge in practice. That is also related to land return and land management, not just

, yes. So, $880,000 over those two financial years, $440,000 and $440,000 has been allocated and publicly announced and committed to truth-telling commissioners, just for the first two years.

CHAIR - That's in 2027-28 and 2028-29?

Ms GRAY - 2025-26 and 2026-27.

CHAIR - So there's not funding included in that line item for the commissioners beyond that time, is that what you are saying?

Ms GRAY - Not at this stage.

CHAIR - Just another thing.

Ms GRAY - Yes, it's just too -

CHAIR - So, they're not going to be sacked out for two years, are they?

Ms GRAY -It is not unusual to - we have an allocation there -

CHAIR - It's bit more unusual in this year's budget than it is in every other year's budget, I can assure you of that.

Mrs ARCHER - And I think this also goes to, and I have said it before, but the kind of nature of Closing the Gap and where I think you're trying to get to is transformative across all of government as well. So, I think that the work that is being done in this portfolio, in these areas, is to begin to drive that transformation as well.

Ms GRAY - I would say we are at the end of this year now and we have only six months left. So, effectively, you could add that six months on if you rolled over the first portion of that funding. So, there will be a little bit of lag at the end of those two years, and we are planning for that. I can also break down the remaining amount.

CHAIR - Sure, yes. Sorry, I interrupted you there.

Ms GRAY - So, out of the $440,000 that's allocated for the truth-telling commissioners, there's $250,000 allocated in 2025-26 and indeed $1 million over the forward Estimates for the Coalition of Peaks partner and we are quite delighted with this commitment because it allows the Coalition of Peaks partner to plan and participate with certainty. The funding to date has only been year-to-year funding for the Coalition of Peaks partner.

Similarly, for the first time in this budget, we have baked in $600,000 over the forwards. So, breaking it down to this financial year, that's $150,000 for the Tasmanian Regional Aboriginal Communities Alliance. Again, that enables them to plan and participate with some certainty. There's a commitment to Palawa Business Hub in this line item as well and, of course, the economic participation of Tasmanian Aboriginal people is a key priority of Closing the Gap, the target.

CHAIR - How much is that for 2025-26?

Ms GRAY - That is $200,000. That's $800,000 over the forwards.

Ms O'CONNOR - Sorry to interrupt. Just for clarity, where would the Palawa business club be? North, south, or is it a statewide sort of setup?

Mrs ARCHER - Statewide. Yes, the Palawa Business Hub is statewide, a statewide network of Aboriginal businesses that's really having some very yeah impressive -

CHAIR - That must be all, that adds up to $1.4 million. Is there something else there?

Ms GRAY - Yes, funding for Reconciliation Tasmania.

CHAIR - So, how much is that in 2025-26?

Ms GRAY - $100,000.

CHAIR - I will have to get the maths crew of the table to re-calculate for me then.

Mr HARRISS - Sarah.

Ms LOVELL - Mine adds up to $1.4 million.

Ms GRAY - Yes, and $50,000 for the eldest council.

CHAIR - That's all out of that $1.4 million.

Ms GRAY - Yes.

CHAIR - I will go back to you, Dean.

Mr HARRISS - So, time-frames for appointment of commissioners, do we have some understanding on that?

Mrs ARCHER - Look, as we said, I think it's important that we don't rush it. It's very important to have that conversation with community and ensure that it is Aboriginal-led, and I keep saying it, but it is quite critical and so, we will move in response to what community tells us, which I know is somewhat unsatisfying for the purpose of the work that we sometimes do here, but I think it is very important.

CHAIR - The number's right, Dean, you'd be pleased to know.

Mr HARRISS - Yes.

Ms GRAY - We're also pleased to know.

CHAIR - I've got my backup man. My wingman over here

Ms THOMAS - Who finds the extra missing zeros.

Mr HARRISS - Thank you, Chair.

CHAIR - Did you have questions on this area?

Ms O'CONNOR - No.

CHAIR - It was helpful to get that breakdown, but it is apparent that there is funding for things that will inevitably need to continue in the out-years that aren't in the budget papers. That's a clear statement and factual. There are no other programs under this; obviously you've outlined them all and we've touched on what each one of them does. I don't have any more questions and I'm happy to complete early if other members don't have questions.

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Ms O'CONNOR - Is Larapuna one of the areas that the government would like to see formally returned as as we tried to do when we were in government.

Mrs ARCHER - It's fair to say it falls into one of the more complex categories - not the, as Steve referred to low hanging fruit categories. It's about also showing exactly how, as you have said, that there's really important work being undertaken there, that has been done by Aboriginal people.

Ms GRAY - Did you want to talk about -

Mrs ARCHER - Oh yes, that's a good opportunity. We might just take the opportunity, as you offered it to talk about Nukara, a really exciting piece of work.

Ms GRAY - I was particularly excited to respond to your question because I've had the absolute honour and privilege to learn that thinking from working with Caroline and with key Aboriginal leaders over the past few years. It made me think of Dewayne Everettsmith and hearing him talk once about ecosystem thinking as opposed to ego system thinking. It's just

changed the key priority reforms on Closing the Gap, are just good public policy. We are all connected to country. We're all just passing through. For Aboriginal people, the targets will not be achieved unless we commit to and embed in our DNA those key priority reforms. That means truly sharing power at the table with Aboriginal people. I am so proud that we've been able to do that on two key things.

On Truwana/Cape Barren Island, the approach that we've taken with the steering committee for that little island and the achievements we've been able to make by having Catherine and Aaron from the Cape Barren Island Aboriginal Association side by side with deputy secretaries and the CEO of Homes Tasmania. They've been fighting for title for six Aboriginal houses on that island. For the first time ever, title is going to be transferred. We're responsible for municipal and essential services on that island. We're upgrading machinery and that's all being done together with Aaron and Catherine making the decisions, not government. We have practical examples of this and Nukara. Nukara is part of that future generations thinking. It's a real opportunity. It was funded from our Closing the Gap capacity building grants and it is the number one priority of our coalition of peaks partner to put the care and protection of Aboriginal children back in Aboriginal hands and the lessons that we've learned from the commission of inquiry and the transformational thinking that's required there is the same in Closing the Gap. We are, in ministries and everyone at this table is committed to really embedding the priority reforms so that we get the shift in thinking we need, which is about being connected to country and it is about our environment as much as it about the social progress.

Ms O'CONNOR - That was beautifully put, Mel. You've moved a few of us to tears!

Ms GRAY - We will be showcasing Nukara on Friday at Joint Council, and it is -

Mrs ARCHER - It's a very exciting transformation opportunity**.**

Ms GRAY - It's Aboriginal-lead, it's not my strategy. I don't know if you wanted to add anything or Caroline about Nukara.

Ms SPOTSWOOD - It's important to acknowledge the work of the Tasmanian Aboriginal Centre as a part of the coalition in the development of Nukara. Wendy Moore is the lead for that and there was consultation throughout the whole state in regard to the development of the strategy, the actual plan and the associated documents.

In regard to transforming government, bringing it back to Closing the Gap, the transition of Aboriginal children to be with family and community is of the utmost importance.

Ms O'CONNOR - Excellent, yes.

CHAIR - Thank you. Perhaps a good note to finish on.

Mrs ARCHER - What? Making Ms O'Connor cry?

Ms O'CONNOR - I saw you, minister, having a little cry yourself.

CHAIR - Thank you for your time. We wish the best for tomorrow's welcome function and the the session on Friday. I think it's a great opportunity for Tasmania to -

Mrs ARCHER - I think it's also important just to note before we close that it would be remiss of me not to mention that the federal minister, Senator Malarndirri McCarthy did arrive in Tasmania quite a few days early and has also been travelling around and talking extensively with community. For that, we're very grateful.

The committee adjourned at 5.26 p.m.