WEDNESDAY, 26 AUGUST 2015

ESTIMATES—HEALTH AND AMBULANCE SERVICES COMMITTEE—HEALTH AND AMBULANCE SERVICES

Estimate Committee Members

Ms L Linard (Chair)
Ms RM Bates
Mr SL Dickson
Mr AD Harper
Mr JP Kelly
Dr CAC Rowan

Member in Attendance

Mr MF McArdle

In Attendance

Hon. CR Dick, Minister for Health and Minister for Ambulance Services
Mr M Carey, Chief of Staff

Department of Health

Mr M Walsh, Director-General
Ms S Middleditch, Deputy Director-General, Corporate Services Division

Hospital and Health Services

Ms F Dougan, Chief Executive, Children's Health Queensland Hospital and Health Service
Ms J Hartley-Jones, Chief Executive, Cairns and Hinterland Hospital and Health Service
Mr S Drummond, Acting Chief Executive, Metro North Hospital and Health Service
Ms J Squire, Chief Executive, Townsville Hospital and Health Service
Mr K Hegarty, Chief Executive, Sunshine Coast Hospital and Health and Health Service
Mr R Calvert, Chief Executive, Gold Coast Hospital and Health Service

Queensland Institute of Medical Research Berghofer Medical Research Institute

Professor F Gannon, Director and Chief Executive Officer

Queensland Ambulance Service

Mr R Bowles, Commissioner
Ms K Magill, Director, Executive Services, Office of the Commissioner

Committee met at 9.01 am

CHAIR: Good morning and welcome to the Health and Ambulance Services Committee's public hearing for the examination of the Appropriation Bill 2015. I acknowledge the traditional owners of the land on which we are meeting today and pay my respect to their elders past and present. I am Leanne Linard, the member for Nudgee and chair of the committee. Ms Ros Bates, the member for Mudgeeraba, is the deputy chair. My fellow committee members present today are Mr Steve Dickson, member for Buderim; Mr Joe Kelly, member for Greenslopes; Mr Aaron Harper, member for

Thuringowa; and Dr Christian Rowan, member for Moggill. A number of other non-committee members of parliament have been granted leave to participate in the hearing today. At this stage I welcome Mark McArdle, member for Caloundra, to the hearing.

Today the committee will consider the Appropriation Bill 2015 and the estimates for the committee's areas of responsibility which are health and ambulance services. Estimates hearings are an important feature of the operation of the parliament and provide members with the opportunity to ask questions of ministers and responsible chief executives about proposed government expenditure. We are fortunate enough to have a full day with the minister. I ask members to use the time wisely and ask relevant questions. I remind members from the outset that today's hearing does not provide members with the opportunity to ask any question of the minister at all but, rather, those that are relevant to the Appropriation Bill before us.

I remind everyone present that any person may be excluded from the proceedings at my discretion as chair or by order of the committee. I ask that all mobile phones or pagers be either switched off or switched to silent. On behalf of the committee, I welcome the Minister for Health and Minister for Ambulance Services, the Hon. Cameron Dick, the director-general and officials of the Department of Health, hospital and health service chief executives, the Health Ombudsman and other officials and members of the public. For the benefit of Hansard, I ask officials to state their name the first time they answer a question and to bring their nameplate if they come to the table to answer a question.

I now declare the proposed expenditure for the portfolio area of Health and Ambulance Services open for examination. The question before the committee is—

That the proposed expenditure be agreed to.

Minister, would you care to make an opening statement?

Mr DICK: Thank you very much, Madam Chair. It is a great pleasure to be with the committee today to talk about Queensland Health. Queensland is the most decentralised state in Australia, and regional Queensland is very important both to this government and to me as minister. Since I have become minister, I have visited every hospital and health service in the state except for the Torres and Cape Hospital and Health Service, but I will be there soon. What I see is a system which has some heroic people—not just dedicated surgeons such as Bernie Whitfield, who does wonderful work as head of ear, nose and throat surgery at Logan Hospital, but also local workers such as Helen McMonagle, the sole dedicated nurse at the Isisford Primary Health Care Centre in the central west; Darrell Thompson, the paramedic at Ravenshoe in North Queensland who calmly directed the treatment and movement of the 21 people injured in the blast in that town in early June; Ann Aitken, the Director of Nursing at Atherton Hospital who received the first of the Ravenshoe burns victims on that day; Adrian Carson, a great champion of Indigenous health across our state; and Adam Lo, who is reaching out to young people, in particular with mental health issues, in my electorate of Woodridge and the areas around it.

I also had a wonderful afternoon listening to hospital and health service staff on the Gold Coast as they discussed their ideas at a public forum on innovation and for better and more efficient health services in that part of our state. This is the sort of health service I want to lead—one that is engaged with each other, that wants a better system and with an executive which listens to its workforce.

People rarely join our health system in Queensland to make money. They join it because they want to make sick people better. They want to stop people becoming ill in the first place. They want a better and healthier Queensland. I want to encourage this passion and goodwill and build upon it. Health is the biggest department in the Queensland government. We have 72,000 full-time equivalents on staff, or to put it another way nearly 86,000 real people working for Queensland Health either on a full-time or part-time basis, with another 4,000 working for the Queensland Ambulance Service. It is a system which needs leadership.

Since I have become minister there have been changes. I make no apology at all for scrapping the gimmick related to a supposed guaranteed time for surgery put in place by the previous government, as it was addressing a problem which did not exist. The number of people getting their surgery within clinically recommended times within Queensland was sinking rapidly, mainly because of federal government money going into our system, an initiative that was started by the last federal Labor government. But the gimmick did not cover people waiting for a specialist outpatient appointment, and there were over 100,000 of them waiting beyond clinically recommended times for an appointment or for a diagnostic test.

We have also reworked the Mental Health Act after the flawed process of consultation from the previous government. The system I want to lead is one where openness and accountability are the hallmarks, people feel that their contribution is valued, and people feel and know they are listened to. That was not the case with the previous government's review of the Mental Health Act. Honourable members have much to examine today, but I am always ready to look at ways of doing things better. This estimates process is designed to allow honourable members to find out more about our system.

I am accompanied today by the director-general of the Department of Health, Michael Walsh; the Commissioner of the Queensland Ambulance Service, Russell Bowles; senior executives of the department and the QAS; and the chief executives of the 16 hospital and health services around the state. I wish to acknowledge not just their work but also the work of the Department of Health and the hospital and health services as well as the QAS in helping me to prepare for today. The process has enabled me to get a better view and understanding of our health system. On that note, I am very happy to take questions.

CHAIR: I call the member for Caloundra.

Mr McARDLE: Thank you very much, Madam Chair. We have had Labor's Jo-Ann Miller protection racket and now we have Labor's IBM protection racket. We know that we have in this chamber today the former attorney-general, who deferred any decision by cabinet to take action in regard to IBM, and we have the then acting DG, who was there when the payroll debacle went live.

CHAIR: Member for Caloundra, do you have a question?

Mr McARDLE: I refer to page 8 of the SDS which deals with ICT and infrastructure capital and to page 34 which deals with the number of pays that are made on time. I ask the director-general: you were the acting DG at the time the payroll went live. There were thousands of Queenslanders who did not get paid at all or who did not get paid on time and had to go cap in hand to get a monetary payment. Do you apologise for what happened during that very sad period of time?

CHAIR: Member for Caloundra, point of order: do you have a question?

Mr McARDLE: I just asked the question, Madam Chair.

CHAIR: About the appropriation before the House? I remind you that under standing order 112—

Mr McARDLE: At page 34 on-time payments are referred to. Page 8 of the SDS deals with ICT and infrastructure capital. This is a legitimate question in regard to whether or not the now director-general is apologising for what took place back in 2007-08 and onwards.

CHAIR: I remind you that we are here to discuss the appropriation for the financial year not for—

Mr McARDLE: Madam Chair, that is very clearly the fact when you look at page 8 and page 34. This is a very clear opportunity because I want to know very clearly whether the director-general apologises for what took place to so many Queenslanders over a long period of time.

CHAIR: Member for Caloundra, I ask you to ask a question that is relevant, under standing order 181(g), to the appropriation before the House. You have not asked about—

Mr McARDLE: Madam Chair, I did ask the question. It is relevant to the SDS—

CHAIR: Member for Caloundra, I am speaking. I ask that you give me the respect of finishing my point of order. The point of order is that you have not asked a question that relates to the Appropriation Bill before the House. I remind you that standing order 181(g) relates. Please rephrase your question or I will rule it out of order.

Mr McARDLE: Madam Chair, again I make it quite clear: the SDS at page 8 and page 34 deals with payments on time. It is very clearly relevant.

CHAIR: Ask a question about the appropriation before the House in the time period before the House, not 2008 to which you refer.

Mr McARDLE: Madam Chair, that is my question. You need to make a ruling one way or another.

CHAIR: I thank you, member for Caloundra. I rule your question out of order and ask you to ask a question that does adhere to the relevance or rule of standing order 181(g).

Ms BATES: Madam Chair, I move a motion to seek the advice of the Clerk in relation to the SDS and the question under the standing order asked by the member for Caloundra.

Mr DICKSON: I second that, Madam Chair.

CHAIR: I ask the member for Caloundra: do you dissent from my ruling?

Mr McARDLE: Madam Chair, the motion has been put. If I may speak to the motion, the advice of the Clerk has been sought—

CHAIR: The committee will now adjourn to a private meeting. Member for Caloundra, you are invited to attend if you wish to put your argument to the motion as put.

Proceedings suspended from 9.11 am to 9.20 am

CHAIR: I call the member for Caloundra.

Mr McARDLE: Madam Chair, to the director-general: I go to page 8 of the SDS. It refers to $9 million being reallocated in 2015-16 towards ICT at the Sunshine Coast Public University Hospital. What assurances can you give that that project and the money spent thereon will not be in such a mess as occurred under the payroll debacle?

Mr Walsh: The Sunshine Coast has stringent governance procedures in place to ensure that ICT projects are implemented in line with best practice principles. We apply PRINCE2 methodology as well as Managing Successful Programs methodology, which is an international methodology. This clearly outlines a single point of responsibility that is being implemented in relation to the Sunshine Coast ICT projects—in fact, all ICT projects within Queensland Health. This ensures that there is a single responsible owner, a person, an individual, who has the authority to ensure end-to-end responsibility for the delivery of an ICT project. They are supported by people who are delivering the project, a project director, a program manager as well as the supplier if there are contracted people to supply the services. So we are ensuring that by applying these principles we provide for a successful implementation of all ICT projects, including the ICT project at the Sunshine Coast Public University Hospital.

Mr McARDLE: Director-General, can I say that in years gone by the chamber down the hallway heard very similar words—very similar words—and you have made an eloquent statement but there is a real fear about what could happen. Can you give a guarantee that what occurred will not occur again with the $9 million on the Sunshine Coast University Hospital—that we will not be facing the same problems?

Mr Walsh: I can guarantee that I am doing everything possible in my power and that all of the people working in the department as well as in hospital and health services are doing everything in their power to ensure successful implementation of ICT projects and all other projects—just as they are doing everything in their power to ensure the safe delivery and the timely delivery of health services. All of us in Health, as the minister identified in his opening statement, are committed to ensuring: that we work to keep people healthy—that is our first intent; that, if people are not healthy, we provide safe and timely services; that we work with partners to ensure we can keep efficient use of our hospitals; that people who do not need to be in hospitals are not; and, finally, that we have a sustainable system that is efficient in the way it is run. So, yes, I can guarantee that everyone is doing everything within their power to ensure the success of projects as well as services within Health.

Mr McARDLE: Let us hope we do not sit here in three years time and the LNP has to correct those words by making the changes that are required.

CHAIR: Member, do you have a question?

Mr McARDLE: I go to my next question. Could I please have the CEO of Children's Health Queensland Hospital and Health Service to the table?

Ms Dougan: Good morning.

Mr McARDLE: Recently, there was a report published into the Lady Cilento Children's Hospital. Traditionally, what happens is a draft of that report is forwarded to both the executive and the board of the hospital. Did you receive a draft report?

Ms Dougan: We had the opportunity to review the draft report and provide feedback and comment.

Mr McARDLE: That draft report led to written submissions back to the authors of the report?

Ms Dougan: That is correct.

Mr McARDLE: Did those submissions come from both the board and the executive team?

Ms Dougan: That is correct.

Mr McARDLE: Were those submissions forwarded to the department or the minister's office as well?

Ms Dougan: They were.

Mr McARDLE: To both?

Ms Dougan: Not to the minister's office.

Mr McARDLE: They were sent to the department?

Ms Dougan: Yes.

Mr McARDLE: Do you know who they were marked attention to?

Ms Dougan: To the review team.

Mr McARDLE: Did you sign, as CEO, one or both of those reports?

Ms Dougan: Yes.

Mr McARDLE: Are you able to table a copy of the draft report and a copy of the signed submissions by both the board and the executive team?

Ms Dougan: I can acquire that for you today.

Mr McARDLE: Will you have that tabled before midday today?

Ms Dougan: I will go back to my team and get that.

Mr McARDLE: Thank you very much. Director-General, the submissions from both the executive and the board were received by your department, I have just been informed. What did you or the department do with those submissions?

Mr Walsh: In relation to the review, the draft report was received about a week before the report was finalised. The process that the review panel had agreed to undertake with the people who provided information that they interviewed in relation to the report was that they would provide a draft report, as the chief executive of Children's Health Queensland has indicated, to the board, to the executive of the hospital as well as to Mater services in order to provide feedback on the draft before finalisation. That information was provided back to us and forwarded on to the review panel who took into account that information. It was unedited by us in relation to the information that went back, and the review panel made their decision independently in relation to how they wanted to finalise the report following feedback from people who—

Mr McARDLE: You mentioned that you also—

Mr Walsh: Can I just clarify?

Mr McARDLE: Of course.

Mr Walsh: What the review panel had asked people to do in providing that feedback was to correct statements of fact. So the review panel's role clearly was to ensure that it assessed independently and formed a view as to what they concluded and what they found, but they did ask people to correct errors of fact or to clarify that. When the report was provided to people for feedback, it was not on commenting about the review panel's findings; it was about commenting on whether or not the review panel had ensured that the factual things were recorded accurately.

Mr McARDLE: We will certainly make that call when we see them today. You mentioned that the Mater was also asked for comment on the report. Will you table that report?

Mr Walsh: I am happy to table the feedback from the board, from the executive and from the Mater, yes.

Mr McARDLE: By midday today?

Mr Walsh: As soon as we are able to get that—

CHAIR: Can I just as a matter of information advise the director-general that, in relation to any reports that are requested by any members of the committee, it is at your discretion as to whether you table them. That is just for your information.

Mr Walsh: Okay. I need to clarify it too, because it was a report prepared and went to cabinet, so we need to clarify the status of the documents.

Mr McARDLE: Did the submissions go to cabinet?

Mr Walsh: The—

Mr McARDLE: The report went to cabinet.

Mr DICKSON: It is not a cover-up?

Mr McARDLE: Just hold on. Did the submissions go to cabinet?

Mr Walsh: The final report went to cabinet.

Mr McARDLE: But not the submissions?

Mr Walsh: They are working documents of cabinet submissions. Not all working documents of cabinet submissions go to cabinet.

Mr McARDLE: Did the submissions from the CEO of the board, the Mater and the executive team go to cabinet?

Mr Walsh: None of the working documents that the review panel used to undertake its review and prepare its final report went to cabinet. The final report went to cabinet.

Mr McARDLE: So they can be tabled.

CHAIR: Member for Caloundra, they can be tabled; it is at their discretion. I simply gave the information. The committee itself cannot make anyone table any documents.

Mr McARDLE: Both the director-general and the CEO have said they will table the—

Mr Walsh: Let me clarify that—

CHAIR: That is fine. I was just advising that it is up to them.

Mr McARDLE: Director-General, my actual question was: when the department got the documents, where were they sent to? Let me clarify that. They went to the review. Did they go to the minister's office or was a briefing note prepared—

Mr DICK: Can I just say that it was an independent review and none of those documents came to me. I did not ask for them and the member should be careful about impugning—

Mr McARDLE: With all due respect, Madam Chair, I have a legal right to ask the DG and the minister cannot interfere with that right.

Mr DICK:—the independence of three individuals—

CHAIR: Sorry, Minister, point of order.

Mr DICK:—who are of high standing and that is what you are seeking to do. You are seeking to impugn—

Mr McARDLE: I have a legal right to ask the DG.

CHAIR: Point of order. I do appreciate, member for Caloundra, that you are asking a question of the DG and that you may do so directly, but if you are asking about any operations within the minister's office, obviously that would be appropriately—

Mr McARDLE: No, what I am asking, Madam Chair, is: did the director-general forward a copy of the submissions to the minister's office—I am not asking what he did with them—or was a briefing note prepared by the department for the minister? The director-general can certainly answer those questions.

Mr Walsh: No, the documents were not forwarded to the minister's office and, no, a briefing note was not prepared.

Mr McARDLE: So the minister had no knowledge of the submissions—is that what you are telling me—based on what you have just said?

Mr Walsh: I do not know—

Mr DICK: I have not seen any submission. I have not seen any document.

Mr McARDLE: Again, Madam Chair, I am going to make the point that I am asking the director-general to answer the question.

Mr DICK: I have not seen any document or any submission.

CHAIR: Point of order. Member for Caloundra, I appreciate that under standing order 181 you may ask a question directly to the DG, but you cannot ask a question of the DG in relation to what the minister does or does not know. That would more appropriately be directed to the minister, who is present in the room at the moment.

Mr McARDLE: But I can ask the question, Madam Chair, that on his knowledge the minister had no knowledge of the contents.

CHAIR: That is a matter of opinion and that is in contravention of the standing orders—

Mr McARDLE: So we will have those tabled by the end of the day today.

CHAIR:—so I thank you to respect my ruling.

Mr McARDLE: So we will have the draft report, as I understand the CEO and the DG, and the submissions from the Mater, the board and the executive tabled by midday today.

CHAIR: Thank you, member for Caloundra. We have noted your request and those present have noted that it is at their discretion. Can we please move on.

Mr McARDLE: Madam Chair, I want to be very clear. They both agreed to table them. I do not want a loophole to be left out there—

CHAIR: Member for Caloundra, there is no loophole. I have ruled on this matter. I ask that you move on to a new question or I will move on to somebody else.

Mr DICKSON: Point of order. Madam Chair, this absolutely sounds like a stitch-up or a cover-up. These points have been made very clear. The deputy director-general said they would table this report, the DG said they would table this report and, whoop-de-do, then we go and get the minister overpowering them. What are they hiding?

CHAIR: Member for Buderim, there is no point of order other than I consider that an imputation and I ask you to withdraw it.

Mr DICKSON: I will withdraw.

CHAIR: It is simple: if they wish to table it, it is at their discretion. It is simply in accordance with the standing orders. I have stated that information and they have said to you that they will look at the documents and table them if that is appropriate. I do not see that there is an issue. I ask you to move on to the next question, please.

Mr McARDLE: I would like, if I could, to have the CEO of the Cairns and Hinterland Hospital and Health Service come to the table.

CHAIR: Member for Caloundra, we have time for just one more question.

Mr McARDLE: CEO, good morning. With regard to the Cairns Base Hospital, what is the nurse-patient ratio for the acute patients within the hospital—morning, afternoon, evening and weekend if they are different?

Ms Hartley-Jones: It depends on the wards, obviously, because in intensive care we have nurse-to-patient ratios of one to one plus extra nurses for support for those nursing staff. On the acute wards they are, I believe—but I would like to, if I may, clarify my facts—in the region of about one to five or seven, depending on the acuteness of the ward.

Mr McARDLE: Is that across the full day and night, or does that vary during the time of day?

Ms Hartley-Jones: All staffing ratios vary during the time of day—

Mr McARDLE: Would you take it on notice?

Ms Hartley-Jones:—apart from intensive care. Yes, I am happy to take it on notice.

CHAIR: Minister, are you happy to take that on notice? The minister is the only one who can take it on notice.

Mr McARDLE: Fine.

Mr DICK: I am just waiting for a question.

CHAIR: The member for Caloundra has asked if you would take on notice and provide ratios.

Mr DICK: I am happy to consider the matter. If I can provide information today that is satisfactory, I will, but I will discuss it further with the chief executive. I may be able to provide the information directly to the committee today. I will consider it and by the end of the day I will provide a response to the committee, either a direct response or I will take it on notice or something. But let us interrogate it. Let us face it, Chair, we have eight hours together today. That is plenty of time to investigate these issues and I am happy to come back to the committee later in the day.

CHAIR: Thank you, Minister.

Mr McARDLE: I want to be very clear. Is the minister telling this committee here that he may give information on the nurse-patient ratio if he feels it is important or he believes it is competent—

CHAIR: No, member for Caloundra—

Mr McARDLE:—given that the nurse-patient ratio is one of the cornerstones of the—

CHAIR: Member for Caloundra—

Mr McARDLE: It is unbelievable!

CHAIR: Point of order. Member for Caloundra, I allow you the respect of asking your question when it is in order with the standing orders. I ask that you also respect me as chair and that when I am speaking you do not interject. What I understood the minister to say is that he took it on notice but if he can provide the information earlier he will provide it at today's hearing. Can we please move on. Your time has almost expired.

Mr DICK: The answer is that I am not taking it on notice. I do not know the answer. I am going to take advice on it. I will consider it. If I can provide a response to the committee today, which I thought might be useful to the member for Caloundra rather than having to wait and go through the process of taking it on notice and giving an answer on notice. I thought it might be more convenient for the committee to give information. Can I say that this is standard process. This is what I did for three years when I was a minister previously. No-one on a committee ever objected to me looking into things and trying to bring something back to the committee on the day. I am very happy to do that. If that does not resolve the issue, I will consider what further action we take including taking it on notice.

CHAIR: Thank you, Minister.

Mr McARDLE: I will take the minister's comment as, 'I might do something at some point in time in the future.'

CHAIR: We will now move on to the member for Greenslopes.

Mr KELLY: It gives me great pleasure to be here at estimates today questioning the minister, having formerly worked in Queensland Health. Minister, I refer to page 4 of the SDS. If I can start by asking about the overall Health budget, what are the key overall numbers for this portfolio and how do they relate to key initiatives?

Mr DICK: I thank the member for Greenslopes for his question. I do know he is very committed to our public health system in Queensland and health generally and he brings a wealth of experience from his very long career as a nurse and a clinician in our health system in Queensland. I thank him for the question.

The operating budget for 2015-16 will be a record $14.183 billion. This is good news for the people of Queensland and good news for people all over Queensland who rely on our health system. The Palaszczuk government has sought to restore balance to the health system with significant investments in front-line services, preventive health and patient safety. Our first budget provides additional funding of $2.3 billion over four years to ensure that Health and Ambulance Services keeps pace with the ongoing growth in demand for services.

The budget also provides additional funding to tackle critical areas like the specialist outpatient waiting list, known as 'the waiting list for the waiting list'. This was an area completely ignored by the previous government and brushed aside by the member for Southern Downs, the opposition leader, when he was the health minister. Our commitment to this issue can be seen in the allocation of $361.2 million over four years to attack the wait for the wait. We are developing a sensible, phased strategy to tackle the significant number of outpatient long waits, that is, people waiting longer than clinically recommended for treatment or an appointment in the Queensland health system. We are not so arrogant to think that we have all the answers here, but we are undertaking this work in consultation with health experts who deal with waiting lists on a daily basis.

Going back to what the member for Caloundra was talking about, we put our money where our mouth is. The budget also delivers on election promises by the Palaszczuk government to put more nurses into hospitals after 1,800 nurses and midwives were ripped out of our health system during the previous government. It is no wonder that the member for Caloundra does not want to talk about the last three years. If I was the member for Caloundra I would want to airbrush the last three years from history as well. It is nothing to be proud of. They are happy to talk about things that occurred six or more years ago, but there is nothing they can talk about in relation to the budget before the committee.

We are delivering on our election commitment. We have a significant number of election commitments in Health which we will continue to deliver on. We are investing an additional $212.3 million over four years in important nursing workforce initiatives to improve patient safety and healthcare outcomes in Queensland hospitals. As part of these commitments over the next four years we will employ up to an additional 400 experienced nurses to help patients navigate the health system. We will offer up to 4,000 additional places to new Queensland nurse and midwifery graduates, and the member for Greenslopes will understand how important it is to get those new nurses in and get them

trained in our hospital system. Sixteen new nurse educator positions will be established to support these graduates as they enter Queensland's nursing and midwifery workforce, which will support effective local implementation of the graduate program.

For the first time in our state's history and as one of the few jurisdictions in the world, we will legislate mandatory nurse-to-patient ratios in acute wards. I thank all of those stakeholders, including the Queensland Nurses' Union and others who we have worked very closely in a collaborative and open way. We were not demonising them, not excluding them from the minister's office, not excluding them from the department, as happened previously. We are a government that will embrace those individuals to work with them.

Research shows that nurses have the biggest impact on patient safety and better health outcomes for patients. That is why there was so much community outrage about the former government's approach to this critical section of the workforce. We want to strengthen our nursing workforce, which leads to shorter periods of stay in hospitals, improved clinical outcomes, reduced wait times and better access to health care. They are important initiatives. We have a proud tradition in the Australian Labor Party of supporting our public health system, going back to 1938 when we were the first place in Australia to offer access to free public wards, something we are very proud of. I am proud to be a member of a Labor government that is continuing that tradition.

Mr KELLY: Referring to page 9 of the SDS and page 60 of Budget Paper No. 3, the Capital Statement, for the benefit of the committee can you provide an overview of the department's capital program?

Mr DICK: Thank you, member for Greenslopes. I advise the committee that the total capital investment program for the Health portfolio in 2015-16, including capital grants, is $1.3 billion. That funding will progress a range of health infrastructure priorities including hospitals, health technology, research and scientific services, mental health services and information technologies.

The Palaszczuk government is investing an additional $180 million over four years to refurbish and modernise ageing and outdated hospitals in regional Queensland. Our Enhancing Regional Hospitals program will fund vital upgrades and repairs at Queensland Health facilities including at Roma, Hervey Bay, Gladstone and Caloundra hospitals. As part of this investment, structural defects and a range of clinical functionality and backlog maintenance issues will be addressed at the Roma Hospital. Hervey Bay Hospital's emergency department will be expanded to meet increasing demand for services. Gladstone Hospital's ageing emergency department will be upgraded and the Caloundra health service will be refurbished to accommodate service delivery changes associated with the commissioning of the Sunshine Coast Public University Hospital.

I am pleased to report to the committee that these upgrades will drive jobs for regional Queenslanders. We estimate that approximately 940 construction jobs will be created as a direct result of these upgrades over the next four years, which is a great thing for rural and regional Queensland. The capital program in 2015-16 also includes $179 million to continue the statewide rollout of clinical and administrative support systems and technology equipment replacement, and $45 million to continue delivering a range of asset renewal and enhancement works across the state under our priority capital program.

Mr KELLY: I refer to pages 4 and 8 of the SDS. What additional funding did the 2015-16 budget provide for the Sunshine Coast Public University Hospital?

Mr DICK: I thank the member for Greenslopes for his question. The Palaszczuk government's first budget provides over half a billion dollars of the additional funding required in relation to the new Sunshine Coast Public University Hospital. This is in stark contrast to the previous LNP government which did not provide sufficient funding in the outyears in their last budget. The member for Caloundra did not bother to read the budget papers when he made a statement in the House saying that the money was there. I will point out clearly where these measures in Budget Paper No. 4 are clearly locked into the forward estimates without question and without doubt.

Firstly, the budget provides additional operating funds of $2.3 billion over four years to ensure that health and ambulance services keep pace with the ongoing growth in demand for services. That is at page 76 of Budget Paper No. 4. This measure provides the additional operating funding required for all hospital and health services, including the hundreds of millions of dollars required in relation to the Sunshine Coast Hospital and Health Service. The exact amount of additional funding that will be provided to each HHS will be determined as part of the negotiation of service agreements, but the $2.3 billion is there. The money has been allocated by the government across the forward estimates.

The additional funding provided in the budget is consistent with the Health department's estimates of increased activity in the Sunshine Coast Hospital and Health Service—increased activity including, and caused by, the opening of our new hospital. Remember that the forward estimates of the last LNP budget went up to 30 June 2018. It has been left to our government to fill the shortfall in funding, and that is what we have done in our first budget.

In relation to transition funding, our government has provided additional funding of $193.5 million over four years to support the transition of services across the Sunshine Coast Hospital and Health Service. That is at page 76 of Budget Paper No. 4. This funding will allow the Sunshine Coast Hospital and Health Service to complete the planning and commissioning of services at the Sunshine Coast Public University Hospital. This will ensure its successful opening in November 2016. Importantly, it includes funds to recruit and bring on board the necessary staff ahead of the new hospital opening. This funding also covers all of the change, management and other preparation work required to ensure that from day one the new hospital will provide safe, high-quality patient care and that other hospitals within the Sunshine Coast Hospital and Health Service continue to provide services to their community.

As I have said earlier, the budget provides additional funding of $180 million over four years for the Enhancing Regional Hospitals Program, which is on page 105 of Budget Paper No. 4. That budget paper states that the capital works required at the Caloundra Health Service will be funded by this program. This funding will enable the Caloundra Health Service to be reconfigured for its role post the opening of the Sunshine Coast Public University Hospital.

When it comes to ICT funding, the budget approves internal reallocation of $9 million in 2015-16 towards the commencement of a range of ICT initiatives and upgrades in relation to the new hospital. That measure is on page 85 of Budget Paper No. 4, which states—

The full cost of the project and required funding allocation will be determined following the finalisation of the project business case.

We have provided internal reallocation in the budget of $1.2 million over two years to finalise the planning and refurbishment of Nambour General Hospital, which is on page 4 of the budget paper. Can I thank the chief executive, Kev Hegarty, and the board, chaired by Emeritus Professor Paul Thomas, for the work they are doing to bring that hospital to life. It is a very significant project. It will be informed—and I will hopefully say more about that as the hearing continues—about the outcomes of the Lady Cilento Children's Hospital commissioning review. We want to avoid an opening and commissioning debacle at the Sunshine Coast and we are already implementing things. I do want to thank the Sunshine Coast Hospital and Health Service and their leaders for the great work they are doing in keeping a very close focus on the delivery of that project.

Mr HARPER: Good morning, Minister. As part of the 4,000 strong QAS health team, it is good to be here today as part of the estimates process. Minister, I refer you to pages 60 to 247 of the SDS which provide details in relation to the hospital and health services. Minister, can you give the committee an overview of what hospital and health services in North Queensland will be receiving in the 2015-16 period?

Mr DICK: Thank you, member for Thuringowa. I know that, like the member for Greenslopes, you bring a quarter of a century's experience as a paramedic at the front line of our health services. You bring that experience to our parliament and to the examination of what happens in the Health portfolio, and I know that is of great value to our parliament and certainly to our parliamentary party and our government.

The north of our state obviously plays a very important part as a driver of the state's economic growth. There is a very large population in the north of our state which requires the constant delivery of new and improved services. I would like to touch on some of the funding initiatives in this budget which support people living in the north of our state: $11.58 billion, or 81.6 per cent of the record Queensland Health budget, goes to our 16 hospital and health services. They deliver those services to Queenslanders and also to other organisations like the Mater Health Service.

The operating budget for the Cairns and Hinterland Hospital and Health Service is $712.8 million in this year's budget. That is an increase of 7.8 per cent or $45.5 million this year. Significant investments this financial year include: $6.8 million to increase hospital capacity to support improved flow from the emergency department; $2.8 million in recurrent funding for mental health community care services; $1.3 million to operate the new PET-CT scanner; $450,000 to enhance public mental health through the Assertive Mobile Youth Outreach Services team; and $40 million of capital funding to complete the construction of the $446.3 million Cairns Hospital redevelopment. That project will

deliver an additional 168 beds overall, an ambulatory cancer care centre, new pathology facilities and a new low-risk family birth centre. The additional capacity will enable the Cairns Hospital to increase services including surgical intensive care, birthing, rehabilitation and mental health services.

Again can I thank the staff of the Cairns and Hinterland Hospital and Health Service for the work they did in responding to the tragic events of the accident at Ravenshoe. Everyone in the north of our state did a magnificent job in responding to that, including the team at the Cairns Hospital, Innisfail Hospital, Ravenshoe and other places. I just want to commend them again.

Mackay Hospital and Health Service has an operating budget of $327 million this year, which is a $6.9 million increase. That will include $8.5 million to finalise the $408 million Mackay Base Hospital redevelopment, an initiative and vision of the previous Labor government in Queensland that has now come to fruition. What a great privilege it was for me as Minister for Health to open that facility, which will serve Mackay city and surrounding districts and areas for many years to come. It is an outstanding facility and it was such a great privilege to be able to open that. That completed redevelopment will provide 318 beds and offer the local community a wider range of public health services. It will be equipped to offer additional and extended specialised services, enabling more patients to be treated locally. In addition, there is $5.3 million for the priority capital program to refurbish and replace infrastructure at Bowen Hospital.

In the north-west of our state there is $148 million in this year's budget, an increase of $8.3 million or 5.9 per cent, and $10 million to finalise the Mount Isa Health Campus. In terms of the Torres and Cape Hospital and Health Service there is: $179.5 million, an increase of $7.8 million or 4.5 per cent this year; $3.8 million total funding for the Cooktown maternity service in this budget this year; $1.3 million for additional staff accommodation at the Kowanyama Primary Health Care Clinic; Townsville—which is something of great interest to you, member for Thuringowa—$804.6 million this year, an increase of $46.5 million or 6.1 per cent; $5.4 million for ongoing support for the Medical Clinical Decision Unit; and a $2.8 million increase in funding for the reintroduction of maternity services at Ingham Hospital, something which is very important for that community.

There are capital funds to complete the new $334 million Townsville Hospital expansion—another significant project for that community—$18.4 million with a whole range of significantly expanded facilities; $9 million to complete a planned $12.1 million clinic for elective surgery funded by the Commonwealth government under the Health and Hospital Fund regional priority round—so that is our contribution to that initiative—$2.8 million to rebuild intensive mental health care, and I know that is an important item for the member for Thuringowa and we have talked about that before. That will help rebuild mental health care for young people, including additional day services and an expanded youth residential mental health service, which was something that we promised in the election for the people of Townsville. There are significant investments going into the north of our state, as there are in other parts of our state.

CHAIR: Thank you, Minister. I think we have time for one more question.

Mr HARPER: In a similar vein, could we also get an overview of the Central Queensland and Wide Bay area in the 2015-16 budget?

Mr DICK: Thank you, member for Thuringowa. I will try and quickly get through these important initiatives in the central part of our state. For the Central Queensland HHS there is $448 million, which is a 4.7 per cent increase, an increase of $22 million; $2.8 million for the operation of the 20-bed mental health community care unit in Rockhampton, bringing total recurrent funding to $3.9 million; $2.2 million for the operation of an eight-bed older persons mental health unit. Capital projects for this financial year include: $6.5 million to complete the new intensive care unit, which is an important thing for Rockhampton; $5.1 million to complete the final stage of the Rockhampton Hospital expansion; and $2.5 million to complete the new rooftop helipad, which I have inspected with the member for Rockhampton. That will be a very significant improvement for Rockhampton and Central Queensland. Instead of patients having to be medivaced to the airport and then driven up the hill to the hospital, they can now be flown straight into the hospital. That will help all of Central Queensland—for example, road accident patients and people working in the mining industry who may be injured and need to be medivaced to Rocky. That will be a great thing for the major regional hospital in the centre of our state.

For the Central West Hospital and Health Service there is an operating budget of $62 million. I am pleased to say that is an increase of 7.8 per cent in this year's budget, an increase of $4.5 million. That includes $1 million to enable increased operating time in Longreach for the Flying Surgical Service and Flying Obstetrics and Gynaecology Service in addition to the provision of increased surgical and orthopaedic services. Capital funding of $14.4 million will be provided to continue the $17.5 million

Alpha Hospital and collocated emergency services project. I know this is a very significant project that has been embraced by the community of Alpha and other communities in the central west of our state. It is a pilot project which will collocate hospital, ambulance, police, fire and emergency services, and I am happy to support this terrific initiative.

With regard to the Wide Bay Hospital and Health Service there is $488.9 million this year, an increase of 6.7 per cent or $30.6 million. This includes: $4.9 million to establish an ophthalmology service which allows patients to be treated within the HHS area rather than having to leave their community and travel elsewhere; $2.2 million to establish cardiology services, again allowing patients to be treated within the hospital and health service area; and $1.3 million to replace existing CT units at Hervey Bay and Bundaberg hospitals to provide up-to-date CT services for those communities so people can be treated in their local community, which I think will be a significant thing. The Hervey Bay emergency department will be upgraded as part of our regional hospital enhancement project.

CHAIR: Thank you, Minister. I call the member for Caloundra.

Mr McARDLE: I would ask the CEO of Townsville Hospital and Health Service to come to the front desk, please. Ms Squire, you heard me ask a question of the CEO from the Cairns HHS. Can you advise the committee what the nurse-patient ratio is at the Townsville Hospital for acute patients across the seven days of the week, morning, afternoon and evening, and the various levels of acute patients?

Ms Squire: I cannot give you the precise numbers at the moment, Mr McArdle, but what I can tell you is that we work on a business planning framework which provides four hours per patient day across our hospital and health service in all of our facilities. Again I would refer to the minister, but if you require further information I can provide that if agreed.

Mr McARDLE: Minister, will you take that question on notice and supply the answer in the time frame allocated by this committee?

Mr DICK: I am happy to try and get you an answer today if I can, member for Caloundra. If we cannot, then I will consider what further steps we need to take.

Mr McARDLE: Thank you very much indeed. I would like to call to the table the CEO of the Metro North Hospital and Health Service, please.

Mr DICK: There is an acting CEO for Metro North today. The CEO is currently on family leave.

Mr McARDLE: Good morning, Mr Drummond, and thank you very much. You heard me ask questions in a similar vein to Cairns and Townsville. With regard to the RBWH, can you supply the nurse-patient ratio for acute patients throughout the hospital of varying degrees and across the seven days of the week for morning, afternoon and evening?

Mr Drummond: At the Royal Brisbane and Women's Hospital we operate on the business planning framework, so we work a nursing-hours-per-patient-day model which varies across all of the different acute areas. Again, I will defer to the minister about the supply of that information.

Mr McARDLE: And I will again ask the minister, as they are similar questions, would he undertake to supply that information in the time line?

Mr DICK: I am happy to look at that, member for Caloundra, and see what we can do today.

Mr McARDLE: Thank you very much, Mr Drummond. I would ask the CEO of the Sunshine Coast Hospital and Health Service to come to the table, please. Mr Hegarty, thank you for coming today. Mr Hegarty, under Labor in years gone by, did they outsource any services on the Sunshine Coast for the health department?

Mr Hegarty: Yes.

Mr McARDLE: What were those services?

Mr Hegarty: We currently have an outsourced radiation oncology service.

Mr McARDLE: And Ramsay?

Mr Hegarty: And of course a relationship with Ramsay both at the Noosa Hospital and more recently at the Sunshine Coast University Private Hospital.

Mr McARDLE: So public patients are being treated at Ramsay under a Labor contract for outsourcing plus oncology under a Labor contract for outsourcing?

Mr Hegarty: Yes. One of those contracts was signed during the immediate preceding government's time, but the initiative was under a Labor government, yes.

Mr McARDLE: And they were put in place by a Labor government?

Mr Hegarty: Yes.

Mr McARDLE: Thank you very much indeed. Minister, a letter dated 5 February 2015 from the Premier to Peter Wellington on page 2 under the heading 'Public Service' states—

Previously in government, Labor had a policy of employment security and no-contracting-out provisions. Labor will restore this policy.

You have just heard the CEO of the Sunshine Coast HHS say that there are two clear instances where outsourcing under the Labor government did occur—one is public patients to Ramsay and oncology as well. Would you agree with me that that statement that I read out is not correct in that Labor did in fact contract out services to the private sector and the letter in that sense is in error? I will table the letter. I seek leave to table the letter.

Mr DICK: I think I have read the letter, Madam Chair, but I am very happy for him to table it.

CHAIR: Is leave granted? Leave is granted.

Mr DICK: I think it is a public document and it does not come as a surprise. In relation to contracting out, I want to say a number of things. We will continue to deliver health services to Queenslanders in a safe, efficient and clinically effective way for the benefit of Queensland communities. We have done that previously as a government. We have a very longstanding relationship with Mater Health Services across Queensland. That is something that all governments have supported and something that Labor has supported and we do continue to support those sorts of arrangements.

We made a number of commitments relating to outsourcing. There are a number of recent examples, both in Queensland and other states, where contracting out has seriously impacted on the ability of hospitals to deliver quality health care. You only have to look across the river to see this. It is a great pity that the former health minister could not take the 20-minute walk from his office to Lady Cilento to see the problems that happened at that hospital as a direct result of contracting out—a direct result—including the delivery of food services. Very basic services were unable to be delivered from day one by the contractor when that hospital was opened, causing great distress to families who had children in that hospital. I find it extraordinary that he failed to properly supervise and exercise any oversight over the commissioning and opening of that hospital.

We of course have stopped the sale of Pathology Queensland. That was on the selling block. We know that the previous government had that ready to go to contract out and to sell Pathology Queensland. At the Sunshine Coast Public University Hospital pathology will be delivered through the public system. Other services earmarked by the Newman government included catering, cleaning and porterage as well as pathology and radiation oncology for privatisation. In line with our election commitments, we have overturned this decision, returning catering, cleaning and porterage, pathology and radiation oncology services to the public system at the Sunshine Coast Public University Hospital.

I went to the Nambour Hospital and spoke to staff there. I go all through the hospital. I really like to find the operational services team, in simple terms and non-bureaucratic terms: cleaners, cooks, wardsmen—the people who do such vital work. I met two cooks who had worked in Queensland Health—one from 1976, so a period now of almost 39 years, and another one standing right next to her who had worked for us for 28 years—and they said to me, 'Thank you for saving our jobs.' A number of staff said that to me. We are going to keep those people because they bring such incredible and important value to our health system.

We are going to restore fairness and decency. We will do that. We are not going to take an ideological approach like the LNP, which was to put it all on the selling block and to put it all out. We are not going to do that. We have made commitments. We will continue with the contracts that we have and we will continue to consider those as a government as they come up from time to time. What I will not do is contract out our staff workforce. I will not be sacking more than four staff a day, which is the rate that staff went out the door when the member for Southern Downs was the minister for health for 1,047 days. He sacked more than four Queensland Health staff a day. I am not going to contract out their jobs. I am not going to lose 12 nurses a week, which happened under his stewardship of the portfolio. I am not going to sack nine allied health workers each fortnight. I am going to support our staff. They are the heart and soul of our health system. They will have my support and I admire them—I can say that very genuinely to this committee—greatly for the work that they do and I am always impressed and sometimes in awe of the work they do in public hospitals across our state.

Mr McARDLE: I thank the minister for, in essence, agreeing with my question. I want to call the CEO of the Gold Coast Hospital and Health Service to the table, please. Thank you very much indeed, Mr Calvert. I want to talk about code black and code black in the sense of threats or acts of violence to

staff, patients or visitors as the case may be. As I understand, there are three levels of code black at the Gold Coast Hospital. That is correct, is it not—level 1, level 2 and level 3? You have to answer yes or no. You do not know?

Mr Calvert: I will check, but code black is a code black. We have a response to code blacks.

Mr McARDLE: I beg your pardon?

Mr Calvert: A code black in our hospital is a code black and that draws a standard response.

Mr McARDLE: In terms of that standard response, can that vary based upon the level of threat it is assessed at? For example, would you call in police on every occasion or not?

Mr Calvert: No.

Mr McARDLE: No, so there might be various levels of code black. Code blacks are reported to a central system; is that right?

Mr Calvert: In the hospital?

Mr McARDLE: Correct.

Mr Calvert: Yes.

Mr McARDLE: That central system collates each hospital's data on a weekly, daily, monthly basis; correct?

Mr Calvert: Yes.

Mr McARDLE: You could access that data quite readily to advise this committee of the number of code blacks and the break-up on a daily basis, couldn't you?

Mr Calvert: No, not readily. Obviously in the hospital we have a number of operational areas which deal with many things that present risk to staff and patients, and a variety of operational scenarios can happen in the course of any year and they are all given a colour code. The collective aggregate of those codes is not routinely aggregated and reported on in any way to any of our performance report committees, so it is not something I can easily just tell you straight here from my iPad.

Mr McARDLE: No, not from your notes here, but the data goes to a central system as you said earlier, if I recall correctly.

Mr Calvert: I am happy to look into what information I can access easily and if the minister is happy—

Mr McARDLE: The point is this: code blacks are recorded by the Gold Coast Hospital, are they not?

Mr Calvert: Yes.

Mr McARDLE: Okay. They are recorded at a central database. They are not recorded all over the place, are they? There is some place that they go to. There is some number that is telephoned. There is somebody who is put in motion to deal with this matter.

Mr Calvert: There will be, yes.

Mr McARDLE: Okay, but are you saying to me that that data is never collated and never acted upon?

Mr Calvert: It is acted upon at the time. It is not something we routinely monitor as part of our performance monitoring system.

Mr McARDLE: Are you saying that you do not review that data to assess the level of risks and what should happen in a set of circumstances?

Mr Calvert: I am not sure I understand your question.

Mr McARDLE: If you have 100 code blacks in a month—and they could be various things—are you saying that no action is taken on the fact that we have 100 code blacks in a month and we need to put in place processes?

Mr Calvert: No. If we had a set of things going on in the hospital that were departing from normal experience and they jumped to a level in the way you are describing, then, yes, we would take action because it would be something that was operationally a problem and we would respond accordingly. But it is pretty constant throughout the year in that it is just a handful of incidents in a week perhaps, or not even that.

Mr McARDLE: All right. Can you describe for me what a code black is?

Mr Calvert: It is an incident—sorry, I should read this, should I? I refer to Budget Paper No. 4 at page 10—

Mr DICKSON: I raise a point of order. Are witnesses supposed to actually answer questions themselves or are they held on puppet strings and somebody else gives them the answer?

CHAIR: Sorry, member for Buderim, but there is no point of order. The question was asked and Mr Calvert is seeking to answer that question and may do so as he sees appropriate.

Mr DICKSON: The gentleman is reading something that somebody just handed to him for a simple question.

CHAIR: Member for Buderim, may I repeat there is no point of order.

Mr DICKSON: This does not—

CHAIR: Member for Buderim, I ask that you hear my ruling. There is no point of order. A question has been asked. Mr Calvert is able to respond in whichever way he deems proper, and if he wishes to read from a document then he can.

Mr DICKSON: Happy to hear the answer.

CHAIR: Thank you.

Mr Calvert: So—

Mr McARDLE: Mr Calvert, I will repeat the question, sorry. What is a code black?

Mr Calvert: A code black is a violent incident demanding a response from the security services.

Mr McARDLE: I want to look at this document, Gold Coast Health Service District Procedure Document GCDPRO0738V2, and I seek leave to table the document.

CHAIR: Is leave granted? Leave is granted.

Mr McARDLE: Thank you. Just look at that document. The document in fact details a procedure as to what is to occur when a code black happens. If I recall the document, it refers to dialling 222 and I think that goes to a central bank, wouldn't it?

Mr Calvert: Yes.

Mr McARDLE: Right. So therefore there is a central bank of data in the hospital. Do you know if that data is then sent on to Queensland Health for assessment by them or not?

Mr Calvert: I do not know.

Mr McARDLE: You do not know?

Mr Calvert: 222 is the central phone bank.

Mr McARDLE: Correct.

Mr Calvert: We deploy security guards or whatever is appropriate depending upon what happens. The incidents are relayed by the operational manager on call and a judgement is made about the grade of response. It can be anything from an immensely unwell patient displaying violence through to a violent altercation in the emergency department requiring police presence. The range of circumstances is very wide.

Mr McARDLE: Absolutely. I do not doubt that for a second, Sir. You are absolutely right. But my point is this: I would have thought that this data would be kept somewhere. Do you recognise that document?

Mr Calvert: Yes, it is one of our procedure documents.

Mr McARDLE: Good. So you see that 'in emergency situation, all staff dial 222'.

Mr Calvert: Yes.

Mr McARDLE: So the data must be collected. That is my premise. Is that right?

Mr Calvert: Yes, I am sure the data will be collected. It will not be collected by dialling 222.

Mr McARDLE: No. I accept that.

Mr Calvert: Dialling 222 just generates the response.

Mr McARDLE: Otherwise why do it? The next point is: is that data collected at a central point?

Mr Calvert: When you say 'a central point', do you mean a central point for the Gold Coast Hospital and Health Service or do you mean a central report and reported to Queensland Health?

Mr McARDLE: For the Gold Coast hospital itself.

Mr Calvert: I am sure it will be but it is not a report that is generated in a way that I examine on a regular basis.

Mr McARDLE: Okay. Are you able to provide that data to this committee?

Mr Calvert: I will check.

Mr McARDLE: I will ask the minister. Minister, will you undertake to provide the code black data for the Gold Coast hospital for the period 1 February 2015 to the date hereof?

Mr DICK: I will have to defer to the executive of the hospital as to what data they have and what they can provide. I will talk to Mr Calvert at a break to see what information he has. If we can provide the information, we will provide it. We will see what they keep at the hospital. You have had the opportunity to ask him directly. He has given you direct answers. I have not spoken to him. I am listening to your questions and listening to Mr Calvert's answers. I am happy to talk to him in the break and see what information is available.

Mr McARDLE: That is fine. Director-general, do you know if the code black data—

CHAIR: Member for Caloundra, just so you know, this is the last question.

Mr McARDLE: Yes. Director-General, are you able to advise the committee whether code black data that is identified in that document—and I accept that it is a wide scope; it has to be by definition; you cannot narrow that scope—is collected anywhere in Queensland Health because it deals with here threat or act of violence with or without a weapon due to acts of terrorism, illegal entry, vehicles or mail threats? Is that collected anywhere in Queensland Health?

Mr Walsh: The system of Queensland Health where we have the department as assistant manager and the hospital and health services as statutory bodies running health services, each health service is responsible for ensuring that they have a policy to be able to respond to incidents that occur in their facilities. That is a structured policy. But the data, if there is any data collected from those responses that is aggregated or collected is not provided to the department or aggregated at a central point. But they are required to ensure they have policies and comply with those policies.

Mr McARDLE: Thank you very much.

CHAIR: I call the member for Greenslopes.

Mr KELLY: I refer to pages 60 to 247 of the SDS, which provide details in relation to each of the hospital and health services. Minister, can you give the committee an overview of what hospital and health services in the southern part of Queensland, including South-East Queensland, will be receiving in 2015-16?

Mr DICK: Thanks very much, member for Greenslopes. I appreciate your question and thank you for it. Can I just say in response that I will ascertain what the policy position is in relation to serious incidents, code black incidents, at the Gold Coast hospital and whether there has been any change to the policy since the government has changed. I have not directed hospital and health services to change any policies or procedures in relation to those sorts of serious incidents that may have been in place under the previous three years of the LNP government. So I will ascertain what the policy framework is. I, of course, expected coming to office after a period of heightened security, tensions across Queensland—you may recall the previous Premier changed a whole range of security status and security response positioning for a whole range of government buildings, including this parliament and others—my expectation is that the previous minister would have in that context ensured that there were appropriate security and safety policies in hospitals. I will see what they are when I report back on this issue. If there is anything that has not been done, if there is anything that needs to be improved because of any lack of action by the previous government, I can certainly commit to this committee that I will be looking at that.

In relation to your question, the operating budget in the Darling Downs region, for example, in the south-west of our state is $637.8 million a year. That is an increase of $21.3 million. Money in that budget allocation will go to the mental health community care unit. There are a number of those throughout Queensland. I opened the new community care unit in Toowoomba a few months ago. There is $3 million to operate that facility. There is $1.7 million, one-off operational funding for the

$9.6 million equity funding establishment of a magnetic resonance imaging service in Toowoomba—that is, a new MRI going into Toowoomba to support the city of Toowoomba and the Darling Downs region.

For the Gold Coast Hospital and Health Service, one of the biggest in our system, there is $1.19 billion this year—an increase of 12.1 per cent on the Gold Coast or $128.8 million. That is a growing part of our state and significant investments include $9.3 million for an integrated care service to improve patient outcomes, $2 million to increase access and meet the ongoing demand for acute mental health services and ongoing community mental health care. In addition, there is capital funding of $31.8 million to finalise the Gold Coast University Hospital. Construction is largely complete.

I move on to two big hospital and health services. For Metro North, there is funding of $2.17 billion this year, an increase of $84.8 million or 4.1 per cent over last year. There are significant investments there: $13.4 million to restore services at the Biala sexual health clinic, with total funding of $3.2 million over four years. Again, that is a commitment, as you know. We have discussed previously, member for Greenslopes, the challenge of ensuring that we have an effective sexual health service delivered across our state. Biala was something that was axed by the previous government—all but closed—a very, I think, significant loss. But we have reinstituted Biala. We will re-fund it with $13.2 million over four years. There is $1.6 million in increased funding for community mental health initiatives in Metro North. In terms of capital projects, there is $7.8 million for the expansion of the intensive care units—so more intensive care unit beds at Redcliffe Hospital and the establishment of an intensive care unit at Caboolture Hospital. There is $2.6 million to expand the Prince Charles Hospital rehabilitation unit by eight beds.

For Metro South—something very close to your heart, somewhere where you worked previously, member for Greenslopes—there is an operating budget of $2.2 billion this year, an increase of 6.8 per cent or $127.9 million. Funding for capital projects includes $19.8 million for the PA Hospital to undertake a major transformation change in relation to digitising that hospital, leading the way as a digital hospital. I know Terry White, the chair of the board, and Dr Richard Ashby, the chief executive, are very keen to ensure that that project is effectively implemented. There is $8.9 million to complete stage 2 of the $10 million Southern Queensland Centre of Excellence in Indigenous Primary Health Care—something that we will continue to fund. The majority of that money has been provided by this government. I think it is an initiative that started under the previous government. I fully support it. That will be situated at Inala. I know that Metro South is very proud of that initiative.

There is $6.9 million to finalise the $145 million jointly funded Logan Hospital expansion program—something that I am very proud of and an expansion funded by the federal Labor government, supported by our state Labor government now. That is making a huge difference in what happens to communities in the city of Logan, including the electorate of Woodridge. That project has delivered a new emergency department, increased treatment spaces for adults and children as well as a new day surgery unit, rehabilitation ward and simulation and improved staff facilities.

In the south-west of our state, there is funding of $126.9 million this year, an increase of 6.7 per cent or $7.9 million. There is $430,000 for additional urology and ophthalmology services, which is a great thing for the very broad region of the South West Hospital and Health Service. It covers a large part of our state—a lot of small communities that need support. It is good to know that they will be supported with additional urology and ophthalmology services. Roma Hospital will be upgraded, of course.

The Sunshine Coast Hospital and Health Service, I touched on previously. It has an operating budget of $752.7 million this year, an increase of $57.2 million or 8.2 per cent. I have mentioned the investment of more than half a billion dollars into the Sunshine Coast Public University Hospital in this budget alone, with more to come.

The West Moreton Hospital and Health Service services Ipswich and the districts west of Ipswich. It has an operating budget of $469.8 million, an increase of $12.6 million. That includes $18.6 million growth for a broad range of public hospital services spanning in-patient, outpatient and emergency department services. So there is a lot happening in the southern part of our state.

Mr KELLY: Thank you very much. In a similar vein, Minister, can you give the committee an overview of what Children's Health Queensland will be receiving in 2015-16?

Mr DICK: Thank you, member for Greenslopes. Thank you for the question. The operating budget for Children's Health Queensland is $612.3 million this year. That will be an increase of $151.5 million or 32.9 per cent from the 2014-15 operating budget. That increase reflects the amalgamation of the Mater Children's Hospital and the Children's Health Queensland Hospital and

Health Service—the combination of the Mater coming in with the Royal Children's at Lady Cilento. So there is a significant increase for the Children's Health Queensland Hospital and Health Service. That is a network of hospitals.

All public hospitals in Queensland have the capacity to treat children. Children should be treated close to their community if they can be. That is my view. So if there is an injured child or a child who might be sick in Townsville, if they can be treated there then they, of course, should be treated closer to their family and their community. That is my view as an example. Lady Cilento, of course, is a large tertiary hospital that is designed to treat very serious or chronically ill children. We have world-leading experts in so many areas at that hospital. That is the major large tertiary hospital and children can be referred to and treated at that hospital from anywhere around Queensland, particularly where they have chronic conditions. That was the piece that was missing in the puzzle, I think—or the mosaic—of Queensland children's health treatment previously and that is the purpose of Lady Cilento. That hospital is doing wonderful work with some extraordinary staff, who I cannot praise highly enough for the work that they do there. So there are significant investments for Children's Health Queensland this year, our Hospital and Health Service for children.

There is $2.7 million for our government's election commitment to re-establish and expand the school-aged nursing service, with total funding of $11.4 million over four years and $700,000 to strengthen the persistent pain service at Lady Cilento Children's Hospital, with total funding of $1.7 million over three years—a new service announced, a new initiative of this government to help children with chronic pain problems. That is part of a broader commitment that we have made to refresh our commitment to Queenslanders who have chronic pain to try to help them. It is another election commitment that we made that we will be delivering. But the first piece is to look at paediatric chronic pain to help children who have chronic pain. I met a young girl at the hospital who had referred pain really after a simple thing like a sprained angle. Now, she has chronic pain as a consequence. Those chronic conditions can sometimes develop from simple injuries. She has been on the path to recovery now because of this new initiative, which I am very pleased to say. There is capital funding of $51.5 million to be provided to finalise projects in relation to the Lady Cilento Children's Hospital. Can I say that the Centre for Children's Health Research will be a significant research institute in our state focusing on young children and children and paediatric health care.

CHAIR: Member for Greenslopes, we have about three minutes left before the break. So there is time for one last question.

Mr KELLY: I refer to page 5 of the SDS. Can the minister explain how the structure of the department impacts on its budget in that context and what was the Hunter review?

Mr DICK: Thanks very much, member for Greenslopes, for your question. The Hunter review was commissioned by the acting director-general of the department and completed the work of the future state realignment team commenced by the former government. The review incorporated extensive consultation with staff and senior executives in the Department of Health as well as hospital and health services. I have always said that the review was about getting stronger, making sure that the Department of Health was stronger to support our hospital and health services, not smaller.

One thing that I am really delighted about is that there was a very high level of staff input—over 1,000 submissions from people within the department about what the Department of Health should be doing in the future. As we know, under the previous government, the voices of staff were closed. They were shut down. The previous government did not want to listen to them, but we had 1,000 people. I think what that demonstrates is this uncapping of commitment, the removal of the gag that was on staff in the health system previously, who felt threatened. They have told me that directly. They felt threatened and they felt that they had to be silent under the previous government. I am happy for them to be able to contribute. I think 1,000 submissions demonstrates that. It was a very supportive and consultative approach, which I believe was very well received by the department compared to previous attempts at restructuring the department.

We have made it clear that we are a government that listens to its workforce. The review recommended revised structural and governance arrangements for the Department of Health. The recommendations also included: the development of a charter of responsibilities between the Department of Health and hospital and health services to set agreed roles and responsibilities for each; the creation of a clinical excellence division; the elevation of the position of the Chief Health Officer to deputy director-general by creating a new prevention division; and the creation of a public health manual, which sets out clear roles and responsibilities for statewide public health priorities, including instances where the Health Protection Division will step in to coordinate issues of statewide significance.

The new Department of Health organisational structure was implemented on 3 August. There have been no forced redundancies through the implementation of the new scheme. I think that it has been very well accepted. I want to thank the department and the leadership team for the high level of commitment they have made to implementing it. I think it will significantly strengthen the department and what it can do in the future.

CHAIR: The committee will now take a break for a short period and resume at 10.45 am.

Proceedings suspended from 10.30 am to 10.46 am

CHAIR: Welcome back, Minister and officials. The committee will continue with its examination of the estimates for the Department of Health, hospital and health services and the Health Ombudsman. I also now welcome the Queensland Mental Health Commissioner.

Ms BATES: My question is to the CEO of the Gold Coast University Hospital. Mr Calvert, you struggled a little bit before about a code black. Obviously they are very serious armed or unarmed threats and injuries to staff and the public as well as hostage situations et cetera. You also mentioned that it was difficult to get the information on the data. I can tell you that on average you have about 60 code blacks a month at the Gold Coast University Hospital. The vast majority of those are unarmed. The latest one was about six weeks ago when a patient grabbed some trauma shears out of the pocket of a nurse and tried to stab the nurse. Will you be able to provide this data, because obviously it is out there, it is not terribly difficult to get, and my understanding is that it is collated on a weekly basis? I would like to know if you would be able to provide that.

CHAIR: Member for Mudgeeraba, just a point of clarification: do you have a new question because that question has already been asked?

Ms BATES: It is further from the first question. It is asking a little bit more about it. Would you be able to provide the data for the Gold Coast University Hospital based on the fact that it is well known that your data is available?

CHAIR: Member for Mudgeeraba, that is the same question that was asked before the break. The minister mentioned that he was considering it. Did you have a further question?

Ms BATES: No, thank you.

Mr McARDLE: Director-General, I want to talk about the nurse-patient ratio and the QNU involvement. It is clearly a cornerstone of the government's policy. Are you able to indicate whether there is a separate branch or sub-branch within your department that is dealing with the nurse-patient ratio in relation to talking to and acting with the QNU? Is there a body that does that?

Mr Walsh: The work in relation to nursing and nursing practice, including the nurse-to-patient ratio development in relation to implementing the election commitment of the government, is undertaken by the Office of the Chief Nursing and Midwifery Officer, which was an existing entity within the organisation and took on the work to undertake the implementation and implement the election commitment.

Mr McARDLE: We understand that there have been a number of occasions when departmental staff and consultancy staff have actually gone to the QNU headquarters and sat down with them to work through this process; that would be right?

Mr Walsh: I commenced in the department on 6 July. I am not aware of any—

Mr McARDLE: Can you take advice from someone behind you who may well know that?

Mr DICK: I know.

Mr McARDLE: Thank you. You have agreed with it.

Mr DICK: No. I know the answer. Do you want to ask me a question? Would you like me to answer it?

Mr McARDLE: No.

Mr DICK: Yes, I know. We have gone to the QNU. We have gone to a number of stakeholders. We are very happy to do that.

Mr McARDLE: Thank you. Director-General, there would be a record kept of attendances at the QNU—how many times you have been there. There would be time sheets, there would be agendas, there would be minutes of meetings, there would be emails, there would be data in relation to who went there, how long they were there for. That would be right, wouldn't it, because you would need to have that information readily available in formulating a policy of this nature?

Mr Walsh: I am not aware of that data being available in the department. If the QNU have records of attendance of people then they are not our records.

Mr McARDLE: You would have a record of going there yourself. The department would keep records of that. There would be minutes of meetings, wouldn't there? There would be agendas prepared; there would be communication between the QNU and the department about what is being discussed.

Mr Walsh: There would be documentation that would be prepared in relation to identifying and developing draft legislation that is provided through the entity—Office of the Chief Nursing and Midwifery Officer—to prepare documentation. Yes, there would be lots of documentation, yes.

Mr McARDLE: There would also be documentation in relation to how many times departmental officers, the chief nursing midwife, attended the QNU, wouldn't there? Surely you would keep records of that. The Auditor-General would want to know because he would be keen to understand how a policy was formulated. He would be looking for that data, wouldn't he? You would keep those records?

Mr DICK: Is this a question about the number of taxi vouchers used in the budget or the cost of petrol or the cost of vehicles?

Mr McARDLE: When I want to ask the minister a question I will put a question to the minister, thank you very much.

Mr DICK: I am just interested.

Mr McARDLE: Director-General, would you answer the question?

Mr Walsh: I am not aware of any data that is collected routinely about all of the activities that individual staff members undertake. If the question is, 'Do we have data collected to identify every single thing an individual did at every particular point in the day?,' then, no, we do not have that data.

Mr McARDLE: No, but, formulating this very important policy, one would anticipate that the relevant section would keep that record.

Mr Walsh: Keep what record? I am not understanding—

Mr McARDLE: Keep record of who went to the QNU, when they went there, how many times. Surely that is the process in the department, because you still have to work out how policy was formulated, who attended these meetings, whether there were email transactions. Wouldn't that be normal procedure for the department?

Mr Walsh: There would be certainly documentation around all of the consultations and stakeholder engagements that happened.

Mr McARDLE: Excellent. That is my question.

Mr Walsh: Whether that documentation captures all of the information that you have identified I do not know because it is not collected centrally and it is not reported. It is the daily workings of the activity of doing the business.

Mr McARDLE: You have already said that it is controlled by a separate body or looked after by a subdepartment. That department would keep that record, surely. Put it this way: can that data be tabled? I am very keen to understand how many times—

Mr DICK: If you want the papers, put a right to information request in. This is what public servants do every day: they talk to people; they spend hours developing policy.

CHAIR: Point of order. Thank you, Minister. Member for Caloundra, you have asked the question and the question has been answered.

Mr McARDLE: The minister cannot answer the question at this point in time.

Mr DICK: I am just trying to assist the committee.

CHAIR: Thank you, Minister. The director-general answered.

Mr McARDLE: You are formulating—

CHAIR: Member for Caloundra, point of order. I addressed this before the break. I do not interrupt you when you are asking a question unless you are not asking a question consistent with the standing orders. I ask that you allow me to rule without an interjection. I say again, the director-general has answered the question. Please move on to a new question.

Mr McARDLE: Madam Chair, thank you. Director-General, are you saying that there was no record of any attendance at the QNU by any member of your department in relation to formulating one of the cornerstone policies of the ALP? There is no documentation, even though quite clearly the minister on ABC Radio made the comment that there were people going to and from. Are you saying that no records are kept about the QNU formulating the policy for the ALP?

Mr Walsh: No, I am not saying that.

Mr McARDLE: Okay. Then what are you saying—that there are records? If there are records, I would like to know what they are.

Mr Walsh: I am saying that in undertaking policy development we engage with stakeholders. Clearly in relation to nursing staff ratios one of the stakeholders is the QNU, along with other stakeholders. The team that would be developing that policy would certainly be documenting and recording the stakeholder consultation that they have.

Mr McARDLE: Excellent. So there is a team that does this. You have just said that there is a team that does this. Can you identify who the team is, how many times they have been to the QNU, or papers or emails or minutes or agendas, or is it simply something that was not done?

CHAIR: Member for Caloundra, can I draw your attention to standing order 115. The questions should relate to one issue and be brief. Then when you ask a question you allow the director-general the opportunity to respond rather than interjecting.

Mr McARDLE: Thank you, Madam Chair. We have a team that does it; you have admitted that. You said the team does it. That team must have correspondence, emails, rosters, briefing notes, meeting notes, facsimiles going back and forth, agendas, minutes of meeting in relation to what is a very important outcome for the ALP. That would not be an unrealistic expectation, would it?

Mr Walsh: As I explained before, the Office of the Chief Nursing and Midwifery Officer undertake a range of policy development issues including the nursing staff-patient ratios. In undertaking that policy they would be ensuring that they are documenting consultations with all stakeholders in order to formulate the policy. The documentation of that would be in a whole range of areas. It is not collected centrally. It is not reported. To actually identify all of the possible documentation that maybe existed in the development of the policy would take an enormous amount of time to actually collect. I cannot answer the question here because it is something that I need—I have not seen the documentation, I have not reported or collected it myself, so I would also be challenged to get that documentation in a very quick time. It just would not be possible.

Ms BATES: Madam Chair, I move that the committee calls on the minister to provide the committee with all correspondence, emails, rosters, briefing notes, meeting notes, facsimiles and other documents requested relating to public servants and publicly funded contractors developing QNU and/or Labor policy at non-government premises.

Mr DICKSON: I second that.

CHAIR: I draw the committee's attention to the fact that the committee cannot require the minister to table anything—it is at his discretion—but we can adjourn to a private meeting downstairs and discuss the motion should you wish.

Ms BATES: Thank you.

CHAIR: We will now adjourn for a short time. Thank you.

Proceedings suspended from 10.58 am 11.04 am

CHAIR: Thank you. The committee adjourned to consider the motion. The motion failed under the Parliament of Queensland Act. We will move on—

Ms BATES: I move that—

The result of the committee's deliberations and how the members voted be made public.

Mr DICKSON: Seconded.

CHAIR: In accordance with the Parliament of Queensland Act, the vote was tied 3-3 and failed.

Mr DICKSON: Thank you.

CHAIR: Member for Caloundra.

Mr McARDLE: Madam Chair, I certainly understand the outcome of the vote. Of course, the concern here is that an open and transparent government is accountable for what they do and looks like a government that is engaging. Here we have an opportunity to ascertain exactly the QNU involvement, which really is the mainstay of the ALP in this matter, and it was turned down. It is a very frustrating exercise and one that I think is very regrettable for this form of government.

Mr DICK: But the legislation enabling and enacting nurse-to-patient ratios will come to this committee—

Mr McARDLE: Anyway, as the minister has not been—

CHAIR: Thank you. Member for Caloundra, do you have a question or do you wish to—

Mr DICK:—including from the Queensland Nurses Union and you can ask them directly.

CHAIR: Order! I call the committee to order. Member for Caloundra, do you have a question?

Mr McARDLE: I have several, I can assure the chair of that. I want to talk about the issue of the emergency departments. I would like to ask the director-general a couple of questions. Director-General, on August 14 this year you issued the patient centred emergency access directive, if I recall correctly—the MEDAI?

Mr Walsh: The policy commenced from 4 August.

Mr McARDLE: Do you have a copy of the document in front of you?

Mr Walsh: Did you want to table that document?

Mr McARDLE: I seek leave to table the document, Madam Chair, which is the patient centred emergency access directive.

CHAIR: Leave is granted.

Mr McARDLE: Director-General, when you look at that document, in the top right-hand corner there are four lines. The fourth line says 'Supersedes: QH-GDL-956:2014'. Do you see that?

Mr Walsh: Yes.

Mr McARDLE: What is that document?

Mr Walsh: I will have to find out what that document is.

Mr McARDLE: I will table a document for you dated December 2014, entitled 'Emergency department access'.

CHAIR: Member, do you seek leave to table the document?

Mr McARDLE: My apologies, Madam Chair; I seek leave.

CHAIR: Leave is granted.

Mr McARDLE: I will give you a chance to look at that document. I understand that you were not the DG at the relevant time. I get that quite clearly. The document, on my understanding, was issued to all HHSs.

Mr Walsh: I do not have the document, yet.

Mr McARDLE: Of course. I comment that when I looked for this I could not find the document on the website. This document was issued on 1 December 2014 by the date at the bottom of page 1—effective 1 December 2014. The document of August 2015 supersedes that, is that correct?

Mr Walsh: That is what the directive says, yes.

Mr McARDLE: That directive of 2014 was issued to the HHSs. Am I right in saying that what it did was request the HHSs to put in place the MEDAI that suited their location—that is, there was a gifting of the power by the then minister to the HHSs to put in place MEDAI, is that right?

Mr Walsh: In relation to the two documents, one is a guideline, so there is no transfer of power or requirement to comply with the guideline. It is simply a guideline.

Mr McARDLE: But you agree with me that there was the—

Mr Walsh: Can I finish the comparison?

CHAIR: Member for Caloundra, you have asked the question. I ask that you let the director-general respond.

Mr Walsh: The document that it superseded was a guideline, as I have explained. A guideline is not required to be implemented; it is a guideline. The directive is a directive. All HHSs have to comply with a directive. The strength of the document that the directive provides says that HHSs do have to

ensure that they provide access, integration, safety, efficiency and collaboration and the steps that they need to take in relation to the mandatory requirements, as are stated in the directive, whereas the guideline does not have mandatory requirements. It is simply a guideline, so no-one is required to have to comply and demonstrate that they are complying with the guideline. It is providing assistance for people to guide the types of strategies and systems and operations they put in place.

Mr McARDLE: I hope you are not saying that the HHSs could not be trusted to look after the emergency department? I hope you are not saying that the HHSs—

CHAIR: Member for Caloundra, I hear an imputation in your question. I ask that you rephrase it, please.

Mr McARDLE: Director-General, are you saying that the guideline was such that you believe HHSs would not comply with it?

Mr Walsh: The use—

Mr McARDLE: That is a question. Do you believe they would not comply with it?

Mr Walsh: Can I answer the question?

Mr McARDLE: Certainly.

Mr Walsh: The legislation that exists to establish the Department of Health and the hospital and health services has an instrument in that legislation, which is a health service directive. The use of a health service directive is to support and ensure and manage the system. When developing directives, the department does not sit and do that in isolation with the entire system. We work with the hospital and health services, we consult with the hospital and health services and we collectively look at whether putting in place a directive is going to improve the operations of the system or not improve the operations of the system. It is there to support HHSs deliver safe and timely services. In the development of this directive, consultation occurred with all of the HHSs to ensure that the directive was clear, that people were able to implement it and then the directive was issued.

Mr McARDLE: Are you saying that there was no HHS that put in place the guideline?

Mr Walsh: I do not have any information about data collected in response to the guideline, no. If HHSs were undertaking strategies and processes and systems in relation to the guideline, that would be something that they would know about. There was no recording or central reporting of the guideline.

Mr McARDLE: Madam Chair, I call the CEO of the Townsville Hospital and Health Service to the table, please.

CHAIR: Member for Caloundra, we might come to that because, if you are pursuing a new line of questioning, we will move to the member for—

Mr McARDLE: No, definitely not.

CHAIR: It is the same line of questioning?

Mr McARDLE: It is the same line of questioning.

CHAIR: Thank you.

Mr McARDLE: I seek leave to table a document.

CHAIR: Leave is granted.

Mr McARDLE: While that is being copied, I point out that the guideline was issued. I do not know whether you were the CEO at the relevant time—that is, back in December last year?

Ms Squire: Yes, I was.

Mr McARDLE: On my interpretation, that guideline followed MEDAI quite closely in regard to—

Ms Squire: Yes.

Mr McARDLE: As a CEO of a HHS, you have a multitude of responsibilities?

Ms Squire: That is right.

Mr McARDLE: One of them is to ensure the ED functions properly, that the NEAT figures are moved, the patients are moved out onto the wards, the ICU functions, surgery occurs et cetera.

Ms Squire: That patients are cared for appropriately and quickly, yes.

Mr McARDLE: So you would take this guideline very seriously, would you not, because it is part of the procedure to ensure patient safety?

Ms Squire: Absolutely, yes.

Mr McARDLE: In fact, if I am not mistaken, you prepared a document conforming to the guideline request?

Ms Squire: I cannot recall personally preparing a document. My health service would have looked at the guideline and made sure that we were accommodating it where we felt it was appropriate.

Mr McARDLE: Exactly. In fact, that would be a very important thing for you to do, would it not?

Ms Squire: We look at guidelines and we also comply with directives.

Mr McARDLE: When the document comes back, I want you to look at it for me. The other issue is that you were consulted about the directive, I understand, issued in August of this year?

Ms Squire: There is a well-established process to consult HHSs before directives are finally issued.

Mr McARDLE: How does that process work?

Ms Squire: The answer is that it depends. The health service chief executives will generally look at those things at their chief executives' forum meeting, which meets every month, or individual chief executives will be asked separately.

Mr McARDLE: I apologise for the quality; it is quite difficult to read. You are aware of that document?

Ms Squire: I recognise it.

Mr McARDLE: That is in essence the document that follows the guideline issued, which I think you said is a very important step in relation to patient care and patient safety

Ms Squire: Yes.

Mr McARDLE: That is right, is it not?

Ms Squire: Yes, absolutely.

Mr McARDLE: Thank you very much for that. I appreciate that. Minister, we finally get to talk to one another! In your media release of 13 August 2015 you said that you 'reinstated the directive that had been rescinded by the LNP'—your words. Why did you not say that the guideline had been issued by the LNP and that that had also been taken up by a number of hospitals, certainly Townsville, just for the sake of being complete, or was the statement simply a political statement to make a point in regard to your ongoing assault on the LNP? Why was that left out?

CHAIR: Can you ask a question and cease with the lengthy preambles, please?

Mr McARDLE: Why did you not simply put the full statement in there? Why did you leave it hanging, as though everything bad had been done by the LNP?

Mr DICK: I will ensure that I run all my media releases past you before I put them out into the public domain in the future!

Mr McARDLE: Wonderful, I appreciate that.

Mr DICK: The reason we implemented the directive was that the guideline had failed. From the repeal of the directive in 2014, ramping incidences doubled. That is the legacy, as much as the member for Caloundra wants to deny what his government did—and I know that he has the questions written for him by the member for Southern Downs, desperate to protect his shoddy and shabby legacy as the health minister. The directive failed. Going to the guideline was ineffective and resulted in a doubling of ramping. That is the reality. That is the reality for patients, for emergency departments and for hospitals, and the government had to act.

Let us get some background on the record. MEDAI, the Metropolitan Emergency Department Access Initiative, was established in October 2011 under the Bligh government to establish solutions to ambulance ramping in Queensland metropolitan hospitals. In August 2012, the Metropolitan Emergency Department Access Initiative report was tabled in parliament following project work undertaken between October 2011 and May 2012. I am sure there are a lot of public servants who

drove to a lot of places to talk to a lot of people. They might have even talked to the union representing ambulance officers, United Voice, about developing policy, because our government and previous Labor governments do not shy away from or apologise for consulting with representatives of our employees or with employees directly. There were 1,000 submissions to the Hunter report.

If the member of Caloundra is in any doubt he need just talk to Rob Borbidge and Joan Sheldon, who absolutely condemned and eviscerated the previous government for their complete failure to consult with anyone in Queensland about decision-making before they did it. He need not listen to me or to the Labor members of the committee; he needs just to listen to Rob Borbidge and Joan Sheldon about the abject failure of that government to consult. I will not apologise for talking to unions, workers, their representatives, stakeholders or to anyone who has an interest in getting policy right.

Minister Springborg accepted the MEDAI recommendations and implemented them on 1 January. Many of the recommendations were implemented through the patient access and flow directive. Once implemented, hospitals could not initiate ambulance bypass; that was the nature of that directive. QAS had a key contact at hospitals that could raise issues. On 22 August 2014 the previous director-general rescinded that directive, and we have seen an increase in ramping—nearly doubling in the recent financial year.

There is this chain of lack of diligence, of lack of oversight, by previous ministers. Lawrence Springborg, the member for Southern Downs, failed to oversight this properly. He allowed the decision to be rescinded. He allowed the Lady Cilento Children's Hospital to open when it was not ready to open. He delegated his responsibilities to others. Tim Nicholls, the member for Clayfield, was too lazy to chase Gordon Nuttall's superannuation, and John-Paul Langbroek was disinterested and too lazy to oversight the implementation of an ICT system to protect children in Queensland schools. There was a pattern of disinterest, disengagement and a lack of responsibility by previous ministers, and that is the reality.

We have reinstituted and implemented the directive, because the directive is more powerful than a guideline. As the director-general said in his evidence, guidelines do not have to be complied with. The directive says that you cannot bypass—or only in exceptional and extreme circumstances—and that, member for Caloundra, is the difference.

This is only the first step. We will be working with the department, unions and the Ambulance Service to look at other initiatives that can improve the operation of emergency departments. This could include greater use of telehealth services and access to better referral options for GP services where it is safe to do so. We are in the grip of a difficult flu season that is creating pressure on our hospitals, but we need to get patients through. We need to get ambulances back into the community. The way to do that is by implementing a directive like this. It was a very good piece of work by the previous Labor government. It was implemented by the previous government. The former director-general rescinded it, and now we have had to reimplement it to rebuild and to make more effective what is happening in our hospitals and our Ambulance Service.

Mr HARPER: I refer to page 5 of the SDS which states that the Department of Health's productivity dividend in 2015-16 will be achieved by reducing the use of contractors and consultants through other sensible saving measures. What amount of money was spent by the Department of Health on contractors in 2014-15?

Mr DICK: The Department of Health spent an estimated $126.1 million on contractors in 2014-15. This was an increase of 25.9 per cent on the amount spent on contractors in 2013-14, estimated to be $100.2 million. The department increased the use of daily rate contractors without following any merit selection processes, without consideration of the significant daily rate fees, up to $7,000 per day, and sometimes duplicating existing Public Service expertise. One of the largest increases in expenditure for daily rate contractors occurred in the office of the director-general, where it increased from $700,000 in 2013-14 to $6.6 million in 2014-15.

As committee members would know, there are a number of valid reasons why contractors might be used. This includes the ability to attract specialist and technical skills to the department to progress areas of priority. However, it is important to ensure that contractors are used only when necessary. To ensure that contractors are used only when necessary, and to assist in the achievement of the department's 2015-16 productivity dividend, since 30 April 2015 the department has implemented a number of controls to actively reduce the use of daily rate contractors.

Since taking up government and since I have become the minister, in trying to deal with this explosion in funding of contractors, since the beginning of May the implementation of the first stage of this strategy has resulted in estimated savings of approximately $541,000 per fortnight through not

renewing or through ending a number of contractors. What does that mean in terms of trying to deal with the explosion in contractors under the previous government that I inherited? What would $541,000 buy each fortnight? It would buy 30 knee replacements, 29 hip replacements, 18 cochlear implants, 166 tonsillectomies, 100 appendectomies, 68 normal birth deliveries. Those sorts of things could be covered by that waste of public money.

I repeat: there was a lack of due diligence, oversight and responsibility by the previous minister, who thought it appropriate that contracting should explode in the department, often duplicating services already being provided by the Department of Health. I think that sort of waste of public money is completely unacceptable. We have taken action to stop it. The department has my full support. Shocked as I was by this waste of public money, we will use contractors—I am not going to deny that—but in a prudent and sensible fashion. Saving $541,000 a fortnight is a significant thing for our public health system, putting it back into front-line service delivery, which is what we committed to the people of Queensland at the last election, and we will continue to do that.

The department has commenced a second phase of this strategy, again with my full support, which involves reviewing approximately 340 contractors and assessing the necessity of their continuation as contractors. Policy and procedures have been reviewed and a robust system is being introduced to ensure all contractors are easily identified and can be regularly assessed with respect to value for money and whether the use of a public servant instead of a contractor is warranted. These are basic protocols. I am surprised they are not implemented. You do a basic value-for-money test—a basic check of whether a public servant is doing the work and whether a contractor is warranted. I know that people of Townsville, member for Thuringowa, and employees in the Ambulance Service, when we are struggling to deal with a significant flu season, want those resources going into front-line service delivery and not into contractors' pockets.

Mr HARPER: I refer to page 10 of the SDS. How many people are currently waiting longer than clinically recommended for elective surgery?

Mr DICK: Elective surgery data is reported monthly, so the most recent data available is as at 1 August 2015. There were 182 ready-for-surgery patients waiting longer than clinically recommended for elective surgery on that date. The notion of long waits can also be considered from the opposite point of view—that is, the percentage of patients on the waiting list who are within the clinically recommended time. The percentage of ready-for-surgery patients on the elective surgery waiting list who were within the clinically recommended time for surgery was 99.4 per cent as at 1 August 2015.

Broken down into the three urgency categories, the figures were 99.9 per cent for category 1 patients, 98.3 per cent for category 2 patients, and 99.9 per cent for category 3 patients. I again commend the staff of our hospital and health services for that outstanding result. The member will recall that we were criticised by the opposition for implementing targets of 98 per cent for category 1, 95 per cent for category 2 and 95 per cent for category 3. These are realistic and genuine targets that did not have exemptions or exclusions, as did the wait-time gimmick, and now we are performing at a level of 99.9 per cent for category 1 patients, 98.3 per cent for category 2 and 99.9 per cent for category 3.

I think that is a significant achievement. Lists will go up and down. I cannot promise that lists will always go down. There will be growing pressure on our health system, particularly as the Abbott federal government strips $11.8 billion out of our health system for 2017 onwards for the next seven years after that. That will put increasing pressure on our health system. But this is a demonstration of the outstanding leadership we have in our hospital and health services—many of the leaders are here today—and also the brilliant work by our clinicians, nurses, administrators who deal directly with patients and others who are working very hard to ensure that we deliver on our targets for elective surgery.

Mr HARPER: I refer to page 10 of the SDS. In relation to the number of people waiting longer than clinically recommended for elective surgery, the member for Southern Downs stated in the parliament on 19 May 2015, 'At the change of government, that was reduced to 73.' Is this true?

Mr DICK: Thank you, member for Thuringowa. The answer to that question is no. It has never been 73. I am advised that the number of ready-for-surgery patients waiting longer than clinically recommended for elective surgery was 290 as at 1 January 2015, when the member for Southern Downs was the minister; 324 as at 1 February 2015; and 250 as at 1 March 2015. However, these were not the figures reported on the hospital performance website. This is because the member for Southern Downs had mandated that the elective surgery long waits at the Lady Cilento Children's Hospital be excluded from the published figures during that period. This meant that the hospital performance

website reported 15 instead of 290 long waits as at 1 January 2015—and can I observe, member for Thuringowa, wouldn't that look like a nice figure in the lead-up to a state election?—102 instead of 324 long waits as at 1 February 2015 and 73 instead of 250 long waits as at 1 March 2015.

There has never been 73 long waits at any time, and the member for Southern Downs, I believe, should have properly known that. The lowest number of long waits that has been recorded was 179, which was recorded on 1 July 2015 this year, since Labor began administering the health system in Queensland. The longest number of long waits under the member for Southern Downs was 210, which was recorded on 1 December 2014. That was two months before the discredited wait-time gimmick was due to commence. The member for Southern Downs now is on notice that it never was 73. I ask him, because he will be observing these proceedings no doubt or reading the transcript at a later time, to properly correct the record of the parliament at the earliest available opportunity.

Mr HARPER: Did the member for Southern Downs's wait-time gimmick have any effect on the number of people waiting longer than clinically recommended for elective surgery?

Mr DICK: Thank you, member for Thuringowa. The answer to that question is no. We all know that the member for Southern Downs likes to take credit for the reduction in the number of elective surgery long waits. Of course he has described himself as the 'fixer' of the Queensland health system. However, the reduction in the number of people waiting longer than clinically recommended for elective surgery had nothing to do with his discredited wait-time gimmick. The reason for this is simple: he announced his wait-time gimmick on 23 November last year and it was not due to commence until 1 February this year. Again, perhaps it is just coincidence, member for Thuringowa, that that was the day after the state election.

The number of elective surgery long waits had already fallen to 253 as at 1 November 2014. As I have said consistently, the steady improvement in elective surgery wait times over recent years has been delivered as a result of increased federal funding and national partnerships which significantly targeted and funded elective surgery. So, if the 'fixer' of the Queensland health system wants to take credit, he should give credit where credit is due and give credit to the former federal Labor government. As I have said before, the national partnership agreements are now being repealed or not renewed by the federal LNP government. Again, this will put more pressure on the state system that will make it more difficult for us in the future because this federal funding, which has helped us in the past, is being denied to Queensland.

Mr HARPER: How did the National Partnership Agreement on Improving Public Hospital Services, which concluded on 30 June 2015, help to improve elective surgery wait times in Queensland?

Mr DICK: Thank you, member for Thuringowa. That is a very important question because that national partnership agreement had a very significant impact. Over the 4½ years to 31 December 2014, Queensland spent $133.1 million of federal funding on improving elective surgery wait times under the National Partnership Agreement on Improving Public Hospital Services. The funding was delivered by a reforming federal Labor government, led by then prime minister Julia Gillard and then prime minister Kevin Rudd.

If you consider the national partnership payments more broadly, and consider those that either directly or indirectly supported the delivery of public hospital services, the last Queensland Labor government received an average of $146 million per year under those national partnership agreements over the four years from 2007-08 to 2010-11, but the Queensland LNP government received on average $303 million per year—more than double—under those national partnership agreements over the two years from 2012-13 to 2013-14.

In addition, from 1 July 2014, the funding model in the National Health Reform Agreement started to apply. Under this funding model, the Commonwealth funds 45 per cent of what is called the 'efficient price' of additional activity performed in public hospitals. It was these increases in federal funding delivered by the previous federal Labor government which delivered the reduction in elective surgery long waits in Queensland.

Under the National Health Reform Agreement for public hospitals, that contribution was to increase from 45 per cent of the efficient price to 50 per cent which would have had a significant impact on maintaining those sorts of waiting list outcomes and those sorts of elective surgery outcomes that we have discussed today. All of that will now be put in jeopardy as the Commonwealth withdraws from this space. As Joe Hockey said, if states want to run public health systems, they will have to fund them.

I do not think it is fair. I do not think it is appropriate. I do not think it is right. The Commonwealth has been a major player in respect of public health service delivery and public hospital delivery since the Chifley government. That is when it started. For the Commonwealth to withdraw, it will put very significant pressure on our state health system.

Mr HARPER: I refer to page 10 of the SDS. The member for Southern Downs stated in the parliament on 19 May 2015 in regard to his wait-time gimmick, 'The program was a $500 million program and it was properly costed; the money was there.' Is that true?

Mr DICK: Thank you, member for Thuringowa. The Palaszczuk government has been open and transparent about our budget and our priorities—when we say we are spending $500 million, we have gone to the trouble of writing it down and publishing what we are going to spend it on. I know it is a minor detail for the member for Southern Downs, but I think it is important to comply with budgetary and cabinet processes in Queensland.

It has now been 85 days, member for Thuringowa, since I asked the member for Southern Downs to meet the same standard, to release the cabinet documents which support the claim he made in the House on 19 May this year. Since my request I have been asked to produce documents by the member for Southern Downs. He has asked me to produce documents! I tabled for the parliament the document provided to me by the Department of Health. It shows the money allocated to the program and the things it was to be spent on. Still all we hear from the member for Southern Downs is deafening silence—not one word or document to support a very significant claim made in the parliament.

The wait-time gimmick, I believe, was just an excuse for the member for Southern Downs, as he was the then minister for health, to spend millions of dollars on advertising in the lead-up to the state election. He was very focused on spending money on advertising but his eyes were completely off the ball when it came to the explosion in the cost for contractors in the Department of Health. His pet project provided $77 million over three years for consultancies, advertising and bureaucracy. Out of the $77 million to be spent on the program, $15 million was to be spent on advertising alone. Yet the program did not provide a single cent for the provision of additional services in any Queensland hospital.

I do not think you can have a better illustration of the differences between Labor and the LNP when it comes to health policy. While the member for Southern Downs's priority was to spend $77 million on self-promotion and bureaucracy, the priority of this government, the Palaszczuk Labor government, and the former federal Labor government was to put money into front-line services. I call on the member for Southern Downs again to release the cabinet documents, to release the Cabinet Budget Review Committee documents, that demonstrate his claim that the wait-time gimmick was costed at $500 million, it was fully funded and the money was there.

CHAIR: Minister, I refer to page 12 of the SDS and the performance measures for specialist outpatient waiting times. How many people are currently waiting longer than clinically recommended for specialist outpatient services?

Mr DICK: Thank you, Chair. Specialist outpatient data is reported quarterly, so the most up-to-date data is for 1 July 2015. The hospital performance website reports some information in relation to the specialist outpatient waiting list. However, it does not report the number of patients waiting longer than clinically recommended. But I am pleased to reveal to the committee today that the number of patients waiting longer than clinically recommended for a specialist outpatient appointment as at 1 July this year was 82,088 Queenslanders. You may recall when we came to government, Chair, that there were over 100,000 Queenslanders waiting longer than clinically recommended for a specialist outpatient appointment. Since we took office in the middle of February, through again the very great diligence and hard work of our staff in the hospital and health services, oversighted and supported by our Department of Health, we have been able to reduce that list from over 100,000 to 82,088 as at 1 July this year. While there is still much more to do this in area, this does represent, I believe, a significant reduction compared to the number that we inherited when we came to office.

As I mentioned previously, the notion of 'long waits' can also be considered from the opposite point of view—that is, the percentage of patients on the waiting list who are within the clinically recommended time. The percentage of people on the specialist outpatient waiting list who were within the clinically recommended time as at 1 July was 60.4 per cent. Broken down into three urgency categories, the figures were: 61 per cent for category 1 patients; 49.3 per cent for category 2 patients; and 70.7 per cent for category 3 patients. In comparison, the percentage of people on the specialist outpatient waiting list who were within the clinically recommended time as at 1 January was 50 per cent. So we have gone from 50 per cent to 60 per cent since we came to office. I think that is a significant improvement.

On 1 January, when the previous minister held office when the LNP was in power, the urgency categories can be broken down as follows: only 55.8 per cent of category 1 patients were being treated within the clinically recommended time; only 39.6 per cent, less than 40 per cent, of category 2 patients—we have increased that by 10 per cent to almost 50 per cent—and, again, only 60.4 per cent of category 3 patients were coming into the system within the clinically recommended time. So let us look at the comparisons: 55.8 per cent to 61 per cent under our government for category 1 patients; 39.6 per cent to 49.3 per cent for category 2 patients; and 60.4 per cent to 70.7 per cent for category 3 patients. So we have had 10 percentage point increases in the number of patients coming into our system as outpatients within clinically recommended time since 1 January to 1 July. That is a significant achievement and, again, I commend all of the staff of the hospital and health services for their work in bringing those lists down.

It is not a magic bullet. Lists will go up and down. But what we have tried to do as a government is focus on front-line service delivery, focus on the things that matter to people. All of the members of this committee, regardless of what side of the House you sit on, will have story after story of people coming to them saying, 'I cannot get into a hospital.' They told me that on Station Road in Woodridge and on Wembley Road at Logan Central Plaza. They did not believe the wait-time gimmick because they could not get in. We have to be realistic and genuine about it. Are we going to bring it to zero? It will always be very hard to bring lists down. It will always be a challenge and I am not going to promise things I cannot deliver. But what I will promise—and this government will promise—is being realistic and genuine and maintaining a strong focus on it, as we have done in this budget with $361 million allocated over four years to help address the waitlist for the waitlist.

CHAIR: Minister, I thank you for your answer. I do have one follow-up question. With reference to pages 7 and 8 of the SDS, what actions has the government taken to reduce the significant number that you spoke about of people waiting longer than clinically recommended for specialist outpatient services?

Mr DICK: Thank you, Chair. I have touched on that briefly. There is $361.2 million allocated in this budget over four years for specialist outpatient long waits. We cannot do this on our own, so we have made a commitment to work with health professionals to develop a genuine, balanced and realistic approach to waiting times at all points of the patient journey—so from when they go to see a GP all the way through to the process for a specialist outpatient appointment and how that works, through to treatment—and that may be surgery or otherwise in a public hospital; we have good results there on our focus on elective surgery—and then through to recovery.

We will work with leaders in the hospital and health services in the department and in the broader health space to improve what we are doing there. We announced a number of initiatives in the budget, as I have said, and we made commitments before that. On 10 March this year I committed $30 million to be made available to hospital and health services. That funding was made available from existing resources to deliver additional activity by 30 June. So we have seen the benefits of that, and I am informed that has delivered more than 10,000 additional specialist outpatient appointments in that period.

On 29 April this year I convened a wait-time summit which brought together health professionals from all parts of the state who deal with waiting lists on a daily basis. The purpose of that summit was to commence discussions and build consensus on how to address the challenge of wait times at all points in the patient's journey—an example of how the department will work effectively, because the department can bring that skill, as the central agency, to bring together all of the work and oversight, working in partnership with hospital and health services to deliver better outcomes. That is why we need a strong centre.

On 4 May the government announced that an additional $30 million would be provided from existing resources over the next two years to clear the backlog of patients waiting longer than clinically recommended for an outpatient appointment with an ear, nose and throat specialist by 30 June 2017. That has been informed by working with people like Dr Bernie Whitfield, a significant leader in ENT surgery and treatment in our state. We are listening to people like Dr Whitfield. He is looking at ways to train up GPs in the community so that some of the basic treatments that can occur in hospital can occur in the community so that people do not have to go on a waitlist. They do not have to come into a hospital; they can be treated by a GP. I really commend that sort of innovation, and I thank people like Dr Whitfield for his contribution. He, like so many others, is trying to address this problem. As I mentioned previously, there is $361.2 million over four years to tackle that specialist outpatient waiting list. We have a long way to go, but we are working with diligence and enthusiastically to try to address these issues, with further work to come following consultation with the health sector.

Mr McARDLE: Minister, I want to go back to the MEDAI and the guideline. The phrase you used was 'the guideline has failed'. The guideline was issued to HHSs, and we have in the room today 16 CEOs or acting CEOs of HHSs. The guideline would only fail if it were not put in place by the HHSs. Who of the CEOs of the HHSs do you say failed, to warrant the directive going back in? They are all here. Who failed? You also made the comment that ramping has doubled, so who failed?

Mr DICK: The reality is that ramping doubled following the removal and rescission of the directive in August last year. That is the reality.

Mr McARDLE: It implies you do not trust them.

Mr DICK: I hope you have been listening to my evidence today, member for Caloundra. I think on a number of occasions I have praised the leadership of hospital and health services.

Mr McARDLE: That is my exact point, Minister.

Mr DICK: I have met every one of those chief executives. I have been to meetings with them. The reality is that the numbers went up. The directive had been effective. It is for the member for Southern Downs to explain why he decided to oversight the decision of the director-general to remove the directive when we have seen a doubling in that. It is beyond me. He implemented it, it was working well and then he took the foot off the pedal.

Mr McARDLE: He gave the power to the HHSs.

Mr DICK: He was distracted, not providing due diligence—

Mr McARDLE: Who do you not trust, Minister? Which of the CEOs do you not trust?

CHAIR: Member for Caloundra, you have asked a question. Please allow the minister to finish answering the question.

Mr DICK: I would say that it is a more detailed document, too. The reality is that the directive is a more detailed document that contains more strategies than a guideline, and I think that is important. It is not as though we ignored hospital and health services in developing the directive. The evidence today from a chief executive very clearly was that we work in partnership to develop these things. I did not implement it immediately because we had to work with hospital and health services, we had to work with the Ambulance Service, we had to work with—shock, horror—unions and talk to them about their members—those men and women at the front line driving ambulances, treating patients, senior paramedics in the back of ambulances and our emergency department specialists. That is what we do. We talk to people to get it right, but it contains more strategies than the guideline.

I do not blame anyone in our hospital and health services, but leaders need to take responsibility. The member for Southern Downs oversighted a department that rescinded that directive, and we have had a doubling in ramping since. Action had to be taken. We have consulted with our hospital and health services. We listened to our leaders such as the chief executives. We have now implemented the directive, and I look forward to addressing those issues going forward with new mechanisms as well over time.

Mr McARDLE: Minister, it was a political stunt and you know it. It is as simple and as straightforward as that. You took the opportunity and you did something because you thought you could hurt the Leader of the Opposition.

CHAIR: Member for Caloundra, is there a question?

Mr McARDLE: That is the only issue that drove you. You spent all day on that exact topic, and that is the truth.

CHAIR: Member for Caloundra, I remind you again under standing order 115 that the rules are quite clear as to asking a question. Is there a question, or are you making a statement which would not be consistent with the standing order?

Mr McARDLE: I want to move on to medical cannabis, Minister. The media release of 19 April this year was I think the first release issued by you and the Premier in regard to medical cannabis. I will table a copy if I get consent shortly. About halfway down it states—

Ms Palaszczuk said Queensland's trial would be coordinated by NSW Health, and would allow Queensland and national experts to look deeper into the issue.

Do you remember that? It then goes on to state—

By broadening the trial to beyond New South Wales, we will get an even better picture of what benefits this treatment can provide, and what conditions respond favourably and unfavourably.

You are then quoted in the *Courier-Mail* of 27 July—

Mr Dick said the government hoped to begin trials in Queensland in 2016 off the back of the New South Wales trials which are expected to report back by the end of next year.

At this point in time those statements are in conflict. Are we doing our own trials here in Queensland or are we linking into New South Wales? If we are linking into New South Wales, what monetary commitment have we made to New South Wales to assist in those trials if they engage Queenslanders?

Mr DICK: Thank you, member for Caloundra, for your question. Can I clarify something you said by way of comment. I think it is offensive to say that I implemented a directive for political purposes. We had a significant problem—and we continue to have problems—in relation to ramping at hospitals. Patient care and safety are very important to me.

Mr McARDLE: You have made your point, Minister. Medical cannabis—

Mr DICK: I gave you the opportunity to have a good go, member for Caloundra. Having recent experience of emergency departments personally, I know what happens in emergency departments. In relation to medical marijuana let me say this—

Mr McARDLE: Minister, you have had your crack. Are we doing trials up here or is New South Wales doing the trial, because the statements are inconsistent?

CHAIR: Please let the minister answer the question.

Mr DICK: We will work in partnership with Victoria and New South Wales on medicinal cannabis. This is the first trial conducted into the possible benefits of medicinal cannabis in Queensland's history. For a government that did nothing for three years to criticise a government that has made a commitment to explore this for families who are looking to medicinal cannabis as a way forward I think is extraordinary. We are currently in discussion with New South Wales counterparts to collaborate on research design in establishing a process for Queenslanders to participate in trials. The New South Wales government has announced a commitment, and we are going to work with them. We will commence trials—that is our aim—in 2016 as details are finalised, and further updates will be provided to the community. There is a difference between trials for adults and trials for adolescents. Adult trials are continuing in New South Wales, but the trials in relation to children have not started. That is the commitment the Premier and I made.

The Premier and I made a commitment on behalf of the government that we would work in relation to the use of medicinal cannabis for paediatric purposes. There is one area of interest for us—children with severe drug resistant epilepsy. That is an important thing for our government. That is our commitment. We are developing that. I know that the Chief Health Officer in Queensland is talking to the Chief Health Officer in New South Wales regularly, and we are trying to develop how we will work with that.

There are other things that we are considering as a department. It is a complex issue, but we are not afraid to engage with complex issues. That is what our government is doing. We have done it in a number of ways over time and we will continue to do that, but there is a great call for this in the community. We do have clear parameters and boundaries, which for us are clinical trials for the use of medical cannabis for paediatric use, particularly for children with drug resistant cases of epilepsy. I have met a number of parents to try to explain what we are doing. We are committed to it but we want to get it right. It has to be safe and effective. We have to have the right partners to deliver it. We are not deaf to the pleas of those families—I want to make that clear—and we will continue to work closely in developing this policy.

Mr McARDLE: Minister, you say that the trials commence next year in New South Wales. What is the financial commitment Queensland has made to contribute to the cost involved if Queensland citizens are going to be part of that trial? What is the financial contribution we have made? It might well be that you have done so, but what is it?

Mr DICK: No, what we will do is scope out what we are going to do as part of the trials first. That makes sense to me, that we work out—

Mr McARDLE: Scope out?

Mr DICK:—what our involvement is going to be in the trial.

Mr McARDLE: So you do not know? Who is doing the trials in New South Wales? Do you have any idea? Which organisations have been selected?

Mr DICK: We are working in collaboration with the New South Wales government to develop the nature of clinical trials. That is what we do. I anticipate it will be about the same investment as New South Wales.

Mr McARDLE: Which is how much, Minister?

Mr DICK: Probably $3 million, but I am not going to commit public money until we know the nature of the trial to be conducted. I think that would be foolish but we are committed—

Mr McARDLE: Is Queensland on the oversight body? There is an oversight body associated with the New South Wales trials. There always is. Are we on that body?

Mr DICK: We are working closely with New South Wales to develop the parameters of a clinical trial. It will not just be us. We will be working with scientific specialists. We will be working with leading clinicians to develop it. It will not just be government. That is what we do: we talk to people. But we have said that 2016 is our target. We anticipate spending about the same amount as New South Wales, and that will come from within existing budgets. We will find the money; there is no question about that. We will find the money. We are committed to it, and I hope this has bipartisan support. I certainly hope it has bipartisan support after three years of inactivity and a lack of diligence and oversight by the previous health minister, who said no consistently to people. We have said yes. There is a range of challenging issues that come out of saying yes, but it is the right thing to do. We are going to do that for Queensland families and deliver that in the future, but we have to get it right—the right clinical trial, make it safe and make it effective—

Mr McARDLE: Minister, you cannot tell me how much. You cannot tell me who is going to run the trials. You cannot tell me whether we are on the oversight body in New South Wales in regard to the trials. What you are simply saying is that something is happening somewhere. Queenslanders deserve better than this because, with respect, you and the Premier made this a very big announcement. Today you have failed miserably in answering what I would have thought are pertinent questions. Then you go on in the *Courier-Mail* to look at research to 'see if we can accelerate the process'. Again, it appears that we are going out on our own. I am dismayed that you cannot provide basic answers to basic questions.

CHAIR: Is there a question?

Mr McARDLE: Madam Chair, I will stop there and I will pass my question over to the member for—

Mr DICK: No, I will take that as a question. You cannot speak for two minutes and then just say, 'I'll pass it over.' From a government that did nothing to a government that is engaged with the issue—that is what Queenslanders have seen. What I have said also publicly in response to that issue you quote from the *Courier-Mail* is that we will look at work that has been done overseas, we will look at clinical work that has been overseas. Why? To see if we can shorten or otherwise truncate the process. So if work has been done in other places around the world that does not need to be replicated, then we are not going to replicate it here, but we do have standards in our nation that we seek to apply to the use of a range of medicines and pharmaceutical products, and we will continue to scope the trial to get it right.

CHAIR: I call the member for Moggill.

Dr ROWAN: I refer the minister to pages 73 and 145 of the SDS which outline the opening of new medical services and the recruitment of additional doctors. I ask: does the health minister support the comments by the member for Bundamba, Jo-Ann Miller, on 20 August 2013 when Mrs Miller said—

> What the minister has is Tahitian doctors ripping off the system in the form of VMOs. We have a situation whereby VMOs have been ripping the guts out of the health system to the tune of hundreds of millions of dollars ... What we have here is white-collar crime.

I ask: does the minister support those comments?

Mr DICK: I think it is interesting that the member for Moggill would ask about the treatment of VMOs in our public hospital system. You do have more front than David Jones—I will give you that much, member for Moggill.

Dr ROWAN: I do take offence and I ask him to withdraw.

Mr DICK: What? That you have got more front than David Jones. I thought that was a compliment.

CHAIR: Minister, I ask you to withdraw.

Mr DICK: I withdraw—completely and utterly. Can I say in relation to VMOs that we have worked extremely closely with them—something that is completely opposite to what happened in the last three years. Again, perhaps this is why there was no diligence by the previous minister—because he was too busy trying to force them on to Work Choices style contracts and there was a demand of the previous government that all should comply. There was no engagement. Thousands of doctors in the public health system—the people we rely on every day to deliver important critical health services to Queenslanders—were abused and vilified by the previous government. Leaders in the health system and leaders of professional organisations were not willing to stand up for their members and have their voice heard, and there were many of those.

So in relation to VMOs and to all of our doctors what I say is this: we will work with you, we have reached an in principle agreement, as all members know, in relation to an enterprise bargaining framework. We have got a new agreement, 2½ per cent wage increases for the next three years, improved professional development for junior doctors. We have had 15 meetings. Again, shock horror, I do not know where they were—maybe at their office, maybe at ours. But we make no apology—

Dr ROWAN: Madam Chair, I raise a point of order.

Mr DICK: We have had 15 meetings with ASMOF Queensland and Together Queensland to get this right.

CHAIR: Minister, I will hear the point of order.

Mr DICK: So we are going to work closely with our doctors. We are going to respect them—

CHAIR: Order! Minister, there is a point of order. I will hear the point of order.

Dr ROWAN: The question specifically was: does the minister support the comments of the member for Bundamba and Minister for Police, Jo-Ann Miller, in relation to her comments about VMOs?

CHAIR: Thank you, member for Moggill. There is no point of order. The minister can answer the question as he deems appropriate. I hand back to the minister.

Mr DICK: I think I have answered the question.

Ms BATES: I raise a point of order, Madam Chair.

CHAIR: Obviously, as long as his answer remains relevant.

Ms BATES: Point of order, Madam Chair. The current Speaker has made it very clear under standing order 118 that a minister's response should be answering the question. On behalf of the member for Moggill, I ask the minister to answer the question.

CHAIR: Minister, I take you back to the original question and ask you to remain relevant under 118.

Mr DICK: Thank you. I support all of our doctors. I support all of them. I support all of my cabinet colleagues—can I make that clear. I support all of my colleagues in the cabinet. That is my responsibility as a line minister.

Dr ROWAN: Minister, thank you for answering the question, that you agree with Jo-Ann Miller in relation to her comments about VMOs.

Mr DICK: Every member of this parliament is entitled to their own view. They are entitled to their own view about issues. Can I say since 2013 that things have moved on significantly—certainly since we have come to power. My view is that our doctors are worthy of support. I will go through some of the things you have said, member for Moggill, over time and I wonder whether your position will remain consistent or whether that will change over time as well.

Dr ROWAN: I refer the minister to page 6 of the SDS where the Alcohol and Drug Information Service and Drug and Alcohol Advice and Referral Service is also mentioned. I also refer to page 83 of Budget Paper No. 4 which references the Alcohol Fuelled Violence Program, with $32.1 million over four years. What specific new alcohol and drug services will be opened in 2015 to directly assist those with drug and alcohol disorders, such as ice, and where will they be located?

Mr DICK: So the question relates to ice as well as to alcohol related violence. I will acknowledge the National Ice Taskforce. I will get you some more information about what we are committing in this budget, but we are working closely and we are awaiting the outcomes in relation to the use of ice in our community and the national task force. It is something that was discussed by health ministers at the previous health ministers meeting. I raised it as an issue. I put it on the agenda for discussion by colleagues.

We have done a lot of work already, but we are not going to rush to investment until we know the outcome of the National Ice Taskforce. It would be I think remiss of us as a government not to look at that overall work. There are people involved like Professor Richard Murray, who is the dean of medicine at James Cook University, and Ken Lay, who is the former Chief Police Commissioner in Victoria. We want to look at all of that before we make a complete investment. We do invest significant sums in response to alcohol and drug problems. As you have identified, we have allocated $5.3 million to 2018 to fund the delivery and coordination of one project—the drug and alcohol assessment and referral course.

We have a strong position on alcohol related violence; you asked that question as well. We will implement our election commitments that will include legislation dealing with these measures: 1 am lockouts and stopping the service of alcohol at 3 am; reinstating the moratorium on very-late-night/early-morning licensed trading; banning the sale of high-alcohol content drinks after midnight; and conducting an education and awareness program. We have already done some work there and we will commit funds to that as necessary.

Dr ROWAN: In relation to an earlier question in relation to code blacks at the Gold Coast Hospital and Health Service, do you know how many are related to ice related episodes presenting at the emergency department there? Is that information available?

Mr DICK: I do not know whether it is available. I do not know the answer, but I do know that, at every hospital I go to, I go the emergency department and I do not think there has been a hospital in Queensland—I cannot recall a hospital that I have gone to—where it has not been raised by me, by emergency department intensivists and specialists. It is a problem in our hospitals. It continues to be a problem in our community. It requires a community response. We cannot just fix it in Health. It cannot just be a policing response. It has to be a community response, and governments need to work together at various levels and we need to work across government. We take it very seriously. We have already got an advertising campaign out there in the community. I have spoken to the director-general before about it—about ensuring that hospital and health services are supported. I will continue to work with the chairs of our hospital and health services when we meet regularly about issues relating to ice. But it remains a problem.

I will give you some statistics here which I think demonstrate the gravity of the problem. The reported use of ice by existing methamphetamine users has more than doubled in recent years, increasing from 22 per cent in 2010 to 50 per cent in 2013. People who use ice are reporting that they are doing so more frequently. In 2013 there were approximately 87,000 Queenslanders who had used methamphetamines at least once in the previous 12 months. That is a lot of Queenslanders when we consider that. So our hospitals are at the front line. We will support them and we will continue to do so.

Dr ROWAN: Madam Chair, given that it is such a significant public health issue, could I ask the minister to take on notice in relation to code black incidents not only in the Gold Coast Hospital but across Queensland—as we have previously asked in an earlier question today—and if there is information relating to the number of those incidents that are related to people affected by ice and what risk that means that we have that information tabled for the committee.

Mr DICK: I will consider it. Firstly, I will take advice on whether that information is available. It may not be broken down by drug or alcohol. I do not know the answer to that. I am happy to consider it if there is further information we can provide to the committee. But I am not going to task hospital and health services to do something they do not do if it is going to waste resources and waste time diverting them away from front-line service delivery. So I will consider before the end of the day what is available and I will come back to the committee.

CHAIR: Thank you, Minister. I call the member for Greenslopes.

Mr KELLY: I refer the minister to page 18 of the SDS. How many people are currently waiting longer than clinically recommended for dental services?

Mr DICK: Thank you, member for Southern Downs—sorry, I have just promoted you then. That is not a job you want, I do not think. Member for Greenslopes, you are doing a fine job in the capacity that you are working in at the moment.

Can I indicate to the committee that the clinically recommended wait time for the dental waiting list is within two years, and I am advised that there are currently zero people waiting longer than clinically recommended on the dental waiting list in Queensland. So we have made significant strides there. I know a lot of investment has come through previously, but that has had an impact on where we stand today.

Mr KELLY: Again, with reference to page 18 of the SDS, how did the National Partnership Agreement on Treating More Public Dental Patients help to improve dental wait times in Queensland?

Mr DICK: Again, this is an important national partnership agreement that was developed and delivered by the previous federal Labor government and agreed to by Queensland, and it has had a big impact. The number of people waiting longer than clinically recommended on the dental waiting list—known as dental 'long waits'—did not start to decline until February 2013. At that time, the member for Southern Downs had already been the health minister for 11 months. However, that same month—February 2013—was the month that the National Partnership Agreement on Treating More Public Dental Patients commenced. It is a very clear document. You are not in any doubt of what the document was designed to do by its title—the National Partnership Agreement on Treating More Public Dental Patients.

That national partnership agreement was announced by the federal Labor government in May 2012. It recognised that dental long waits were an issue for all state governments and that the federal government needed to step in and share some of the burden. It was structured so that the states had to meet performance targets in order to receive most of the federal funding. So it was performance based. During the member for Southern Downs's time as health minister, Queensland was eligible for $62.6 million in federal funding under the national partnership agreement.

Before the member for Southern Downs became health minister, there was no national partnership for dental services. This means the previous Queensland Labor government did not receive a single cent for dental services under a national partnership agreement. When you see that federal money coming into Queensland, you see the impact, you see the benefit it can have. I call on Tony Abbott to reverse his decision to rescind or to terminate or to not renew national partnership agreements because it has an impact on what we can do. More importantly, it has an impact on patient care and treatment around the nation, and I think they have been very significant measures.

CHAIR: We have time for one more question.

Mr KELLY: It is interesting you bring that up, Minister, because my next question is about those cuts. What cuts has the Abbott government made to the National Partnership Agreement on Adult Public Dental Services?

Mr DICK: Thank you, member for Greenslopes. I will give you an overview and an outline briefly of where the money is going and how it has stopped coming to Queensland. Very regrettably, the Abbott government has cut the funding to be provided under the National Partnership Agreement on Adult Public Dental Services. The national partnership agreement was announced by the federal Labor government in December 2012. Under that national partnership agreement, Queensland was to receive funding of $177.6 million over the three years from 2014-15 to 2016-17. But in last year's federal budget, the Abbott government deferred the start date from 1 July 2014 to 1 July 2015. Then in this year's federal budget, the Abbott government reduced the funding in the first year from $40.1 million to $30.3 million—almost a $10 million cut—and claimed that funding after this was 'subject to negotiations with the states'. So three years of certainty and $177.6 million has become just one year and $30.3 million. It is not the way to run federal-state relations when it comes to funding our public hospitals and important services like dental health services.

We all know the impact that good oral care has on general health. I have been to the Browns Plains health clinic with the member for Logan. I have met the dentists there who are doing extraordinary work and thinking innovatively about new ways to improve dental care for children in particular. There is a process whereby if children can sleep with their mouth closed it changes the way their mouth, their palate and their teeth form in a more regular fashion. There are simple methods like that. That is world research in Finland that is being considered for application in Browns Plains in the city of Logan, including for constituents of mine who go to that community centre for treatment and for constituents from the member for Logan's electorate.

But we cannot do that if the money dries up. I call on this committee as part of your report to call on the federal government to reinstate these national partnership agreements. This is too important for politics; we have got to put the politics aside. This is too important for the members of this committee,

including the LNP members, to let these issues slide because there will be a price to be paid by Queenslanders, including vulnerable Queenslanders who need health care. As a committee, that is what I am calling on you to support please.

CHAIR: Minister, thank you. The committee will now adjourn for lunch. The hearing will resume at 1.15 pm. The committee will continue examining the estimates for the Department of Health, health and hospital services, the Health Ombudsman, the Queensland Mental Health Commission and also the Queensland Institute of Medical Research.

Proceedings suspended from 12.15 pm to 1.16 pm

CHAIR: Welcome back, Minister and officials. The committee will continue its examination and also welcomes the chief executive officer and representatives from the Queensland Institute of Medical Research.

Ms BATES: My question is to the director-general. Earlier this year there was an incident in the Mental Health Unit at the Gold Coast University Hospital where a patient had fashioned a dinner plate into two shanks and threatened a staff member. Subsequently, the police and the Dog Squad were called and a police dog apparently subdued the patient. Are you aware of this incident?

Mr Walsh: Can I just clarify? The hospital and health services section of the day has finished. This is a question regarding a hospital and health service facility. We are not dealing with that question due to the time frame of the day. They were dealt with up to lunchtime.

CHAIR: Director-General, obviously as you are representing the Department of Health, if there is anything relevant that you have to add in response to that, you may. Otherwise I appreciate that it is related to hospital and health services and that they have departed the session.

Mr Walsh: No, I am not aware of that incident.

Ms BATES: This morning we discussed in detail code blacks and it was pretty obvious this morning that there was a deal of confusion about what constitutes a code black. This obviously would have come under Queensland Health's directions for a code black. I am informed that a code black was not called. I am also informed by the staff that there is a practice currently at the Gold Coast University Hospital where staff are discouraged from calling code blacks because it looks bad for the hospital. Are you aware of any direction or anything like that from the CEO or the director of nursing at the hospital?

Mr Walsh: The way that the legislation sets up the health system in Queensland is that the department is the system manager, so it ensures there are the structures, processes and funding agreements with hospital and health services, which are established as statutory bodies. The operational elements of health services are actually managed by statutory bodies that have a chief executive and a board. The department does not run the operational services within the Queensland health system. Therefore, the issues of what happens within a facility within a service are the responsibility of the chief executive and the board and, therefore, the board chair.

Ms BATES: Sure. So the director of nursing and the CEO do not have any line reporting to you as the director-general?

Mr Walsh: No, that is correct; they do not. There is a service agreement that is signed between the director-general and the chair of the board under which the board then discharges all of the service delivery responsibilities for the facilities in their hospital and health service.

Ms BATES: Who has the overall direction of code blacks in terms of reporting what happens to them? We had that discussion this morning about the data, that the data is actually available. From a Queensland Health perspective Queensland-wide, do you have reported to you major code black incidents where there would need to be a change in policy at a Queensland Health level?

Mr Walsh: As in the response to the previous question before lunch, the data about responding to incidents within hospitals is not reported centrally to the department. That is information that would be within the hospital and health service. The question of whether or not it is collated and reported within the hospital and health service is one for them.

Ms BATES: So all of the information ends up in the HHS and you as the director-general have no idea what is happening in the HHSs?

Mr Walsh: There is lots of information and data that is reported to the department. Most of that data gets reported in the SDS and other documents such as the annual report. That data, as you know from here, relates to financial arrangements, staffing arrangements, clinical safety, and quality and performance measures. The actual data around incidents is not.

Ms BATES: I am also informed that there was an investigation triggered by an email. It comes under safety and wellbeing and workplace health and safety. Do you have any jurisdiction over that as the DG?

Mr Walsh: Again, the operational matters within facilities that operate within a hospital and health service are the responsibility of the chief executive and the board of that service. They are a statutory body independent of the department and, therefore, that is an issue that they are responsible for dealing with. Not all matters that occur within a hospital and health service are required to be reported to the department. There is a whole lot of information that is reported to the department. Under the service agreement, we require certain information to be reported, and this is not one of the things that we require to be reported.

Ms BATES: Thank you. My next question is to the director-general. In the response to question on notice No. 17 about readmission rates at 48 hours back to ICU units, that they are not adopted as a marker for clinical performance and that the data is not readily available, are you aware of any data collected by Queensland Health in relation to readmissions to ICU? This is a patient who has been an ICU patient, has gone out to the ward and then within 48 hours has been readmitted to the ICU unit.

Mr Walsh: We do have readmission data that relates to patients once they are discharged from hospitals and whether it was a planned readmission or an unplanned readmission. In relation to the actual flow within a hospital, again there are elements of that flow which we report publicly. If we take the steps as to whether a person comes through the emergency department or they come through the elective surgery pathway, we report the waiting times that they have in the emergency department and flow into the hospital. In relation to elective surgery, we have the waiting time to get—

Ms BATES: I understand that, but it is from the ICU to the ward and back again. Do you have that data?

Mr Walsh: That information is not centrally reported. However, we do have, and have re-established, a Clinical Excellence Division within the department to actually strengthen the focus on patient safety and quality. I would anticipate that all of the flow steps that would be occurring in all hospital facilities—that they would be working with HHSs to actually identify issues and problems and how that would be resolved. Whether that included centrally reporting data—it may or it may not—the department certainly has a role working with HHSs about clinical activity.

Ms BATES: Are you aware that a readmission to ICU within 48 hours automatically triggers a reportable clinical incident and that this data about a reported clinical incident is also provided to the Australian and New Zealand Intensive Care Society under their unplanned admissions and readmissions back to ICU? You are already producing clinical incident reports for patients who have had to go back to ICU after being in the ward. Where the answer is that the data is not readily available, I would suggest to you that it is readily available under clinical incident reports. I would ask that you provide that data, particularly for the Gold Coast University Hospital.

Mr Walsh: If the data exists and is currently collected within the department, I am happy to make it available, absolutely.

Ms BATES: Thank you very much. My next question to the DG is—

CHAIR: Is the minister happy to take that? Essentially you are asking him to take that on notice.

Mr DICK: The director-general has said that if the information is available in the department he is happy to provide it.

CHAIR: So you are happy for it—

Mr DICK: If he is happy with that, I am happy with that.

Ms BATES: My next question to the DG is in relation to the high-dependency unit at the Gold Coast University Hospital. I have been informed that the unit was opened as a response to the lack of ICU beds and that high-risk surgical patients were intended to be nursed in that unit to take pressure off the intensive care unit. Are you aware of any staffing difficulties with this unit? Are you aware of any critical incidents which led to this HDU being closed down due to unsafe nursing practices that were operating there?

Mr DICK: On a point of order, Chair, it is quite clear under the legislation. You do not have to read far into the legislation. Section 8 of the Hospital and Health Boards Act sets out the responsibilities of the director-general and they are: statewide planning, managing statewide industrial relations, managing major capital works, monitoring service performance and issuing binding health service

directives to health services. So he is the overall systems manager. It is very difficult for the director-general to be asked specific questions about the operation, including staffing, of specific hospitals in specific hospital and health services. It is unfair to him.

Ms BATES: With all due respect, Madam Chair, the minister has just said that the DG is responsible for statewide planning. Statewide planning would include intensive care units and high-dependency units. So it is a question related to the statewide planning of a relatively new hospital on the Gold Coast which obviously is having some teething problems.

Mr DICK: That is not what statewide planning is. I am asking for the committee to be fair to the director-general. I do not want it to be said that the director-general is not exercising responsibility or does not have understanding of these issues when, under law, he is no longer responsible for those issues. We have had four hours of opportunity—

Ms BATES: Minister, that is not my intent at all.

Mr DICK: Thank you. That is fine. I just wanted to clarify that.

CHAIR: Order! The minister has raised an objection about the scope of questions, as is his right. I would remind the member for Mudgeeraba that the director-general is able to answer questions that relate to his purview as the director-general of the Department of Health and that we are now considering matters that are related to the Department of Health, Office of Health Ombudsman, Queensland Institute of Medical Research and Queensland Mental Health Commission and that the hospital and health service boards have departed. Director-General, it is well within your rights to say, 'That is not relevant. I cannot answer that question.'

Ms BATES: Director-General, you are responsible for the staffing in Queensland Health; is that right?

Mr Walsh: In the legislation there is the provision to prescribe employers for all of the HHSs. At this point in time, out of the 16 hospital and health services eight are prescribed employers. Those eight prescribed employers are Children's Health Queensland, Gold Coast, Metro North, Metro South, North-West, Sunshine Coast, Townsville and West Moreton. The other eight HHSs—Cairns and Hinterland, Central Queensland, Central West, Darling Downs, Mackay, South-West, Torres and Cape, and Wide Bay—are currently being considered to be provided prescribed employer arrangements. Prescribed employer means that they take on responsibility for the employment of all the staff.

Ms BATES: I understand that. My question relates to—

Mr Walsh: I am answering the question, 'Do I have responsibility for employing staff at the Gold Coast Hospital and Health Service?' I understand that was the question, so I am providing the response to say—

Ms BATES: Is it a yes or a no?

Mr Walsh:—they are a prescribed employer. Therefore, they are responsible under the industrial relations statewide arrangements.

Ms BATES: As the director-general, if there was a major clinical incident that caused statewide planning to be changed—and I am talking about the high-dependency unit. My understanding is that a staff member cut off the top of a central line with scissors and the patient almost bled out. That is a major clinical incident, which I am pretty sure you would be aware of. As the director-general, can you tell me that that unit was closed down? If it was closed down, is it going to be reopened? My understanding is that the concern was the lack of training of the staff in that high-dependency unit and that the unit would be reopened when staff were suitably trained. Are you able to answer that question about the future of the high-dependency unit at Gold Coast University Hospital?

Mr Walsh: That is an operational question about the operations of the hospital which was for consideration up until lunchtime, and therefore this is a question that should have been asked of the chief executive of the operational service.

Ms BATES: I will move on. My next question is in relation to another patient at the Gold Coast University Hospital. This is about ICU beds and the lack of ICU beds, which has been a major concern for staff and obviously for planning. You need to look at where you need to put in new ICU beds, whether it is the Gold Coast University Hospital or the Robina Hospital. This is in relation to a patient who had a serious chest injury. He in fact had a fractured sternum, ribs and contusion to the lungs. There was no ICU bed for this patient, but he was admitted anyway into the cardiothoracic unit. Within six hours

of admission a MET call resulted in the staff believing that the staff had been narcotised and they turned his PC off and gave him some Narcan. In reality this patient was having a slow arterial bleed from his lungs, and subsequently a MET call happened again and he finally went to the OR. Luckily, he survived.

My understanding is that this incident has been investigated and a root cause analysis was done. I would like to know what the outcome of the analysis was and whether the investigation was transparent? This is a major clinical incident; you would have to be aware of this. As the Director-General overseeing Queensland Health, are you aware of incidents like this at the Gold Coast University Hospital and what is the outcome for patients in the future?

Mr DICK: On a point of order, Chair, this is exactly what I foreshadowed. The member for Mudgeeraba is saying, 'Of course you would know this as the Director-General.' It completely misconceives the statutory and operational arrangements for Queensland Health now which were implemented by the last Labor government and taken up and continued by the previous LNP government, of which the member for Mudgeeraba was a minister and then a member. To presuppose that the Director-General 'of course would know about it' begs the question that he did not know about it and he is not discharging his responsibility. That properly is not in his legislative responsibility now; that is how the system works.

I am not against those questions being asked. There is an appropriate authority to ask, and that is a hospital and health service. It seems a deliberate tactic by the member for Mudgeeraba to now ask these detailed operational questions of the director-general when she has had four hours to put them quite properly to chief executives. I want to ensure that the director-general is being treated fairly in this estimates committee hearing.

Ms BATES: I am happy to take the answers on notice.

Mr DICK: It is unfair to him otherwise and that should not be a basis of questioning.

CHAIR: The minister has raised an objection about the scope of questioning and I did rule on this before, Deputy Chair. You were asking questions of an operational nature of the director-general which is not in his purview. You could have asked them in the earlier session, at which it was decided by this committee who would be present. I ask you to move on to a new line of questioning which relates to the responsibilities of those present or we can move to another questioner.

Ms BATES: The government is apparently committed to strengthening the Queensland public healthcare system. I note that on page 119 of the SDS the target for the percentage of elective surgery patients treated within clinically recommended times has decreased. My question is to the director-general: why would the government want to reduce targets for the elective surgery waiting time for Queensland in the Gold Coast Hospital and Health Service area?

Mr Walsh: Can I just clarify that on page 119 we are talking about the category 1 percentage of elective surgery patients at the top of the page?

Ms BATES: Yes.

Mr Walsh: Percentage of elective surgery patients treated within clinically recommended times, categories 1, 2 and 3. The target estimated in 2014-15 is different to the target estimated in 2015-16. The rationale for shifting the targets is that they are indeed a target. We are exceeding those targets currently and as you can see, the target previously was a fixed number. Now what we are asking all HHSs to work towards is not reaching a number such as 97 per cent, but to exceed a number such as 95 per cent and to get as much further beyond that as we can.

Ms BATES: That is explained in the SDS somewhere?

Mr Walsh: I do not believe that the explanation that I have just provided—

Ms BATES: That is the intention. That is not actually—

Mr Walsh: Correct. In actual fact, we want HHSs to have nobody not meeting these categories and by setting a target below that number, then we are saying that we are accepting there are going to be people who are not. These are the discussions, as you heard previously today, that we have with the chief executives. This is about striving for excellence. Hospital and health services are signed up to that and do everything they can to ensure that everybody makes the targets. By adjusting them we have said that you have to get beyond this, but you have to go for excellence in getting to everyone meeting the target.

Mr HARPER: I refer to page 5 of the SDS. How has the Abbott government cut federal funding for public hospitals in Queensland?

Mr DICK: Thank you, member for Thuringowa. Queensland Health has a record budget this year of $14.183 billion. That comprises Queensland government funding of $9.293 billion, Commonwealth government funding of $3.525 billion, user charges and fees totalling $1.229 billion and $136 million in other revenue.

In 2011 the historic National Health Reform Agreement changed the role of the Commonwealth as the big taxing government in the Commonwealth with significant taxing power and the significant ability to raise revenue which was to help fund efficient growth in public hospital services. The Commonwealth agreed to fund 40 per cent of efficient prices, as we have talked about earlier, increasing to 50 per cent from 2017-18. This was signed by all states and territories including Barry O'Farrell in New South Wales, Ted Baillieu in Victoria and Colin Barnett, who was still the Liberal Premier of Western Australia.

There was the promise of no cuts to Health which we heard many times before the last federal election. All I have ever asked of Tony Abbott is for him to do what he has asked of other people his entire political career, which is to keep their promises. He promised no cuts to Health, and of course in the first budget the federal government indicated that they would tear up that National Health Reform Agreement. From 2017-18 in his first budget he says that the Commonwealth government will only fund CPI plus inflation growth. That does not take into account the growth in the cost of technology, the ageing of the population or increased expectation of health service delivery. That is going to create a significant problem for us in the future.

The Commonwealth Treasury—not a state figure—says the changes will reduce federal funding for public hospitals by $57 billion from 2017-18 to 2024-25, and it gets worse over time: $1 billion in 2017-18, $2 billion in 2018-19, $4 billion, $6 billion, $7 billion, $10 billion, $12 billion and then finally $15 billion over each of those years right up until 2024-25. On a state basis, on a population basis, that will be a cut to our state of $11.8 billion in terms of what we would otherwise be anticipating.

Mr HARPER: What impact will these federal funding cuts have on services in Queensland hospitals?

Mr DICK: Thank you, member for Thuringowa. They are just not numbers in a spreadsheet; they actually impact on the real world and what we will be able to do for patients. We had a federal government that was genuinely committed to caring for all Australians and to improving health care, but if the Abbott government's cuts go through then we will lose all those gains. In Queensland we have modelled the numbers on a population basis. Based on the proportion of hospital and health services costs going to doctors, nurses and health practitioners, in the model that we have 16 per cent goes to doctors, 26.5 for nurses and eight per cent for health practitioners. The impact in 2017-18 would be 164 doctors, 580 nurses and 165 health practitioners who will not come into our system if that funding program does not continue. By 2024-25 the impact is around 1,500 doctors for that year, 5,300 nurses and around 1,500 health practitioners.

The average annual impact from 2017-18 to 2024-25 is 818 doctors which will not come into our health system in Queensland, 2,895 nurses and 824 health practitioners. In a state where our population is growing and ageing, we will not have the clinical staff we need. That will impact on service delivery, including all of those targets we have talked about today and how we achieve those targets.

Mr HARPER: Referring back to that subject, what cuts has the Abbott government made to the national partnership agreements? Can you articulate that further?

Mr DICK: We have discussed the Abbott government's cuts to the National Partnership Agreement on Adult Public Dental Services. In addition, he has cut potential reward funding in 2015-16 and 2016-17 for meeting elective surgery and emergency department targets under the National Partnership Agreement on Improving Public Hospital Services. It was agreed nationally that all states and territories would work towards achieving emergency department targets and elective surgery targets, and if you achieve that you get performance reward payments. That is going to go. There has been a $3.2 million cut over two years for the National Perinatal Depression Initiative, which helps women who face depression or a serious mental health episode during pregnancy or immediately afterward, and they have terminated the National Partnership Agreement on Preventative Health. We know that if you get the money right in preventative health it can stop people from coming into the broader health system, but that is now gone.

In the financial years 2008-09 and 2013-14 the Commonwealth provided on average $1.66 billion per year to the states and territories through health related national partnership payments. Based on current budget projections, national partnership funding declined significantly from 2014-15. The source

of federal funding for states and territories falls to $1.13 billion in 2014-15, $604 million in 2015-16 and $165 million in 2016-17. We are going from a place where the Commonwealth, through national partnerships, was putting in $1.66 billion a year to $165 million—a tenth of that—in 2017, during which time our population will age and grow. You can join the dots and you can understand the significant impact that will have.

CHAIR: I refer to page 7 of the SDS and the additional funding to restore services at the Biala sexual health service. What are the intended public health effects of this investment?

Mr DICK: Thank you, Chair. We know that the last Liberal National Party government in this state made some very bad decisions in its haste to supposedly save money, but the decision to shut down and downgrade the Biala sexual health clinic would rank as one of the most reckless in the terms of the health of Queenslanders. I know the previous minister liked to suggest that all of those services should be provided by GPs and the state had no role. That might be a great idea in principle, but in practice for sexual health that often does not work. There are a great many people who wish to remain anonymous when dealing with sexual health matters, and as an international city we have many visitors who need sexual health services that are not eligible for Medicare. It is in the interests of all Queenslanders for those people to receive treatment. We cannot afford to put the health of Queenslanders at risk to win an argument about who is responsible for primary care. That was the strength of the Biala clinic, which was a confidential service provided to people whether they had a Medicare card or not.

That is why the Palaszczuk Labor government's budget reinstates services at the public sexual health clinic at Biala to provide a full range of testing, counselling and information services to any person at risk of a sexually transmitted infection. There is a recognised need for at-risk population groups to have access to appropriate and comprehensive level of services for sexual health and HIV. The vision for this service within the Metro North Hospital and Health Service is to provide one that is centred on Biala and the CBD of Brisbane with outreach services to the northern parts of the hospital and health service in areas of need such as Redcliffe and Caboolture. Clinical staff and community partners have been consulted to develop the model of care and referral pathways, again consulting with the community about the best models of care and the best clinical pathways. I am hopeful that a revitalised Biala will ensure that service is provided in a contemporary manner in keeping with best practice. I think it is very important to have the appropriate skill mix of additional multidisciplinary staff so we have other people there as well working to help people in the community. I think that is an important initiative that our government will deliver.

CHAIR: Thank you, Minister. In a similar vein but a little more broad, with reference to page 7 of the SDS and the funding provided for a sexual health strategy, can the minister advise what are the goals of the strategy and how it will be developed?

Mr DICK: We have many very significant sexual health services throughout Queensland, but it is fair to say that many of those have developed organically in communities and in different ways across Queensland. There has never been a statewide plan to define what sorts of services should be provided. In fact, the department has investigated this matter and I am advised that no government in Australia has ever prepared a sexual health strategy, so this is another example of Queensland leading the way.

The goals of the strategy will be to outline the needs of different people in the population for sexual health services, look at where the gaps are and look at how we might reprofile or reorient services to deliver that for a changing health profile in Queensland. We need to outline what sorts of services should be provided by hospital and health services, what should be provided by primary health care and how we build linkages.

The sorts of areas it will look at include prevention, clinical service provision and community education to meet the needs of all Queenslanders, including specific population groups. The sexual health strategy is a significant opportunity to progress that work across our state. It is an important opportunity to elevate sexual health as a topic in its own right. Sometimes it is neglected and seen as a subset of infectious disease or only relevant to the gay, lesbian, bisexual, transgender or intersex community, but there is a lot more to it than that. It is equally not relevant to everyone, but it actually is something that all Queenslanders should have an interest in, whether they are straight or gay. We all have an interest in ensuring appropriate sexual health across Queensland, young or old.

We hope to complete that by 30 June 2016. We will consult broadly. We have representatives on the steering committee. Some of those include Professor Charles Gilks, Head of the School of Public Health at the University of Queensland; Professor Cindy Shannon, the well-known Pro-Vice-Chancellor

of University of Queensland Indigenous Education; clinicians like Dr Darren Russell, the director of Sexual Health Service at the Cairns and Hinterland Hospital and Health Service; Dr Tony Allworth, the director of infectious disease at the Metro North HHS; and Dr Graham Neilsen, a general practitioner specialising in sexual health.

Consumer representatives are also really important such as Leah Hardiman, President of Maternity Choices, as are representatives across other government agencies such as Communities, Child Safety and Disability Services, Education and Training and Corrective Services. So that is a very important group that will help deliver that strategy. We have allocated $5.3 million over four years so it gives us the capacity to improve services. We are looking forward to the development and the completion of that by the end of June 2016.

Mr KELLY: Minister, with reference to page 5 of the SDS, could you please provide additional information about the Nurse Navigator initiative, including the funding being provided, the distribution of the roles and a brief overview of how these positions will improve the health system experience for Queensland patients suffering from chronic diseases?

Mr DICK: As part of the government's determination to deliver the best health outcomes and the highest standards of patient safety, we have committed $105 million over four years to delivering up to 400 nurse navigators to the Queensland health system over a four-year period. Those positions will help coordinate care, particularly for patients suffering from chronic illness, to ensure those in frequent contact with the health system are being directed to the appropriate centre of clinical service to address their needs. Our objective is to help people stay out of hospital and the emergency department by providing the kind of direct contact and follow-up care that the research tells us is fundamental in reducing the need for frequent recurrent bouts of hospitalisation and improving patient safety.

Nurse navigators are care coordinators who will ensure that at-risk patients have their needs met across the health network, delivering improved health outcomes and freeing up resources in tertiary care. The distribution of the nurse navigator positions will be according to identified need across Queensland and will be rolled out progressively over the next four years, and we think they will make a difference in the lives of Queensland patients.

Mr KELLY: Thank you, Minister. Further to your comments on the Nurse Navigator initiative, could you advise what measures have been put in place to ensure the 400 nurses to be allocated under this innovative program will not duplicate existing services and therefore ensure the best outcome for patients and value for money for Queensland taxpayers?

Mr DICK: That is a very good point and I thank you for the question. We want to deliver nation's best practice when it comes to health outcomes in Queensland. Our Nurse Navigator initiative draws on international research which, as I have already touched on, contends that care coordination of this type returns $8 for every $1 invested. Under our initiative our chronically ill patients will, for example, be identified and appropriate intervention strategies designed to help them get the optimum benefit out of their interactions with the health system. It is another example of a government with a bold and innovative plan when considered alongside our commitments to improve nurse-to-patient ratios and our Refresh Nursing and Nursing Guarantee to provide work opportunities to new graduates and our school-age nurse initiative, recognising the central role our dedicated nursing staff play in our health system.

It is fair to say that some care coordination services do already exist, especially in the area of cancer services—and you are probably aware of those, member for Greenslopes, from your previous experience as a nurse—but that is why we want to pursue staged implementation. We want to invest time and resources in the planning process. Certainly nurse-to-patient ratios have been implemented in other places around the world and they have not been implemented very effectively. We want to get that right. We will do it in a staged process and we will do the rollout of these other commitments in a staged way as well so they deliver benefits.

Mr KELLY: Thank you. You will not be surprised that I have more questions about nursing.

Mr DICK: I know it is a passion of yours.

Mr KELLY: Very much so. Could you please provide further detail around the government's school-age nursing initiative, including the areas in which these nurses will operate and the model by which the scheme will be implemented?

Mr DICK: I am delighted that our school-age nursing initiative will provide 20 nurses at a cost of $11.4 million over three years to deliver additional nurses to help children from some of our most disadvantaged areas to get a healthy start to life. Work is currently being undertaken to map existing

services and identify those services where the greatest need exists and the greatest benefit can be delivered. After careful consideration we have decided to take a hub-and-spoke approach to the implementation of this program that would mean locating a hub of nurses within an identified location who would then branch out to school communities to deliver services. This will ensure there will be greater coverage and broader access than if nurses were stationed in individual schools and it will ensure the delivery of maximum benefit from the scheme and that it most efficiently delivers the health outcomes it was conceived to produce at the start.

Mr KELLY: Thank you. Could you please explain why improving the ratio of nurses to patients in acute wards will improve the health outcomes for Queenslanders?

Mr DICK: Thanks again, member for Greenslopes. You know that one of our key election commitments was to legislate nurse-to-patient ratios. This is no surprise—so surprised, it seems, was the member for Caloundra—because it is something that we developed in opposition and we announced to the world. In fact, it will come before this committee. We have been working with a range of stakeholders to develop the implementation of the policy, and that includes the Queensland Nurses' Union. Why? Because that is the peak industrial organisation that represents nurses in Queensland. There are 34,000 nurses that work across the Queensland health system and many of them—a very large number of them—are members of the Queensland Nurses' Union, and I make no apology for consulting broadly on this policy initiative and working very closely with the QNU and other stakeholders to make sure we get it right.

Our commitment to legislate in acute wards of one to four in the morning, one to four in the afternoon and one to seven overnight will be implemented by legislation. It is worthwhile noting that this enhances our original election commitment, which was one to four in the morning, one to four in the afternoon and one to eight in the evening. After consultation with some of the key stakeholders, that commitment was changed to one to seven to reflect best practice in patient care. We are doing that because patient safety is very important.

Research tells us that improving the ratio of nurses to patients has discernible benefits for the health outcomes of patients, with statistical reductions in both morbidity rates and the length of patient hospitalisations. That is why it is important, but we are going to have a staged rollout. It will start from 1 July next year and we will do it in 33 hospitals in acute wards that will cover the state. We will have hospitals in regional, rural and remote parts of our state as well as in large metropolitan centres that will be part of this. We need to get it right. We do not want to have the unintended consequences that came from other nurse-to-patient-ratio initiatives that have been implemented in other places around the world. We want to get this right and there will be capacity to consider where we go from there once we get this right and we implement it effectively. So it is complex and we think the work that we have done will help implement it in a phased way that will make sure it is effective.

Mr KELLY: With reference to page 5 of the SDS, could the minister please explain how the implementation of the government's Refresh Nursing program will create career opportunities for Queensland nursing graduates and help secure adequate coverage of the state's future nursing needs?

Mr DICK: The Refresh Nursing initiative is a program designed to help graduate nurses get a kick-start to their career by providing up to 4,000 places for newly qualified registered nurses in Queensland's health and hospital services over a four-year period. This initiative will help ensure we have a sustainable workforce plan in place that will help safeguard the health system against the unexpected workforce shortfalls as more experienced nurses move into retirement, and you will have experience of that from your professional experience of some of our older nurses now moving out of the system as they reach retirement age. We want to make sure we have young and committed nurses coming through the system as well. I think it will also help young nurses get a foothold in our system and gain valuable experience in preparation for what I hope is a long and caring career helping other Queenslanders. I think it is a great investment in Queensland's future and is an important component of our nursing strategy.

The distinction between this government and the previous government is very clear: where they cut nurses and midwives, we are seeking to restore those front-line services in hospitals. All of us are aware of how much pressure nursing and our valued nurses were placed under during the last government. We want to take that pressure off. We want to help them. We want to support them, and these initiatives that I have talked about—nurse-to-patient ratios, nurse navigators, nurse graduates and our school based nursing program—will not only help our nurses but more importantly help deliver better patient outcomes across Queensland.

Mr DICKSON: My question is to the director-general and it relates to page 4 of the SDS. Are there any concerns at the lack of planning investment by the Labor government to properly service the transport and traffic needs for the Sunshine Coast Public University Hospital and whether that will have a detrimental impact on the safe start-up and timely delivery of health services to the Sunshine Coast?

Mr Walsh: Not that I am aware of, no.

Mr DICKSON: Have you sought any advice from the department of main roads and transport on the effect that scrapping the $440 million Mooloolah River interchange project will have on the timely delivery of health services by the new Sunshine Coast Public University Hospital? To make that point very clear, we are delivering the Royal Women's Hospital on the Sunshine Coast on a two-lane road and the Labor government has decided not to build the road network that is able to service that hospital. I would like a clear, lengthy explanation as to how that problem is going to be fixed before the end of next year.

Mr Walsh: In answer to a previous question, one of the things we identified was to ensure the implementation of projects successfully there needed to be a single point of responsibility for delivering a project such as the Sunshine Coast Public University Hospital. The person who is the single point responsibility is in fact the person who is going to be running the service, and that is the chief executive of the Sunshine Coast Hospital and Health Service. They have end-to-end responsibility to ensure that all of the initiatives to deliver the hospital successfully are identified, progressed, negotiated and, where necessary, to inform me if we need to work across government at director-general level in relation to that. The particular issue that you have raised around the road network has not been raised since I have been in the job for seven weeks.

Mr DICKSON: Director-General, just to make this point extremely clear: you are becoming aware of it for the first time today by the sounds of it, and I am very saddened by that because there have been questions asked in parliament. This has been an ongoing issue for many, many years after the hospital was relocated from the University of the Sunshine Coast to its present location. Who will take responsibility when this road network fails when the hospital opens—you, the minister or that person you spoke of earlier? What will be the consequences?

Mr DICK: I raise a point of order. Just by way of clarification, the member for Buderim says that questions have been asked in the parliament. I do not recall any question being asked of me about this issue in the chamber. The only other place it could have been asked is question time, so that is an unfair proposition to put to the director-general. Unless it is a rhetorical question that he asked himself—

Mr DICKSON: Through you, Madam Chair—

Mr DICK: So it is not fair to say that—

Mr DICKSON: I have asked the question of the DG—

Mr DICK:—and not fair to put that to the director-general.

Mr DICKSON:—and I am happy to move on to the next question. Obviously, there is not an answer to the question I have asked.

Mr DICK: No, no, I am just seeking clarification about that.

Mr DICKSON: Please take it on notice, because—

CHAIR: Member for Buderim, order! The minister was raising objection. We allow the minister to conclude the objection he is raising, and he did. Please move on.

Mr DICKSON: I would like to move on to the next question. This is to the director-general again. I welcome the focus on the delivery of ICT services to the Sunshine Coast university hospital in the wake of the calamitous Queensland Health payroll system debacle of the previous Labor government. I ask: where is the money reallocated from and what services will no longer be provided? Will any of the funding be outsourced or will this project be delivered internally? I am referring to page 8 of the SDS.

Mr Walsh: The funds that were allocated to the Sunshine Coast university hospital for ICT are additional funds. So they are not being reallocated from anywhere else; they are actually additional funds to the service.

Mr DICKSON: Thank you for that. What are the expected results of that $9 million investment? What do you expect to get for that?

Mr Walsh: To ensure that the hospital is able to open and have the infrastructure—that is, the communications rooms, the servers, the network connectivity and all of platforms in place—to ensure that it can deliver the electronic systems that will be in operation at the opening of the hospital. That is

what the additional funds are allocated for. Again, all elements of the project to deliver the Sunshine Coast university hospital, including the ICT components, including the workforce change, including the building, all sit under a single person responsible, which is, as I have indicated before in previous answers, leading practice in terms of how to deliver projects. You have a single point of accountability end to end so you do not have any elements of anyone saying, 'It is their responsibility or their responsibility,' and you cannot resolve it. The chief executive of the Sunshine Coast Hospital and Health Service is the single point of accountability. So in relation to ICT, it is additional funds that are being provided and it is to ensure that the hospital, when it opens, has the right ICT available to deliver the electronic systems that will be operating.

Mr DICKSON: Director-general, thank you. What I have ascertained from the last two questions that I have asked is that somebody else is responsible for the delivery of the $2 billion hospital, the $440 million roadwork and now the $9 million investment in the ICT. This person must be extremely responsible and you must have so much faith in these particular people. I will leave that with you on notice.

CHAIR: Member for Buderim, do you have a question or are you just making a statement?

Mr DICKSON: I am making a point. I am happy to move on to the next question. I refer to the SDS—and this is to the director-general again—and the internal reallocation of $2.7 million over three years, including $1.1 million for the 2015-16 budget. The area that I am looking at is on page 7 of the SDS. I refer to the $2.7 million to be spent on the communications strategy on the initiative by the Labor government to exclude children who are not fully immunised from child care. I ask: what specific service will no longer be provided to encourage child-care providers from excluding children from child care who are not fully immunised?

Mr Walsh: As you are aware, in terms of operating a service you are required to ensure that you have efficiencies that you can deliver without stopping or ceasing services. So the reallocation of $2.7 million does not see a direct impact on any services. As you pointed out, the funding is there to support legislation in relation to children who are not vaccinated who will attend child care. So it is there to support the Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015, which was introduced into parliament on 14 July 2015 and authorises an early childhood education and care service to refuse or cancel at their discretion the enrolment or attendance of a child whose immunisation status is not up to date. So the funding is identified out of efficiencies within the department. It is not actually reducing any services within the organisation.

The policy that it is supporting ensures that we promote immunisation and protect children, their families and those who work with children against vaccine-preventable conditions. Presently, the Public Health Act protects a child-care centre from liability where the centre excludes a child with a contagious condition; however, not if the child is not immunised, their immunisation is not up to date or if the child is at risk of contracting such a condition.

Mr DICKSON: Director-general, thank you for that. I do not want to take you into the bill either. I think we will skirt around the outside. What initiatives are in place to encourage Queensland families to immunise their children? Has funding been increased on communications and strategies that detail the benefits of immunisation throughout Queensland?

Mr Walsh: We have provided funding allocations to ensure that we are communicating to the public about immunisation and the benefits of immunisation and driving towards a 95 per cent rate of childhood immunisation for children at six months, 24 months and five years. The allocations from one year to the next are roughly equivalent to each other. This year we are allocating funds similar to last year to communicate to families about immunisation and other public health strategies. There is a range of public health strategies that we communicate with the public about, such as chronic disease, obesity, drug and alcohol abuse and so forth.

Mr DICKSON: I have another one for you, director-general. What measurements are being taken to close significant gaps between performance targets for non-Aboriginal and Torres Strait Islander patients as compared to Aboriginal and Torres Strait Islander patients?

Mr Walsh: Sorry, the question is?

Mr DICKSON: I am referring to pages 10 and 11 of the SDS under 'Service performance'. What measurements are being taken to close significant gaps in performance targets for non-Aboriginal and Torres Strait Islander patients as compared to Aboriginal and Torres Strait Islander patients?

Mr Walsh: There is currently a government strategy to halve the gap in children aged zero to five-year mortality rates by 2018. That is aimed to close the life expectancy gap for adults by 2033 in line with the Council of Australian Government's National Indigenous Reform Agreement. Queensland

is presently on track to achieve those National Indigenous Reform Agreement targets relating to child mortality rates and has made significant progress towards reducing the gap in relation to adult mortality rate trajectories. The commitment from the government to address Aboriginal and Torres Strait Islander health disparities is articulated in a recent publication. If the minister were okay, I would be happy to provide that document called *Making tracks* to the committee

Mr DICKSON: That is fine, director-general.

Mr Walsh: In that document we articulate a whole range of strategies, including an investment of more than $200 million over three years towards closing the gap initiatives.

Mr DICKSON: Thank you very much.

Mr Walsh: These initiatives include—I thought the question was what initiatives are we—

Mr DICKSON: Director-general, you have covered the next one that I had ready to pass on to. I think you have covered it sufficiently for me. I appreciate that.

CHAIR: Point of order. Thank you, member for Buderim. The director-general can answer the question as he sees fit without you interjecting. If you had finished, move on.

Mr Walsh: I just had a little bit more. I do not believe I have answered the question about what strategies specifically. We have talked about the fact that we have a global—

Mr DICKSON: Director-general, if you give me the short version that would be great. I have another two questions for you.

Mr Walsh: Okay. I am happy to table the document.

Mr DICKSON: Go for it.

Mr Walsh: And for you to see them in the document. I am happy. The document will contain the strategies.

Mr DICKSON: Thank you so much. I would like to move on. This question is again to the director-general. I refer to the large gap in the percentages of males and females in Queensland who engage in levels of physical activity for health benefits. I ask: what programs and campaigns are in place to specifically encourage women and girls to live active and healthy lifestyles?

Mr Walsh: I am happy to take that question on notice—

Mr DICKSON: That would be great—

Mr Walsh:—and provide the committee with specific details.

Mr DICKSON: I will add a little bit more so you can take that with you as well. Any joint initiatives with the departments of sport and education—

CHAIR: Minister, you are nodding. Are you happy for that question to be taken on notice? Sorry, member for Buderim. As a matter of process, the minister is the only one who can take a question on notice. I am just confirming that he was happy to do so.

Mr DICK: There are a number of preventative health strategies and exercise strategies that we have developed. Our 10,000 steps—

Mr DICKSON: Madam Chair—

Mr DICK: We are happy to look at that.

Mr DICKSON: I am happy. I asked if the minister would take it on board—

Mr DICK:—And consider that. I will take it on notice. That is fine.

Mr DICKSON: Thank you, Minister. I greatly appreciate that. The add-on was relating to any joint initiatives from the departments of sport and education.

Mr DICK: I am not taking that on notice. I will take the first question on notice, which was what strategies are being implemented to make children more active.

Mr DICKSON: That is correct.

Mr DICK: Those other questions should properly be directed to other departments, but I will provide information about what Queensland Health is doing.

Mr DICKSON: You have answered it by not passing them on. I refer to the integrated mental health service, the Mental Health Alcohol Tobacco and Other Drugs Service. I ask the director-general: could you outline the priority areas of actions in the health department in the fight against Queensland's ice scourge?

Mr Walsh: I think we have had this question earlier. I am happy to provide further information around what is happening in relation to the department and the systems dealing with the ice issue. The first thing is that the ice issue is being progressed collaboratively across Australia through the COAG Health Council and then the Australian health ministers' advisory committee that sits under the COAG Health Council. We are collaboratively working on a task force that is looking at ice and its impacts. That task force has prepared a range of information that is currently being finalised to look at the impact and potential responses and strategies of how to deal with that.

As has previously been mentioned here, the use of ice among methamphetamine users has increased and that our front-line health services and drug and alcohol services are responding to those issues by ensuring that we have local strategies to respond to the local issues that occur on the ground. Hospital and health services receive funding to provide those services and have local consultation with the non-government organisations and other partners that they work with to ensure that the strategies meet the needs of the local community. The issues that might be occurring on the Gold Coast may be different from issues that are occurring on the Sunshine Coast, or in Cairns. So we set the system and the framework in place through ensuring that we have an overall strategy that sits within the drug and alcohol response strategy.

Our framework is a harm minimisation framework. It is a framework that is adopted by all Australian governments, including the federal government. It has three elements to it. First of all, it is about supply reduction. There are strategies to ensure that supply is reduced and they can be strategies that are undertaken by the Police Service or other services that—

Mr DICKSON: The VLAD laws are working very successfully. I am sure you would support that.

Mr Walsh: The second element is about demand reduction. The first one is supply reduction. The second one is demand reduction. That is ensuring that there are education strategies and local development strategies to discourage the use of ice, again, locally, through the local initiatives and local community groups that exist in an area as well as broader areas. The third and last component of the harm minimisation approach is in relation to harm reduction. If supply reduction and demand reduction do not successfully mean that people stop using an element such as ice, then we have to have treatment services available to ensure that we are able to respond to the health issues that may arise in relation to that. So the framework that we use and the funding that we provide to all of the hospital and health services ensures that they are working with their local partners around supply, demand and harm reduction strategies.

Mr DICKSON: The last question I have for you is earlier today I heard you talk roughly of 87,000 people who have become ice addicts in Queensland. What processes do we have in place to assist those people once they have become addicted to this drug? Is there anything that the health system is doing or are there any new initiatives that are on the books coming from other countries that can assist us in this massive problem that is facing us all in this country?

Mr Walsh: Yes. This is one of the issues that all Australian health services are grappling with at this point in time. Certainly, our initiatives are ensuring that, working through our drug and alcohol services, we are increasing the services available to methamphetamine users, including ice users. There are a whole lot of initiatives that hospital and health services are delivering around treatment services. So we have provided funding for hospital and health services to respond to local issues.

We are going to be considering the outcomes of the COAG Health Council methamphetamine ice task force, which should inform our further development so that we are able to provide additional services that are targeted towards initiatives that we know are the ones that are going to be the most successful. The task force is looking internationally to see what is leading practice in response to this issue and how best to deal with the impact on individuals, families and their friends and communities. So certainly we are supporting HHSs and in response to the task force we will be looking at additional support and additional services.

Mr DICKSON: Director-General, thank you very much for your fulsome answer.

Dr ROWAN: Director-General, in relation to new alcohol, tobacco and other drug services that are going to deal with those who are suffering with dependency across Queensland, specifically in the next 12 months where will new services be opened given that ice is a problem for urban, regional and rural Queensland?

Mr Walsh: What I would like to do in relation to the treatment services—I think it is probably best, rather than trying to list all the services here, because I am not actually sure that I have all of them—is take it on notice to give you a fulsome list.

Dr ROWAN: Sure. Further to that, is there a rough dollar amount that has been allocated in the budget for those things?

Mr Walsh: Again, I would like to include that in my response to your question.

CHAIR: Minister, you are nodding so you are happy for that to be the case?

Mr DICK: Yes, I am happy to do that, on the basis that ultimately it will be informed, and what further work we do will be informed, out of the national ice task force so there will be more to come. We will provide an answer, but I can assure you that there will be more to come.

Mr KELLY: Minister, I refer to page 18 of the SDS which has the target rates and actual rates of vaccination amongst Queensland children. Could you outline what proposed legal or other arrangements you will be implementing to achieve this?

Mr DICK: Immunisation, as you know well, is one of the most successful public health interventions introduced in Australia. Ninety-two per cent of Queensland children are fully immunised. The Public Health (Childcare Vaccination) and Other Legislation Amendment Bill 2015 was introduced into the parliament by me on 14 July and authorises an early childhood education and care service to refuse or cancel at their discretion the enrolment or attendance of a child whose immunisation status is not up to date. That bill supports the policy initiatives of the government to promote vaccination and protect children, their families and those who work with children against vaccine preventable disease.

Presently the Public Health Act 2005 protects a childcare centre from liability where the centre excludes a child with a contagious condition or if the child is at risk of contracting such a condition. A childcare centre is also free to exclude a child solely on the basis that they are not fully immunised. However, this is not covered by any legislative protection from liability. The bill does not require the centre to exclude a child. Instead the bill protects the centre from liability if, after following a prescribed process, a child's enrolment or attendance is refused or cancelled on the basis of their immunisation status. This process involves, as I have touched on earlier today, the centre requesting the parent provide an immunisation history statement for their child and giving the parent an opportunity to comply with the request.

Mr McARDLE: Point of order, if I may. For clarification, this is a bill before the House, as I understand it, at this point in time, and it would appear that the minister is actually debating the terms of the bill itself which should not occur in these circumstances. I just ask for a ruling on that point.

Mr DICK: I am happy to move on. I am not trying to bend the standing orders or anything.

CHAIR: Thank you, Minister.

Mr DICK: The director-general answered previously and the point was not taken so I thought I would provide that, but I am very happy for the committee to pursue that.

CHAIR: The member for Caloundra has raised a point of order under standing order 231 in regard to anticipation of discussion of a matter on the *Notice Paper*. That rule is relaxed in estimates hearings as it relates to the appropriation so, Minister, please continue.

Mr DICK: Thank you, Chair. I think I have touched on some of the highlights of the bill. The childcare centre can ask for that information to be provided—the immunisation history statement—but if the parent fails to provide that or the statement reveals the child's immunisation status is not up to date the centre may still enrol the child or allow the child to attend.

Mr McARDLE: I thought you ruled the point of order was a valid point of order.

CHAIR: Sorry, member for Caloundra, are you raising a new point of order?

Mr McARDLE: I am raising the point of order that I believe that you had ruled that my earlier point of order was a valid point of order, but the minister is still going on in relation to the terms of the bill.

CHAIR: The minister may answer the question in regard to the bill as long as it relates to the appropriation before the House.

Mr McARDLE: But he cannot debate the content of the bill. He is talking about the issue of a certificate that would allow an operator to make a determination whether to allow somebody to bring their child in or not. That is part of the bill, not the SDS.

CHAIR: Member for Caloundra, thank you. I have heard your point of order. I rule that the minister's answer is relevant. He is able to describe the policy which goes to the appropriation that we are here to hear today and the minister may continue.

Mr DICK: That is fine. I have touched on the highlights of the bill. I thought you said on the point of order that the standing orders relaxed that rule on anticipating debate for the purposes of examination of budget appropriations, provided it is relevant.

CHAIR: Correct.

Mr DICK: That is fine. That is why I continued, but I am happy to move on.

Mr KELLY: Thank you for taking immunisation so seriously. It is not something that we can ever relax on. Following up that question, I notice that on page 7 of the SDS an internal allocation of $2.7 million will be made to support implementation. Could you advise the committee on how those funds will be spent?

Mr DICK: Thanks, member for Greenslopes. In the Queensland budget for 2015 the Service Delivery Statement for Queensland Health provides for an internal reallocation of $2.7 million over three years—we have had that discussed earlier—including $1.1 million in 2015-16 to implement the legislation. Part of that money will be to support some targeted advertising around vaccination.

There is a lot of discussion about this government repealing or throwing out things that were done previously. Well, things that were bad and were not good for Queensland, things where we promised to repeal, we have, but things like the advertising campaign for vaccination, including for adults, have been continued by this government. I was very happy to continue that. I thought it was a sensible initiative of the previous government, so that allegation does not hold water. When there are good things that have been done—the mental health plan—we are going to continue those sorts of things. We are going to put targeted money into advertising around vaccination. There will be several goals around that advertising, but I think an important goal is to use the passage of the legislation to cement social norms around vaccination—that it is a very important part of our public health system and it is something that all parents in particular should take very seriously.

A message we want to get out is that if you vaccinate your child in time you will have nothing to worry about, both in terms of child care and in terms of their health. One of the challenges with social media in recent years is that it has become a source of misinformation around vaccination, but social media cuts both ways. The Light for Riley phenomenon on social media has been an incredible campaign that has been led by the family of Riley Hughes, a little baby boy who died from whooping cough at just 32 days old. Over 75,000 Australians have signed up to support the Facebook page and to emphasise the importance of vaccination. I know that Riley's family are very passionate about championing the issue of vaccination across Australia. We want to support their message and, more broadly, get credible information into the public realm. We will be looking at a range of different media like TV and digital, YouTube, social media and so on.

The other aspect of the implementation will be spent supporting childcare centres to understand their new powers and protections so they can support vaccination. We will be working with the department of education. I have spoken personally with the education minister. We are working closely on this to develop some printed and electronic materials to provide to childcare centres so they have got information, information they can give to parents, which I think will be a very important point of contact. We will be working through childcare industry forums as well. We will also be providing a service to answer inquiries from childcare centres so that kindergartens, outside-school-hours-care centres and other entities that are covered by the legislation can contact us and get the information they need.

Mr KELLY: Thank you. With reference to page 18 again of the SDS, is the government pursuing any other strategies to raise the level of vaccination rates in Queensland?

Mr DICK: Thank you, member for Greenslopes. Today, just this morning, I announced a new vaccination drive, the Drive to 95, to achieve 95 per cent immunisation among young Queenslanders. Currently in Queensland 92.3 per cent of all children up to the age of five years are immunised. Some 92.3 per cent of children five years and under are vaccinated or immunised, but that is below the national state target of 95 per cent. Our estimate is that there are 35,000 children under five in Queensland who are either not vaccinated or behind schedule. With the federal budget changes, if they do not get vaccinated by 1 January those families may lose access to family tax benefit, so we want to help families get ready for those changes. This program means that the department will contact the parents of every five-year-old child in Queensland who is not up to date with their vaccinations using the 13HEALTH call centre. Families will be offered a referral to their local GP or to vaccination clinics to assist them to get up to date by 1 January 2016. We will be increasing vaccination clinics to ensure there is a greater capacity to help kids get vaccinated.

We want to ensure that we get the maximum health benefits that come from vaccination out in the community. It is government being proactive, reaching out into the community, using that very important call centre that provides important health information to the community, using that to do outbound calls from 1 October. We are going to go through our data to make sure that our data is up to date and then from 1 October we will start the outbound calls. There will, of course, be people trained in that. We have a range of staff at the 13HEALTH centre who are experienced in providing health information so they will reach out to the community, connecting with GPs and vaccination clinics, to help the Drive to 95. I think it will be an important public health issue for our children in Queensland.

Mr HARPER: Minister, I refer you to page 16 of the SDS which outlines performance for mental health services. I understand that a range of services are delivered through a range of non-government organisations. Would workers in those organisations be the beneficiaries of the national partnership on pay equity?

Mr DICK: Thanks, member for Thuringowa. It is something that is not talked about very much, but the workers and employees in those important service delivery organisations need our support. One of the important reforms of the last federal Labor government, delivered through the states, was the national partnership on pay equity. That national partnership emerged from a decision of Fair Work Australia. It was handed down on 1 February 2012. That decision granted an equal remuneration order for the social and community services sector, workers and staff members who had historically been underpaid compared to their comparatives in other industries. The Commonwealth's commitment was providing funding for its share of the wage increases for in-scope programs funded through existing national specific purpose payments and national partnership agreements. It has principally had an effect on disability organisations. However, it also provided salary supplementation to organisations providing services under the National Partnership Agreement on National Mental Health Reform.

The type of services, and number of organisations, that were affected in the previous years leading up to this budget were: in 2012-13, around seven organisations were delivering housing and support packages under the national partnership agreement on mental health—these continued into 2014-15; in 2013-14, 22 organisations were funded to deliver on all service types under the NPA—housing and support packages, the Mackay Transitional Recovery Service from 1 July 2013 and personalised support services from December 2013 and they continued into 2014-15; and in 2014-15, 26 organisations were funded to deliver on all service types under the NPA on mental health and I expect a similar number will be the beneficiary in this financial year. This is an important way to supplement and support wages for those important employees in the mental health sector.

Mr HARPER: Minister, could you please outline how funds have been and will be allocated to those organisations?

Mr DICK: Regrettably, member for Thuringowa, there appears to have been some problems in getting this funding out. I am advised that the national partnership agreement on pay equity was signed by the Prime Minister on 18 July 2013, but it was not signed by then Queensland premier Newman until 14 months later, on 10 September 2014. The delay in signing meant there had to be retrospective payments, so the Commonwealth paid Queensland the 2012-13 supplementation of $308,630 in October 2014 shortly after the NPA pay equity agreement was signed. This was money to top up organisations for services that were meant to be provided under the mental health reform NPA in the 2012-13 year.

Out of that $308,630 payment, I am advised only $8,040 was actually paid to organisations for 2012-13 activity. That is because Queensland significantly underperformed against its estimated activity for 2012-13 in terms of actual service delivery. Then in the 2013-14 payment we had an allocation from the Commonwealth of over $1 million—$1,054,760—yet Queensland Health only paid $350,480, about one-third of that, to the organisations, so we had an underspend of $704,280. The 2014-15 payment was an allocation of $1,308,200. Queensland Health paid only $717,625 to the organisations, so there was an underspend of $590,357. So now the Queensland government receives less money in future years to offset this and Queensland organisations miss out. What is worse, we have had fewer services out on the ground. This is what happens in mental health if you have a minister who does not pay attention. Mental health is often overlooked and so often it is the first place to go backwards if you have a minister who is not hands on and who is hands off and, as I have said previously, is not exercising the due care and diligence that you expect ministers to carry out. Thankfully, we are focused on it now. I have asked the deputy to focus on it and remain focused on it. I think 2015-16 will be the first financial year that Queensland Health actually spends the whole entitlement that those service providers are entitled to under the national partnership agreement.

Mr KELLY: Thank you, Chair. Minister, I refer to page 34 of the SDS. I note that Queensland Health Corporate and Clinical Support has the role of managing statewide industrial relations. Can the minister outline if any changes are planned to occur in this area?

Mr DICK: Queensland Health is one of our state's great institutions with a proud history of delivering quality health care whenever and wherever it is needed. Like so many Queenslanders, I grew up believing our public hospital system was among the best in the world. I and my family have strong personal and positive experiences of it. The LNP treatment of our senior doctors, forcing them onto, as I said earlier, their Work Choices style individual contracts was a significant shock to the community and to those doctors, and was felt much more broadly in the community as an unnecessary attack on working conditions. In a submission last year to the state government, the Australian Salaried Medical Officers' Federation Queensland indicated that over 70 senior doctors had resigned outright from Queensland's public hospitals as a direct result of the introduction of the Newman government's contracts.

Our government has restored the protections all government employees enjoy and moved quickly to rebuild the working relationship between those charged with managing the health system and those entrusted with the care of its patients, including senior doctors. As a government, we have restored fairness and independence in our industrial relations legislation, we have restored the right of Queensland doctors to bargain collectively, we have abolished statutory contracts that were forced onto doctors and we have allowed doctors the dignity of access to unfair dismissal laws. Doctors will now be able to do what they do best—that is, look after the people of Queensland without the constant threat of unilateral employment condition changes. We are committed to moving forward with our state's medical profession and to put the LNP debacle of doctors' contracts behind us.

Mr KELLY: Still on industrial relations, I note on page 32 there is reference to discussions with medical officers. Is there any outcome from those discussions?

Mr DICK: I can advise the committee that the government has reached in-principle agreement with the doctors' main bargaining bodies, the Australian Salaried Medical Officers' Federation Queensland as well as Together Queensland, about a new enterprise agreement. Under the proposed new certified agreement, doctors working in public hospitals will receive a wage rise of 2.5 per cent per annum for each of the next three years. The agreement allows for improved professional development for junior doctors, as well as a motor vehicle allowance for part-time doctors. We have had 15 meetings with representatives from ASMOFQ and Together Queensland. The spirit of those meetings has been cooperative and productive. I thank those organisations for the way that they have worked in good faith with the government. I thank our departmental staff in industrial relations who have worked very diligently on working forward on these complex issues and reaching agreement.

Doctors will shortly have the opportunity to vote on the offer, an offer that, combined with recent changes to legislation, delivers on our government's commitment to protect our doctors and partner with them to restore confidence in our health system. We want to send a clear signal to our workforce that we value them and their work. We will have differences from time to time with unions, but the important thing is that we keep consulting and that we keep talking to one another. As a government, we are committed to quality health care for Queenslanders. It is a commitment we share with our doctors and front-line staff and paramedics, in particular, amongst so many others in our health system. It is a commitment that we will deliver together.

There is still a ballot to be held and I am very respectful of that process that needs to be completed. I am proud of the way that the department has gone about delivering this significant positive change and I thank the officers, who I know personally have worked very hard to resolve issues in dispute between the representatives of doctors and the government to try to work through these things in good faith. That has been the characteristic of these negotiations: good faith, fairness and openness in our dealings with one another.

Mr KELLY: Going back to page 34 of the SDS, I am interested in hearing about developments in industrial relations for other professions. Could you please update the committee on the progress of the dental technicians and health professionals' agreement and any budgetary impacts?

Mr DICK: I am delighted to advise the committee today that the department has offered health practitioners and dental officers a 2.5 per cent pay rise and an extension of professional development entitlements as part of a new pay deal. As a government, we are committed to restoring fairness for our workforce and rebuilding the relationship with our people, which the previous government damaged through its ideological approach. The negotiations for a new agreement for health practitioners and dental officers began last year and were referred to arbitration when the parties could not agree.

Following the election in January, we restarted meetings with the relevant unions and these negotiations, I can say, were very productive and collaborative. We have now avoided expensive and antagonistic arbitration and, instead, have come up with a collaborative solution.

I advise the committee of the key elements, which include: a 2.5 per cent wage increase for health practitioners, effective from 17 October 2014, with a further 2.5 per cent increase from 17 October 2015; and a 2.5 per cent wage increase for dental officers, effective from 17 October 2015. The offer also includes an extension of the professional development entitlements to temporary staff and an increase to the current professional development allowances paid to health practitioners and dental officers, based on the proposed 2.5 per cent wage increases from 17 October 2014 and 17 October 2015. The cost has been factored into the existing budget and amounts to around $94.158 million over the life of the agreement. It is a significant offer and I thank the parties for the way they have engaged in good faith again with that process.

CHAIR: Thank you, Minister. I call the member for Caloundra.

Mr McARDLE: My question is to the director-general. It has been 98 days since the House passed a motion requesting the elective surgery wait-time guarantee be put back in place and 82 days since low-level birthing services be put in place in Charters Towers, Yarrabah, Mossman and Cloncurry. Can you advise what steps have been taken by the Department of Health to comply with the parliament's resolutions?

Mr Walsh: In relation to birthing services, as you would know, the department has recently re-established birthing services at Beaudesert and Cooktown. As you have heard today in a previous question, Ingham has also been funded for the re-establishment of birthing services. The services in terms of Yarrabah, Mossman, Cloncurry and Charters Towers are actually under consideration. When you actually have to ensure that the service is safe—

Mr McARDLE: What does the word 'consideration' mean in the context of the motion agreed to by the House and by the government, as well?

Mr Walsh: If the services are safe to be provided—in other words, that there are no risks that cannot be mitigated and dealt with from a clinical perspective for the provision of those services, then they can be established and operated at the service.

Mr McARDLE: Let us get a time line. It has now been 82 days. What is your time line to determine if it can be achieved? You have Beaudesert, Cooktown and Ingham. You have precedent there to look back on past history. At what point in time will you say that Queensland Health should have the idea of it going ahead or not going ahead?

Mr Walsh: I think the issue here is that it should be established when it is safe.

Mr DICK: That is what I said.

Mr Walsh: To put in an artificial time line of when it will operate means that you are imposing potential risk to people, because it may not be safe on that time line. The issue is that the services will operate when it is safe, when we have people in place to be able to deliver them in the models of care and the surrounding support services that exist for that location. In all of these locations, we are looking at ensuring that it is actually low-risk births that can be provided—

Mr McARDLE: That is the motion.

Mr Walsh:—at those locations. Being able to ensure that we can assess the risk associated with a person's pregnancy to provide the antenatal and postnatal care that surrounds that and the staff that are available, trained and delivered to be able to—

Mr McARDLE: Of course. It was done in Beaudesert and Cooktown, so there are no qualms about that. Who is doing the consideration? Who in the department or which subsection of the department is doing that consideration?

Mr Walsh: The work to look at whether a service should be established and operating is done by the newly established Clinical Excellence Division within the department—

Mr McARDLE: Are they here today?

Mr Walsh: That division previously did not exist in the organisation.

Mr McARDLE: They are not here today? They are not here today, are they?

Mr Walsh: As you are aware, that new organisational structure came into place, as has previously been stated, in early August. They are the ones looking at the clinical safety and quality issues of ensuring whether or not a service can be operating in relation to a service.

Mr McARDLE: Are they here today? Is anybody from that division here in the chamber today? I request the minister—

Mr Walsh: I am not sure I understood the question about who is actually in the chamber. I do not—

Mr McARDLE: You have said that the Clinical Excellence Division is looking at this. If somebody is here to whom I can put the question directly, I will ask the minister if I can actually ask that person the question. If there is somebody here outside—

Mr Walsh: You can ask any question.

Mr DICK: You can ask the director-general or you can ask me. That is who you can ask. If we want someone else to answer it, we will ask them to answer it.

Mr McARDLE: If the division is looking after this, all I need to know is whether there is somebody here in the chamber today who could directly tell me—

Mr DICK: It is the minister and the director-general.

Mr McARDLE:—what they are actually doing?

CHAIR: Member for Caloundra, the question is not relevant to the appropriation. Can you put a question relevant to the appropriation?

Mr McARDLE: It is.

CHAIR: You are asking if particular people are here today. How is that relevant to the appropriation before the committee?

Mr McARDLE: Because the director-general cannot give me the answers that I want, so I was going to ask the minister if there was somebody in the chamber today I could ask the question of.

CHAIR: Member for Caloundra, you can certainly ask the minister and the director-general who are present here today.

Mr DICK: We are happy to answer the questions.

Mr Walsh: First of all, can I say that I believe I have answered your question in relation to birthing services—

Mr McARDLE: I do not think you have at all.

Mr Walsh:—in terms of what 'consideration' means.

Mr McARDLE: I can guarantee you have not.

Mr Walsh: It means that we are ensuring that the services can be provided safely—

Mr McARDLE: But you cannot tell me—

CHAIR: Member for Caloundra, with respect, this morning I spoke to you about interjecting. After everyone here has been polite enough to let you ask your question without constant interjections, I think it would be polite and appropriate that you allow the director-general or the minister or whomever is answering to respond to the question that you asked. It is obviously important enough for you to ask it; please allow them to respond.

Mr Walsh: In response to 'When will the services operate?', when it is safe for those services to operate. When all of the factors that need to be in place to ensure that they are safe, that assessments can be made, that the clinical services can be delivered, that responses and risks can be mitigated, that is when they will operate. I do not understand when you say that a service is going to be in a particular time frame.

Mr McARDLE: I asked you whether you could indicate a point in time when the department could decide if it was safe. Will it take you two years or 18 months? That is not an unreasonable question given the background of Beaudesert, Cooktown and Ingham. You have the precedent there. You know the demographics. You know the population. You know the population of women who are able to give birth at a given point in time. You are able to indicate quite clearly the clinical requirements for this to happen. There must be a time line you have in place. It would not be open ended, would it?

Mr Walsh: Every clinical service is unique to that location. The issues facing Charters Towers are different from the issues facing Cooktown, Ingham, Beaudesert or Yarrabah. Therefore, they are unique and are looked at individually in relation to how the service can operate, what distance exists in

relation to surrounding services and what other specialists need to be in place, recruited or additional, in order to achieve the service. Yes, all of those factors are looked at to ensure that when the service is safe to operate it will operate.

Mr McARDLE: Regrettably, you cannot give any indication of when that might happen?

Mr Walsh: The time frames are when it is safe to operate it.

Mr McARDLE: All right. As the surgery wait-time guarantee was passed 98 days ago by the House, has that progressed at all?

Mr Walsh: In terms of the wait-time—

Mr DICK: On a point of order, Chair. This has very little to do with the budget and, in any event, the member for Caloundra knows that a motion passed by the parliament is not binding on the executive. We have had a debate on that. The government's position is clear. If the member wants to ask me as a member of the executive about both of those motions, I am very happy to answer them, but the executive is responsible for the administration of departments of state. That is what I do every day for a living. If the member wants to ask me about the status of those motions, I am very happy to do that, but it is going in the back door to ask public servants directly about matters not binding on the executive to implement, as important as they are.

CHAIR: Thank you, Minister. Member for Caloundra, the minister is correct. I ask that if you are to pose such questions you pose them to the minister and not the director-general.

Mr McARDLE: Director-General, were you given instructions to put in place the notice of motion of 19 May 2015 reinstating the elective surgery wait-time guarantee as a consequence of the House passing that motion?

Mr DICK: On a point of order, the member is misrepresenting the motion. The motion did not say 'the' elective wait-time guarantee; the motion said 'an' elective wait-time guarantee. That is precisely what the government has done—99.9 per cent for category 1 and 99.9 per cent for category 3. We are delivering elective surgery to Queenslanders. That is what it says, and the member should not misrepresent the motion.

Mr McARDLE: On a point of order, that is not right at all and the minister knows that.

Mr DICK: That is not what the motion says. Read out the motion, then.

Mr McARDLE: The minister has no right to answer the question under standing orders. The question was very clear: has the director-general received instructions from the minister to implement the motion passed by the House on 19 May 2015? Yes or no?

CHAIR: Again, member for Caloundra, I ruled earlier that that is a matter for government. If you want to ask a question about a motion decided in the House, I ask that you ask the minister.

Mr McARDLE: It is not about the motion; it is about the operation of the motion. The motion is quite clear.

CHAIR: Perhaps the member could ask the minister whether he gave instructions, but ask the questions of the minister.

Mr McARDLE: No.

Mr DICKSON: He's covering it up.

Mr McARDLE: This is ludicrous.

CHAIR: I'm sorry, point of order—

Mr DICK: It is a non-binding motion, member for Buderim. You know that. Stop misrepresenting.

CHAIR: Order! I called order.

Mr McARDLE: Is it going to be simply a massive hide in regard to the motion of the House? Is the House of no consequence?

CHAIR: Member for Caloundra –

Mr McARDLE: Is the House of no consequence? That is the point.

CHAIR: Member for Caloundra, I am speaking. It has nothing to do with hiding, and I do not appreciate your language. It has to do with you not asking the question of the appropriate person who is present, and that is the minister. The issue is not the orders before the House. I have made a ruling. If the member is asking about the motion, please move on.

Mr McARDLE: That is a legitimate question to ask the director-general, given this motion. There is nothing wrong with my asking if the director-general received instructions from the minister to put in place the motion. He is the head of the department and he would be the one person who would receive the directions. He can answer that question 'yes' or 'no'. It is the operation of the motion; it is not about the motion, per se.

CHAIR: As I understand, the motion is not binding; it is a decision for government. I have made a ruling in regard to that. If you wish to ask questions in regard to the motion, which is not binding, it is a matter for the minister to answer and not the director-general. I have clearly made a ruling, and if you wish to dissent from that ruling I ask you to tell me now.

Mr McARDLE: I am not going to dissent from the ruling.

CHAIR: Then I ask that you move on from the line of questioning or direct it to the appropriate person.

Mr McARDLE: He will not answer the question.

CHAIR: Member for Caloundra, I have a two-year-old and a four-year-old at home. I have endless patience. But I am saying to you: please stop interjecting and allow other people here—both me as chair and the minister or whoever is answering the question—adequate time to respond to your questions.

Mr McARDLE: I will move on. The point has been made. I ask Professor Frank Gannon, the director and CEO of QIMR, to come to the table, please. I have often heard the phrase 'if you think research is expensive, try disease'. You are head of one of the most important bodies in this state in regard to medical research. We are perhaps the first nation in the South-East Asian region in regard to clinical excellence across the region. Can you outline where we should be heading in regard to medical research so that we best encapsulate the universities, the research and the PhD students moving forward and where funding should be put to capitalise on the best outcomes clinically and also in the South-East Asian region? It is a lengthy question.

Professor Gannon: A lengthy question that could get a lengthy answer, so I had better be careful with myself. QIMR Berghofer—it has been in existence for 70 years now; this is its 70th birthday—is proudly part of Queensland Health's efforts to ensure the community has better health care generally. As a point of information, the funding we get from Queensland Health represents 17.5 per cent of our total expenditure, so we leverage the $18.9 million that we gratefully receive from Queensland Health to over $100 million through our efforts to attract external funding. In doing so, it is precisely to address the general point the honourable member makes. We are a medical research institute, not a research institute, and we are very clear in our minds that that means that our work must have an impact on the medical practice and on the medical wellbeing of people generally through avoidance. In doing so, we have stressed in our presentations at various stages the need to ensure that our work gets translated. 'Translation' is a word that was not around when we started. It is not a word that is in our title, but it is what we do every day.

The translation that we are involved in is perhaps best looked at by the outputs and the areas. A significant event in the last year was receiving certification from the TGA for our cellular therapy unit at QIMR Berghofer, and that has opened the way for greater clinical trials in areas of direct relevance to the public. In fact, in putting together the data for a meeting like this, it is intriguing that we are currently involved in 55 clinical trials. Five of those are new internally, 13 are ongoing internally and 37 are with individual groups outside. Very often you have a clinical research organisation that organises a trial in which we would be involved. These are in areas of direct importance, particularly cancer but also malaria and other areas that I will not have the time to go into. Those are two major ones.

In the cancer area we are having a direct impact on the disease burden. In leukaemia, our clinical trials are directed towards reducing the very high incidence of bad outcomes from grafts versus hosts in leukaemias. More generally, we have fantastic work going on in immunotherapy. I think immunotherapy is a word that will be on everyone's lips, because Jimmy Carter spoke about immunotherapy when he got melanoma and secondaries, and his secondaries are in glioblastoma in the brain. We also have clinical trials ongoing in glioblastomas, which are obviously a very severe disease which hits many people including those in this room and their families. The glioblastoma trial is now at phase 2, where we have taken our understanding of the immune system and how to stimulate it, to bring that to get patients' bloods, stimulate them in our facility, the Q-Gen facility to which I referred, and get them back into patients. In those areas we are having a very direct impact on reducing the burden.

Also in the area of malaria we are the go-to location for the Bill and Melinda Gates Foundation through MMV in Switzerland to carry out clinical trials with newest drugs that will alleviate disease, which is not our disease here but which is our responsibility and our responsibility to our neighbours. With climate changes and polar movements of disease, it could one day be our problem. We are working very heavily on that with, I think, 15 trials in that area. They bring the trials to us because we are the right place. The member did ask about the relevance, and I think this illustrates some of the relevant areas.

Another area which is very relevant to the burden of disease is dementia, depression and other mental health areas. We have been silently and quietly working on that. We are not usually shouted as being the leaders in this area and we do not shout about it until we have something that is factual and well based. The basis of being able to shout now is that there was a national competition for funding in the area of dementia organised by the National Health and Medical Research Council. We were the one in Queensland, of five total in Australia, that got significant funds to work on dementia—$6.4 million. That is major funding, recognising what we have been doing all the more.

In terms of where the funding should go, there are two aspects to this. It is easy to think of disease end points, but we will not get there without the people. The biggest challenge we have now is the structure of our scientific community. Funding for scientists, those carrying out the work, is very precarious. In fact, I often liken it to the funding for a politician. Every few years you go up again, you get tried and, rightly or wrongly, change happens.

Mr DICK: I can assure you the funding stops sometimes, too!

Professor Gannon: You can understand our common shared interest. Those were the leaders. We are carrying out those trials to which I was referring on what we call 'soft money'. They get five years of a contract and then they have to reapply. There are very harsh conditions of funding in the NHMRC—10 per cent success rates for some funding areas, particularly those that affect the post docs and the teams. Wherever we can, we will have to shift our emphasis to ensure we have the right teams that are doing the right work and can continue to do so.

Mr McARDLE: Thank you very much. Much appreciated.

Dr ROWAN: I refer the director-general to Labor's previous very own triple-P program: the trifecta of the payroll fiasco, the fake Tahitian prince and the Patel saga. I refer to page 9 of the SDS where $179 million is allocated to continue the statewide rollout of clinical and administration support systems and technology equipment replacements. I ask the director-general whether he will give a guarantee that there will be no other failed IT project and/or corporate system failures of the magnitude of Labor's previous failed payroll system?

Mr Walsh: I was asked previously today to give a guarantee. What I can guarantee is that everyone is working to ensure that the implementation of all initiatives, whether they be ICT or other initiatives, is successful and that we are implementing leading practice governance and implementation strategies to ensure that those people who are working very, very hard to ensure the success of the implementation of all the initiatives are supported with the policies, structures and procedures to ensure that their hard work and diligence will end in success. As I have talked about before with the committee, that is using the internationally recognised principles of managing successful programs and the PRINCE2 methodology. Both of those are publicly available to the committee in terms of applying the principles of ensuring a single point of accountability, clear governance structures and all the other elements that must go into a successful project. Yes, I can guarantee that everyone is working diligently to ensure the success of that and that the practices and processes we have in place to support that are the leading practice.

CHAIR: The committee will now adjourn for afternoon tea. The hearing will resume at 3.30 pm, when the committee will examine the estimates for the Queensland Ambulance Service.

Proceedings suspended from 3.00 pm to 3.31 pm

CHAIR: Welcome back, Minister, and welcome, Commissioner Russell Bowles and officials from the Queensland Ambulance Service. I call the member for Caloundra.

Mr McARDLE: I would like to ask the commissioner some questions, if I may. I seek leave to table a document. I have a copy here for the commissioner as well.

CHAIR: There being no objection, leave is granted.

Mr McARDLE: Commissioner, the document is an ABC News report—therefore, it must be gospel. It refers to a document prepared by the National Coronial Information Service, or NCIS. That reference is located about two-thirds down the front page. It also refers to an intentional self-harm fact

sheet. The heading is quite clear. The article deals with the high suicide rate amongst emergency workers from PTSD. It says that between 2000 and 2012 there were 110 deaths involving police, paramedics and firefighters—26 of those were paramedics. It does not say, on my reading, that the suicide was as a direct result of working for the ambulance, but it implies a connection between PTSD and working for the ambulance and then taking what I would say is a very, very dramatic step for them and their family. Is there a record or a history of paramedics in this state taking their own lives?

Commissioner Bowles: The QAS is quite fortunate in this respect. Before I continue I should that one life lost through suicide in any workforce is a sad tragedy. For the last 23 or 24 years the Queensland Ambulance Service has had in place an employee support system called Priority One. It is a multilevel system that basically works around the fact that we have peers who are trained right throughout the state. So we have a network of peers and they are given initial training and then they are brought back. They are also mentored on an ongoing basis by a professional psychologist who we also contract to throughout the state and, as I say, it is a multitier system.

We have reviewed this system twice in the last 20 years. We reviewed it about 10 years ago just to see how well it was working, and either late the year before or early last year we reviewed the peer support services again. Professor Jane Shakespeare-Finch from the Queensland University of Technology, with Emeritus Professor Raphael—I think is their name; I will have to clarify that—from a notable Sydney university, also provided some oversight of the review. Basically this latest review found that our staff do have a tremendous ownership of the organisation, so they feel like they actually belong to the organisation and bond with the organisation. It also showed that they do have an in-built resilience.

In terms of numbers—and these are approximate numbers, but I think they are fairly close—since 1991 the Queensland Ambulance Service has had approximately 11 suicides from staff. So in the last 24 and a bit years, there have been 11 suicides from our staff. I am led to believe by our Priority One manager that that is actually lower than the societal average, although 11 is still quite tragic. As far as post-traumatic stress disorder is concerned, I am also led to believe by the data that, due to the resilience that is built up but also through the efforts of our Priority One counsellors, who I put on record do a tremendous job, the numbers are actually less than the normal values in society.

Mr McARDLE: Sorry, I missed that last point. They are less than what?

Commissioner Bowles: They are less than the post-traumatic stress that you would see in society.

Mr McARDLE: The work of our paramedics and ambulance operators is, to say the least, traumatic—

Commissioner Bowles: Very much so.

Mr McARDLE:—because of some of the things that they do see being first responders, and also in regard to other incidents it is quite dramatic and traumatic. PTSD, I would have thought, would be an outcome over time—it would build up over time—of seeing so many incidents. I would have thought that there would be a number of people who would show or exhibit PTS symptoms. This paper refers to a psychiatrist Sam Harvey, who they say specialises in PTSD. He says that one in 10 emergency workers had symptoms consistent with PTSD. I cannot vouch for that or not, but I would suspect that, with the work that you and your men and women do, that is quite likely because they see things that I would never see.

Commissioner Bowles: There are a couple of components to that question. Unlike many other workforces, we psychometrically test our people before they come into the workforce for prevalence of suicidology, post-traumatic stress disorder and a range of other behaviours. So we have that net at the front. Obviously we will never catch everyone, but it is a significant factor. In fact, I saw some media articles in recent weeks from other ambulance services nationally that are going to go to a psychometric testing regime. That is something that the QAS has had in place now for many, many years, whereby there is a norm of the type of work that we do and people are tested psychometrically against that for their suitability to the role. So we do have that.

As I say, even the theory around post-traumatic stress has changed over recent times. It is now much more of an approach whereby our peer supporters and our psychologists recognise exactly what you say, that the role of a paramedic is a very stressful job. We see things that the rest of society do not necessarily have to see in their life. But, as I say, the key to the health of paramedics and first responders is effective mechanisms such as multilevel employee assistance schemes and also making sure that you get the right employee at the front end.

Mr McARDLE: Commissioner, you record data such as lost time incidents, do you not?

Commissioner Bowles: Yes.

Mr McARDLE: One of the subcategories is psychological/mental stress. Do you know how many incidents occurred in the 2013-14 and 2014-15 years?

Commissioner Bowles: To put a little bit of context around that, lost time injury claims more broadly have been decreasing and have decreased over the last three years.

Mr McARDLE: No. This is lost time incidents, not days off. This is about recording the number of incidents. Do you know the number of lost time incidents relative to psychological or mental stress? They are incidents.

Commissioner Bowles: As I say, we do report on the data. We do actually have the data. From memory, it is fewer than 10 accepted claims in 2013-14 and 2014-15—that is, fewer than 10 accepted WorkCover claims for psychological injury.

Mr McARDLE: Do you know how many non-lost time incidents occurred in 2013-14 and 2014-15 in relation to psychological and mental stress?

Commissioner Bowles: Sorry, not off the top of my head.

Mr McARDLE: What does the term 'lost time incident' actually mean? I understand the word 'claim'. I understand the word 'accident' and 'days off' but what does 'lost time incident' mean?

Commissioner Bowles: It is called an LTIFR actually, which is lost time injury frequency rate. Basically that is the number of injuries per million hours worked of your workforce.

Mr McARDLE: Are you able to say in the last five years, by year, the number of paramedics who have been diagnosed with PTSD—it is a multibarrelled question but it is not difficult—the numbers of people so diagnosed who are paramedics who have been medically retired or those who have been diagnosed who have been redeployed to safer duties?

Commissioner Bowles: As I said before, in relation to accepted claims for psychological injuries—which is a broader category than post-traumatic stress disorder, but it is the catch-all of psychological injuries—in the last year I am fairly sure that there were fewer than 10 accepted claims. Over the last five years I think we have seen a decreasing claims history.

Mr McARDLE: Commissioner, I will repeat the question and I might ask the minister whether he would take it on notice. The question is this: in relation to the diagnosis of PTSD over the past five financial years, can the commissioner advise how many paramedics have been diagnosed with PTSD, how many have been retired medically because of that diagnosis and/or how many have been redeployed to safer duties over those past five years, with a yearly breakdown? I am just clarifying that for the commissioner.

CHAIR: Member for the Caloundra, could you clarify for the purposes of the committee the relevance of your question to the Appropriation Bill, please?

Mr McARDLE: Madam Chair, what I am trying to establish is this: one of the elements in relation to providing fit paramedics to undertake the tasks associated with taking patients to and from is the stress factors they are under—taking patients to and from an incident, to a home, to the hospital, to the ED. It is a KPI as to whether or not a person is fit and able to achieve that outcome. What I am simply asking is: can the commissioner perhaps take it on notice?

Commissioner Bowles: I can give you the last three years of accepted psychological claims, if that helps. In 2012-13, there were 10—and we are talking about a workforce of around 4,000.

Mr McARDLE: That is diagnosed cases?

Commissioner Bowles: That is the number of accepted claims of psychiatric or psychological injuries—so it is a broader category than post-traumatic stress disorder. There were 14 accepted claims in 2013-14 and there were 13 in 2014-15.

Mr McARDLE: So 10, 13 and 14, I think you said it was?

Commissioner Bowles: Ten, 14 and 13.

Mr McARDLE: My apologies; thank you for that. And those who may have been medically retired or redeployed to safer duties?

Commissioner Bowles: I could not tell you that off the top of my head—

Mr McARDLE: No, I appreciate that.

Commissioner Bowles: What I would say is that I think we are a fairly caring organisation and in the first instance we would always try to redeploy within the workplace, but sometimes that is just not possible due to the nature of the injury or illness.

Mr McARDLE: Would that information be available?

Mr DICK: Is it available?

Commissioner Bowles: Yes, we would be able to find it, I would imagine.

Mr McARDLE: Would the minister consider taking that on notice?

Mr DICK: I am happy to take that on notice for the same time frame, the last three years.

Mr McARDLE: Commissioner, the LNP government moved to increase penalties in relation to assaults on what are termed public officers, of which paramedics and QAS personnel are a component, from seven to 14 years. Can you indicate in the 2014-15 financial year how many offenders were convicted of serious assaults of ambulance officers?

Commissioner Bowles: The number of offenders?

Mr McARDLE: Yes.

Commissioner Bowles: We had 170 physical assaults across the workforce—

Mr McARDLE: Is that for 2014-15?

Commissioner Bowles: Over 2014-15. Can I say that just one assault of a paramedic is one too many.

Mr McARDLE: I could not agree more. I think the minister would agree with that as well.

Commissioner Bowles: We also had 56 occasions of verbal assault. Whilst they were not physically assaulted, the paramedics were not feeling comfortable with the environment at the time. We encourage all staff to go to the appropriate service, being the Police Service, to report assaults. We send a supervisor to the individual who has been assaulted in the main. Sometimes there are some practicalities around that. We deliver services from 290-odd locations throughout the state, and some of those locations are very small towns with a population of only 250 people so it is quite difficult in those circumstances, but we make every effort to ensure that assaults are reported to the police. In relation to your question, the exact number of people who have been found criminally liable for assault escapes me at this point.

Mr DICK: On a point of clarification, Chair, we record datasets for officers reporting physical assault and reporting verbal assault, but we will not have the data on convictions. I do not think we capture that data. That could be asked of another minister.

Commissioner Bowles: And you would not know always.

Mr DICK: We would not necessarily have that, but those numbers are clear. I agree with the member for Caloundra and the commissioner that one assault is one assault too many.

Mr McARDLE: To clarify, there were 170 physical assaults in 2014-15 and 56 verbal assaults in 2014-15. I think they are the figures you gave to me.

Commissioner Bowles: That is right.

Ms BATES: My question is to the commissioner. Commissioner, you obviously have arrangements between EDs and the QAS dealing with patient flow. I have been able to find the Patient Access and Flow Health Service Directive Guideline for Capacity Escalation Response, which I am happy to table for the benefit of the committee. In that it has level 3.3.3, which is defined as the inability of ED clinicians and QAS to provide services within accepted time frames. This question may have to be taken on notice. How many instances of this particular code, where EDs are completely blocked, have occurred at the Gold Coast University Hospital and Robina Hospital? In a more broad sense, is it enacted on a regular basis or is it something that you strive to not have happen?

Commissioner Bowles: We do it very actively, to be quite honest. Do I have it down to each LASN in front of me right at this point? No, but it is something that we do keep. We take escalations very seriously, with the introduction of the Metropolitan Emergency Department Access Initiative. It gives QAS a say in hospital block. There are three levels of escalation, as you have just pointed out. The first level is dealt with in the ward. That is dealt with by the nursing sister in charge or with the local ambulance supervisor, but it is dealt with pretty much in the ward itself. If a level 2 escalation happens within the hospital, QAS has an opportunity to speak to the hospital executive to get access block resolved. Then there is level 3 where it becomes bigger than the hospital so we talk to the executive or their representative of the HHS.

Ms BATES: There are other levels of code yellow that I am aware of. Are you aware of code yellow 6.3?

Commissioner Bowles: They are internal escalations to Health, and that would be a much better question for a HHS.

Ms BATES: I have a question for the director-general. There are different codes, as in code black, code yellow, code red, code purple for a bomb and all those sorts of things. My understanding is that code yellow 6.3 is loss of essential services for staffing and overcrowding emergencies—

CHAIR: Member for Mudgeeraba, we are asking questions on the Queensland Ambulance Service at this point of time.

Ms BATES: I know, but this is to do with the Queensland Ambulance Service as well. We just talked about 3.3.3, which is blockage in an ED. I want to know how many instances there have been of loss of essential services where there has been no ICU capacity and the Ambulance Service has not been able to take a patient to a relevant ED—like a patient who requires ICU treatment but there is no ICU capacity. Are there instances of that at the Gold Coast University Hospital and Robina? Obviously you will have to get back to me with that on notice—

CHAIR: If it is relevant to the Queensland Ambulance Service then the commissioner can answer it. If it is not and he cannot answer it, then he does not.

Ms BATES: Let me clarify: have you had incidences, whether you call it a code yellow or whatever, where you have been unable to take a patient to an ED because there have been absolutely no ICU beds in that hospital?

Commissioner Bowles: It is very unlikely that we would be aware of the ICU capacity of each and every hospital, but one thing I will assure you is that if the patient is sick enough we will go to the closest, most appropriate hospital.

Ms BATES: My next question is—

CHAIR: Is it a similar line of questioning?

Ms BATES: Yes, it is.

CHAIR: Just one more.

Ms BATES: Have you had to bypass either the Gold Coast University Hospital or Robina Hospital due to a code black and the hospital being in lockdown? On how many occasions has that occurred?

Commissioner Bowles: We do over a million responses a year, and I have no doubt that the Gold Coast hospital has been on a code black, but we have what we call a patient safety distribution room which has oversight of the network in a live environment. This was one of the initiatives that came out of the MEDAI arrangements. Basically, it distributes patients. The responsibility went from the health system to the ambulance system to distribute amongst the ED network in the metropolitan area. We have some agreed-upon parameters with HHSs which are pretty much quantitative and clinical, so we take the right patient with the right illness to the right hospital, and we try to work to thresholds to even out the bumps, for want of a better word. One of the things that ambulance services, whether it is nationally or internationally, cannot do is control the input to the system. That is why the patient safety distribution room is so much more important in that broader network because, as I say, we can iron those bumps out and give you a better throughput. It is obviously a HHS thing, but it can reduce some of the back-end issues on the hospital if we get it right at the front end.

Ms BATES: Commissioner, are you notified by the relevant hospitals that they cannot take patients for whatever reason—whether they have no ICU beds or they are in lockdown because of a code black? For you to be able to make the determination to take a patient to another hospital, which I understand you would, how are you notified of that?

Commissioner Bowles: We have a system that is called iRoam. Basically all of our cars in the south-east of the state where these issues are, in the main, are satellite tracked. I can log on to an application at my desk and tell you that there are seven units at the royal Brisbane hospital and there are four on the way there or four requesting to go there. That gives us live visibility of all of our resources, and that allows us to distribute appropriately amongst the network

Mr HARPER: It would be completely remiss of me not to acknowledge Commissioner Russell Bowles, my former boss, who is here today. Not too many people have withstood the test of time, Commissioner. I know that you are very proud of the thousands of dedicated staff out there who deliver outstanding care right across Queensland. Welcome to the estimates. We welcome your contributions today. My first question is to the minister. I refer to page 49 of the SDS and I note the QAS commitment

to patient and staff safety. Following recent events where a Queensland paramedic was diagnosed with measles, can the minister outline the actions undertaken to protect staff and patients in the portfolio against preventable diseases?

Mr DICK: I say again that I take very seriously my responsibility to minimise the risk associated with preventable diseases to patients, staff and the community. On 20 May this year I announced in parliament my support of the QAS's plan to move from recommending vaccination to mandating vaccination for QAS operational employees. The QAS has an infection control framework in place to help protect employees from contracting preventable diseases and illnesses. Under this framework, all existing operational employees are eligible for reimbursement of immunisations and serology costs relating to a range of infectious diseases including measles and hepatitis B. Funding for these financial reimbursements is budgeted for as part of the Queensland Ambulance Service's local ambulance service network budgets.

QAS operational employees who have been engaged since 1 July 2015, however, are now required to be vaccinated against specified diseases as a mandatory condition of employment. Undergraduate students participating in clinical placements will also require evidence of immunisation status against those specified diseases from 1 January 2016, so we have moved forward on that. New employees from 1 July 2015 must be vaccinated and evidence must be provided for students on clinical placements from 1 January next year. New employees and students will be required to meet these costs. The new QAS mandatory vaccinations are diphtheria; tetanus; pertussis, which is whooping cough; hepatitis B; measles; mumps; rubella; varicella, which is chicken pox; influenza; and tuberculosis for selected individuals only based on risk criteria. So that is TB on the determination of risk criteria.

The department is also examining the prospect of a wider vaccination program amongst health workers. A steering committee has met twice and is developing a policy development paper on healthcare worker vaccinations. I think it is something important that we look at. A healthcare worker vaccination working group to sit under the steering committee will develop an implementation plan for this policy position, and it is expected that the working group will have developed an implementation plan within three months of the policy decision. That is a larger amount of work. There are many more staff in our system, but I think it is something we have to examine. We have to progress that. I have asked the department to do that in consultation with hospital and health services to look at how we might move that forward, but I think that is an important way to protect staff and to protect patients.

Mr HARPER: I refer to page 54 of the SDS which describes the income for the Queensland Ambulance Service. Can you please advise the committee of key initiatives that those funds will be used for?

Mr DICK: Thanks again, member for Thuringowa, for your question. The Palaszczuk government's record $14.18 billion investment into the health of Queenslanders includes a significant boost, you will be pleased to know, for the Queensland Ambulance Service—a service that has supported the community well and played a significant role most recently in the incident that occurred at Ravenshoe. We are delivering a record $633.3 million operating budget for the Ambulance Service in 2015-16. That is an increase of 7½ per cent, or $44 million, on the 2014-15 operating budget, and an increase of $39.2 million on the actual amount spent in 2014-15. This record budget allocation is great news for Queenslanders and for our hardworking paramedics, emergency medical dispatchers and patient transport officers. It will enable the Ambulance Service to keep pace with the ongoing growth in demand for services due to our growing and ageing population.

This funding increase will enable the Ambulance Service to recruit an additional 75 paramedics throughout the state in 2015-16—a 25 per cent increase on the 60 positions funded in 2014 in the last year's budget. This will provide the service with enhanced roster coverage to help meet the growth in demand for ambulance services. Paramedics are often, as you know, member for Thuringowa, the first point of call in our communities when we are in need, and there are myriad examples in recent months.

As a government, we are committed to making sure our front-line emergency services staff are supported. Key deliverables in this financial year include completing the statewide rollout of replacement defibrillators. I had the opportunity to see the new LIFEPAK at Whyte Island when I visited there with the member for Lytton. We looked at the fantastic training that happens for new paramedics with real-life scenarios, like problems in nightclubs—I still call them nightclubs—problems with the potential drowning of a child and road accidents. These are real-life scenarios for new paramedics to engage with. It was great. I saw the new LIFEPAK. It is much lighter and much smaller. It does not have paddles anymore, it is straight on to the chest. It is a very significant piece of equipment that I think will help paramedics. So that will complete that rollout.

Another key deliverable is expanding extended acute therapy for patients suffering the most serious form of heart attack. Previously, only critical care paramedics would deliver clot-busting drugs, thrombolysis, or refer patients directly to cardiologists in cardiac catheter laboratories. The QAS will extend this capability to all advanced care paramedics—approximately 92 per cent of the paramedic workforce—utilising a decision support model. The member for Thuringowa and I were at the Thuringowa station in the member's electorate to have a briefing by staff on those two decision pathways. It was great to participate in that and to see the high-level work that is being done in relation to cardiac arrest.

Another key deliverable is reviewing extended paramedic practice options to ensure the service complements the evolving needs of the community. That will ensure that lower acuity and chronic illness management are aligned to the patient's circumstances and are flexible enough to change as the patient's condition changes. This will involve working with the community and HHSs to identify alternative pathways of care better suited to a patient's need, rather than mandatory referral to an emergency department. So I think that lower acuity response trial has been very effective. It has my support and there is more work we will do there.

At the other end, another key deliverable is expanding the higher acuity response unit service. I launched the service on the Gold Coast. It is a 24-hour-a-day service to attend to patients with severe injuries. These are the highest level of paramedics, as you know, member for Thuringowa, administering anaesthetics, doing ultrasounds on accident sites and administering warmed bloods. The commissioner has briefed me on that. They will provide lifesaving services almost at the standard of an emergency department at a critical care incident and then will link back to emergency departments en route. I think it is a terrific initiative and I would like to see that expanded and I am glad it will be in this budget.

Then of course another key deliverable is finalising the rollout of operational iPads for paramedics as part of the QAS operational mobility strategy. That will help paramedics on the ground doing their work. Again, that is another initiative of the commissioner that I am very pleased to be able to support.

Mr HARPER: You have touched on a number of good things happening in the Queensland Ambulance Service. I refer to page 55 of the SDS and the balance sheet for the Queensland Ambulance Service. Can you please tell the committee about the Queensland Ambulance Service's capital program for the 2015-16 budget that may have an effect on the balance sheet?

Mr DICK: Thank you for the question. At the same time, the government needs to provide the Ambulance Service with the infrastructure, the bricks and mortar, they need to deliver improved services. A $45.4 million capital budget for the QAS this year will fund a range of capital works including: the completion of replacement ambulance stations at Miriam Vale and Russell Island, including a residence at Russell Island; the completion of the design phase and the start of construction on new or replacement ambulance stations in Bundaberg, Collinsville and Birtinya on the Sunshine Coast; the continuation of planning works on the replacement ambulance station on Thursday Island, which includes relief quarters; and the start of design work for new ambulance stations at Rainbow Beach, Kenilworth and Yandina on the Sunshine Coast as well as a replacement ambulance station at Coral Gardens on the Gold Coast. The funding in the budget will enable the QAS to commission 155 new and replacement ambulance vehicles in 2015-16.

The QAS also recently commenced the rollout of the new power assisted patient stretchers. This is an important initiative. As you know from your experience, power assisted stretchers will provide an enhanced work platform for paramedics and greatly assist in improving patient and officer safety. They will ensure the QAS has the modern facilities and resources it needs to continue to deliver high-quality emergency care and patient transport.

Can I also add that there is $13.9 million for capital and minor building works and strategic land acquisitions. That includes: $8.4 million to plan or deliver new replacement, refurbished or redeveloped ambulance stations at the locations I have mentioned previously; $2.5 million for strategic land acquisitions to secure suitable located sites for our forward Capital Works Program; and $3 million for minor works to ambulance facilities. I know the minor work that can be done on ambulance stations can really improve that station's capacity to operate and it provides a better workplace for paramedics. That covers alteration, refurbishment and expansion of various ambulance stations across the state.

Capital works projects recently completed include the Injune Ambulance Station and the Pittsworth Ambulance Station. I was very pleased to go to Gladstone to open the new Gladstone Ambulance Station. It is a refurbished ambulance station that is making a really significant difference to the lives of those paramedics working in that community. It is one of the biggest and busiest ambulance stations in Central Queensland.

Mr HARPER: Following on from that response on the capital program, are you able to provide more information about the new or replacement ambulance stations being planned?

Mr DICK: Thank you for your question. I will give you a bit of a breakdown of that $8.4 million capital funding to commence or complete 10 new or replacement ambulance stations: $600,000 for Russell Island to complete the replacement ambulance station and residence; $2 million for Miriam Vale to complete the replacement ambulance station; $1 million for Collinsville, this is for design and the start of construction, to commence construction on the replacement ambulance station; $2 million in Bundaberg to commence construction of a new ambulance station as part of the proposed $5 million colocation project with the Queensland Fire and Emergency Services; $2 million for a new ambulance station at Birtinya in the $6 million proposed colocation project with the new Sunshine Coast Public University Hospital, which will also include third party carers' accommodation units; $100,000 to commence planning for a new ambulance station in Kenilworth; $100,000 again for Yandina for the same thing; $300,000 for the Rainbow Beach station to commence planning for a new ambulance station; $200,000 to continue planning for a replacement ambulance station on Thursday Island; and $100,000 to commence planning for the replacement ambulance station at Coral Gardens on the Gold Coast.

Mr HARPER: I refer to page 49 of the SDS. Can you please provide more information about the rollout of those new power assisted patient stretchers that you mentioned?

Mr DICK: Thanks again for that question. There is $21 million over the next five years in the statewide rollout of the new Stryker Power-PRO stretcher. They have a load capacity of 318 kilograms and are proven to reduce the rate of manual handling injuries for paramedics. I recall a statistic that paramedics have a higher rate of workplace injury than officers in the Police Service, so that is an important thing we need to do. We need to work on that to reduce that, and providing this sort of equipment will do that. It will help with obesity in our community. We know that is an issue.

Can I provide some information to the committee. In 1980, only one in 10 people were overweight or obese, but two out of three Australians are now overweight or obese. As I said earlier, between 2000 and 2010, the injury rate for paramedics was more than two times higher than for police officers. About 44 per cent of serious injuries to paramedics involve muscular stress from lifting and carrying, so this is a very significant investment in trying to address those challenges.

I know there are a lot of other programs that the commissioner takes very seriously in relation to workplace health and safety. A safer workforce is a healthier workforce and a more productive one. The work paramedics have to do is hard enough as it is, let alone having to face the potential of injury through a range of challenging workplace incidents.

The Stryker Power-PRO incorporates a battery powered hydraulics system that lowers and raises the patient. There is less physical stress on paramedics. They are also faster to retract and load into the ambulance, meaning paramedic crews will be able to save that little bit of extra time on their way to hospital. There have been 32 stretchers rolled out, with another 153 planned by 30 June 2016. I think that is great news for paramedics, patients and the community.

Mr HARPER: With the announcement of the 75 additional paramedics, could you please tell us whereabouts through Queensland they will be located?

Mr DICK: I am very happy to announce where they will be located, and thank you for the question. I think it is a great thing for Queensland that our state, from the cape all the way through to Coolangatta, will benefit from increased staffing. Two Indigenous cadets will be placed in the community at Ravenshoe. This is a response from the call of the community in Ravenshoe for more staff following the incident up there. It is not just a response to that; it is a planning decision made by the commissioner about growing our staffing in the north of our state—the Far North of our state in that incident—and also providing training opportunities to Indigenous Queenslanders. I think that is a terrific initiative and I thank the commissioner for it.

In Cairns we will have the equivalent of 2.8 paramedics to meet increased demands, particularly for low-acuity cases, so to take the pressure off paramedics having to work in higher level incidents. There are two Indigenous traineeships to provide more frequent second officer response and improved officer safety and to support Indigenous employment in Ravenshoe. In Townsville, the Kirwan station will move to a six-line roster to enable consistent day, afternoon and night coverage. That is the equivalent of 2.6 paramedics.

In Central Queensland, we will have the equivalent of 1.3 paramedics at Biloela so the officer in charge can be off roster to provide better supervision to paramedics, and I think you know that that is an important thing. In Gladstone, we will have the equivalent of 1.3 paramedics. That is actually

operation supervisors, so that will be a senior operation supervisor to improve supervision in that area. As I said, Gladstone is one of the biggest stations responding in Central Queensland, so we are putting in a senior supervisor position to help support our on-ground paramedics. In the Wide Bay at Bundaberg, there are nine paramedics. That will provide additional day and afternoon shifts and two officers on that basis. We need a total of nine to staff there. Again, that is a growing part of our state in the Wide Bay.

In the south-west at Roma, we will have an operations supervisor. In the Darling Downs LASN, at Murgon there are five paramedics. We will upgrade the Murgon station from a category 4 to a category 5, providing two-officer day, afternoon and night shifts with continuation of on-call arrangements. At Oakey, a paramedic and officer in charge can be off roster again to provide better supervision.

At the Sunshine Coast at Birtinya, we will have the equivalent of 6.1 full-time equivalent paramedics to meet increased demand for acute services. The first allocation of staff will be towards the Birtinya station; however, they will be located in other stations over time until the station is completed—two crews, one day and one afternoon shift, seven days, 10-hour shifts. So that is a big resource commitment on the Sunshine Coast. Also on the Sunshine Coast, we will have the establishment of a low-acute response unit with the equivalent of 4.7 paramedics. There are 2.4 paramedics going into Maroochydore, clinical deployment supervisors to ensure optimal deployment and priority of dispatch.

In the West Moreton region, Ipswich and to the west, Rosewood gets upgraded from a category 3 to a category 4 station, with 3.3 paramedics there. In Ipswich, we will have a senior operations supervisor to improve supervision in that area—that is equivalent to 1.3 full-time equivalents. In Metro North at North Lakes, we will have a patient transport officer, with 4.7 equivalent full-time positions. There is increased demand for patient transport services. There are two paramedics going in at Kedron as part of the higher acute response unit. For the member for Greenslopes, in the South Brisbane station, patient transport officers will be increased by the equivalent of 4.7 full-time equivalents. That is to deal with increased demand for patient transport services.

At Cleveland station there are 7.8 full-time-equivalent paramedics. That is because of increased demand during the day. At the state operations centre in Brisbane there is the equivalent of 12 staff. They will be emergency medical dispatchers and supervisors to enhance our patient transport system and additional call taking, dispatch and supervision. So all parts of Ambulance—call dispatch, patient transport, on-the-ground paramedics—are benefitting across Queensland. That is a significant investment in staffing to improve our response and our service delivery to Queensland.

Dr ROWAN: Just to follow on from that, I want to come to the Queensland Ambulance Service Commissioner. I have heard the minister outline where those 75 additional paramedic positions are going to be placed in 2015-16. I want to confirm that there are not any additional paramedics planned for the next 12 months for the suburbs of western Brisbane, into ambulance stations there. Is that correct?

Commissioner Bowles: That is correct.

Dr ROWAN: Can I clarify the opening hours of the Pinjarra Hills Ambulance Station? Is it open 24 hours a day, seven days a week?

Commissioner Bowles: No, it is staffed by 5.3, which is four paramedics and one officer-in-charge, and there is a relief component in that also. Its workload is suitable to that level of coverage. You cannot forget that Kenmore is down the road and provides coverage into that area after hours.

Dr ROWAN: What are its current opening hours on a weekly basis?

Commissioner Bowles: It would be an eight-on six-off station. Basically, that means that you work eight 10-hour days and then you have six days off. That is the norm for that category of station.

Dr ROWAN: I refer the Queensland Ambulance Service Commissioner to page 6 of the SDS in relation to $2.5 million over three years, including $800,000 in 2015-16, to establish an agreement with Health Consumers Queensland to assist those advocating on behalf of patients. I ask: have you been consulted on this proposed agreement with Health Consumers Queensland? Will your paramedics and Queensland Ambulance Service officers be involved in its proposed implementation?

Mr Walsh: Are you talking about the third dot point?

Dr ROWAN: Page 6 of the SDS, where it references Health Consumers Queensland and the $2½ million over three years, including $800,000 in 2015-16.

Mr Walsh: Can I just clarify that that is the department, not the Queensland—

Dr ROWAN: The specific question is: has the Queensland Ambulance Service Commissioner been consulted on the proposed agreement and will paramedics and Queensland Ambulance Service officers be involved in the proposed implementation given that it is health consumers across Queensland; it covers a broad range of people?

CHAIR: Sorry, my understanding of the question is that you are merely asking the commissioner if he has been consulted?

Dr ROWAN: Correct.

Commissioner Bowles: It formed part of the Department of Health. Do I have a specific recall of being consulted on that? No, but do not forget that the department is a big department and we also have executive managers that may well be talking on any subject at any time.

Dr ROWAN: Thank you. My final question, again to the Ambulance Service Commissioner, is in relation to Budget Paper No. 4, page 83—and I know we touched on this earlier—in relation to data that is captured as far as assaults are concerned in relation to paramedics and Queensland ambulance officers. Is there data related to recording the episodes of intoxication that are involved in assaults on ambulance officers and paramedics, not only in relation to alcohol fuelled events but also those related to substances, whether they be illicit substances that are involved, synthetic drugs or other things such as ice, for example? Is that specifically recorded as part of the assaults data that is captured by the Ambulance Service?

Commissioner Bowles: As you can imagine, the role of a paramedic in those circumstances is very challenging. To elicit the exact cause is not always possible. You can obviously draw conclusions from time to time as to whether it be alcohol or one shielding a drug issue or a whole range. Do we have exact data on the exact patient causation? No, because we treat patients symptom-wise, whereas at a hospital you would have toxicology and a whole range of other diagnostic things available to you that can actually give you a much more definitive picture. That is why paramedics treat symptomatically.

Dr ROWAN: That is why I wanted to come to that. In relation to emergency departments, where often these people are taken for clinical treatment and management, given some of the physical and psychological sequelae that are occurring, if emergency departments are capturing that data—and presumably they are—and there is some cross-reference back to the Ambulance Service, would that be helpful as far as systems are concerned, looking at assaults on ambulance officers?

Commissioner Bowles: We do share data and share a whole range of information.

Dr ROWAN: So that information would be of assistance? On the actual forms, which is data collected from the Ambulance Service, are there tick boxes on there if ambulance officers believe that alcohol or illicit substances such as ice are involved?

Commissioner Bowles: You can clearly make a notation about it, but is that a definitive list of what is wrong with a patient? No, and not everyone wants to tell people exactly how they have got to that state. That is why I say that a lot of the time we do just treat symptomatically. If we do know and someone comes and says, 'It is heroin,' we have things that can reverse the effects; we will again treat symptomatically.

Mr DICKSON: My question is to the commissioner. What population on projected sites is required for the establishment of ambulance stations, taking into account the soon-to-be established Yandina and Kenilworth sites? Has the department looked at growth areas such as Palmview and also Caloundra South? I do not want an ambulance station taken away from Kenilworth; please do not get me wrong. I want them everywhere, but what numbers have given you the motivation to put them in those particular areas when we have huge population growth in the other two areas I mentioned?

Commissioner Bowles: It is not always numbers and population growth. If I use the example of Gracemere outside of Rockhampton where I grew up, it has had a township there that is growing for some time but during the day everyone exits the town and either goes to the sector west of there or comes into Rockhampton. So the workload did not actually require a station, although the population was growing. It has only been in the last five years that we have actually put a station in a community like Gracemere.

There is a whole range of drivers that go into where you site an ambulance station. You mentioned Yandina, for example. Having worked on the Sunshine Coast—I was its area director from 1998 to 2003—I have a rough idea of the road network. Do not get me wrong: it has changed a lot since then. As you would know, Yandina is quite a strategic place in terms of where you can go. You can go over to the coast quite easily through the back way and through Coolum. You can go up into Nambour. You can go north into Eumundi or Noosa. You can pretty much go anywhere.

Mr DICKSON: You could probably get to Kenilworth, too.

Commissioner Bowles: Yes, you probably could. We have first responders at Kenilworth. We have had first responders at Kenilworth now for—I was there when they were established. I cannot remember the exact date, but it would be about 1998, I would imagine, or around that period. We have members of the community who volunteer and basically run an ambulance service in Kenilworth. I cannot quite pull the numbers off the top of my head, but those first responders are busier than some of our permanent stations.

Mr DICKSON: Commissioner, I have the greatest respect for your organisation. Can you please take on board those two growth areas on the coast for future reference?

Commissioner Bowles: Will do. As I say in terms of Eudlo, Palmwoods and all those areas, we are constantly looking.

Ms BATES: My question is to the minister. You mentioned before that two out of three patients are now overweight or obese. Was that population in Queensland, or is that the population of people who use the Queensland Ambulance Services?

Mr DICK: Sorry, that is a general advice I got—the general population statistic as distinct from people using the Ambulance Service. It has increased significantly over 35 years. The data we have is that it increased from one in 10 to two in three in 35 years. The definition of obesity—it is not hard to be overweight, in a sense. It means that there is a significantly larger number of people who have developed obesity and weight conditions. It is not people using the Ambulance Service, per se. It is not a determination of them, but that impacts on the demand for the services (a) because of chronic illness that occurs from that and (b) there is a larger number of larger people with whom the Ambulance Service has to engage. I do not want to take up time, but I have a few other statistics. Are you interested?

Ms BATES: Obviously there is an increase in bariatric patients, and that is a cost to the health service, whether it be the ambulance or hospitals. Have you done any costing models into the future about what the impact of an increasing number of bariatric patients in the health system is going to cost governments into the future?

Mr DICK: I have not done that work. I am not aware of the work. There may be work that is happening within the department, particularly in that clinical excellence area and in the Ambulance Service, but it is impacting on how we do clinical service delivery and operational service delivery. Regrettably, it is becoming part of our system's design and delivery. Queensland has the highest rate of obesity in Australia. Sixty-five per cent of adults measured overweight or obese and 28 per cent of children. Over 90 per cent of Queensland adults and almost 95 per cent of children do not eat enough vegetables. Chronic disease—and this is the challenge; the challenge is the impact that weight has on the development of disease. Chronic disease causes about 80 per cent of deaths, hospitalisations and allocated expenditure in Queensland with its impact growing. That is the challenge. There is a very significant problem coming through with diabetes, cardiovascular disease and a range of other chronic illnesses because of obesity. If we can address that—I think to be honest there is a bipartisan view on that. We all have a challenge in the health space to take that message to the community.

Ms BATES: Unfortunately, the Gold Coast is in the unenviable position of having the fattest kids in the country in terms of childhood obesity. My next question is to the commissioner. Commissioner, you would be aware of a report from the Auditor-General last year which raised some issues that Queensland patients arriving by ambulance into our emergency departments are more acute than in any other state? I am not sure what the terminology is in Queensland, but in Victoria signal 1s are the most acute patients coming in by ambulance. The Auditor-General raised the fact that they are true signal 1s; they are not actually downgraded when they come into the emergency department. It is not like someone has graded them at this and then when the doctor sees them in the ED they downgrade them. They are actually coming in as the sickest of the sick. The Auditor-General had not further investigated as to what that cause may be. From an operational perspective, can you shed any light on that? Do you see that yourself, that the patients are more acute than you have had in the past?

Commissioner Bowles: I think it goes to basically the last question. I always used to say—I still say it; it is just that I have added one to it—that the only thing that has changed during my time in the Ambulance Service has been the patient, and it has changed quite significantly. If I use your area, look at the plus 75s; approximately six per cent of the population is older than 75 years but they consume 28 per cent of everything we do. You have a lot of growth in our different patient cohorts, whether they are obesity driven, comorbidity or the ageing population. Queensland is a place where people want to live. Wherever you have people who fall into those categories in a state like this, we are going to be taking those sick people to our accident and emergency departments.

Ms BATES: Are you saying that your budget might have to increase for more paramedics? If we have the sickest of the sick, we need to have the best of the best to look after them. Has that been factored into future service?

Commissioner Bowles: We have grown by 75 this year. If I can just add to that. When I say the only thing that has changed is the patient, the way in which we respond has to change too and it has. In the metropolitan areas we cannot keep sending two people out in a truck to each and every patient because patients are different. We have introduced low-acuity units, and we try to divert them away from EDs in the first instance and to make a relationship between the patient and a general practitioner or someone else who can help them. They are normally in unmarked Subaru type vehicles with one officer, although sometimes they are marked. There are a whole range of responses to this new patient that we as an ambulance service have to implement, and resourcing is just one of them.

Dr ROWAN: I want to ask a follow-on question regarding obesity. With reference to page 49 and the commissioning of new vehicles and power assisted stretchers, what proportion of your equipment has to be customised to deal with the obesity epidemic, given that hospitals themselves are having to invest in significant infrastructure when it comes to beds, chairs, wheelchairs and other equipment? Is the investment by the Queensland Ambulance Service matching the prevalence of the growth of obesity disorders in the community?

Commissioner Bowles: Yes, I suppose it is one of those how-long-is-a-bit-of-string questions. Out of the 155 new ambulances that were referred to, some are front-line operational response vehicles, some are patient transport and some are four-wheel drives for rural places. The practicality of the new type of stretcher may not be the right choice, but all of those vehicles with the correct components will be fitted with the new Stryker stretcher. What we have done over the last five years or so is we have had vehicles in places like in Northgate, Beenleigh, Toowoomba and around the state where we would have to drive long distances to repatriate patients. The new powered stretcher gives us the ability to do that in every new ambulance. As they roll out across the state we have options throughout the whole state, so our capacity just grows quite significantly across the whole state.

Mr McARDLE: Commissioner, you record data under the heading of 'Value for money', do you not?

Commissioner Bowles: We publish on our website a section entitled 'Value for money'.

Mr McARDLE: Do you have any idea of the meal overtime figure for 2014-15?

Commissioner Bowles: Roughly $14 million to $15 million for 2014-15, but that would be a ballpark figure.

Mr McARDLE: I think in late 2013 the QIRC looked at this and made a determination. Could you give me an update as to where the QAS is at in relation to this?

Commissioner Bowles: Yes. I think in November or December 2013 the QIRC put down a wages rate and said 2.2 over the next three years. They then released the determination in May or June 2014, I think.

Mr McARDLE: You are quite right.

Commissioner Bowles: That had a new meal management clause in it. Basically, it said that the current window is 2½ hours. It said extend it to four hours and a 4½ window, and that came out as part of the determination. I will give you a good rundown of where we are up to. We wanted to make sure that our paramedics—who, as you know, work really, really hard—get 2½ hour breaks before we remove the penalty. We think that is a fair approach. We want to make sure that before we widen the window, we make sure that people are getting the breaks that they need so that they can respond well.

Just to put that into some perspective, throughout the state on day shift at the moment we would have 300-odd crews from Thursday Island down to Coolangatta. The ones who are on 12-hour shifts, you have to put through a pretty small window or otherwise they meet a penalty clause. We want to make sure that we give them 2½ hour breaks, so we got in an IT expert basically to tell us where those 300 crews are in the spectrum of their day. We wanted a program that will go from green to orange to red to say that they are out of their meal window and they need to have a meal, and that is a tool that will help. As you can imagine, it is very difficult to make sure that everyone is getting their meal break when you are sitting in a busy communications room that takes 650,000-odd 000 calls and God only knows how many normal ones a year. So we wanted to build them a tool.

In December last year I sent out a letter to the entire workforce explaining that the approach we are going to take is to consult with staff, and we will continue on to develop this tool. I think it even said that we would hope to have a solution in 12 months. That was December 2014, so I suppose we would

hope to have a solution by December this year. The tool is now being trialled. It is in Townsville as we speak being trialled, and we are going to go to the Sunshine Coast, the Gold Coast and Brisbane very shortly with the tool. That is the electronic tool that I was referring to.

We have also attached a project person to it because, as I said, we want to consult widely. We went out to the staff and we asked if anyone was interested in how we can best resolve this issue. We were trying to get feedback on the ground, and I think we got about 70 applicants of which we accepted 12. That working group is now working with us as an organisation to find the best way forward to make sure that our paramedics get a break, but we have to give them the tools to do that and it is in train.

CHAIR: Thank you, Commissioner. Minister, you have taken a number of matters on consideration throughout the day. Are there any updates that you would like to provide to the committee at this time, bearing in mind that it is about 4.35 and it is close to the end of the hearing?

Mr DICK: There are a number of things I would like to go through with the committee, if I may, to address some of those issues. The first is the report prepared in respect of the commissioning of the Lady Cilento Children's Hospital.

On the matter of the report into the commissioning of that hospital, it was a report that was conducted independently of government. We had three highly skilled health professionals: Adjunct Professor Debora Picone AM, Chief Executive, Commission on Safety and Quality in Health Care and former director-general of two New South Wales government departments; Mr Mark Tucker-Evans, the chair of Health Consumers Queensland; and Mr David Roberts, Health Leader, Oceania, Government and Public Sector, Ernst & Young. I can inform the committee that I did not direct them on how to conduct their review. I did not interfere in anyway with their findings. I am advised that a draft report was provided to parties for factual review and submissions were provided back to the independent review panel. I did not see, nor ask to see, any of the submissions to the review panel. However, on the release of these documents I am advised that they may be subject to cabinet in confidence principles and rules that have been consistently applied by successive governments of all political persuasions. Further, the release of information is also a matter for the independent panel. I ask to take the matter on notice to further investigate these matters and consider the request and respond to the committee in accordance with standing order time lines.

In relation to the nurse-to-patient ratios issue, this morning we had questions from the committee on specific nurse-to-patient ratios currently operating in some nominated hospitals. The fact is that ratios vary between wards so it is very difficult to determine a set nominal figure that expresses a current single overall ratio in a particular hospital. The ratios are different for medical and surgical, different for cardiac and ICU, different for paediatrics and emergency departments; however, all nursing staffing requirements are regulated by the processes set out in the business planning framework.

The business planning framework assesses the number of full-time equivalent positions required against the number of occupied bed days expressed as patient hours per day. Following a baseline audit by the department, and in line with our commitment to phase in the implementation of nurse-to-patient ratios in acute wards in 33 nominated hospital and health facilities, we have identified our full-time equivalent gap of 247 at this time—that is an estimate—required to meet our commitment to legislated ratios of one to four in the mornings and afternoons and one to seven overnight. I table the business planning framework*,* fourth edition*,* for the consideration of the committee.

CHAIR: Leave is granted.

Mr DICK: There were also questions about code black. I can inform the committee that emergency codes used in hospitals are nationally consistent and are set by Standards Australia. Standards Australia has released two Australian standards that define code blacks: AS 3745 and AS 4083. These standards set out standardised colour codes for notification, identification and response activation to be used in local emergency response procedures. The colour codes are: code red, fire and/or smoke; code purple, a bomb threat; code blue, a medical emergency; code black, a personal threat; code yellow, an internal emergency; code brown, an external emergency; and code orange, evacuation. In Queensland the hospital and health services are responsible for setting local procedures and guidelines. Hospital and health services use the above standardised codes to inform their local documents.

The Gold Coast Hospital and Health Service has a procedure code black, personal or facility threat, ID—I understand that is the document identification—PRO 1094 that describes the processes for ensuring the safety of all human and physical resources within the Gold Coast Hospital and Health Service. I seek leave to table that document *Code black: personal facility threat, Gold Coast Hospital and Health Service.*

CHAIR: Leave is granted.

Mr DICK: I am advised that this document was last updated on 24 January 2014. I am advised that the Gold Coast University Hospital has on average 62 code blacks per month.

I was asked about readmissions to hospitals in relation to intensive care units. I am advised that hospital and health service intensive care units provide data on patient readmission directly to the Australian and New Zealand Intensive Care Society, otherwise known as ANZICS. ANZICS is a national professional body and a leading advocate on all intensive care related matters. Information is sent from hospitals direct to ANZICS. ANZICS captures readmissions within 72 hours as a standard approach. This relates to the adoption of the Australian Council on Healthcare Standards indicators, including rapid response calls to adult patients within 72 hours of ICU discharge as a measure of safety, quality and performance.

Readmission rates at 48 hours have not been universally adopted as a marker of clinical performance, and data to reflect this outcome is not readily available. Extensive querying of the ANZICS database would be required to develop the requested report. We do not collect that information on a 48-hour basis.

The director-general undertook to table a copy of the Making Tracks Indigenous Health Policy. I seek leave to table two documents: the Making Tracks Policy and Accountability Framework and the Making Tracks Investment Strategy 2015-2018.

CHAIR: Leave is granted.

Mr DICK: There was discussion during the examination of the appropriation for the Health portfolio of the Mooloolah River interchange. When I met with the member for Nicklin, Peter Wellington, last week to tour the Nambour General Hospital, I also discussed this particular issue with the chief executive of the Sunshine Coast Hospital and Health Service and the project team involved in the construction of the Sunshine Coast Public University Hospital. I have asked the chief executive to ensure that any issues associated with traffic around the hospital are appropriately considered and raised with the relevant bodies.

However, on the matter of that road project itself, that project was announced by the former state government on 19 August 2014 as an unfunded commitment, with future funding to be provided through the asset sales plan. It is not often that I quote Jarrod Bleijie, the former attorney-general and member for Kawana—and I hope not to do it very often—but in a report published in the *Sunshine Coast Daily* on 25 October the then attorney-general and member for Kawana, Jarrod Bleijie, told a meeting of development industry figures that the $440 million Nicklin Way-Sunshine Motorway-Mooloolah River interchange would be built only if the LNP state government was returned at the election. It was an unfunded election commitment. I seek leave to table that article. The article went on to say—

Under the Strong Choices campaign, only the LNP Government will deliver these vital pieces of infrastructure ...

That is the only way it would have been delivered. It was unfunded and cannot properly be represented as something in which a commitment has properly been made, other than by way of politics.

CHAIR: The minister sought leave to table that article. Is leave granted? Leave is granted.

Mr DICK: I have sought advice from the Minister for Main Roads about the current status of this project. The Department of Transport and Main Roads is finalising the planning phase for the Mooloolah River interchange project. TMR is preserving the planning corridor. Property owners within the planning corridor who wish to sell their properties may be eligible for purchase by TMR under the early acquisition policy. TMR is working with property owners in the planning corridor to advise them of their options under the policy. Early acquisition is not compulsory, and while the corridor is being preserved and the project remains unfunded for construction property owners are able to remain in their homes. On completion of planning and potential assessment by Building Queensland, timing for construction of the MRI project will be subject to competing priorities and available state funds.

I was also asked about the relevant physical activity programs for young girls and women. I want to provide an overview to the committee of those physical activity programs, and this is for a range of individuals including women and young children. The Department of Health works collaboratively with a range of partners to promote physical activity to children. There are a number of programs. The PEACH program delivered by the Queensland University of Technology across Queensland is a parent led, family focused healthy lifestyle program that supports parents and carers who are struggling to manage their child's weight. It offers families practical advice and information about healthy eating and ways to increase levels of physical activity over a six-month period.

The second program is Life Education. Life Education is a child focused health promotion charity dedicated to empowering children with the knowledge and skills to live healthier and safer lives. The Life Education program contains modules that include physical activity amongst other issues including smoking, sexual health, nutrition, cybersafety and alcohol. The program is delivered in primary schools across Queensland via mobile vans.

The Good Start Program—something I am proud of that is delivered in the Logan community and Logan City, including the electorate of Woodridge—hosted by Children's Health Queensland, provides culturally tailored healthy eating and physical activity messages to Maori and Pacific Islander children and their parents to reinforce health messages for the whole family. Multicultural health workers with knowledge and strong links with their local communities provide cross-cultural training to health professionals on how to work effectively with children and families of those target communities.

The fourth program is the Learning, Eating, Active Play, Sleep—otherwise known as LEAPS—program. The LEAPS program is a professional development program delivered by QUT and NAQ Nutrition to early years educators. Participants learn to integrate the Australian government's national healthy eating and physical activity for early childhood guidelines into daily activities at their setting and convey messages to families and carers to promote healthy growth and development. The program is delivered face to face across Queensland and is also available online.

The fifth program is the Physical Activity Innovation with Schools project, which delivers creative new ways for children to be active as part of their school day. Funding for the Physical Activity Innovation with Schools program began in 2014 in two regions within the department of education and training and employment—Central Queensland and Darling Downs south-west. As the member for Buderim asked, there is a partnership across some agencies there, including Education. The project taps into the inherent expertise of school leaders and classroom teachers and develops trials and shares innovative ways to incorporate physical activity into school time.

The sixth program is Have Fun—Be Healthy. The Have Fun—Be Healthy program provided through Playgroup Queensland focuses on delivering fun, healthy eating and physical play sessions in playgroups for families with children under school age. The sessions are designed for parents to enjoy doing the activities with their children—it is an important thing for parents to be active with their children and to create an active culture—and to spread the message of healthy eating and physical activity through play.

The seventh program is the Healthy Active School Travel project. That project—I think a number of members of the committee and many members of the parliament are aware of that—encourages children to be more active by encouraging primary school students to cycle, walk and use public transport to and from school. It is operated in Cairns, Townsville, Ipswich and the Gold Coast.

In relation to adults, the department is developing or implementing strategies to encourage adults to be more active. The Department of Health is working collaboratively with a range of partners to promote physical activity to adults. Those programs include—and some of these are election commitments which we are now delivering—the 10,000 Steps program. This is a free program for individuals, workplaces and communities that encourages the use of step-counting pedometers to monitor daily physical activity levels. A lot of that is now online, so people can download an app they can use. It is delivered by the Central Queensland University and is available to all Queenslanders.

Another program is Heart Foundation Walking. Heart Foundation Walking is Australia's largest free walking network consisting of walking groups led by volunteer walk organisers through the Heart Foundation to all Queenslanders as well as a vital community of walkers who track their activity online. Again, we committed to funding the 10,000 Steps program for an additional period as well as Heart Foundation Walking and we will be doing that in this term of parliament.

There is also the Get Healthy Coaching and Information Service. The Get Healthy service is a free and confidential information and phone coaching service that provides information and support for Queenslanders to make healthy lifestyle changes, including being physically active. The Healthier. Happier campaign is a social marketing campaign designed to promote the benefits of leading a healthy lifestyle rather than focusing on weight or weight gain. It is positive and inclusive and encourages everyone to take small, incremental steps to improve their health regardless of their size. The website includes a series of fitness videos, fact sheets and general information to support adults to be more physically active. I think it was an initiative of the previous government and I support it.

The Health for Life! program is an important initiative of our government. The Health for Life! program is designed to identify Queenslanders at risk of developing diabetes, cardiovascular disease, obesity and some cancers and support them to maintain healthy choices. That will target 10,000

Queenslanders. We will work closely with those 10,000 Queenslanders through a range of partners, both within government and external to government, including Diabetes Queensland and other organisations. We want to help target reducing risk factors by increasing physical activity, and that goes back to that issue we were talking about earlier in the committee of obesity. That is a targeted program looking at supporting 10,000 Queenslanders, and I look forward to that rolling out.

CHAIR: Minister, thank you. I thank you for the timeliness of your reporting back to the committee on those issues given consideration earlier.

Mr HARPER: Minister, I refer to page 49 of the SDS and the importance of investing in our workforces. Can you please tell the committee more about the Classified Officer Development Program and its continued operation in the QAS?

Mr DICK: The Classified Officer Development Program commenced in February 2014 as an internal QAS staff development initiative. Eight CODP courses were conducted in 2014-15, with 221 QAS officers in charge and supervisors participating in these courses. The CODP is a six-month, flexible program focusing on developing leadership skills and knowledge for OICs—that is, officers in charge—and supervisors to be well equipped, prepared and confident to deal with the challenges of their roles within the QAS both now and into the future. The program aims to build the confidence, leadership capabilities and behaviours of these officers to lead their teams in the delivery of front-line health services to the Queensland community. The CODP residential program is facilitated over four days and uses a blended model of delivery from external experts, QAS facilitators and specialist guest speakers. The web based sections of the QAS's collaborative online learning provide a wide variety of support and resources for CODP participants including links to contemporary best practice leadership and management materials.

OIC positions were initially identified to participate in the CODP. However, this has since been expanded to include other supervisory positions in the QAS. Scott Arbuthnot and Associates were engaged to facilitate the first three days of the four-day CODP conducted in 2013-14. During 2014-15, following a program review, Scott Arbuthnot and Associates were engaged to facilitate the first two days of the four-day CODP. The remaining two days were facilitated by QAS staff and specialist guest speakers. The Queensland University of Technology has been contracted to facilitate two days of the four-day CODP for a further six courses in 2015-16. There were 129 participants in 2013-14, 221 in 2014-15 and a projected 180 in 2015-16. So it is a way to improve capacity and develop skills of leaders and potential leaders in the Ambulance Service.

Mr HARPER: Thank you, Minister. I refer to page 49 of the SDS in relation to the operation of the QAS. Can you please update the committee on the rollout of the Government Wireless Network and its impact on the QAS?

Mr DICK: I can inform the committee that the Queensland government will be delivering digital voice radio and narrowband data technology to all public safety agencies in South-East Queensland, including the Queensland Ambulance Service. The Government Wireless Network is a fully managed service through Telstra and Motorola, and implementation is being led by the Department of Science, Information Technology and Innovation but has a number of direct impacts for the operation of the QAS. In 2015-16 the QAS, in partnership with the department, will finalise the rollout of the QAS component of the Government Wireless Network project across South-East Queensland. The GWN provides the state's public safety agencies with a fully integrated, secure digital radio communications network. The Government Wireless Network brings the QAS, QPS and QFES onto the same radio communications platform to assist in improving efficiency and effectiveness of front-line operations.

The Government Wireless Network replaces ageing analog based radio technologies that do not support cross-agency communication and are not secure. The Government Wireless Network is designed to maximise emergency response effectiveness through vastly improved radio coverage including significant in-building signal penetration, all delivered with impressive audio quality. The Government Wireless Network project will improve operational safety for paramedics by providing crisp, clear voice communication, encryption and increased radio coverage resulting in a reduction in radio black spots, portable and vehicle radio location services with global positioning system tracking, systems linked to operational centres and the availability of an emergency call duress button on portable radios, providing QAS officers with the ability to instantly call for emergency assistance. In respect of those assaults that we had discussed earlier in the hearing, I think that is an important capability that will be built into the system.

The Government Wireless Network will also provide three transportable radio transmission sites. These are fully deployable self-contained transmission sites with backup power and consumables that will provide up to 48 hours of unassisted operation in the case of an emergency such as a flood or

cyclone, so that would help the Ambulance Service work through the peak of a natural disaster with 48-hour capacity there. They are capable of being deployed to remote sites including those with rugged access tracks—I know you have been down a few of those in your time as a paramedic, member for Thuringowa—so we need to be able to deploy them remotely.

Queensland is the first jurisdiction to implement a shared, trunked, multiagency digital radio communications network since the release of the national framework to improve government radio communications interoperability prepared by the National Coordinating Committee for Government Radiocommunications. This means that other Australian jurisdictions are monitoring how effectively Queensland addresses the challenges of interoperability during the rollout of the Government Wireless Network.

The Government Wireless Network has multiple redundancies and business continuity processes for complete resilience. It is a strong system. I think that will improve the capacity of the QAS to respond. It is a stronger communications network. It has a number of positive aspects to it. There has been a lot of thought put into it. Again Queensland is leading the way, but we want to make sure it is effective and can operate effectively as part of our important Ambulance Service delivery. If we are at the end, Madam Chair, I just wanted to make a few thanks when the time is appropriate.

CHAIR: Yes, we are. We have about one minute, so please do.

Mr DICK: Thank you, Chair. I thank the committee for their interest in the portfolio today and for your questions. I also thank in particular my staff for assisting me—my ministerial staff—but, more importantly, the departmental staff, the staff of hospital and health services and the staff of the Queensland Ambulance Service. Those members of the committee who have served as ministers before know how much time and effort goes into properly considering issues for these portfolio examinations and I want to express my thanks. It is an outstanding department. I am very privileged to lead it. I know that there are a lot of people who have done a lot of work to support the preparation of this hearing for me and I want to express my thanks to them.

CHAIR: Thank you. The time allocated to consider the estimates of expenditure in the Health and Ambulance Services portfolio has expired. On behalf of the committee I thank the minister, director-general, chief executives and officials for your attendance here today. The video broadcast of the hearing will be available on the parliamentary website soon and a proof transcript of proceedings will be published by approximately 8 pm. Minister, you responded to a large number of matters earlier. If you find that there are any outstanding, the deadline for answers to questions taken on notice and any clarifying material is 5 pm on Friday, 28 August. Thank you very much. I declare the hearing closed.

Committee adjourned at 5.00 pm