LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-2018

(Reference: Appropriation Bill 2017-2018 and Appropriation (Office of the Legislative Assembly) Bill 2017-2018)

Members:

MR A WALL (Chair)
MS B CODY (Deputy Chair)
MR A COE
MS C LE COUTEUR
MR M PETTERSSON

PROOF TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 27 JUNE 2017

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Secretary to the committee:
Mrs N Kosseck (Ph 620 50435)

By authority of the Legislative Assembly for the Australian Capital Territory

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APPEARANCES

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Amended 20 May 2013

The committee met at 10 am.

Appearances:

Fitzharris, Ms Meegan, Minister for Health, Minister for Transport and City Services and Minister for Higher Education, Training and Research

Health Directorate
- Feely, Ms Nicole, Director-General
- Strachan, Mr Shaun, Deputy Director-General, Corporate
- Mooney, Mr Colm, Executive Director, Project Delivery, Health Infrastructure Services
- Wood, Mrs Mary, Acting Deputy Director-General, Innovation
- Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
- Bone, Mr Chris, Acting Deputy Director-General, Canberra Hospital and Health Services
- Wood, Mr Daniel, Acting Executive Director, Surgery and Oral Health
- Kelly, Dr Paul, Chief Health Officer and Deputy Director-General
- Vivian, Mr Trevor, Chief Finance Officer
- Kohlhagen, Ms Linda, Executive Director, Rehabilitation, Aged and Community Care

Chief Minister, Treasury and Economic Development Directorate
- Overton-Clarke, Ms Bronwen, Deputy Director-General, Workforce Capability and Governance Division

THE CHAIR: Good morning, and welcome to day eight of the estimates committee 2017-18 inquiry. In today's proceedings we will examine, in a very condensed manner, the expenditure proposals and revenue estimates for the Health Directorate in relation to budget statements C. As one of my staff took great delight in telling us, it is in the vicinity of $750 million an hour that we are examining this morning.

As usual, these proceedings will be recorded and broadcast live online through the Assembly's broadcasting service. If you are taking a question on notice, could you please use the words, "I am going to take that question on notice." It makes it easier for our secretary and Hansard to note what is being taken on notice.

Before we kick off, can I check that everyone is familiar with the pink privilege statement and aware of its implications? Thank you. Minister, I will hand over to you to make a very brief opening statement.

Ms Fitzharris: Thank you very much, Mr Chair, and thank you very much to the committee for understanding that I am not particularly well today, and for having a condensed hearing. I really appreciate it. I have some opening statements, which I will table in the interests of time, on behalf of both me as the Minister for Health and Minister Rattenbury, the Minister for Mental Health.

THE CHAIR: Okay.

Ms Fitzharris: Having said that, I am very happy to take questions from the committee.

THE CHAIR: Thank you very much, minister. I call on directorate officials to try to keep their responses succinct and to the point, which will allow for a broader range of questioning. Likewise, I say to committee members: if the scope of your questioning can also be honed appropriately, that would be appreciated.

Minister, I will kick off with the first question. In your capacity as a member of this place, when did you first become aware by any means, be it oral, written, formally, informally or through a casual discussion, of the problems that related to the electrical switchboard at the Canberra Hospital?

Ms Fitzharris: I have made a number of statements about this matter. I certainly have put a number of dates on the record with respect to becoming aware of incidents at the hospital. Certainly, as the Minister for Health, I was aware in the prior Assembly, and in the 2016-17 budget, that there was quite a significant infrastructure upgrade package, "Upgrading and Maintaining ACT Health Assets", otherwise known as UMAHA. There were elements in that budget package to upgrade the electrical switchboard at the Canberra Hospital—quite an extensive package of works. In that vein I understand that there were some issues to be upgraded, that there was some infrastructure that certainly needed attention and that was the entire purpose of the significant investment in last year's budget.

With the incident on 5 April at the Canberra Hospital with the fire in the switchboard, which then caused the power outage at Canberra Hospital, I have gone back over the work that was undertaken since the announcement in last year's budget, and I understand that there were also discussions with Minister Corbell at last year's estimates hearing.

THE CHAIR: When did you first become aware that the electrical switchboard was rated as a high or extreme risk?

Ms Fitzharris: I do not recall a specific date.

THE CHAIR: Are you able to take that on notice?

Ms Fitzharris: Yes.

THE CHAIR: Having become aware of the increased risk rating of either "high" or "extreme", what action did you take in response to that upgraded warning?

Ms Fitzharris: As I understand it, as with every organisation, including, of course, ACT Health, there is a very robust risk management process in place. There was significant work done in 2015 in order to inform the decision that cabinet took to invest in the UMAHA program in last year's budget. As a result of that the cabinet made the decision about that $93 million investment. It was then rolled out over that time period. I have subsequently given statements to the Assembly about the timing of the contract to specifically address the switchboard renewal item.

THE CHAIR: What discussions did you have with the former Minister for Health regarding this issue?

Ms Fitzharris: None specifically.

THE CHAIR: None specifically?

Ms Fitzharris: Other than in the context of cabinet deliberations on the 2016-17 budget, where cabinet obviously agreed to a $93 million package of work.

THE CHAIR: Did your awareness of this issue bring to your attention or alert you to other possible maintenance issues with the ageing electrical infrastructure at the hospital?

Ms Fitzharris: Not specifically, to my recollection.

THE CHAIR: Are there any other electrical switchboards, panels or circuitry that are rated as extreme or high risk currently at Canberra Hospital?

Ms Fitzharris: Not to my knowledge, but I will hand over to the directorate officials.

Mr Strachan: In relation to your question, building 12 is another area where there is an electrical main switchboard replacement program. That is scheduled to be addressed between now and February 2019.

THE CHAIR: That is a very long window for—

Mr Strachan: You will appreciate that this is a very technical area. We are dealing with issues here in relation to buildings that in some cases are 20, 30 or 40 years old. The issues around building drawings, particularly reference material, are obviously an incredibly significant starting point for the purpose of actually referencing a lot of the electrical drawings.

Obviously, because of the issues around patient safety and the effective operation of the health service, we are moving this through in a very controlled and risk-mitigated environment. As a consequence of that, we are doing everything we can practically. We are also doing everything we can in terms of looking at effective risk mitigation around putting in ancillary units to assist with the operation and safeguarding the performance of the electrical systems.

You may already have seen outside building 2 particularly that there are two 1,000 kVA generators on stand-by, to effectively govern that. We have also put a series of remediation steps in play, in terms of making sure that the current performance of building 2, which has the main board currently working through the upgrade, has a level of fallback and redundancy associated with portable panels and other aspects as well. So we are doing absolutely all that we can to make this our most serious priority in terms of the upgrade of the electrical systems at the hospital.

MRS DUNNE: Minister, in relation to the switchboard upgrades for both buildings

2 and 12, can you provide on notice a time line for the work that has been done, the contracting process? I believe a contract has been let for building 12 as well as building 2?

Ms Fitzharris: Yes, I can take that on notice.

MRS DUNNE: Is it the case that there is a contract in place for building 12 as well as building 2?

Mr Strachan: In terms of that process, we are actively working through the process of design and other aspects of mitigation. We are in different stages, obviously. The main stage at the moment is the upgrade of the main board of building 2, and we are doing active design and consulting work in relation to the process for building 12.

MRS DUNNE: I have a couple more questions. It was reported in the chamber, and I think in answer to a question on notice as well, that you are now conducting thermal scans of the main switchboard. What is the purpose of the thermal scans? I gather it is on a three-weekly cycle.

Mr Strachan: In relation to that, part of our active mitigation around everything is looking for heightened levels of detection in relation to heat and any sensory issues associated with that. What we wanted to do, particularly with the new management I have in play, is to be seen to be very proactive around the active maintenance, monitoring and any effective mitigation that needs to be taken. One of the recommendations that was taken out of that is to make sure we have a consultancy in place that gives us a level of independent assurance.

MRS DUNNE: The minister referred in the chamber to a three-weekly scan. What exactly do you expect to find by scanning something thermally every three weeks?

Mr Strachan: Again it is not uncommon in a lot of high traffic and electrical areas where you do a thermal scan across the switchboard. You look at the detection around the number of switches that are contained in that. If they have adverse or high readings then we want to make sure that we have appropriate load shedding and other aspects. So it is very much a proactive process—

MRS DUNNE: I understand that. What I am trying to work out is this: you seem to be doing it once every three weeks; why is it once every three weeks rather than a more constant monitoring? I am not being critical; I just want the information.

Mr Strachan: Now that we are in contract, and particularly in relation to building 2 and the main board, we have our consultants on board; they are in there every day. They are doing everything from looking at the drawings to the functional design of what is required for the replacement. So we have very active visual levels of detection going on all the time.

MRS DUNNE: Is the three-weekly scan still going on?

Mr Strachan: Yes.

MRS DUNNE: A final question: in answer to a question on notice to Mr Coe, which came in yesterday, you refer, minister, towards the end, to "upgrading and replacing required labelling to switchboards while simultaneously"—and this is the bit that I would like to know about—"reviewing and attending to minor open-cable penetrations in the main electrical switchboard". What are minor open-cable penetrations in the main electrical switchboard?

Ms Fitzharris: I will let Mr Strachan answer that question.

Mr Strachan: I might get Colm to come up to address that point.

Mr Mooney: Could you repeat your question, please?

MRS DUNNE: What are minor open-cable penetrations to the main electrical switchboard? This is a very techie question from someone who knows nothing about electrical works.

Mr Mooney: Yes.

Ms Fitzharris: You will know more in a second.

Mrs Dunne: I can hardly wait for that!

Mr Mooney: The items that you picked up there are in relation to cables within the board. The electricians go in and check for any signs of looseness in cables, any signs of deterioration in the access points for cables from within the main board. It is a techie term, for sure, but it is really just checking for housekeeping and the tidiness of the cable routing. Over time, things can wear out. Some of these boards, as was mentioned earlier, have been in place for 45 years. So it is a visual inspection and then, if anything is picked up through a combination of the visual inspection and the thermographic checks, a further action plan will be implemented.

MRS DUNNE: So it is making sure that the sheathing is correct and the connections are tight?

Mr Mooney: In one respect, yes.

MS CHEYNE: I have a supplementary. What processes does ACT Health have in place to ensure that infrastructure and equipment are maintained or reviewed on a regular basis?

Ms Feely: I will hand over to Mr Strachan, and Mr Mooney will back him up. They are the two who are responsible for it.

Mr Strachan: In relation to the process—

Ms Feely: I am responsible for it but not on a day-to-day basis.

THE CHAIR: That is a whole other inquiry!

MS CHEYNE: I know the minister is happy to take responsibility.

Mr Strachan: In terms of the process, in the past 12 or 18 months in particular we have gone through an extensive process of looking at the general condition and performance of our assets, both fixed and portable. We also have a process of rating everything, potentially a health assessment in terms of the risk framework. So we are continually looking at the general performance of our assets and the fixtures and equipment that support the hospital. As a consequence of that we have improved our governance in terms of the general day-to-day and monthly assessment in relation to the performance and evaluation of our assets.

UMAHA is essentially a subset of that. At the end of the day, as you would appreciate, 80 per cent of our asset base is essentially buildings and plant and 17 per cent is roughly the portable assets that are run around it. UMAHA is an investment we have in terms of making sure that the life cycle management aspect of those assets is being addressed.

Mr Mooney: Within health infrastructure services we have a combination of the project delivery side of our business and also the facility management side of our business. As mentioned earlier, within UMAHA they operate and maintain ACT Health assets. That is a significant body of work that covers all aspects of building services and it brings the facility management teams together with the project delivery teams.

Taking that foundation, we have active risk registers for all of our health infrastructure issues. We are also developing strategic asset management plans to ensure that the focus of the health infrastructure services group is very much aligned to risk, embracing risk and also strategic asset management planning. Because it is all within one umbrella group, we have clear communication from the beginning of a project to the end of a project. Our facility management people are very much the owners of the job after it is finished, but they have been involved in the full journey, which is a good outcome.

Mr Strachan: We are fostering an environment around addressing potential risk and also proactively managing the risk. This has been a significant change that the D-G has brought to bear in the executive structure, particularly in terms of the relationship I have with Colm and his team. I think we have significantly improved our preparedness to identify, to get on board with essentially identifying, and at the same time mitigating, and also now proactively planning to invest.

MS CHEYNE: For how long have you had risk registers in place and how often are they reviewed?

Mr Strachan: From my perspective, the risk registers to some degree have been there, but all I can really say is that over the past 12 to 15 months there has been a significant improvement in terms of the consolidation, stratification and identification of risk.

Ms Fitzharris: I certainly understand the community's interest in the April incident at the hospital. Obviously, on the hospital campus there is relatively very new

infrastructure and relatively quite old infrastructure as well, across ACT Health's full suite of built assets. I am very confident that with the processes that have been outlined, with a particular focus on it particularly over the past 12 to 18 months, the directorate has a very good understanding of the nature of the asset base that ACT Health manages. That knowledge and the approach were underpinned by that UMAHA budget initiative last year. It is rolling out very methodically. It has identified priorities. It is working on them and, as has been discussed, it is actively and proactively monitoring any known risk.

There is always risk in managing such a large portfolio of assets. We are cognisant that there is a range of ages, which is why this budget also makes investments in some of the wards at Canberra Hospital, in some of our other infrastructure, as well as planning for the future with new infrastructure to replace the old.

MS CODY: Thank you for coming in today, minister. I would like to delve a little deeper and find out how we are going with the new nurse-led walk-in centre for the Weston Creek region.

Ms Fitzharris: Certainly. As you know, we were very pleased to make commitments to expand the number of walk-in centres we have in the ACT from two to five. The additional three will be built over the course of this term. In this year's budget we have funded both the building and the operations of the Gungahlin walk-in centre. The reason we have prioritised that is because there is an existing community health facility in Gungahlin town centre and there is capacity to quite easily add the walk-in centre there.

The work that we will be doing over the next year is to plan for the Weston Creek region walk-in centre. That work is underway as a result of this budget. We need to identify a good location for that. That work has only just started. I was at the Weston Creek Community Council about five or six weeks ago and I spoke to them about the location. There was some other discussion about the broader need for community infrastructure in the region, and we will keep that in mind, too, as we go through the planning for both the location of the walk-in centre and potentially any other community infrastructure that the ACT government might have already invested in or might look to invest in in the region.

MS CODY: I have used the Tuggeranong walk-in centre on numerous occasions. Is this also working towards helping people on the south side to access medical care? I note that the budget talks about that.

Ms Fitzharris: Certainly, and we have the grants to bulk-billing practices on the south side as well. That is really around the Molonglo Valley and the Tuggeranong region. The reason we made those commitments is that we know there is a relative lack of access to bulk-billing practices on the south side. We know, as you know very well, about Weston Creek and the growing Molonglo Valley. Again it goes to the growth of the city and the changing nature of some parts of our city. With brand-new suburbs in the Molonglo Valley and a much older region adjacent to it in Weston Creek, there is a need for additional community infrastructure.

A piece of the work that we will be looking at over the course of developing the

Gungahlin walk-in centre is how we can even further improve the model. With respect to some of the ways that we might look at that, the walk-in centre model is quite specific to its own region. For example, the Gungahlin town centre has a number of local GPs, and many of them bulk-bill. Perhaps there is an opportunity to work even closer with them in the development of a nurse walk-in centre in Gungahlin.

Weston Creek and the Molonglo Valley in particular might have slightly different needs. That is part of the work that we will do, because we know that the nurse walk-in centre model is successful and we know we can potentially look at improving it to provide better access to the walk-in centre as well as using our facilities and our services to provide better access to primary care, which is one area, particularly with GPs, that the ACT government does not have a direct role in. I am certainly interested in making much better use of our enabling power to better connect those services for people in the community, particularly where they are accessible, particularly where they are free and particularly where they provide services that are currently not available, particularly on the weekends and after hours.

MRS DUNNE: I have a supplementary. In relation to the proposed Gungahlin walk-in centre, you mentioned, minister, that there might be cooperation with existing practices. Before the announcement, was there discussion with the existing practices in Gungahlin about how the situation of a new walk-in centre might fit with the existing medical services provided in the town centre?

Ms Fitzharris: I certainly understand that over the years there have been discussions with a range of stakeholders, including individual practices, as well as representative bodies. Labor made this commitment last year around building a nurse walk-in centre in Gungahlin. There have not been specific conversations yet, to my knowledge, with local practices one on one, but there will be.

MRS DUNNE: You said in the past there have been some conversations. Could you, on notice, outline what those conversations were, when they took place and with whom?

Ms Fitzharris: I believe there were conversations around the development of the nurse walk-in centre model some years ago. I will see what we can provide.

MRS DUNNE: So not specifically about the development of a walk-in centre at Gungahlin?

Ms Fitzharris: Not specifically, to my knowledge, no.

MRS DUNNE: That was my question in the first place. You did touch on this before: with the grants for bulk-billing, could you elaborate on what you think those grants will look like and what they were before?

Ms Fitzharris: I will hand over to Mary Wood.

Mrs Wood: The government has announced the grants to assist with bulk-billing. There are a variety of ways you can do that. As the minister alluded to, the decision for doctors to bulk-bill is one for them. There will be a number of criteria that we are

developing to provide incentives for doctors to bulk-bill, and possibly allied health professionals, too.

MRS DUNNE: For example? You are still in the process of putting together these incentives; is that the case? Was this a cabinet submission without having the incentives built into it?

Ms Fitzharris: There will be grants, and when the grants go out—

MRS DUNNE: What are the incentives?

Ms Fitzharris: We are developing the criteria for the grants scheme. That work is underway at the moment. Some of the additional allied health services could include, for example, physiotherapy and diabetes support management. One of the things we will do is talk with some of the stakeholders, who may be able to inform the criteria for that grants scheme so that it achieves the outcomes that we are looking to achieve: to provide better primary health care in regions where there currently is a relatively lower provision of primary health care, in ways that the ACT government can support existing and new practices.

MRS DUNNE: Is the aim of the scheme to provide expanded primary health care or to provide expanded bulk-billing?

Ms Fitzharris: Both. Where they may be bulk-billed, primary health care services delivered in existing or new practices in the Tuggeranong Valley or in Molonglo.

MRS DUNNE: Okay, thank you.

MS LE COUTEUR: First, I have a supp on the walk-in centres. You talked about Gungahlin first, because physically that is sorted. But do you also look at the average income, for instance, to establish an area of need for walk-in centres?

Ms Fitzharris: Not specifically. In terms of—what do you specifically mean?

MS LE COUTEUR: At the bottom level, the walk-in centres are free and thus are affordable to everybody. Do you look at areas of Canberra where affordability is more of an issue because they are free?

Ms Fitzharris: Not specifically, other than to say that where there are two existing nurse walk-in centres in Belconnen and Tuggeranong, what we know is that suburbs in those two regions are among the lower income suburbs in Canberra where we see more specific locational disadvantage, particularly on the fringes of some of those regions as well.

Certainly in the context of both the walk-in centres and the bulk-billing grants, particularly with the bulk-billing grants, we did see that if you looked at a map of where there are existing bulk-billing GP practices in the ACT, it is quite clear that there is a gap in the southern parts of the ACT. This was specifically why there is a focus on Tuggeranong. But also because of community infrastructure that is currently in place in Molonglo, we had also identified need there.

MS LE COUTEUR: What I was actually going to ask is this: what role has ACT Health played in the establishment, or beginning the establishment, of the drug and alcohol court? I appreciate that it has not quite been established yet.

Ms Fitzharris: In the very early stages the primary objective that I have is to work with the Attorney-General around the provision of alcohol and drug services as a result of the court being established, but that work is very much in its early days.

Ms Feely: ACT Health had input into the business case that was developed by the Attorney-General's department.

MS LE COUTEUR: Are you working on how there will be adequate pathways for people, because that basically is what my question was going to be? What pathways either now exist or will exist in the future to ensure that people are not only directed to rehabilitation services but also, basically, can actually get there immediately so they are not stuck on a waiting list for six months or a year, in which case the whole purpose is gone?

Ms Fitzharris: That is a very important part of the work that is underway at the moment. Really, the purpose of the drug and alcohol court is to provide better access to services, remove people from the justice system and provide more equitable and better outcomes for people who do have drug and alcohol addictions. It is very fundamental that this is a system-wide approach and not just about establishing a court. That is very much on my mind, as it is on the directorates' minds that are involved in this.

MS LE COUTEUR: Do you think that in the future there will be more funding for these services? My understanding is that there are waiting lists at present.

Ms Fitzharris: I suspect that we will be having this discussion in next year's estimates and also looking at the effectiveness of our existing programs as well and, with the establishment of a court, how that all works together.

MS LE COUTEUR: Finally, how do you coordinate with JACS and any other agencies to manage cases at present across the health and law enforcement agencies?

Ms Fitzharris: There would be a number of different programs. The one that first comes to mind I think is the through-care program, but of course there are—

MS LE COUTEUR: That is fairly much a minority of the population, we can say.

Ms Fitzharris: Yes, it is, but also, of course, there is the role of justice health, which is within the ACT Health Directorate. It is within Minister Rattenbury's portfolio. I think it is listed in these hearings for Minister for Corrections. He is responsible for justice health, for the mental health part of the portfolio. There is a range of work underway. I do not know if we can talk specifically to that; I will invite Tina Bracher to come forward and talk to that.

Ms Bracher: The specific question that I heard you ask is: how do we work with

corrections to—

MS LE COUTEUR: Not just corrections; other agencies. I guess I am specifically saying not just corrections. I am aware of the through-care program.

Ms Bracher: Absolutely.

MS LE COUTEUR: But hopefully not everyone with drug and alcohol programs ends up in AMC. How do you work with the rest of the ACT government to manage cases?

Ms Feely: I will jump in here before we go back to specifics in relation to justice health. There is a subcommittee that has been formed across jurisdictions. The D-Gs from education, Community Services, Health and JACS all meet on a regular basis. We are working constructively to look at numerous issues, but that is the primary group that meets. We are working through setting up the strategies as to how we can close the gaps on certain issues, how we can prioritise delivery of care in a coordinated fashion. So there is that group.

We also meet as directors-general every fortnight. Matters are often raised at the strategic board. That is where we have a lot of discussions and, believe me, there is a lot of telephone traffic between various directors-general if things need to be elevated. We speak very regularly between the four of us on a whole variety of issues. In a general sense, there is an overarching strategic group of directors-general that meet to discuss these issues. I will now hand back to Tina Bracher to answer your question about the justice health and the mental health issues in particular.

Ms Bracher: To pick up more broadly, for the division that I manage we have a lot of connections across government. We work very closely with police and our crisis team works very closely with police in supporting people in community and having more of a health response than a police response in community, and with the Ambulance Service as well.

Under the new Mental Health Act ambulance officers can now be officers that can detain people under the Mental Health Act. That is an example of how we work with police. We work very closely with the court system. We provide a lot of court reports for people around their wellness to present to court and any mitigating health issues, and mental health issues specifically, that might have been part of their judicial process.

We work very closely with the Community Services Directorate in a number of their portfolio areas: care and protection and ACT Housing in particular. We work very closely with those directorates to try to support the mental health care of people in community and who are coming out of prison.

We also work across government with the department of education. We have a couple of joint initiatives to reach into schools. We certainly have close contact with the teachers in schools through our CAMHS service, the Child and Adolescent Mental Health Service.

MS LE COUTEUR: Thank you.

MRS DUNNE: I go to the issue of elective surgery waiting times. I want to delve into strategies that might be used to address this. Can you tell me what the average occupancy is for the surgical suites that are dedicated to elective surgery in the ACT and the Canberra Hospital?

Mr Bone: Yes. The overall occupancy for the hospital sits at 90 per cent.

MRS DUNNE: No, the surgical suites, not the hospital.

Mr Bone: Specifically on the surgical wards, I would like to take—

MRS DUNNE: No, sorry, I am actually meaning the theatres.

Mr Bone: The theatres?

MRS DUNNE: Yes.

Mr Bone: Can I take it on notice, please?

MRS DUNNE: Okay. Just to clarify, what I am asking is: what is the occupancy rate for surgical suites?

Mr Bone: Yes.

MRS DUNNE: Specifically—you guys might stand to correct me—are there surgical suites which are dedicated to elective surgery?

Mr Bone: No, the—

MRS DUNNE: Or it is all—

Mr Bone: theatres do both planned and unplanned surgeries.

MRS DUNNE: Sorry?

Mr Bone: The theatre suite does both planned and unplanned—

MRS DUNNE: Okay, so it is all in?

Mr Bone: Yes.

MRS DUNNE: So you do not have dedicated suites for elective surgery?

Mr Bone: We have allocated theatre times, yes.

MRS DUNNE: You have allocated theatre times, but they are not dedicated to particular suites.

Mr Bone: Yes.

MRS DUNNE: Are you looking at options in relation to reducing waiting times that would increase the throughput of the theatre suites?

Mr Bone: Yes, we are always looking at options to improve the throughput of theatres.

MRS DUNNE: Could you elaborate on what the options might be?

Mr Bone: We are currently exploring the time that we start theatres, the turnaround time for patients between cases and how we use each of the allocated times, both in the planned and unplanned theatre suites, so that we are maximising each of the session times for patient throughput.

MRS DUNNE: Are you looking at, say, extending the hours of operation into later in the day or on to weekends?

Mr Bone: We already use the weekend option, and we are re-exploring that in the 2017-18 budget so that we can minimise our over-boundary patients.

MRS DUNNE: Sorry, over-boundary patients?

Mr Bone: Those patients waiting longer than—

MRS DUNNE: Yes, okay.

Mr Bone: clinically appropriate.

MRS DUNNE: Yes, thanks.

Mr Bone: We are not at the stage, that I am aware of, of exploring the use of theatres further into the evening.

MRS DUNNE: You are using them on the weekends but not—

Mr Bone: Yes.

MRS DUNNE: What time do you normally pull up stumps on a weekday?

Mr Bone: I would need to defer to Daniel Wood. Daniel Wood is the acting executive director for surgery and oral health. He would be able to answer that far better than I can.

MRS DUNNE: Okay.

Ms Fitzharris: Could I just add to that—for the committee's benefit and to recognise the quite extraordinary work that has been done over the past 18 months to reduce the elective surgery waiting times—with the blitz that was undertaken over that time, as of 30 September 2015 there were 1,442 patients on the long wait list and as of

31 March this year only 292. That has been a significant reduction through some of the strategies that were mentioned, but of course the main impact is on those people who were on the list and who no longer are. We will continue to focus very heavily on that. We are also introducing a new strategic indicator around that to demonstrate the focus of ACT Health on keeping these lists low, because we know that they do have an impact on patients.

MRS DUNNE: Are you saying that there are now only 292 people who are waiting longer than clinically advised for their—

Ms Fitzharris: As of 31 March?

MRS DUNNE: As of 31 March? How was the reduction of 1,200 or 1,400 achieved? Was that through the blitz? There was a lot of orthopaedic work done at John James?

Mr Bone: Yes.

MRS DUNNE: And what else was done?

Mr Bone: We had the blitz, where we used increased capacity in theatres, we used weekend work and we used work with our private partners to achieve that reduction.

MRS DUNNE: Could the committee get on notice, please, the breakdown in the cost of the blitz between the allocation of private providers and extra hours et cetera?

Mr Bone: The different initiatives?

MRS DUNNE: The different initiatives in that blitz?

Ms Fitzharris: We can provide that. I just note that those procedures undertaken with our private partners were undertaken at public hospital rates. That was part of that. We can provide more information on that.

MRS DUNNE: Going back to the theatres and their operation, what time do you pull up stumps, generally speaking? What time do you plan to pull up stumps on a weekday for elective surgery?

Mr Wood: Thank you for the question. Routinely at the Canberra Hospital and Health Services operating rooms, elective lists are scheduled to finish at 5 pm.

MRS DUNNE: Routinely?

Mr Wood: Routinely.

MR COE: What time do they start?

Mr Wood: Scheduled theatre start time is 8 am. Patients are ready to go for their surgery at 8 am. They will have their work-up prior to that for elective lists.

MRS DUNNE: In relation to the blitz, apart from outsourcing to private providers,

where did you find the staff for the extended hours in the theatres?

Mr Wood: During the elective surgery wait list reduction strategy, the blitz?

MRS DUNNE: Yes.

Mr Wood: We utilised extra hours and additional hours for our part-time and full-time staff in nursing; we used our VMOs for anaesthetics; and we used our VMOs and our staff specialists for surgery—surgeons.

MRS DUNNE: Within existing capacity? You did not recruit extra staff for a limited period to—

Mr Wood: I will take that as a question on notice.

MRS DUNNE: In relation to the extended periods, did you have to buy extra kit? You have to have a certain amount of surgical kit and you cannot reuse it on the same day and all that sort of thing. If you were extending the time of operation, did you have to buy extra surgical kit?

Mr Wood: It is my understanding that some additional surgery equipment was purchased.

MRS DUNNE: Could you elaborate on that on notice?

Mr Wood: Yes I could elaborate on notice.

THE CHAIR: Minister, what did you say the figure was as at the end of March?

Ms Fitzharris: Two hundred and ninety-two.

THE CHAIR: Are you able to provide on notice what that figure has been at the end of each month from January through to the end of May?

Ms Fitzharris: Yes.

MR PETTERSSON: Minister, I was wondering if you could expand on the new preventative health strategy announced in the budget.

Ms Fitzharris: You may be aware of much existing work that has been undertaken on this across a wide range of portfolios right across government. Really the work is looking at what we know is a growing burden of chronic disease on the population, and what that means is that people get sick and they live with chronic disease over a long period. It impacts on their ability to be productive, to be healthy, to participate in the workforce, to participate in normal day-to-day activities. Some of those statistics are really quite alarming, particularly around people living with chronic diseases such as heart disease, diabetes and a range of other diseases.

We made a commitment last year to develop a preventative health strategy. That work has begun. It is important to note that it builds on existing work. We held a

stakeholder forum in April, to which some members present came. I did extend an invitation to the committee on health and ageing, I think it is officially called, of which a number of members were able to come, which was great. That really demonstrated my intention to involve as many people as possible in this work. My objective is to have this work completed by the end of this year as a result of the forum. We were also lucky enough to hold that forum on the back of a Public Health Association global conference in Melbourne. We had a couple of international speakers join us, which was terrific.

My next step is to continue our work within government on the healthy weight initiative, which was an initiative funded under the towards zero growth strategy, which was really the government's obesity strategy which was developed four or so years ago. My next step is to actually engage directly with the community around preventative health, to talk directly with the community in an engagement process that has a broader conversation with the community about what measures they think might be successful. We have a lot of excellent data; we have a lot of excellent work; and I think our practitioners are widely in agreement on it.

Dr Kelly and I attended a forum a couple of weeks ago at Parliament House called prevention fest, which was a discussion and a launch of a document from the Australian Health Policy Collaboration about certain measures that governments could take collectively across Australia. There is a lot of work that we can do here. There is a lot of work that we need to do nationally.

I think there are a couple of sectors that have not really been as broadly engaged as they could have been. One is the broader community, and the other is probably industry. There are some real challenges with some industry-related issues that I am interested in working through.

One of the things discussed at that forum was that we really know now that the evidence is very strong about what the biggest risk factors are and what the implications are for individual health and the community's health. We need to get out and make the case to the community so that we can build up their desire for governments to take action.

MR PETTERSSON: You mentioned some industry-related issues. What are they?

Ms Fitzharris: In fact, we have a pretty exciting program that we developed in partnership with the Canberra Business Chamber—and I could get Ms Overton-Clarke and Dr Kelly to speak to it—with a couple of local businesses to work with them about better ways to promote healthy eating and healthy choices in their venue. One was a cinema. One was two IGAs, one in Nicholls, one in Kambah. One was the Hellenic Club. The other was a cafe in Macgregor. That provided some really interesting data that it is not bad for business to promote healthy food choices in their venues, and that was a good piece of work that we will continue with the Business Chamber over the course of the next financial year.

There are some broader industry-related issues that are in the domain of health ministers, really with food ministers, around labelling of foods, in particular added sugar and "as prepared" labelling on food packaging. That is something that will be

discussed amongst food ministers later in the year.

Of course in this budget we have invested another $4 million in a range of preventative health initiatives which we will work on at the same time as we are working on the preventative health strategy.

MR PETTERSSON: You mentioned the healthy weight initiative a couple of times. I ask this question, and I cross my fingers: how is obesity tracking in the ACT?

Ms Overton-Clarke: I have been chairing the healthy weight initiative with Dr Kelly over the past 3½ years, and the whole emphasis, of course, of the strategy has been on an across-government program. As the minister says, in the transition to the preventative health strategy we will be making sure that it stays very much as targeting all sectors of the community.

Certainly a big focus in part has been through schools and the work that has been done with school children, including assessment of canteen menus. We recognise very much that children are our future and that the impact on them can be the greatest, but of course we have been modelling across ACT government and, as the minister says, into workplaces—all sorts of government effort across the way. As the minister just said, we are actually, after three years, seeing some very promising results. Ensuring that children in particular are maintaining the amounts of fruit and vegetables in diets and physical activity is a large part of it. I will hand over to Dr Kelly to talk about the results of some of the evaluations.

As you can imagine, a number of these things are reported on an annual basis. So we have got some results on an annual basis, and some are on a longer period. But we are really pretty excited about the children's results.

Ms Fitzharris: That 2016 report was released just this morning, and at a very high level it does show that fewer kids are drinking sugary drinks, more kids are walking and cycling to school, lots of people—kids and adults included—are eating enough fruit but not enough veggies. Once again, if everyone eats more veggies we will be doing better. There are a whole range of different initiatives which have really contributed to this quite outstanding result, and I think the work done a number of years ago on those policies is a policy that other governments are looking at and implementing in jurisdictions across Australia.

Dr Kelly: The original question was about the preventative health strategy. This is a very welcome development, and we are really looking forward to expanding and refocusing the healthy weight initiative. As has been mentioned by the minister and also Ms Overton-Clarke, there has been some really excellent progress over the last while.

In terms of the growth of obesity, zero growth, and whether that is sustainable, that is a long-term prospect. I have said to this committee before that this is a marathon, not a sprint. It has taken us a generation to get to where we are. It will take a generation to get back to where we should be in terms of obesity broadly in the community.

What we have put in place, though, to chart that progress is a whole bunch of interim

measures, and many of them have been mentioned already. Very excitingly, I know, because this is the first time anywhere in Australia we have been able to reverse the decrease in riding and walking to school in the primary school age group. In the report that was launched today there is evidence for the first time that we are actually not tracking the same way as every other jurisdiction in that age group in terms of active travel to school but in fact we have reversed it.

That talks about doing evidence-based work, which is feasible, and we have done that through pilot work. We have scaled it up so that now the majority of kids in the ACT have access to the programs, not only the ride and walk to school program but fresh taste, which is another one around nutrition in schools. We are taking a very systemic approach in that setting. They are two programs that are reported on in the evaluation. The other one the minister went to last week—I do not know if you want to talk to that—is it's your move.

Ms Fitzharris: Yes, certainly. It is also a measure now in the budget papers. It's your move is a program with high school students. As Dr Kelly mentioned, we had a really exciting opportunity last week to go to one school where four schools competed against each other to make a pitch to a shark tank, which was made up of Mick Spencer—I do not know if anyone knows Mick Spencer who was on the TV program *Shark Tank* and runs ONTHEGO Sports—and Dr Greg Boland from the University of Canberra. The students pitched to us their ideas that have been developed through a design thinking approach with high school students. We had four pitches, all with quite different things. All four addressed key issues around preventative health.

The one that won was a fantastic program from Lanyon High School where they particularly recognised issues in their local area about kids after school not having access to activities. There are a lot of kids who may not want to be involved in competitive sport, may not be able to afford to be involved in competitive sport, which, for me, was a particularly good approach about this group. They are going to have a student-led program, run after school, just for kids to be active. It is for those kids who are not otherwise involved in organised sport; it is just not for them. They recognised that there was this gap; they were going to fill it. They were not only going to fill it for their school, they were going to fill it for the surrounding schools in the region as well as those kids coming from primary school, going to the primary schools in their local region and saying, "When you come to Lanyon high you will be able to get involved in this. Not only will you be able to participate but when you get into year 10 you will be able to be part of a leadership group that will actually run this program." They won $1,500 to develop this program. I will be really excited to see how a particular student-led program can have some sustained change in that school. It was great.

Dr Kelly: The minister mentioned the prevention first event the other day. One of the key elements that came from that, to me, that I heard was that the hardest to reach group in this in relation to healthy lifestyles broadly, but particularly in relation to good nutrition and physical activity, is that teenage group. It is a real transition moment. The fact that we have been able to roll this out now into a number of schools—and we want to maintain that into the future—is a really important thing, I think. Whilst these could be seen as small, fairly encapsulated issues, if you roll it out to all high schools then you are covering that whole group—not everyone will engage

but a number will—and that will spread the word about health, not only physical but also mental health.

MR PETTERSSON: Something that has been playing on my mind this whole time is: how do you gather the data on these measurements of childhood obesity? Are there physicals going on in schools? Is that where we are getting these numbers from?

Dr Kelly: We have a number of data sets in relation to this. Firstly, we have the information about birth weight, so that is where it starts. Every child born in the ACT, their weight is one of the elements that is collected so we have the start point. We have our kindergarten screening program, and whilst that is a voluntary program, almost all kids entering kindergarten are part of that program. That is actually a measured weight. We have a survey program in year 6 currently, which is not every year—it is every three years at the moment—but that is a self-reported weight. We also have a weight measurement in high school—another survey—and then our general health survey which includes children.

One of the other announcements made in the budget was around the year 7 health check. Whilst we have not worked out fully what will be checked at that point, definitely one of the considerations is about looking at how we can monitor that age group.

MS LE COUTEUR: Thank you for all these. I am not sure I have managed to take it all in, but there is one I am interested in. With the funding that will come out of this, is this going to be potentially allocated to NGOs? Will there be some sort of tender process for the community to get involved?

Ms Fitzharris: Possibly. Nothing is ruled out. As I said at the forum, nothing is ruled out and there is that possibility. I am also conscious that we have a range of health promotion grants and health innovation grants which we are currently looking at in the scheme of all of this.

One of the issues we need to consider is how much money we are already expending on a range of prevention measures. But the simple answer is that nothing is ruled out, and we know that when NGOs are in close partnership with us and also with the commonwealth we can have greater bang for our buck with the NGOs delivering some of these programs than with us doing it directly.

MS LE COUTEUR: The impression I get from the discussion is that the scope of preventative health is basically everything apart from surgery. Is there, in fact, a more defined scope?

Ms Fitzharris: I will let Dr Kelly talk to this in particular, but certainly one of the things that came up at the forum we held in April was that prevention can apply very broadly to a whole range of things. In my invitation letters to people for the forum it was quite specific about the key risk factors identified that lead to long-term poor health outcomes. I have said even though the preventative health strategy will recognise other work the government is doing—obviously we have significant work underway in domestic violence and in terms of affordable housing—the healthy weight initiative in itself is a reflection of how whole-of-government some of these

initiatives are. The preventative health strategy will be quite specific on our key risk factors, in particular looking at the impact it has in terms of heart disease and diabetes for a start.

Dr Kelly: The definition of "prevention" is broad. It is important, as has been stated in various announcements from the government, for the preventative health strategy to focus on something that is manageable. We have started with healthy weight. That is looking at just a couple of things in a way but they are important elements in terms of prevention and risk for chronic disease, which we know is causing not only a large amount of the burden of disease for our community but also a large amount of the health costs. We can do a lot to increase the size of the bucket, but if we are not turning off the tap that bucket will always overflow. My view is that prevention is absolutely key to all of these matters.

Dr Overton-Clarke: I add that one of the reasons that Chief Minister's and Health have sat so closely side by side over these past 3½ years—and as Dr Kelly has always reminded me and the rest of the steering group—is that evaluation is a really crucial part of all of this. While we have been focusing on both adults and people in the workplace and children, part of the move into the preventative health strategy is to look at what we have been doing over the past three years to see where the most effective impact we can have is through the evaluation that Health has been doing very carefully alongside. I think we have learned a lot over the past 3½ years, and the transition into preventative health is the natural next stage in terms of effectiveness.

MS LE COUTEUR: Minister, you talked a bit about some external consultation. Are these strategies largely being developed internally? Is there a consultation plan?

Ms Fitzharris: Yes, certainly from the forum. I think I may have just finalised a letter that was delayed because I was overseas for a couple of weeks, so my apologies for the delay in the letter coming out. But the letter was to follow up with people who participated in the forum and to talk about the broader engagement work that we will do with the community. We will keep in touch over the course of the next six months about the strategy itself.

MRS DUNNE: In relation to the accountability indicators—you touched on this, minister—you have a new indicator which is the number of schools recruited to it's your move, and that is 12. Is that aimed at high schools?

Ms Fitzharris: It is just high schools.

MRS DUNNE: So how many high schools do we have in the ACT?

Ms Fitzharris: How many high schools in the ACT?

MRS DUNNE: I am trying to work out the longevity of this accountability measure. If you are looking at 12 in the first year, how long do you expect it to be before everyone who can be involved is involved?

Ms Fitzharris: It is important to note that this is across all school sectors, so all school sectors are participating, just as they are in other programs like the ride and

walk to school and the active streets for kids programs, which fall under a different portfolio for me.

Ms Overton-Clarke: My notes say that to date more than 6,500 students have participated in or been influenced by it's your move initiatives in high schools.

MRS DUNNE: I was actually thinking about how many schools. If you want to recruit 12 this year and there are probably only about 35 or 36 high schools, that means that that is an accountability indicator that has probably a three or four-year life cycle.

Ms Fitzharris: It is probably also how it endures in schools as well. Given it is a new one in terms of recruitment, it may be that it changes over time to be an enduring feature of a high school and not just a one-off, that is, Lanyon high did it last year and they will not do it next year. We would like to keep the schools engaged on an ongoing basis in the program.

MRS DUNNE: It possibly means that that indicator needs a bit more thinking.

Ms Fitzharris: Yes, sure. I will take that on board.

MS CODY: You were talking to Mr Pettersson about the healthy weight initiative. Are we still using BMI as a measurement index?

Dr Kelly: Yes, that is the agreed international standard for looking at a population level. It often comes up in this committee, Ms Cody, about whether that is a good thing for individuals, and I will let other people decide themselves. There are issues at an individual level: big bulked-up people, particularly males, can have a large BMI but not a high fat content, for example, and the opposite could also be true—people with a low BMI may still have excess weight. But at a population level it is important to think that we have not all just beefed up like the Brumbies over the last little while, all 400,000 of us, so it evens out over time. There are particular technical issues in relation to children because of growth and so forth, but if you account for age in those statistics, as we always do, that also evens out over time. As a way of tracking how things are going at a population level, it remains the gold standard, if you like.

MS CODY: Is there any appetite to look at that?

Dr Kelly: If the WHO and the CDC in the US change their recommendations, of course we will look at it.

MS CHEYNE: My questions relate to youth mental health. A variety of reports and statistics are available to indicate that about 25 per cent of teenagers, in particular teen girls, have depression or anxiety. I appreciate there is a budget initiative for health checks for year 7 school students to identify students who are at risk of developing moderate or severe mental health issues or chronic diseases and I appreciate that is a step in addressing issues early. But apart from referral programs like Headspace and CAMHS as well as the proposed adolescent mental health unit planned for the centenary hospital, what specific programs or initiatives are available for that 14 to

17-year-old cohort?

Ms Bracher: In this current budget cycle we have a couple of initiatives focused on that age group in our CAMHS service. There is an extension of our consult liaison service in the Canberra Hospital. We have CAMHS clinicians—child and adolescent mental health clinicians—assessing adolescents over the weekends as well as during the week. Currently it is our general mental health clinicians that do that, but we are focusing specific CAMHS skills into that service.

There is also some enhancement of a program that we currently run into schools, which is an in-reach program where we work with the teachers and the Department of Education psychologists. That has been underway for a year or 18 months now.

MS CHEYNE: Enhanced in what way?

Ms Bracher: Some additional budget for additional full-time equivalents: 2.2 FTE in addition to the current cohort. Our intention with the budget initiative that has gone into the Department of Education is to work closely with the new psychologists in Education as a conduit between those on-the-ground psychologists and our child and adolescent specialist mental health service. They are the new initiatives focused on this age group in self-harm and mental illness and across the whole spectrum.

Our child and adolescent mental health service is focused on the mental health and wellbeing of young children, young adolescents in this age group. We have two child and adolescent mental health teams, one on the south side and one on the north side. There are something like 16 full-time equivalents in both of those teams that see a range of children and young people in the context of their families.

MS CHEYNE: If they go through CAMHS, what is the average time for people to get an appointment? When they first make contact, how is someone determined to be a priority?

Ms Bracher: In all of our mental health services we do an emergency screen, and all emergency presentations get seen on that day. I will just make the point that that is for CAMHS or older persons or our adult services.

MS CHEYNE: What does that screen involve?

Ms Bracher: It is a mental health screen that our mental health clinicians do. It assesses risk of suicide and self-harm.

MS CHEYNE: It is a series of questions, presumably?

Ms Bracher: Yes. There is a national triage scale that our crisis team uses. It is a nationally validated triage scale for mental distress and risk. Our crisis team uses that, and that has a decision-support algorithm behind it where—please don't quote me on the numbers—if somebody is rated as a one, they need to be seen immediately; if somebody is a two then it is within 24 hours or something, right through to the person can be seen the next day or over the course of the next week. I believe the triage scale is one to seven.

MS CHEYNE: Mental health is not an exact science. I am trying to think of a sensitive way to talk about this, but are there occasions when triage assessments are wrong?

Ms Feely: The management of risk?

MS CHEYNE: Yes, that is right. For example someone might not have a plan in place so they are not a priority but they are still at risk, and then three months later or something like that—

Ms Bracher: We take a risk management approach. There are two points to make: we are a human service. Like any other aspect of health care, our clinicians all come to work to do the right thing every day, and sometimes they make errors of judgment. That is a very small proportion of the time, but we need to be open and transparent about that across all of Health.

The other point to make quite genuinely is that our risk assessments are a point-in-time assessment. For example, if somebody rings up our crisis team at 6 o'clock in the evening and a quite valid assessment is done at that point in time and then something in addition happens between 6 o'clock and a further incident, our crisis team is not aware of that and cannot take that into account. We have had a number of cases where significant incidence of self-harm and unfortunately suicide have occurred after a period of time following our assessment, even within 24 hours following our vigilant and accurate assessment at that point in time. If something has happened after that—there has been a change in the family dynamic or there has been a phone call or something—and that person's mental health deteriorates further unbeknownst to our service, unfortunate outcomes can occur.

MS CHEYNE: Thank you. I appreciate how candid you are being on such a difficult topic. We have touched on teen self-harm a few times. What are the broader strategies in place to reduce that?

Ms Bracher: You asked a question earlier about our wait times for our CAMHS service, the child and adolescent mental health service. I think that goes some way to answering your question about what strategies we have in place.

Up until 2015, we had a ring up and waitlist model of entry into our child and adolescent mental health service. Emergency people would get seen, but there was a number of weeks wait for people in quite significant amounts of distress; not life-threatening distress, but significant amounts of distress. We also were worried about those people and the wait time they had.

Our clinical director at the time and our operational director changed our intake model of care for CAMHS, our child and adolescent mental health service, based on a model from Townsville in Queensland and Western Australia where every person who rings up, every family, child or adolescent who rings up, is given a choice appointment. That usually happens within a day or two of that phone call. That choice appointment is an assessment done by a mental health clinician. We set those up. We have a child and adolescent psychiatrist—I am going to say "in the back room"—there. We have

three or four choice appointments where a mental health social worker, nurse or psychologist will assess the child or adolescent. They come out of that assessment and consult with the CAMHS psychiatrist, and then put a plan in place. That might be anything ranging from "We need to take you to the emergency department now" to "We need to refer you back to your general practitioner," "We can refer you out into a community organisation" or "We can make an appointment for you to come into our child and adolescent mental health service.

We now do not have a waitlist. We do not put people on a waitlist. We offer anybody who rings up an appointment, which might be a day or two down the track, but at least everybody has got an appointment. There is reassurance value for the family around that child that, "I have only got to get them here until there," which is currently two days.

MS CHEYNE: When did that initiative begin?

Ms Bracher: In 2015.

MS CHEYNE: On support mechanisms available, I understand there is a critical shortage of psychiatrists across Australia. Is there any work underway in ACT Health to help boost that or approach people to come to Canberra?

Ms Fitzharris: All of the above.

Ms Bracher: There is. You are right; there is a national shortage of psychiatrists. They are a speciality area, and an area of need. We can recruit through the commonwealth's area of need program internationally for international medical staff, and we do that. There is a long lead time in getting psychiatrists internationally. We have recruited a number from the UK over the past couple of years. The lead time is something like 10 to 12 months from interview to having the person on board.

What are we doing inside ACT Health? We have our registrar training program, which is around growing our own psychiatrists. That is an extensive time and resource commitment to growing our own psychiatrists. Three or four of our current registrar cohort will be starting as consultant psychiatrists with us over the next six to eight months, so they are almost there. We also use international and national recruitment companies to do executive-type searches for us. We have used those over the past couple of years to bring in—

MS CHEYNE: With success?

Ms Bracher: Varying. We recruited our two clinical directors through a recruitment company. Our community adult clinical director came through a recruitment company. Our child and adolescent mental health clinical director, who we have recruited just recently, was an internal candidate. With our forensic clinical director—that also changed over in the past six months—a recruitment company brought that candidate forward to us.

MS CHEYNE: I just have two final questions on this. I say it will be quick every time, I know, chair, but then I am done with this topic. I want to go to page 17 of the

budget statements C. Unless I am completely misinterpreting what this means, and I can be known for that, so please tell me straight away if that is the case, the accountability indicators under b in table 25, "Children and youth mental health program community service contacts", are accountability targets. How are targets determined? For me, it seems a bit backwards. Would we not want targets to be going down in terms of contacts? In some cases, would we want it to be going up because we want people to be accessing the service? I am just interested in how that target is calculated or determined.

Ms Bracher: You are right; the intuitive—

Ms Feely: It is not a bad question, no.

MS CHEYNE: She has asked herself the same question many times.

Ms Bracher: You are right: at a population level, we do want contact to be going down with the service.

MS CHEYNE: Yes.

Ms Bracher: That goes to the points that Dr Kelly was making earlier about the wellbeing of our community as a whole. With regard to clinical service provision and therapeutic interventions, for those people in need we would want an increase in access for people. This is an access indicator; it is not an outcome indicator. It is really just a measure of how many contact points people have with our child and adolescent mental health service. You will notice that some of the other indicators are also output indicators in the same way.

MS CHEYNE: Yes.

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Ms Bracher: How are they determined? Each year we measure our current performance against that range of measures. We know what our outputs are. Each year, we have been fortunate to have growth initiatives. We do a calculation with these. For example, with the child and adolescent consult liaison service that I talked about earlier, there will be some additional outputs that we expect that those additional staff will be able to provide. There is a calculation, year on year, of increasing our outputs based on our current performance and additional growth. Does that make sense?

MS CHEYNE: Yes, and I will re-read the transcript just to clarify my understanding. My final question is this. It is more just to save time on Friday. How does mental health in schools work? You mentioned the in-reach program. Is that all funded from the Education Directorate or does the office for mental health also fund school staff? What is the split there or the collaboration there?

Ms Bracher: The office for mental health is coming into view, and it is not a funding body at this point in time. We can probably speak on that more fully in the next estimates round.

MS CHEYNE: Sure.

Ms Bracher: Our interactions with the Department of Education are predominantly through our child and adolescent mental health service. The teachers ring up that intake line, as well as families, and they come into those choice appointments. We also have the early intervention team that I talked about a little earlier that goes into schools and runs programs, specifically in schools, designed around wellbeing. Last year, the Department of Education provided us with the names of two schools that they wanted us to focus on. We did an in-reach program that was really concentrated on and targeted around two schools, not across all of the schools. That is where the enhancement in this year's budget cycle has given us some additional FTE to work with education to target more schools but also to be that conduit between the initiative in the Department of Education around additional psychologists, to be the conduit between their psychology staff and our clinical service.

MS CHEYNE: Thank you. Thank you, chair; I appreciate your indulgence.

Ms Fitzharris: Could I just mention something on a broader point. I know that Minister Berry and I have spoken, and will continue to speak, as our directorates do, about the range of programs. I have responsibility for programs in Health—in fact, in all my portfolios, but principally in Health and Transport Canberra and City Services—that have a presence in schools or are about schools, particularly when you think about ride and walk to school and traffic management around schools, so we are very conscious that there is an intersection and we know that the directorates work closely on that. We also have school nurses within ACT Health that have a presence at some schools. We are looking to expand that over the course of the term.

We are very conscious that there is a range of work. We are also conscious that, as in many forums that I go to, people say, "In order to improve health outcomes for kids, can't you just run this, this, this and this through the school curriculum?" I am very conscious that there is a lot asked of the school curriculum, there is a lot asked of teachers to deliver that, and a lot of different areas look to achieve outcomes for kids in a six-hour window of kids' schooling, 40 hours a week. There is a lot that needs to happen outside of that to embed some of those initiatives. Minister Berry and I are both very conscious about that and the impact that it has on schools and getting the right balance with the right programs being run through in school time.

I will just go to the Lanyon High School example, which is another example of where you can effectively use school grounds. I know that Minister Berry is very keen on this. At the end of the school day and in the school holidays, you have school facilities available for community use, to broaden that out to a whole range of initiatives.

THE CHAIR: We had scheduled a break. Do people need to stop or are we happy to continue through? We will continue through. Mrs Dunne?

MRS DUNNE: I just have a follow-up mental health question.

THE CHAIR: Yes.

MRS DUNNE: In relation to the budget initiative on page 103 of what used to be called BP3 in relation to the office of mental health, what is the current thinking in

relation to the office of mental health? When I received a briefing, I think in February or March, there was a discussion paper foreshadowed for the structure of the office of mental health. Have I missed the discussion paper? Has it come out?

Ms Fitzharris: More broadly, I would make a comment on Mr Rattenbury's behalf that it is very much on his mind that again he is not ruling anything out at this point. He is very keen to establish that and demonstrate the government's commitment to it through the funding over the next four years.

MRS DUNNE: I am just wondering how you work out what the funding is if you do not know what it looks like.

Ms Fitzharris: There may be a range of ways that existing funding is brought together. We certainly know that there is a foundation of funding demonstrating the government's commitment to establishing the office over the next four years. There is a lot of work to be done to build on that $2.9 million commitment in this year's budget.

MRS DUNNE: And the discussion paper? What has happened with the discussion paper?

Mrs Wood: I can answer that. There is a draft discussion paper being prepared for Minister Rattenbury.

MRS DUNNE: But it has not seen the light of day?

Mrs Wood: No, so it has not been circulated yet.

MRS DUNNE: It was just that it was foreshadowed with me in February or March that there was a discussion paper, and I just wanted to make sure that I had not missed it.

Ms Feely: There will be, and I might just say that Minister Rattenbury will be expecting a discussion on it when he returns from overseas.

MRS JONES: I want to ask some questions around the policies and procedures in the health unit at the AMC. I have been trying to find out a little more information about that through other portfolio areas, but effectively it sits here. How is policy determined for that unit? Who reassesses that unit as it comes to light that we can do better? For a start, that is what I want to understand. How does that work in the department?

Ms Feely: May I jump in? Two areas that I am hearing: how do we assess or do our own policy and then the second bit—

MRS JONES: For that health centre.

Ms Feely: And then the next bit is about what we are doing to look at how we can improve on our delivery. Are they the two parts of the question?

MRS JONES: Are they separate? Are they separate functions?

Ms Feely: Tina, can you answer the first question and I will jump in on the second?

Ms Bracher: The high level policy for having a health service run through the Health Directorate and custodial care run through Corrective Services is embedded in the Corrections Management Act.

MRS JONES: Yes, I am not asking about the legality of it—

Ms Bracher: No, so—

MRS JONES: I am asking about functions within the directorate. Clearly, there has to be some sort of cross body between corrections and Health? Is there such a thing or does no such thing exist?

Ms Bracher: That is where the underpinning principles start. In terms of operational health policy, we determine that inside Health in consultation with corrections. With some policies—operational policies and procedures—around how nurses might do x, y or z, we do not necessarily ask a corrections officer whether that is evidence-based or not, but we do share policies with senior corrections staff around the impact of those policies that they might have on the operations at the prison. Likewise, we ask for corrections to do that with us for relevant policies that might impact on the health and wellbeing of detainees in the prison.

MRS JONES: The reason I ask is because at the heart of it I would like to understand better—to get very specific now—how it is that someone is administered methadone in the health centre and they are supervised for a period of minutes before being released back into the prison, but then we are finding that there is an issue of the regurgitation of methadone. For example, what is the process then for that person, as a policy, to remain longer in the health centre perhaps until we have a scientific basis for knowing how long that methadone remains in the stomach and how long it is until the methadone exits the stomach and is no longer an option for inmates to vomit?

Ms Feely: Regurgitate, yes.

Ms Bracher: When the AMC was first commissioned we did have a shared policy with corrections that the corrections officers would observe the detainees for a period of time after dosing.

MRS JONES: In the health centre or outside the health centre?

Ms Bracher: Actually, initially, for the first six days when a detainee starts on methadone we had a policy where that detainee would come up to the health centre and be observed by Health staff for a period of time after that. Then when detainees were being dosed out in the blocks after those six days, the corrections officers would monitor them for a period of time after they were stabilised on methadone.

Over the course of a number of years with the increasing numbers of detainees, that put pressure on to corrections and on to Health staff to bring the detainees up to the

health centre in sufficient numbers. I think it is fair to say that the observation capacity of corrections and Health was impacted by the numbers of people in the prison over time.

What we have done over the past year, though, is acknowledge and recognise that that is a risk issue. We have now gone back to our process of bringing detainees up to the health centre for the first six days of dosing, if they are inducted onto the methadone program, to be monitored up there very closely by Health staff, nursing staff.

MRS JONES: So as in being housed, but the entire time or—

Ms Bracher: No, no, for the—

MRS JONES: No, simply after dosing?

Ms Bracher: to come up to the health centre to dose, to stay in the health centre for a short period of time—

MRS JONES: How long?

Ms Bracher: They stay up there for up to half an hour, I believe. I can check that number for you.

MRS JONES: Is that based on the methadone exiting the stomach or not?

Ms Bracher: No, it is not based on methadone exiting the stomach. We benchmarked across a number of states as to what their practice was and also our practice in the alcohol and drug service. Without getting too graphic, methadone does not reach the stomach if it has been regurgitated. It is held in other anatomical bits before it is regurgitated.

MRS JONES: I think you should just be graphic, because people need to understand this.

Ms Bracher: Yes, people secrete methadone into their sinuses, up into the back of their nose, into their cheeks, into pockets inside their neck, some down into their stomach. Some people can regurgitate from the stomach.

MRS JONES: Thank you. Also, my understanding is that there is a system being developed for methadone being able to be given as an injection. Are you aware of that and are you looking into that as a possibility for the AMC?

Ms Bracher: I am not aware of methadone being given as an injection.

MRS JONES: I do not think it is available yet; what I have been told is that it is on the cards to be on the way.

Ms Bracher: It certainly has not been discussed, either in our prison-based health service or in our specialist alcohol and drug service at the Canberra Hospital, with the physicians there.

MRS JONES: Can I also check on Suboxone. Am I correct in saying that Suboxone is being administered to some inmates instead of methadone?

Ms Bracher: Yes.

MRS JONES: Are you able to supply, perhaps on notice, the decision-making parameters or how the decision is made about whether it should be Suboxone or methadone for an individual?

Ms Bracher: I can answer that question. There is a medical clinical decision made about the relative benefits of methadone or Suboxone for people. That is a clinical decision and it will depend on each individual person. In the prison, though, because Suboxone is supplied in a—

MRS JONES: A tab.

Ms Bracher: plastic film that is put onto the mucosa in the mouth, it is much more easily divertible—

MRS JONES: That is right.

Ms Bracher: and corrections asked us, based on their intelligence that it was being diverted in the prison, not to use it actively in the prison. What we use Suboxone for is for the first two weeks—if somebody is on Suboxone in community and they come into the prison, we will provide Suboxone and gradually taper—

MRS JONES: My understanding is that Suboxone is not available as a government handout the way that methadone is. That is correct, isn't it?

Ms Bracher: Our building 7 opiate replacement service does prescribe and provide Suboxone as well as methadone, based on clinical assessment.

MRS JONES: That is those who attend, is it, the Canberra Hospital for that program?

Ms Bracher: Yes, or community pharmacies. People—

MRS JONES: Do they? Community pharmacies supply Suboxone as well as methadone?

Ms Bracher: Can do, based on a medical prescription.

MRS JONES: Again, my understanding is that, as you say, the problem with Suboxone is that it can be diverted because it is in a little tab and it can easily be hidden away in clothing or—

Ms Bracher: It is a plastic film or a gel film, actually, not a tablet.

MRS JONES: No, I said a tab—

Ms Bracher: I am sorry.

MRS JONES: Like a Listerine tab, yes.

Ms Bracher: Yes.

MRS JONES: Just to clarify, I understand that it is a clinical decision, but can you give the committee any information about under what circumstances Suboxone is more appropriate? Do you know about that or can you provide that information on notice?

Ms Bracher: Given it is a clinical decision, I would prefer our clinical director for addictions actually to provide that to us as a question on notice. We can provide that.

MRS JONES: That would be great. Also, I still would like to understand what the process is for adaptations or changes to the policies in that health centre, given what goes on in the broader prison. Is there a working group between justice and Health that actually drives any improvements that are required? This area is going to come more and more under scrutiny. We want to get it right. I think everybody wants to get it right, but it is not only Health's concern.

Ms Bracher: Last year we reconvened a collaborative forum. It was convened at deputy director-general level across JACS and Health.

MRS JONES: And how often does that meet?

Ms Bracher: It met three times towards the end of 2016. It has met once this year and it is meeting tomorrow, for the second time this year.

MRS JONES: Yes.

Ms Bracher: That is around the collaborative strategic planning, collaborative business case planning and collaborative policy making.

MRS JONES: Just out of curiosity, minister, if I asked for a briefing on what is happening on that with the discussions there at that level, would that be able to be forthcoming so that I understand how this process is improving?

Ms Fitzharris: I certainly imagine so. I was going to say that Minister Rattenbury is responsible for Justice Health—

MRS JONES: Yes, I do not quite understand how that works.

Ms Fitzharris: Principally because, as you say, it is an area that I know he is focused on as Minister for Corrections and Minister for Mental Health. The area is in the same division as mental health and I think he recognises—

MRS JONES: Do you mean that in his mental health capacity it sits under him?

Ms Fitzharris: Yes, that is right.

MRS JONES: Thank you.

Ms Fitzharris: He is particularly focused on improving the outcomes that these two directorates work very closely on day to day; so I am sure he would be open to that.

MRS JONES: Yes, he certainly needs to be.

Ms Fitzharris: With your question earlier, Mrs Jones, around injections, were you referring to a different method of delivering methadone, ie through eye dose?

MRS JONES: I do not know much detail of it. I was touring a correctional facility in New South Wales. It was mentioned that they were very excited in a sense because methadone was going to be able to be delivered intravenously through an injection. If that is the case, it does, as you can imagine, resolve some of these concerns—

Ms Fitzharris: It is different. I thought it might have been a different—

MRS JONES: because you cannot regurgitate an injection.

Ms Bracher: There are some slow release opiate replacement therapies that are available internationally. I would have to take on notice the reasons why they are not locally available. My understanding is that it is something to do with the TGA and the regulation.

MRS JONES: If that is the problem I think everybody in this place would be keen to see some conversations go on with the feds. If we have people dying and we could do things a bit better, I think we would all support improvements that are significant.

Ms Bracher: The other initiative that the minister has mentioned is the implementation of the electronic dosing system for methadone that we are implementing out at the prison. That is a dosing mechanism that helps us with ensuring that the prescribed dose is actually the dose that is given, that the prescribed dose for an individual person is actually received by the person. Because of the numbers of people at the prison now that are on methadone, we are actually needing—

MRS JONES: How many people are on methadone in the prison?

Ms Bracher: At any point in time that is a different number.

MRS JONES: Sure.

Ms Bracher: It is about 130 of the current muster—in that order.

MRS JONES: Are any of those people women?

Ms Bracher: Yes.

MRS JONES: I understand that there are two health centres now in the prison after

the upgrades as well. So that would change the—

Ms Bracher: There is one health centre but we—

MRS JONES: There is another clinical area or something?

Ms Bracher: do some satellite work out into some of the cell blocks.

MRS JONES: Obviously moving people around is the hardest thing in a—

Ms Bracher: Absolutely, yes.

MRS JONES: Thank you very much.

THE CHAIR: I have got a follow-up question. When someone enters the corrections system, particularly on presenting at AMC either as a remandee or after being sentenced, what determines whether or not that individual goes on methadone if their medical history is not accompanying them?

Ms Bracher: There are a number of reasons. If a person is on the methadone program in the community, we continue that in prison. We continue so that there is a continuity of care, like any other medication, in fact. We do check with the prescribing doctor in the community what their prescription is. A lot of the people are part of the other part of our service, the alcohol and drug service. We have got ready access to their prescribing and dosing information through that. There are a number of people who present to prison in withdrawal. We will do a screening withdrawal assessment. At that point, if the person is withdrawing, we organise for an appointment with the medical staff to do an assessment for prescribing. They are the two ways.

THE CHAIR: What effect does methadone or similar products have on someone that has been a regular user of crystal methamphetamine or ice?

Ms Bracher: We are starting to get into technical pharmacology. My plain English answer is that methadone is for opiate dependence. Crystal methamphetamines are a different chemical substance with an addiction, and methadone is not used for crystal meth addiction.

THE CHAIR: Is there a methadone equivalent that is available for an amphetamine-based addiction?

Ms Bracher: I asked the addictions physician exactly the same question: "What do you do for somebody who comes in really distressed with their ice use?" Likewise, the plain English answer is: the medications that they use then are the sedatives or the relaxants and the sedatives, not an opiate replacement.

MRS JONES: Is the sedative just during the withdrawal phase or ongoing?

Ms Bracher: It could probably be either, I would suggest—plain English version, not doctor answer.

THE CHAIR: Are there instances where there is a co-morbidity of substance abuse and an individual may be treated for both?

Ms Bracher: Yes. The incidence of poly drug use and poly addictions is high. They are not very likely to only be addicted to one.

MRS JONES: Someone might be taking an upper at one point in order to achieve a certain outcome and a downer for another within the same week, potentially.

Ms Bracher: Or what is available at a point in time when you are at using.

MRS DUNNE: This set of questions relates to table 24 on page 16 of budget statements C. What is the national efficient price for the Canberra Hospital for this coming financial year? Come on, somebody must want to answer.

Ms Feely: There are going to be a series of finance questions. I will bring Trevor up to have a chat on this.

MRS DUNNE: Mr Vivian, you should know this off the top of your head—should you not—the national efficient price?

Mr Vivian: I built the table this is on. I want to get it right. I acknowledge the privilege statement.

THE CHAIR: Thank you.

Mr Vivian: Can I get you to repeat the question, just to make sure I answer it correctly?

MRS DUNNE: What is the national efficient price for this coming financial year, 2017-18, for Canberra Hospital?

Ms Feely: It is two different answers.

Mr Vivian: Yes.

Ms Feely: May I jump in? The national efficient price is set by the national body. And then we have an ACT price. It is a cost, not a price, the national efficient price attaching to Canberra. They are two separate issues.

MRS DUNNE: Is there a national efficient price which relates to major metropolitan hospitals?

Ms Feely: Yes, there is. That is $4,910.

MRS DUNNE: I knew that answer, I realise now.

Ms Feely: That is our price.

Mr Strachan: Remember that is for 2017-18 at this point in time.

MRS DUNNE: That was the question I was asking. Does that information appear anywhere in the budget documentation?

Mr Vivian: Not to my knowledge, no.

MRS DUNNE: Why is that? It has been determined for a little while, has it not?

Mr Vivian: It is not something that is ordinarily put in the budget documentation.

MRS DUNNE: Could I ask someone else on notice why that is not normally put in the budget documentation?

Ms Fitzharris: Perhaps instead we could consider putting it in next year's budget papers. I suspect it is in the annual report as well.

MRS DUNNE: In table 24 on page 16 there are a whole lot of services which are based on the national weighted activity units. That is the old cost-weighted separations?

Ms Feely: It is called NWAU, yes.

MRS DUNNE: They attract a price. What is the price of a national weighted activity unit?

Ms Feely: Who would like to take this? I am happy to, but if you would like to go?

Mr Strachan: Remember the NWAUs, the national weighted activity units, have an adjustment factor for the delivery of each level of service. In some cases they may be weighted one, in which case then it is multiplied by the national efficient price to give you $4,910. In other cases the activity units themselves may be multiples of two to three to four and you end up then getting paid for multiple elements against the national efficient price. The national weighted activity units are a measure of putting a weighting across the delivery of service. Then you multiply that by the national efficient price or—

MRS DUNNE: For instance, non-administrative services of 24,000 for this coming financial year, is that a single—

Mr Strachan: No.

MRS DUNNE: Are they 24,000 single provisions of service?

Mr Strachan: No.

MRS DUNNE: Are they one of the multiples which are a fraction of—

Mr Strachan: Yes, they are a fraction of—

MRS DUNNE: Could we have on notice a breakdown of which of those indicators

(a) to (e)—and I have got some questions about (f)—are whole services and which are fractions?

Ms Feely: That is a breakdown of our entire activity, is that what you mean? I am not trying to be difficult.

MRS DUNNE: I am trying to get a feel for what is the dollar value of the services in that table and why we do not have a dollar value in the budget papers.

Ms Fitzharris: There is a national efficient price. Are you seeking to understand what the price is?

Ms Feely: What ours is?

MRS DUNNE: No. There are a number of questions I am seeking to understand. We know what the national efficient price is for next year. It is $4,910. For instance, the 24,000 services in indicator (b) are not 24,000 multiplied by $4,910?

Mr Strachan: No.

MRS DUNNE: It is some lesser figure because those are a fraction?

Mr Strachan: Yes.

MRS DUNNE: I would like to know what the fractions are. Which of these services are whole services and which are fractional services or which are multiple services?

Mr Bone: Just seeking clarity, the national weighted activity units in outpatients are a very small percentage, maybe less than one per cent, of national weighted activity units. And each of those then has got a cost weight to them, whether it is a doctor clinic, a nurse clinic, an allied health clinic or a group clinic. When you see 28,411 weighted activity units, it is made up of tens of thousands. Each of those clinics would have completely different costings.

Ms Fitzharris: Is that what you are seeking, Mrs Dunne?

MRS DUNNE: A more fine-grained analysis of what those figures mean and what they represent in dollars.

Ms Fitzharris: Are you looking at the cost figures or the amount of activity?—

MRS DUNNE: Both.

Ms Fitzharris: Okay. We can do a breakdown of our cost and our activity levels. I think the real questions you are asking go to quite extensive detail, but we can provide more information on our activity levels and the cost we are paying. It is above the national efficient price, which is what the commonwealth will pay, but most jurisdictions are.

MRS DUNNE: That gets me to my next question: what is the average cost of care in

the ACT for the national weighted activity unit?

Ms Fitzharris: We will take those on notice and provide you the cost and the activity levels in a broad sense and then that may answer your question. If not, you can follow up.

MRS DUNNE: We touched on the fact that there is a different level of funding for metropolitan hospitals. How does that vary from the $4,910?

Ms Fitzharris: As I understand it, some non-metropolitan hospitals are under activity-based funding. Some regional hospitals can still get block funding from the commonwealth and are not subject to—is that what you are talking about specifically?

MRS DUNNE: No.

Ms Feely: Are you talking about tertiary level, general level?

MRS DUNNE: Tertiary level, general level, because there is a different level of funding—correct me if I am wrong—depending on the classification of the hospital.

Ms Fitzharris: Right, but that might be a number of different classifications within a metropolitan area.

Ms Feely: It is. That is right. And then within each hospital there are Q and E levels that also attach, in the wonderful world of health funding, different layers of funding based on NWAs and the DRGs and what the weightings are.

Mr Strachan: If I can jump in, the issue around the national efficient price is constant.

MRS DUNNE: Is constant?

Mr Strachan: It is constant; the national efficient price is constant. The weighting for the acuity is different.

MRS DUNNE: Is the weighting sometimes more than one?

Mr Bone: It is, yes. A primary joint, for instance, a knee or a hip, is weighted at four-plus NWAs. I think it is 4.019, off the top of my head. Then you multiply that by the national efficient price. But each piece of activity is then weighted in acuity. When you talk about a tertiary hospital, in a diagnostic-related group you would expect to see a higher number of category A and B diagnostic-related diagnoses. That then weights the activity even higher. In a general hospital you would expect to see DRG C types, which obviously do not have as much weighting per unit.

Usually in a tertiary quaternary hospital you would see—I do not know what the actual measure is—a high number of A and B DRG-related codings at the end of the episodic year. That would then weight the amount of money you get to support the tertiary quaternary-type activity.

Ms Feely: And in the general hospital.

Mr Bone: That is right, yes.

MRS DUNNE: How is the money paid from the commonwealth? Is it paid on a quarterly basis, in anticipation of the number of services, or is it paid on an accounting of the services provided in the previous quarter? How does it work?

Mr Vivian: Basically an estimate is made and it is paid on the estimate. Every year our financial statements have a note going into detail on how the process works. We get draw-downs monthly.

MRS DUNNE: So you get draw-downs monthly based on what?

Mr Vivian: An estimate.

MRS DUNNE: Then you have a reconciliation at the end?

Mr Vivian: Yes. We provide data and they do a true-up process every year.

MRS DUNNE: What is the actual cost of care in comparison to the national efficient price at the moment?

Ms Feely: The ACT Health price—that is combining both Calvary and TCH—is $6,282. Canberra Hospital is at $6,600—I am jumping in to give you the answer to what I am assuming the next questions is.

MRS DUNNE: Yes, excellent.

Ms Feely: And Calvary is slightly under, at $5,258. They are 2017-18 figures.

MRS DUNNE: Could I have on notice the national efficient price and the costs for Calvary and Canberra and the combined costs for the past three years?

Ms Feely: Sure, yes.

Mr Strachan: It is going to be quite a lot of work, but we will give it our best shot.

MRS DUNNE: Thank you. When it comes to cost recovery from New South Wales patients, what is the basis of the ACT's claim and what is the basis of the actual reimbursement?

Mr Vivian: There is a process and we collect the data, but I will take it on notice and give you the details that we go through.

MRS DUNNE: Thank you.

Ms Fitzharris: It changed a couple of years ago, when the commonwealth had a role in working through it with us. That changed two years ago.

MRS DUNNE: So it is just now—

Ms Fitzharris: One on one.

MRS DUNNE: Mainly with New South Wales?

Ms Fitzharris: Yes.

MRS DUNNE: Do we have many other interstate reconciliations?

Mr Strachan: Just in terms of the process, there is an annual contract with New South Wales in relation to cross-border. A state price is negotiated between New South Wales and the ACT. There are other agreements for other states as a consequence of the flow of transient tourists and so on, as you can imagine, and an offset occurs in terms of an annual reconciliation process. But we can relay that detail to you on notice.

MRS DUNNE: If somebody is visiting from Victoria and they stub their toe or break their leg or something, eventually Victoria gets billed for that?

Mr Strachan: That is right.

Ms Fitzharris: But the only specific cross-border arrangement is with New South Wales.

MS CODY: Mrs Dunne was talking about our taking patients from other states and territories. What about us sending patients interstate? Do we have agreements with other jurisdictions on that sort of help?

Ms Feely: It is done on a clinical basis. We have, again, cross-border discussions. If you need to send a patient to New South Wales, that is a discussion that takes place with the individual hospital and then the fees are recouped across the board.

Ms Fitzharris: Sydney provides a number of services, particularly for children, that we cannot, and that comes up intermittently. One of the initiatives in this year's budget is planning for providing more services through the Centenary Hospital for Women and Children so that we can improve those over time. There is some significant capacity in Sydney that we could not probably replicate here—spinal and burns patients and paediatric oncology come up often.

MR PETTERSSON: A supplementary on that: what support is provided to people who have to travel interstate for these services?

Ms Feely: There is a fund that we allow parents, family members, to access to support them in accommodation and other expenses whilst they are interstate.

Ms Fitzharris: And we are looking to expand that.

MRS DUNNE: Does that also apply to people who might be transferred themselves?

Ms Feely: Yes, they can also access it.

MRS DUNNE: What is the daily or weekly quantum of that?

Ms Feely: I will take that on notice. There is about $1 million in the fund.

MRS DUNNE: No, sorry, on a daily rate.

Ms Feely: Yes, I will take that on notice.

MRS DUNNE: And maybe the daily rate there is depending on where you go.

Ms Feely: One or two families or where they are going or whatever.

Ms Fitzharris: Two things to note on people coming from interstate to the ACT, one is that at Ronald McDonald House within centenary hospital, at the times that I have been there, there has always been someone from New South Wales or another state. There is also an agreement with the Abode Hotel in Woden to provide accommodation, through the Canberra Hospital Foundation, so that families can have accommodation close by and so that they are not far from Woden as well. I believe that was funded through the hospital foundation, but it is an initiative of the Abode Hotel chain.

Ms Feely: The decision to transfer is always done on the basis of clinical assessment—best care, right time.

THE CHAIR: I want to go to a complete change of tack, but still talking numbers. Minister, there was an RFT issued yesterday for debt recovery services for what are deemed non-eligible patients within ACT Health. For starters, what is classed as a non-eligible patient when it comes to debt recovery?

Ms Feely: Trevor, through you.

Mr Vivian: I will take the question on notice, but I think we define a non-eligible patient as a person from overseas that is not subject to Medicare and those sorts of arrangements.

Ms Feely: Does not have a medical entitlement.

Mr Vivian: I will get the exact definition for you.

THE CHAIR: How much debt has the directorate written off in the past four financial years in that space?

Mr Vivian: I will take the question on notice.

THE CHAIR: For the RFT that has just been issued, what is the budgeted cost for the hiring of an external debt agency? On notice?

Mr Vivian: Yes, I will take it on notice.

THE CHAIR: What is the targeted debt recovery net of agency fees? Again on notice, I would imagine?

Mr Vivian: Yes.

THE CHAIR: What consideration will be given to patients who are financially unable to pay, and who makes that assessment? What is the current debt owed to ACT Health? And what systems will be in place to ensure that individuals who are financially disadvantaged are not unnecessarily pursued?

Ms Feely: We will take those on notice, thank you.

MRS DUNNE: Just to follow up on that, this came up during the annual reports hearings, when I asked whether we were looking at external debt recovery. I think I was told at the time that we were not. I am open to correction on that, but it seemed that it was not the directorate's thinking earlier this year, in February or March?

Ms Feely: I do recall that. Mr Strachan.

Mr Strachan: Could I just make a comment. It may have been in that discussion that we had some time ago, where there was a pilot, from memory. That pilot involved a couple of agencies, and part of the process, depending on the outcome of the pilot, was Health giving consideration to entering part of that framework and looking at a holistic process for debt recovery across government. Trevor might want to jump in there.

Mr Vivian: Yes. There was a pilot with Shared Services, but when I came as the CFO, one of the things I wanted to look at was if we could recover more debt from patients that were not paying. I had a talk to the area that is responsible for collecting revenue, and they have looked at the possibility of collecting more revenue. The request to market has come from those discussions.

Mr Strachan: Just to clarify, to give you a clearer response: I think at the time it was not necessarily a given that we would enter the debt recovery arrangement, but as a consequence of looking at the outcome of the pilot—again, we would be happy to provide you with some details on that—the decision was taken to investigate the merits of entering into that arrangement.

MRS DUNNE: My recollection, and I will go back and have a look, is that it was not being contemplated.

Ms Fitzharris: We will go back and check that. I can make two points. No-one is ever refused care under any circumstance.

MRS DUNNE: No.

Ms Fitzharris: And there was an Auditor-General's report into debt management, but I will clarify that for the record.

MRS DUNNE: Yes, sure.

Ms Fitzharris: It may have instigated some of the new approaches to debt management across the territory, across all directorates.

MRS DUNNE: Thank you.

Ms Fitzharris: That was in 2015.

MS CODY: Minister, how do the upgraded acute aged-care facilities at the Canberra Hospital support healthcare delivery to our older patients?

Ms Fitzharris: As I mentioned at the outset of the initial questions, all our health facilities, but particularly at the hospital, are facilities of different ages. In addition to investment in new infrastructure, we are very keen to continue to ensure that we invest in some of the older infrastructure. There are two wards that will receive significant upgrades, through this budget, over the next couple of years. That work is already underway. There is also significant work planned around our older Canberrans, in particular those that need subacute care, at the University of Canberra public hospital. We might even take the opportunity, while Linda Kohlhagen is with us, to talk a bit about UCPH, but specifically about the acute aged-care ward upgrades at Canberra Hospital.

Ms Kohlhagen: I think the initial question was about the upgrades to our geriatric ward, which is 11A.

MS CODY: Yes. It was about what we are doing to support our older Canberrans.

Ms Kohlhagen: Our geriatric ward is a 20-bed acute care of the elderly ward. The length of stay is probably nine, 10 or 11 days. People are admitted through the emergency department, so it is for a short-term stay. If they then require subacute care, they are transferred either to one of our other wards on the hospital campus or, hopefully, eventually, to UCPH, which opens next year.

There is money in the budget to undergo some refurbishments of the ward at the moment. It is relatively old, one of the older wards of the hospital. Part of the work we have been doing to establish UCPH, the University of Canberra public hospital, is to look at some of the features of what we call dementia enablement environments. There are things that will make the stay for an individual in the ward a much more calming environment. They decrease agitation and are more suitable for people that have cognitive impairment.

This unit, particularly the aged-care ward, has very high rates of dementia and people that have cognitive impairment. Some of those things are to do with the colours. The walls are painted. We make sure that we have lino that does not have flecks in it, because people might see that as dust and it might cause problems. We make sure that there are not suddenly different colours and changes in the lino and things like that. There are some significant cosmetic changes that we hope to implement in the ward.

We also do not have TVs in the bedrooms. This is a key thing that we hope to introduce into the aged-care ward. That also enables us to provide an opportunity

where we can play programs or have photos of people's families. They can be on a loop. That sort of reminiscent therapy is very good for people that have cognitive impairment. It also has a calming effect as well as occupying their time.

We are also hoping to create in our aged-care unit a pod area that is a bit more secure and has access to an outdoor courtyard. People who have cognitive impairment and/or delirium sometimes become more agitated and want to wander, so we have access to a courtyard, but it is a very open courtyard. It is probably not very stimulating at the moment. As part of the refurbishment, we also want to have a space for a more secure pod area where people who are a bit more unwell can wander and do not just wander in a circle. But we also have access to a courtyard for the general part of the ward as well.

MS CODY: Minister, you mentioned that some of the aged-care services will also be available at the UCPH, the University of Canberra public hospital. Can you expand on that a bit?

Ms Kohlhagen: One of the wonderful benefits of establishing UCPH is that we will be able to collocate our subacute facilities. The environment that I have just described is for older people, generally people older than 65, who are acutely unwell. They need a very intensive medical model to manage their acuity. As they become more stabilised, they may still have what we call functional impairments. They might need help to look at what their home situation is, to help in recovery; they might need a bit more time. UCPH is going to be a wonderful environment, because it will be purpose built to provide that re-ablement and rehab for the older person.

The ward that I described is not for people who might have had a hip fracture. There are, unfortunately, very high rates of falls in the elderly, and at this point in time they are admitted to our orthopaedic ward and then transferred over to the Calvary rehab unit. That type of patient will be transferred to UCPH as well. We have a purpose-built facility that will be able to have great access to GEMS. More importantly, the care that we provide and the clinical services that we wrap around the individual will be tailor made to meet that cohort's needs.

The other benefit for an older population is that we can be more proactive. If people are demonstrating functional decline, we may be able to have them admitted to our day program to try to reduce that decline, and therefore, hopefully, reduce the need to be admitted to hospital when something goes wrong.

MS CODY: Currently your day program is situated at the Canberra Hospital. Is that correct?

Ms Kohlhagen: With the rehab programs, we have a very small day program that is provided out of our rehab unit, called RILU, the rehab independent living unit. We do not actually have a geriatric day program at this point in time. That is a new service that we will be able to establish, hopefully, next year.

MS CODY: Currently there are some aged-care rehabilitation type services offered through the Canberra Hospital?

Ms Kohlhagen: We have a range of geriatric services that we provide. We have what we call a RADAR team, for rapidly and deteriorating at risk individuals, a small team that has geriatric input as well as nursing, OT and social work. They can go and see someone if they are at home and/or in an aged-care facility. We can go and see them and assess them at that point in time. That is a short-term arrangement; again, that is trying to prevent people coming into hospital. We provide geriatric medical clinics at Canberra Hospital. We have an aged-care nurse practitioner who provides clinics in some of the health centres. And then our community-based rehab service is open to all adult ages. It could have people of 19 or 20, as well as those who are in their 70s and 80s.

MS CODY: You mentioned that there are a lot of services. What about dental services? We know that as people age, sometimes problems with their teeth can be just as dangerous as other ailments.

Ms Kohlhagen: Yes, we do have a dental program.

MS CODY: There is a very large connection with infections.

Ms Kohlhagen: Absolutely, but even socially, you need to be able to eat properly so that you can go out and connect with your family and friends. There is emerging evidence about the type of food that you get. In particular, with dementia, there is emerging evidence around the meals that you should provide, the taste and how food looks. There are lots of programs, more in the aged-care facilities. They might provide minced food and thickened food, but it will look like a steak. You eat visually as well. There are lots of different programs like that. And both in the acute area and at UCPH we have, within our programs, access to dieticians and speech pathologists.

MS CODY: Will the new mobile dental vans support elderly patients?

Ms Fitzharris: There is one van, one truck. Yes. There is one at the moment that already does, but with the new ones we will see one dedicated to schools and the other one to aged-care facilities.

Ms Kohlhagen: If people need to see dentists at UCPH, Belconnen Community Health Centre is very close. If they are an inpatient, we could arrange some sort of support for them if that is required.

Ms Feely: Mr Wood knows all about dental vans. Would you like him to give any further advice?

MS CODY: Yes, absolutely. Thank you.

Mr Wood: The surgery and oral health area includes the dental health program. With the mobile dental clinic that was established in 2015, there is a memorandum of understanding with 21 of the 23 residential aged-care facilities in the ACT. The van goes out to the residential aged-care facilities and sees clients there. The clients come into the van. They do diagnostic, preventative and actual treatment in the van. It is staffed by a dentist and a senior dental assistant.

With the new initiative announced in this budget, there will be one dental van and one dental truck. We understand that they are going to go out to primary schools to look at preventative and treatment for students at primary schools at the lower socioeconomic levels. They do a bit of screening now, but because some of the primary schools are unable to provide the environment that is optimal to do the treatment, they have initiated this. It is part of the national oral health plan. With the other mobile vehicle—I think it is the truck—they will go out to socioeconomically disadvantaged people in the community, people that would be reluctant to come into the community health centres.

MS CODY: They will not be like the old school dentists, will they?

Mr Wood: No; very different.

MRS DUNNE: Dentistry has changed a lot since we were at school.

MS CODY: I hope so, because I am still petrified of dentists.

MS LE COUTEUR: Will there be charges for these services?

Mr Wood: No, to my understanding.

Ms Fitzharris: No.

MS LE COUTEUR: Does the ACT have a mandatory reporting scheme for patients whose blood results show evidence of marijuana?

Ms Fitzharris: We might have to take that one on notice. Are you going towards the commonwealth's announcements on—

MS LE COUTEUR: I was basically just thinking about (a) whether it applies and (b) if it does, does it apply to terminally ill patients? And how would this work out? We are supposed to be working towards a system where we can medically prescribe cannabis. I am looking at the interaction of two bits in a system. How is that going to work if this does happen?

Ms Fitzharris: It will happen. Yes, that is right.

MS LE COUTEUR: I mean the mandatory reporting. I do not know whether that happens.

Ms Fitzharris: Okay.

MS LE COUTEUR: If there is mandatory reporting, how will it work? First, does it happen? How does it work with the terminally ill, if it does happen? And how will it work with the ability to prescribe cannabis? How does it all gel?

Ms Fitzharris: Dr Kelly, can you answer that one?

Dr Kelly: Thank you for the question, Ms Le Couteur. I think we would have to take

it on notice about mandatory reporting. I am not aware of any mandatory reporting requirements at this stage. If you would like to ask something more specific about the medicinal cannabis scheme, I can answer some questions, as can the minister, of course.

Ms Fitzharris: The specific area where this does come up is roadside drug testing and the impact of the scheme.

MS LE COUTEUR: Yes.

Ms Fitzharris: Those are some of the issues that we are currently working on.

MS LE COUTEUR: Right.

Dr Kelly: On roadside drug testing, that is a decision for the AFP at the roadside. Staff in my area that work at the health protection service are responsible for the forensic testing in relation to the roadside drug testing scheme and for blood tests that may come after the rapid test that is done at the roadside. Of course, as the minister has mentioned, as the medicinal cannabis scheme rolls out, this is one of the key issues we would need to address in relation to roadside drug testing and other potential impairments that people may have if they are on medicinal cannabis. That is the role of one of the advisory groups which has been set up.

MS LE COUTEUR: Is roadside drug testing the only time you would be testing for marijuana? Are there other times when people have blood tests and this is going to come up?

Dr Kelly: I do not really have anything to do with that. We receive the blood tests through the process that the AFP takes into account in relation to roadside drug testing. I understand that there may be other employers, for example Defence, that do that on a regular basis.

MS LE COUTEUR: In the hospital? Is there any of the blood testing in the hospital—

Ms Feely: Of our staff?

MS LE COUTEUR: No, patients. Patients obviously have blood tests on a regular basis in the hospital. Would any of these involve testing for marijuana? If so, would it be reported to anyone?

Ms Fitzharris: Are you asking whether there is mandatory screening for marijuana use?

MS LE COUTEUR: I am assuming this is incidental. I am not thinking for one minute that it is mandatory. Say you have a blood test. You have gone to hospital and you have a blood test.

MRS DUNNE: And THC turns up. Do you have to report it?

MS LE COUTEUR: If THC turns up, first, is it tested? If it turns up, is it mandatorily reported?

Ms Fitzharris: It is not tested for.

MS LE COUTEUR: If it is mandatorily reported, how would this impact with particularly terminally ill patients—

Dr Kelly: There is no mandatory reporting that I am aware of.

MS LE COUTEUR: No mandatory reporting? Okay. That was the substance of my question.

Dr Kelly: Going to another area, my colleague has just given me a note that sometimes the court orders that such testing take place in relation to matters before the courts.

MS LE COUTEUR: I can appreciate that being separate. I am talking about you as a hospital and medical provider who obviously tests blood on a regular basis.

Dr Kelly: We would not do it regularly.

Mr Bone: We would not routinely test for illicit drugs unless there was a clinical indication to do so. It would not show up on a routine blood request.

MS LE COUTEUR: Okay; fine.

MRS DUNNE: I go to a couple of the initiatives that are agency-funded—for instance, expanding hospital in the home and more nurses for Canberra. First of all, in relation to the hospital in the home program, there is $136,000 in this coming financial year but there is no expectation for expenditure in the outyears. Can somebody explain that to me, please?

Ms Fitzharris: Sure. I will hand over for further detail, but Labor made a commitment to significantly expand hospital in the home. The funding in this year's budget is for that planning. The reason that it is not being funded in this upcoming financial year is that there are a number of important other pieces of work underway that will inform the planning for the expansion of hospital in the home. There is no doubt that this is a hugely valuable service, which is why we made the commitment to expand it. This year we have the territory-wide health services framework, which is under development. It is looking at clinical—

MRS DUNNE: Sorry, when you say "this year", do you mean this—

Ms Fitzharris: Currently and throughout 2017-18. That work will culminate in a range of new clinical service plans. As well, we have the opening of UCPH. So there is one significant piece of clinical services future planning and one significant opening of a new hospital for subacute care. What we want to be in a position to do is to design the expansion of hospital in the home to align with both those two significant pieces of work, which is why there is not funding for the expansion of

services in 2017-18. But you can certainly expect us to deliver on that commitment over the course of this term. I would expect that to start in 2018-19.

MRS DUNNE: Okay, but also it says that this will be funded from inside the agency; so what stops to provide—

Ms Fitzharris: What stops?

MRS DUNNE: What stops to provide this service?

Ms Fitzharris: What stops?

MRS DUNNE: Yes. I mean, if you are funding it from within existing resources, do you have a hollow log somewhere, as we like to say, or is some service going to stop to provide extra hospital in the home?

Ms Fitzharris: No. You will be familiar with the fact that there is the system innovation program. It is a program of efficiencies in workflow and practice within the hospital. As a result of that, there were some identified opportunities for savings from that program that have now been able to be reinvested in the new services. The previous minister made very clear on a number of occasions that any savings achieved from within the hospital due to efficiencies, which in a number of cases are expanding access and improving performance, get reinvested back into health services—in this case both the nurses initiative and the hospital in the home.

MRS DUNNE: From the innovation fund or reinvestment, how much money are we talking about year on year that is being reinvested through innovation?

Ms Fitzharris: It has only been running for a year. This is the first time there has been reinvestment and the total amount in this year's budget is both the nurses initiative and the hospital in the home. It is around $37 million over four years.

MRS DUNNE: It is $36 million over four years for the nurses plus the $136,000. But where will the funding come from for the expansion of hospital in the home?

Ms Fitzharris: That will be something that will be considered in the context of next year's budget.

MRS DUNNE: It may come from reinvestment or it may come from extra appropriation?

Ms Fitzharris: Yes, that is right.

MRS DUNNE: Okay. In relation to more nurses, which is agency funded and that has come through that sort of innovation project, what is the source of the $36 million?

Ms Feely: The—

MRS DUNNE: I am sitting comfortably.

Ms Feely: Two things are at play here. One, we have committed to government that we will move towards a more efficient delivery of health care. As you can see from the differences between the national efficient price and how we are operating, we are looking to remove 50 per cent of the avoidable costs over the next four years.

MRS DUNNE: Can you say that again, Ms Feely?

Ms Feely: Fifty per cent. Regarding the difference between the national efficient price and the ACT price, we are moving to remove 50 per cent of avoidable cost from that price. The reason I put it like that is that historically there are a number of costs that do make the ACT cost base more expensive.

For example, moving from a general to a tertiary hospital in a small community has required us over many years to engage doctors probably at a higher rate than may have been paid in other areas. We also got a lot of commonwealth super entitlements through defined benefit funds et cetera. So there is an element of cost in the ACT system that is not, I think, readily attributable just to an inefficient service. There are costs that have built up over years that over time we will continue to look at.

Then there are costs that I think we as an executive need to look very carefully at—and that we are looking very carefully at—to try to make sure that we are using the available funds in the most efficient way so that we eliminate as much waste or as many poor governance issues, poor management issues, as possible to try to bring down the cost of the providing of services. As we do that, the government has committed that I am allowed to reinvest those funds back into our health service delivery. Unlike in other jurisdictions, where that money may be taken into central provisions—gone—the Health Directorate is allowed to reinvest its money.

In relation to the commitment for nursing, there is also the territory-wide planning that is going on. As you would be aware, there is another billion dollars of infrastructure that will be coming out of the ground in the next three to four years, plus we have got hundreds of millions of dollars worth of initiatives in relation to what we call operational recurrent businesses.

The planning process will determine what will be the workforce requirements of the health service over the next three to five years. As a consequence of that, we are going through a very methodical process, through territory-wide planning, where we are looking at not only what is the model of care that needs to be delivered but also the workforce requirements to deliver that. As we move through that process we will be able to determine what is the right level of resourcing in various areas across the board, whether it be medical, nursing, allied health or, in fact, our corporate side.

The discussion is about both a reduction in waste so that we can then free up funds to be reinvested in the health service and at the same time making sure we have sophisticated and appropriate planning of our workforce requirements to then recruit to. That is the position in a general sense. It is big pieces of work that have been done. What I have said to government is that as we become more efficient, that will free up funds to allow us to reinvest back into frontline services such as nursing. Does that answer—

MRS DUNNE: Yes, and if I can be indulged, Mr Chairman, I go back to my previous set of questions. That was actually one of the questions I was meaning to ask that I overlooked: what are the causes—this may be a piece of homework—of the disparity between the national pricing and the ACT pricing? It has been put to me on a number of occasions that a lot of it is about superannuation. But nurses interstate were all in defined benefit schemes and hospital staff were in defined benefit schemes. They have all closed down across the board. We closed ours in 2006 or something like that—

Ms Feely: I do not believe there is—

MRS DUNNE: I know there is long tail, but I would be interested in some analysis of what are the differences in cost.

Ms Feely: As the director-general, I believe there is an element of the difference between the national efficient price and the ACT price that can be put to those types of historical issues. But I am not going to say that is the sole difference. I believe that there are issues over the years, when you look at them, where the organisation is managed. There are many fundamental issues that, from the government's perspective and from a hard management perspective, can also be looked at or should be looked at to try to close the gap. They are just hard management decisions.

I am not sitting here as director-general saying to you, "The difference is because of super." It is an element. There is also an element too that I believe that the people here in the ACT also benefit very strongly from. It a commitment by a government to actually provide a level of service that normally a 400,000 catchment would not have. So the level of service that is provided here is above and beyond what you would probably see in any other catchment for 400,000 people. You take the people coming in from—

MRS DUNNE: It is not; it is a catchment of probably more—

Ms Feely: You take the people coming in from outside, it could be up to 800,000. Even then, the level of service provision in the ACT is top notch across the board. That also has a cost to it that the government has committed to providing. I can break it down for you in themes as to the actual dollar cost. I am just saying that that is an element of it, but it is not the whole thing. I think our challenge as an executive, all these people sitting in the room, is to manage the business as efficiently as possible, to make sure that we can recoup and remove as much waste from the system as is humanly possible.

MRS DUNNE: How do you marry managing the system as efficiently as possible with the information that came out of questions on notice at annual reports about the large increase in the number of executive staff and the executive salaries? How do you manage to keep the costs down when at the same time the staff bill, in what apparently seems to be administration, is going up?

Ms Feely: Right, again, if I may be open—

MRS DUNNE: Yes.

Ms Feely: The organisation at the executive level has gone through a total renewal. Except for one member over here—acting director-general Paul Kelly—the DDG level has been renewed through an open and transparent process of advertisement and moving through. We have put in place some new positions which did not exist and ones which I am prepared to argue up hill and down dale are very important for the business.

For example, I have put in place a new director of quality. I have moved quality out from just being focused on the hospital to making it more system-wide. That is a DDG position. I have also put in place four what we call 1.3 or more junior executive positions for a couple of years to assist—we call them innovation partners—the operational executives, to keep them focused on the delivery of the reform that is required to actually move through both the territory—

MRS DUNNE: Professional whip crackers.

Ms Feely: That is a good way of putting it: professional whip crackers. For someone who has also worked in an operational perspective in a hospital, it is very easy on a day-to-day basis to keep getting pulled back into the operational issues. So those four people are specifically aimed at making sure that the reform agenda is moved through and that the executive directors are being asked to keep a focus on it. I have advertised a new position coming forth for a new deputy director-general of data and performance. The issues that have confronted the organisation on that speak for themselves. I want someone reporting directly to me at a high level who has extensive experience—not belittling anything you have been doing, Peter, in the past few months—to help settle that situation.

They are the key roles that have been brought into the system. The other one was the head of innovation. I remain confident that for us to be able to deliver an extensive reform, infrastructure and policy agenda for the government, we require people who are focused on that. Each of the positions that have been brought in that have elevated the cost are specifically related to both reform and improvement of performance across the system.

MRS DUNNE: Would you see at some stage that some of those positions might outlive their usefulness or lead to constant innovation?

Ms Feely: The innovation partners are for two years. They are two-year appointments and we will review them. In relation to the role of the innovation side of things, I think innovation is an ongoing requirement. It will need to be moved through and quality must stay. So, no, I do not see them being removed in the immediate short term. Understand that we are really a year into this process, what I call a five-year process. Again, as these contracts come up, I always renew them and make sure that they are still delivering what the government requires to deliver its agenda.

MRS DUNNE: Thank you.

THE CHAIR: This is sort of the end of the abridged time frame that we allowed—

MRS DUNNE: We have hardly started.

THE CHAIR: It feels as though we have barely started today. I dare say that the committee will have a discussion as to whether there are other areas that we still feel need to be examined. If that is the case, we can try to set down another date and come back to you.

Ms Fitzharris: Thank you.

THE CHAIR: That adjourns today's hearings. For any questions that have been taken on notice, we ask that the responses are provided back to the committee secretary within five working days. Five days starts tomorrow, it being day one. A proof transcript of today's hearings will be made available when Hansard has completed that. That will be provided to you also. Thank you.

The committee adjourned at 12.31 pm.