LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Inquiry into Annual and Financial Reports 2021-2022)

Members:

MR J DAVIS (Chair)
MR J MILLIGAN (Deputy Chair)
MR M PETTERSSON

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 1 NOVEMBER 2022

Secretary to the committee:
Dr A Chynoweth (Ph: 620 75498)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

The Assembly has authorised the recording, broadcasting and re-broadcasting of these proceedings.

All witnesses making submissions or giving evidence to committees of the Legislative Assembly for the ACT are protected by parliamentary privilege.

"Parliamentary privilege" means the special rights and immunities which belong to the Assembly, its committees and its members. These rights and immunities enable committees to operate effectively, and enable those involved in committee processes to do so without obstruction, or fear of prosecution.

Witnesses must tell the truth: giving false or misleading evidence will be treated as a serious matter, and may be considered a contempt of the Assembly.

While the committee prefers to hear all evidence in public, it may take evidence in-camera if requested. Confidential evidence will be recorded and kept securely. It is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly; but any decision to publish or present in-camera evidence will not be taken without consulting with the person who gave the evidence.

Amended 20 May 2013

The committee met at 9.02 am.

Appearances

Stephen-Smith, Ms Rachel, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Families and Community Services and Minister for Health

Canberra Health Services
Peffer, Mr Dave, Chief Executive Officer
Culhane, Mr Michael, Acting Deputy Director-General
Zagari, Ms Janet, Deputy Chief Executive Officer
O'Neill, Ms Cathy, Chief Operations Officer
Smitham, Ms Kalena, Executive Group Manager, People and Culture
Mooney, Mr Colm, Executive Group Manager, Infrastructure and Health Support Services

ACT Health Directorate
Cross, Ms Rebecca, Director-General
O'Halloran, Mr Peter, Chief Information Officer, Digital Solutions Division
Lopa, Ms Liz, Executive Group Manager, Infrastructure, Communications and Engagement Division

Major Projects Canberra
Edghill, Mr Duncan, Chief Projects Officer
Little, Mr Martin, SPIRE Project Director, Canberra Hospital Expansion Project

THE CHAIR: Good morning, everybody, and welcome to the public hearing of the Standing Committee on Health and Community Wellbeing inquiry into the ACT government's annual and financial reports 2021-2022. The proceedings today will examine the annual reports for the ACT Health Directorate and Canberra Health Services.

Before we begin, on behalf of the committee, I would like to acknowledge that we meet today on the lands of the Ngunnawal people and pay our respects to their continuing culture and the contribution they make to the life of our city and across our region.

On the first occasion that witnesses speak today, please acknowledge that you have read and understood the privilege statement, which should sit before you on the desk. All proceedings today will be recorded and transcribed by Hansard. They will also be broadcast and webstreamed live. Should a member ask you a question today that you need to take on notice, please say, "I will take that question on notice." That helps our friends in the committee secretariat record what questions to follow up with you after today.

In our first session we will be hearing from Minister Rachel Stephen-Smith, in her capacity as the Minister for Health, and officials from ACT Health and Canberra Health Services. Minister, could you confirm that you have read the privilege statement?

Ms Stephen-Smith: Good morning. I have read and acknowledge the privilege statement.

THE CHAIR: Wonderful. We will now kick it off with questions. I usually start, as Chair, but Dr Paterson has a very important one and I will let Dr Paterson start.

DR PATERSON: Thank you very much, Chair. My first question is around the implementation of the digital health record. The annual report talks about the range of projects being delivered under that program, including the ACT Health app Ecosystem Transformative Healthcare Engine and Repository, the power billing and revenue collection and the Geocluster project. I am just wondering if you can give a bit of an overview of what those projects will deliver.

Ms Stephen-Smith: I will ask Mr O'Halloran to respond to that.

Mr O'Halloran: Good morning. I have read and acknowledge the privilege statement. There have been a range of projects delivered to enable the digital health record to come to fruition. Those projects have been six years in the making. That is a range of things, such as upgrading our critical networks across the hospital, including the wireless infrastructure and the fixed data ports. That work is progressing incredibly well.

We are finalising the last few cables as we speak, this week. That work has spread across all Canberra Health Services sites and also Calvary Public Hospital Bruce, including, in essence, a complete rewiring of the Calvary Public Hospital Bruce site for data networks. On the other underpinning project, the power billing revenue collection, or PBRC, which is our patient billing system, that work has been upgraded. We have gone to a territory-wide solution and we are now using it for day-to-day services under our old systems, ready to go live in the future.

The ETHER, which was the long interface engine, is in production and actually being used today for some of our other systems, such as notifiable diseases. We have also migrated over 1,500 servers or built them in the health enclave for our hosting environment. There have been a huge range of behind the scenes technical projects and the deployment of over 8,000 pieces of equipment across the system.

That work is now largely complete. We are doing the final testing of each device physically—does it work for the workflow? The overall implementation project is tracking well. So we are now at that final stage, 10½ days out from go live, and making sure every final piece is ready.

DR PATERSON: Thank you very much. That is very exciting. What do you expect to happen in staff engagement over the next 10 days, to transition smoothly into live operation?

Mr O'Halloran: We still have a range of staff members to train. We are sitting at, based on which group of staff it is from, training completed by 60 or 70 per cent, up to 90 per cent for some cohorts, and there is certainly a bit of health competition between different cohorts to make sure everybody has finalised their training. So there are those remaining elements of training.

Secondly, we are deploying super users and the tech team across the wards in the coming days. We also have the soft go live in a few days time, on the weekend, which

is where we start cutting over a lot of the administrative processes. We are also doing what is called data migration and extraction, which, in essence, is extracting data from our existing legacy systems and either doing a direct data import or actually having staff re-key some of that key information for things such as oncology treatment plans or surgical bookings and the like. That is all that work we are doing now.

We are also working with each of the staff members to ensure that everyone is comfortable on the wards. We have got staff out across all the wards, all the clinical areas, making sure that staff are comfortable in how to use the hardware that is there and we are continuing to provide phone support, in addition to getting the super users really starting to work with those staff to make sure everyone is ready.

DR PATERSON: Following the digital health record going live, how long will that support for staff continue?

Mr O'Halloran: There is always support for staff use of all of our systems on an ongoing basis. For the first two weeks after go live we will have command centres that will be running around the clock, 24/7 ,with additional super users. They are in a lovely lime green vest—it is very hard to miss—so the staff know who on the floor to go to for help immediately.

Those resources will be there for the first two weeks—very in your face; very available for staff members. We will also be operating, as usual, a 24/7 support phone line, which is staffed around the clock. That will then start to ease off as we go into Christmas and we will pull back on those arrangements .We will not be running the command centres 24/7 but the phone lines and other support will still be there.

The final project team scales down, for most elements, in late March, so the majority of the project team will be there until the end of March, which really gives us time to bed in in the system and identify if there are any things that we thought would work that did not or to optimise any things quickly. We are running that full project team pretty much through until the end of March. We then scale down and there are nearly 90 staff who will maintain the system on an ongoing basis following that.

DR PATERSON: Thank you.

THE CHAIR: Minister—

Ms Stephen-Smith: Sorry; before you go on to the next question, Chair, can I just confirm that there will be no more questions for Mr O'Halloran and he can be free to go?

THE CHAIR: That is fair enough. No. A fast game is a good game. Thank you so much.

Ms Stephen-Smith: Thank you. Much appreciated.

THE CHAIR: Minister, I am interested in talking about nursing-midwifery to patient ratios. Leading up to the last election, all candidates from your political party and my political party signed the ANMF pledge to reach minimum nurse and midwife to patient

ratios. How are we tracking to meet that commitment?

Ms Stephen-Smith: I have some data for the period of 29 August to 25 September. I am not sure if anyone has more recent data than that. I will hand over to Mr Peffer to talk about Canberra Health Services and then we may be able to provide some information in relation to Calvary as well.

Mr Peffer: Thank you, Minister. I acknowledge that I have read and understand the privilege statement. Thank you for the question. There are obviously a couple of elements that we need to satisfy when implementing ratios. For the most recent reporting period for Canberra Health Services, which is 26 September through to 23 October, we were 81 per cent compliant against all three elements of the ratios framework. Within that time frame, we met 92 per cent of the elements across CHS. The reason that we get the divergence is that, at times, we may have a supernumerary team leader but perhaps not the 75-25 ratio skill mix between registered nurses and enrolled nurses. So, for us, the result was 81 per cent, but for 92 per cent we were meeting at least one or two of the elements of the ratios.

THE CHAIR: Great. I have three questions at once, Mr Peffer, so I am trying to figure out which order to give them to you. What was the net increase of nurses that we recruited, in particular to Canberra Health Services, over the last financial year? No doubt we lost some. Some resigned and some moved interstate. No doubt we hired to replace, but I imagine that, in order to meet our nurse to patient ratios, we would need to recruit well in excess of replacement, so I am interested in the net figure of new recruits.

Mr Peffer: I will ask Ms Smitham if she can present that. We will pull up the data on that one.

Ms Stephen-Smith: In terms of what was needed and funded to meet ratios, though, if my recollection is correct, it was 55 net additional FTE for Canberra Health Services and 35 net additional FTE for Calvary Public Hospital. That is what was required on top of what we had, just to meet ratios, but obviously there have been a whole bunch of other changes as well in terms of service delivery, and, as you say, the ons and offs of people leaving and retiring.

THE CHAIR: Of course. While we are pulling up those figures, the trend I would be interested in having a look at is how many are left, because to some degree that speaks to our ability to retain, obviously accepting that some people are going to move interstate and retire. How many people were recruited, as a total figure, and then what is the difference, in terms of how many additional bodies does that put on the floor?

Ms Stephen-Smith: In the context of answering those questions we also need to remember how many people left. We had a significant temporary surge workforce in response to COVID-19, and some of those were people who returned to the workforce and had previously left nursing, allied health or whatever, who were not intending ever to stay, so we need to work through the straight data versus what was an impact of COVID-19.

THE CHAIR: On that, can I assume, then, that if we recruited people especially to help

us deal with the pandemic they were recruited on a certain different contract or we had an understanding at the time that we recruited them that they were to assist with the pandemic, so there would be a way of disaggregating that data to not necessarily have those people included in the kinds of figures I am trying to get to?

Ms Stephen-Smith: I will hand over to Ms Smitham to see what she can help with.

Ms Smitham: I have read and acknowledge the privilege statement. The data with the pandemic nurses and the non-pandemic nurses is aggregated. They were moving about a bit. With a lot of them, as the workload was changing, we were bringing them into the service to work in the hospital as well. So we can see movement. Some were dedicated specifically to vaccinations and testing as well. The workforce, over the financial year, went from a headcount of 3,118 nurses to 3,844 nurses over the 12-month period. We did have staff turnover during that time as well. That is a total headcount of all categories of permanent, full time, part time—all different categories of employees. So the nursing workforce did increase over that time.

THE CHAIR: Sorry; is that figure just the nursing workforce or is that the total number of employees?

Ms Smitham: That is just the nursing workforce and all categories of nurse.

Ms Stephen-Smith: Nurses and midwives.

Ms Smitham: Correct.

THE CHAIR: Would you have similar figures for professionals in midwifery and allied health?

Ms Smitham: Yes. One moment, please.

THE CHAIR: While you are bringing that up, Ms Smitham, I might just ask: how many positions do we currently have vacant, and are they all being advertised and actively recruited for—for nurses, midwives and allied health in Canberra Health Services particularly?

Ms Smitham: Positions vacant is not a number that is easily tracked in our current systems that we operate under. However, every position that is vacant is being actively advertised. We advertise in a range of different platforms, including the ACT Jobs website, but also on SEEK, Indeed, LinkedIn, and a whole range of other areas. We also have an extensive campaign that is being run through the Chief Nursing and Midwifery Officer at the moment for the attraction of nurses across Australia and overseas. A significant amount of investment has been done to attract nurses into the territory as well. So we do have a range of approaches to recruitment.

We also are actively trying to ensure that our recruitment is for a permanent workforce, as much as practicable. We know that there are great careers for people working at CHS, so we try to bring people in and offer a career where they can move from one job to another. The other thing we have done is increase our nursing and midwifery relief pool so that we have better cover for unplanned leave and also planned leave—things like

maternity leave.

THE CHAIR: No worries. Ms Smitham, if you are pulling out those figures, I am happy to take them on notice or we can come back on that a bit later, just so that we can keep going.

Ms Smitham: Yes. That is no problem.

MS CASTLEY: I am not sure whether I missed it or whether it is what you are taking on notice. We are 81 per cent compliant with regard to ratios and we know that the workforce has increased from 3,118 to 3,844. Did you say you were unsure as to exactly how many we need to recruit to make the ratios?

Mr Peffer: No. The ratios framework and how it is applied is in clearly defined areas where the rules are easily observable, so we know if we are compliant or not. A lot of our nursing workforce does not have a ratio applied. For example, we have got nurses out in the community or working in schools and other areas where the ratios framework does not extend to cover some of those services. But in our ward-based environments, where we do have ratios in place, that is where we measure and report against compliance.

MS CASTLEY: So how many more nurses do we need to recruit to meet the ratios? I think that is the question I am a bit hazy on.

Ms Stephen-Smith: The funding was provided and we implemented phase 1 of ratios, to recruit 90 new FTE across the system. That is 55 nurses at Canberra Health Services and 35 at Calvary Public Hospital. That is what the calculation was in those particular wards and areas where ratios were being applied in phase 1—what the current staffing allocation was for those wards to what would be required to meet ratios. That was what was worked out, that was what was funded, and that is what has been delivered.

MS CASTLEY: I understand that, but we are not fully compliant yet, so I am just wondering what that gap is. Whether it was promised or not, I understand that it was 90. I understand that, but how many more do we need to get to the compliance of the wards that we said we would?

Mr Peffer: There are a couple of things that impact our ability to comply with the ratios framework. One of them is being fully recruited to the workforce that we need. Another is our ability to deploy from our relief pool so that, where we do run short in the workforce, we do have essentially a backup workforce that we can deploy to those wards or areas. We continue to be impacted by quite high levels of leave. Some of that is annual leave and long service leave that the workforce is well entitled to—and we have been encouraging people to take that leave and recharge the batteries—but there is also quite a high level of illness that remains in the community and we are impacted by that.

This morning, for example, many of us have just come from our hospital huddle, and 94 per cent of our nursing workforce is there, but it does mean that six per cent is not across the ward environment. The team have done what they can to backfill and they have been able to manage to get us to 94 per cent. But it does mean our wards are

running short at the moment, and our theatres are running short as well. Notwithstanding being fully recruited, the impact of illness and also the impact of this sort of build-up of leave that people have banked for a number of years but are now choosing to take, which we are supporting—all of that is contributing to our ability to comply.

MS CASTLEY: I understand. I was hoping for a number, but I am not going to get that. You said with regard to employing new nurses that you were investing in the attraction of nurses. I am just wondering what it is you are offering to get nurses to Canberra.

Ms Smitham: Thank you for that. We have done some work around our employee value proposition and what is attractive about working in Canberra. We have worked with Chief Minister's and the economic development office on the features and attractions of Canberra in the first instance—how it is a great place to work and it is the shortest commute in Australia and all of those wonderful things that Chief Minister's have been working on in terms of attracting the workforce to Canberra more generally.

More specifically, when we are talking about nurses, we are talking about professional development and the opportunities for research and teaching opportunities, for scholarships, for development right through from a graduate career into senior nursing and midwifery roles. We are also an attractive employer in terms of our remuneration, nationally, compared to some of the other states, and we have excellent enterprise agreements with a wide range of benefits and entitlements for our workforce.

The other feature that our workforce talk about is the benefit of the breadth of experience that you can have at Canberra Health Services, compared to some of the larger systems that you might work in, where you become narrower and more specialised. So there is lots of opportunity for nurses and midwives working in CHS.

DR PATERSON: I was just wondering: for new nurses and midwives, what sorts of programs are in place to support them when they start employment at Canberra Health Services?

Ms Smitham: When new graduate nurses start at CHS they join the Transition to Practice program, where they are supported. They do orientation induction when they first start and then they go out onto the wards and they are supported by senior clinicians for a period, while they learn and build their skills in the workplace. That program goes over quite a period of time. One of the important things, coming into the next financial year, is that we want to have more graduates to continue to build our workforce and create more career opportunities. We are building our mentoring workforce, senior clinicians, to support them as they come in, because they are an important part of our workforce.

DR PATERSON: Thank you.

MR MILLIGAN: This is in relation to executive training. The Canberra Health Services annual report mentions specific IT software, which includes monthly benchmarking packages that measure performance against peer hospitals, and the Canberra Health Services analytics hub. There is also mention of specific executive

training for risk management. What are the costs for both of these IT systems for executives?

Mr Peffer: The first is a digital package that provides a feed of data to our workforce to inform decision-making and assessment and benchmarking, to drive that continual focus on performance. It is less of a training package and more of a platform that we use. We use that through our governance forums and have ongoing discussions that build capability around being able to utilise that data. From time to time we do have our finance and business intelligence team support the executive to learn how to use aspects of those platforms. It does not have a specific cost per se. It is not a structured classroom-type environment; it would more be a peer support-type arrangement that we have.

On the second question, around risk management, we can take on notice the cost of that training. Our risk management framework we have developed in partnership with ACTIA, the territory's insurer. We go through a process of quarterly risk management meetings but also an annual review of that, which ACTIA supports the organisation to do. I will take on notice the question about what is the cost of the training, the risk management training estimate.

MR MILLIGAN: In relation to the monthly benchmarking packages, how do we perform compared to peer hospitals, and what indicators are you benchmarking them against?

Mr Peffer: The Health Roundtable is a hospital-to-hospital benchmarking tool that is used across the country. It also includes hospitals in New Zealand. The usefulness that we find in that tool is that it does compare like with like. Often when data is aggregated to a territory-wide level and then compared to a jurisdiction like New South Wales or Victoria you are dealing with quite different systems in operation, in terms of how networks operate, multiple LHDs and that sort of thing. For us, being able to benchmark against other tertiary trauma centres is very, very useful.

In terms of the indicators that it provides, it has a full suite of quality and safety indicators, many of which you can read about in our annual report or in our quality and safety report, which we put out each year at Canberra Health Services. It is up on our website. It also benchmarks performance in terms of timeliness of care, emergency department performance, bed block within a system—those sorts of indicators that really determine how effectively and efficiently patients flow through the system.

In terms of how we benchmark against our peers: pretty well, on a full range of indicators. There are very few where we are actually below average when compared on a hospital-to-hospital basis. In some cases we are up in the top quartile, and on some indicators—for example, our category 1 and category 2 performance in the emergency department—we were the best in our peer group of hospitals.

MR MILLIGAN: I was just going to ask specifically where we performed well.

Mr Peffer: Category 2 is a particular area of emergency department presentations where we have got the best seen-on-time performance of the peer hospitals across the country. There are a range of quality and safety indicators as well. I might have to take

that on notice and we can provide some examples of where we have top quartile performance for the committee.

MR MILLIGAN: That would be useful. Thank you.

MS CASTLEY: With regard to professional development for the executives, how many hours a year are executives expected to be doing professional development and what does that look like across CHS and across the whole gamut of health in the ACT? Could you talk to me about that?

Mr Peffer: There is not a specific rule that we use in terms of the number of hours that people require for professional development in a year. Really, it depends on the individual and their capability and skill set and what is required within their role. We have executives participate in classroom-based training, and mentor and mentee arrangements both within and across different health services. They may have mentors from around the country, or peer groups that they work with on particular challenges or problems.

For the broader leadership and management cohort across the ACT health system, for Canberra Health Services, the ACT Health Directorate and Calvary Public Hospital we do have a structured learning and development program between our teams that our upper level of management and leaders across the organisations have been participating in. That has been introduced under the auspice of the Cultural Review Oversight Group. It is one of the initiatives to try and bring the three leadership teams together. The regional CEO of Calvary and I each present. We take it in turns. We present to those groups and they go through a structured training program that looks at authentic leadership and communication and a variety of other contemporary leadership topics. That is a full day, off-site program. At this stage, somewhere between 100 to 200 of our leaders have participated in that program and it is ongoing.

MS CASTLEY: Sorry; 100 to 200 hours?

Mr Peffer: 100 to 200 of our leaders across the three organisations have been trained through that program.

MS CASTLEY: Leaders; okay. Could you take on notice to let me know the cost and how many hours all the executives have taken training?

Mr Peffer: Yes. Sure.

MS CASTLEY: Thank you.

THE CHAIR: I might just go back to Ms Smitham. Did you have those numbers from before, those preliminary numbers, or would you prefer to take those on notice?

Ms Smitham: I will take those on notice; thank you.

THE CHAIR: Okay; great. Just clarifying.

MS CASTLEY: I have some questions about the workplace culture review. I am sure

you are aware that we have done a couple of FOIs. Minister, there was a briefing to you on 17 June about the implementation of 20 recommendations for the workplace review and there was a comment about Ms Beauchamp being appointed for the 2022 annual culture review. The FOI document said:

> It is possible that some culture review recommendations may be deemed to have been insufficiently implemented by one or more of the three arms of the ACT public health system. Ms Beauchamp has the experience and diplomacy to communicate this sensitively.

I am just wondering if you can explain what that means—communicate with diplomacy and sensitivity—and what is she anticipating?

Ms Stephen-Smith: Ms Beauchamp has been appointed to conduct the third annual review of the implementation of the culture review, as you note. That report is coming towards completion. I obviously did not write that brief. I would have interpreted it in a particular way, but the brief was written by the Health Directorate, so I might ask Ms Cross to respond to your question.

Ms Cross: I have read and acknowledge the privilege statement. In any review, if you have detailed recommendations, it is open to different parties to have different interpretations of what full completion would look like. In the Culture Review Oversight Group there is a range of different parties.

I am trying to think of an example. One of the recommendations was to hold a leadership summit of clinicians. A decision was taken by clinicians that a leadership summit, as a one-off, was not sufficient; they would prefer to have an ongoing mechanism for collaboration. We interpreted that to mean that the intent of the recommendation had been met. While there was not a summit, the purpose of the summit was to have the ongoing collaboration.

What we were alluding to is that these things are open to interpretation. Ms Beauchamp is a very experienced bureaucrat and understands that context, and therefore would communicate appropriately that this was about the intent, rather than the specific wording, and she would do that diplomatically, not in a way that would be overly sensational or looking for a headline in the *Canberra Times*; she would do it fairly and with integrity.

MS CASTLEY: Can we get a list of the recommendations that are in that situation that you mentioned?

Ms Cross: All of the recommendations and the response are on the public record, so we are happy to provide that. You will see that, if you look at that recommendation in particular, it will be marked as "complete" because the intent had been achieved, rather than that a summit had been held. I am happy to provide you with those responses.

MS CASTLEY: The report will say that they are complete? I am wondering—

Ms Cross: All of the actions are complete at this stage, yes.

MS CASTLEY: I understand that, but which ones were complete with an intent?

Ms Cross: All of them are open to interpretation. We provided our advice as to which ones were complete. With anything like that, if it was to do a review of the recruitment services, we can say, yes, we have done the review, but the intent was, "Have you actually acted on the review?" They are all open to that sort of interpretation. The assessment of the implementation group is that they were all, in terms of the intent, completed.

Ms Stephen-Smith: I note that, in terms of the implementation of the culture review, the meeting papers from the Culture Review Oversight Group are available online. The most recent meeting papers that are available are from 18 July 2022. Those meeting papers contain very detailed implementation of recommendations, consideration of what is complete, what is at risk et cetera. We have been very transparent the whole way through the implementation in publishing these papers so that people can have a look at them and see where we think the implementation of each recommendation is up to, what might be at risk et cetera. That is all available on the ACT Health Directorate website.

DR PATERSON: How important is it, in terms of addressing cultural issues, that the review is flexible, adaptable and can grow through the recommendations?

Ms Cross: The review, at a point in time three years ago, set some important directions for the health system—areas that needed improvement. As you say, as time moves on, it is important to look at them all in context. If we looked back, we would still say we have actually implemented the intent of all of those recommendations because they are still important things. Cooperation and collaboration between clinicians is important. Having the right culture in the workplace and leaders appropriately trained is important.

The actual context of how you implement that might change slightly. During COVID, with things which they may have recommended we do face to face, we may have done them online. That sort of thing is always contextual.

THE CHAIR: I have a supplementary that is very broad. For the layperson who is not paying close attention, or who stops me in the street at a mobile office and says, "There's this culture problem at Canberra Health Services," in the broad, are you convinced that it is improving? As you walk around the hospital, as you talk to your staff, are you convinced that there is an appreciation by your staff that what you are doing is working and is being responded to positively?

Ms Cross: I will make a general comment, and Mr Peffer may want to respond about the hospital. Certainly, if we look at our staff survey results, we can see a high level of engagement. We had quite low reported rates of bullying or any of those sorts of behaviours, particularly compared to the rest of ACT government. I think we did very well in that, which was encouraging. We are always looking to see whether there is inappropriate behaviour and taking appropriate action to address it.

The final answer to your question will probably come from the third independent review by Ms Beauchamp. That will give us an independent assessment of how well we have done and whether we are on track. I will hand over to Mr Peffer.

Mr Peffer: The short answer is yes. There are a couple of ways to go about that. The first is talking to the workforce about what they are experiencing. The reality is that there are some teams that are still struggling. There are some teams that have gone backwards. But the majority of teams have improved, and they are moving forward.

The basis for reaching that conclusion is a greater than 50 per cent response rate. You are talking about 4,000 people filling out a culture survey, and the results coming in are saying that the culture has incrementally improved over 15 years, and it is now the best it has been in 15 years.

I talk to people in the organisation who talk about how wonderful things were 15 years ago and, "We used to have this and that, and this is how things used to work." The reality is that the experience of most people back then was not good. You will always find someone who, 15 years ago, was living in the golden era, and that is how things should run.

The health service has come a long way. I think the community's expectations of its health service have, rightly, come a long way as well, and the experience of the broader workforce is improving. There is a lot of work to do. The last culture results that we had, back in November last year—actually, they landed in December—put us slightly above average, in terms of our overall engagement culture, compared to health services across the country and around the world—public health services. We are slightly above average.

You would not expect that, given what you often read in the public domain or in individual comments here or there. But that is what the data actually tells us. That is independently surveyed, anonymous data from thousands of our workforce. We are confident that we have taken steps to get us to a point, but that does not mean that we take the foot of the accelerator now. That is just the beginning. From here, we push forward as hard as we can. At a point in time, I would like to think that the health service is something that all of the community can be proud of—everyone who works in it—and we can do something really special in Canberra Health Services.

THE CHAIR: On culture, obviously, you are going through a process at the moment where it is, let us say, at the pointy end of a couple of individuals; thus it has found its way into the paper end of the public domain. What new interventions have you needed to do to protect the workforce more broadly from the commentary at best, gossip at worse, that ensues in a close workplace when these sorts of high-pressure points hit the public domain, as we have seen in the paper in recent weeks?

Mr Peffer: On the first aspect of that, my personal view is that I think it is really unfortunate when these sorts of things play out in the public domain. It is not good for anyone. It is not good for the health service, it is not good for our workforce and it is certainly not good for the individuals who are involved, irrespective of which side of the table they sit on.

In terms of how we support the workforce when this happens, it is inevitable that the teams will talk about how things are playing out and what they read about in the paper, which, at times, is accurate and, at times, is a little far from the truth, in terms of what

is happening behind the scenes.

For some of our departments where we have taken action—cardiology being an example—we have stood up a fortnightly forum, which we do in the auditorium with the entire department. We talk about the key operational issues; we talk about the investigations that are in flight, in terms of process, time frames and what we know. Bear in mind that the investigations are undertaken externally to the agency; they are done by independent legal firms. We do not always have line of sight and there is an important role that the Chief Minister's directorate plays in that as well, in terms of undertaking the investigations.

We try and keep people as well informed as we possibly can, and that is probably our best defence against people spreading a rumour or asking a question that goes unanswered. As part of those sessions—I have been to a number myself—we sit there and we answer all of the questions, until we exhaust all of the questions, no-one has any more questions, and that is it for the session.

That is attended by the relevant executive for the division, it is attended by the clinical director—essentially, the head doctor for the specialty—all of the leadership, and Ms Smitham as well, to try and answer whatever questions people might have. With the uncertainty, which we recognise, when you take actions like this, it introduces a big ripple in the pond.

Ms Cross: I would like to add to what Mr Peffer has said, and agree with everything he has said. In the second independent review by Renee Leon, she made the statement that we could do all of these good things around culture. We could put in place new processes and we could follow all of the recommendations, but if staff did not see things changing on the ground, it would not have the impact that we wanted.

While everything Dave says is absolutely right, and while it is very unfortunate when these things play out publicly, the response from staff was that they did want to see this behaviour being acted on; and, if they could not see that, they were going to lose faith in the changes. It is not the way that we want it to happen, but we do need, in some sense, to be seen to take action when the behaviour is not appropriate.

THE CHAIR: This might sound controversial. I do not mean it to be. I am telling you the first thing that came to mind. When you described that meeting where the senior officials stood before the staff and took every question until it was exhausted, my instinct and reaction is that I would not ask a question in that room. Can you tell me how staff are assured that, if that is not, for them, a safe place to have an open conversation—perhaps the senior person in that room is, to them, the person who is participating in poor culture—there are other ways that they can make a grievance known or ask a question?

Mr Peffer: That is a good question. The first thing I would say about that particular department is that I have no concerns that people attending those meetings do not have the confidence to ask questions, and that plays out—which is the sort of environment that we want. We want people to feel confident that they can speak up and ask questions.

Cardiology came through as one of our cultural hotspots. In terms of how it was

assessed through the independent culture survey, it came through with "blame plus", which tells you that you are in trouble, in terms of the culture. That is why we did the deep dive, and we brought in an independent party and opened it up to everyone in the department for an opportunity to go and meet with the reviewer, one on one, anonymously, to put on the record or have their say about what was happening in the department.

A lot of that department took up that opportunity. Off the back of that, and from what came through in that deep dive review, it was sufficient that I was concerned about matters of patient safety, and particularly workforce wellbeing and safety. We commenced a formal investigation and people had the opportunity to participate in a formal investigation—or, as some of them chose to do, not to. They had had their say as part of the review; they did not want to participate in the investigation, and that was fine.

MS CASTLEY: Mr Peffer, you mentioned the golden years of a few years ago and indicated that that cannot be so now. I am interested in why; it also touches on something, Ms Cross, that you said. I think you said that we have to make on-the-ground changes, and there was a bit of reluctance there. What is the difference between 15 years ago and now, and why is there a reluctance to make changes on the ground? Surely, that is the goal here, if someone has a concern with culture.

Ms Stephen-Smith: I do not think, Ms Castley, that you have represented either of those statements correctly, but I will hand over to Mr Peffer to answer the substance.

Mr Peffer: What I was trying to say is that you might have an individual's perception that 15 years ago was when work was the best that it had been. For some time the territory worked quite hard to attract medical specialties to locate here and to build up a workforce. I think there was a general tolerance of recruiting what we could get. That led to some behavioural problems in units that were accepted for some time. People thought, "We need a specialist, we need the service, so we will tolerate that that's how this service is going to run." That would cause an impact for all of those who worked within that unit, whoever that might have been. But that has changed through time, and we say, "Actually, with the experience that everyone has in the workplace, it doesn't matter who you are or what role you perform. We understand the importance of teams in delivering health care, and we understand the importance of teams feeling safe and being able to raise issues."

That is at the heart of why we did Speaking Up for Safety—to say that it does not matter where in the hierarchy you sit; if you see something that is concerning, that could impact patient care, we need you to speak up about it. It does not matter if you are the most junior person. I spoke to some of our transition to practice nurses who were starting just over a week ago. I said to them, "It doesn't matter if you are the most junior person in a situation, if you are worried about something, or something looks wrong, you must speak up, because this is how we make mistakes."

MS CASTLEY: But the stats show that it is worse now than it was then. Anyway, that is—

Ms Stephen-Smith: If I can clarify something for Ms Castley, Mr Peffer was saying

that there will be some people who will look back and say, "Gosh, life was good 15 years ago." But we have been doing culture surveys in the organisation for a long period of time and, even though someone might have thought it was great 15 years ago, our culture survey tells us that the entire organisation, as a whole, was in a culture of blame 15 years ago. Now it is not in a culture of blame.

As an organisation, the independent assessment, through the culture survey, is clearly telling us we are on an upward trajectory of improvement. Some people might look back at that—and, as human beings, we have a tendency to look at the past through rose-coloured glasses as well, forget about the bad things and focus on the good things.

MS CASTLEY: We know funding was cut years ago. It was cut years ago, and—

Ms Stephen-Smith: There is a disconnect—

THE CHAIR: Ms Castley, if you want to take an arguing point, you can come back to the chamber at a time that is not this committee hearing.

Ms Stephen-Smith: The point that he was making is that there is sometimes a disconnect between an individual's perception of the past and what we actually know from independent assessment of what was going on in the past versus today.

DR PATERSON: My question is in respect of the ACT Aboriginal and Torres Strait Islander suicide prevention intervention and postvention and after-care service.

Ms Stephen-Smith: That is a question for Ms Davidson, as the Minister for Mental Health.

DR PATERSON: I will go to one of my other questions. The Weston Creek walk-in centre: imaging services are due to begin in February 2023. Is this on track to happen and will we expect some kind of reduced demand on imaging at Canberra Health Services, at the hospital?

Mr Mooney: I acknowledge the privilege statement. The project you are referring to is the Weston Creek imaging improvements, where we are expanding the current centre. We have CT, ultrasound and X-ray services being put in place. The construction work is due to finish in the first quarter of next year—we are expecting it to be in February-March next year—and thereafter the equipment will be installed and commissioned from there.

DR PATERSON: What sort of impact do you expect that offering of service to have broadly in the southern Canberra region?

Mr Mooney: It is not an area that I am directly involved in, from an operational point of view. It might be a question that—

Mr Peffer: I can respond to that. The immediate impact that we will see is an improved ability to provide outpatient services. At the moment we have our medical imaging department that sits, almost flanked, by the emergency department. On top of it, there is an inpatient tower. The level of demand that comes through the front door every day,

whether that is for emergency surgery or through the emergency department, continues to grow.

With fixed capacity in that department, we know that the first load shedding that occurs, when things heat up, is for elective outpatient scans. We have to prioritise the inpatients. We certainly have to prioritise the emergency requirements as well. That does come at the expense at times of our elective outpatients—people who are walking in to have a scan at the hospital.

Being able to locate part of the department and have it operational off-site essentially segments that, and it will protect the department from the demands of a busy trauma centre. It will much better serve those patients who are able to move through.

DR PATERSON: Will you be able to access ultrasound services there as well?

Mr Peffer: Yes.

THE CHAIR: While we are on walk-in centres, I would be remiss if I did not ask about the Tuggeranong one. In particular, I want to ask about the period of time my constituents saw a lack of access to the walk-in centre during peak times where staff demand was required at the Canberra Hospital. Could you talk me through how some of those decisions were made, particularly to move staff from the Tuggeranong walk-in clinic to the emergency room, and what processes have been put in place to mitigate that risk in the future?

Ms Stephen-Smith: Before someone answers that question about how those decisions were made, it is important to point out that Weston Creek walk-in centre has been closed as a walk-in centre for most of the pandemic, between being a vaccination site and testing site. The inner north walk-in centre is still closed. I think that we need to be a bit clear that we have not focused on Tuggeranong as being the one centre that is affected by changes through the pandemic. Yes, there have been changes at Tuggeranong, and we can go through the reasons for that, but there have been changes at other walk-in centres for different reasons.

THE CHAIR: I understand that. As you would appreciate, Tuggeranong is the one that I get emails about.

Ms Stephen-Smith: I recognise that, but I think we need to put the broader context around it.

Mr Peffer: I will ask Ms O'Neill to respond.

Ms O'Neill: I have read and acknowledge the privilege statement. We have had to struggle right through the pandemic with balancing where we have staffing and where our greatest need is. Some of the thinking behind closing Tuggeranong was not so much about moving Tuggeranong staff per se, because we managed that staffing across the network. We took into account the fact that we did not have enough staff to safely staff every shift across the network. However, we did still have some surplus staff. Rather than having a single person work at Tuggeranong, for example, which is unsafe, we could move them to Weston Creek, where we have additional rooms and a larger

waiting room, and provide more throughput. That was part of the thinking behind that.

We did see corresponding increases in throughput through Weston during that time. Whilst I appreciate that that is not a convenient place to get to, if you are not travelling by car, it was the best decision we could make, juggling all of the pieces.

THE CHAIR: That makes sense. Could I get a better understanding of what has been described to me by a nurse as the walk-in clinic at the emergency room, the new streaming process in which nursing staff who work in walk-in clinics have been offered work in that environment? How did that come about?

Ms O'Neill: Before the pandemic we did start a trial of what we called a treat-and-go clinic, adjacent to the emergency department, which was staffed by walk-in centre nurses. Unfortunately, we had to shut that down two weeks after it started because of the pandemic, because the physical setting for that meant they could not see anybody with any respiratory symptoms, and it just did not work at that time.

When we were experiencing significant and sustained shortages of nurses in our emergency department, particularly through COVID illness, we made the decision to stand up that treat-and-go approach, but within the emergency department, within the fast-track space, to see how effective a nurse-led process in that fast-track area could be for the emergency department. This is something we have been exploring for some time.

It worked extremely well. It did two things. It supplemented the nursing staff on each shift in the emergency department, and it also clearly demonstrated that we can manage a range of presentations to the emergency department by a nurse-led service and get them through their full treatment in the emergency department quickly. The other thing it did was significantly enhance the working relationship between the walk-in centre staff and the emergency department, and we will now see some continuing benefits from that.

That team has now returned to the walk-in centre network, and we are now working, and we are quite a way through the process, to stand up an ED nurse-led service within that fast-track service. Recruitment is underway. They have recruited the first couple of people to work in that service. They need to go through training and assessment, and we will continue to grow that service. You will start to see the benefits of that through some improved time frames, particularly for some of the lower acuity presentations.

Ms Stephen-Smith: I note that one of the staff who went into that treat-and-go service did not come from the walk-in centres but came from a policy role and went back to the front line. Cathie is nodding; yes, that is accurate. I also note that I was in the emergency department the other day, talking to the director and others, and they are very enthusiastic about this model of care. They also recognise the value of the staff having come from the walk-in centre, where they had that authority to work independently, and they think that is really important.

As part of establishing that service, I understand that staff will work in a walk-in centre before they come in to the treat and go, so that they have worked in that environment where they are working independently, and they feel that they have the autonomy or

the authority to do that, rather than having come up from a medically supervised model. I think it has been a good opportunity to try that, through this really busy period.

THE CHAIR: I do not want this to sound critical, because what Ms O'Neill is describing sounds great, but it would appear to me that we were putting quite a lot of effort as a health service over many years into encouraging Canberrans to access health care at walk-in centres, so as to limit the demand on the emergency room for a cough or the sniffles. This appears to me, on face value, as accepting that, to a large degree, that has not worked, and we accept that, for people who are not in an emergency situation, we will still want to provide treatment for them at the emergency room.

Ms O'Neill: I do not think that is the case. Our data clearly shows that our walk-in centres are still popular and are serving an unmet need in the community. Our presentation rates at the walk-in centres are now above pre-COVID levels, so they have continued to rise. We have seen over the last couple of years almost a plateauing of triage category 4 and 5 in the emergency department, whilst overall presentations are going up in the emergency department.

What was also interesting, from the walk-in centre nurses' perceptions whilst they were in the emergency department—because I think there is a school of thought that says all triage category 4s and 5s should not be in the emergency department—was that they found that those people—not all of them, but many of them—probably do need to be at the emergency department because of the nature of their injury or illness.

We need to understand with the triage categories that they are based on a time when a person should be seen, not necessarily the type of treatment that they require. For some of those cases that type of treatment is more appropriate in an emergency department.

The other thing that we are starting to get much better at is educating people that present to the emergency department that could have been treated in our walk-in centres. If this was to happen to them again, or to one of their loved ones, the walk-in centre is a very viable option. We are starting to see that community shift, and that will continue.

THE CHAIR: That is very clear to me. Thanks so much. I will move to Mr Milligan for a substantive.

MR MILLIGAN: Last year, the separation rate for Canberra Health Services staff was 7.5 per cent. It has now increased to 10.8 per cent. Given the significant increase in people leaving this year, what have you heard from employees about the reasoning for them to leave?

Ms Smitham: There are several answers to that question. The staff turnover rate is partially attributed to the turnover in relation to staff moving on and off the pandemic response. It is a bit of an unusual year. It will be interesting to see what the data looks like for the coming financial year.

With the reasons for leaving, we do track exit interviews, and we get a reasonably good exit interview rate. It is for all of the usual reasons—promotion, personal reasons and those sorts of things. The trends are not particularly different. It is too early to say whether there is anything different happening from our usual staff turnover. Our tenure

is still holding at around the seven to eight-year mark, depending on the profession, so we still have quite good retention rates.

MR MILLIGAN: What classification group are they? Are they nurses or medical officers that have driven this?

Ms Smitham: Staff turnover is across the board. It does vary a little bit between the different categories. There is no big spike in one particular work group over another work group.

MR MILLIGAN: Recently, we have seen articles in the *Canberra Times* that have suggested senior nurses are leaving the organisation. Has the separation rate increased for nurses who have spent several years at the organisation?

Ms Smitham: I would have to take that on notice to give you detail about the turnover at particular tenures. Certainly, with any senior nursing staff—particularly with the *Canberra Times* reports—the staff have been replaced by senior nursing staff.

MS CASTLEY: On that data, you said some were leaving for personal reasons. Is that available? Can we get a list of that?

Ms Smitham: Yes. I think we have provided it before; absolutely no problem.

MS CASTLEY: Just a current one; thank you.

Ms Smitham: Yes, that is no problem.

MS CASTLEY: I have a question about the paediatric review. On page 146 of the annual report, it included a list for the acute services in paediatrics and paediatric surgery. On 20 October, Minister, you tabled part of that report into the department of paediatrics. On 12 October, in responding to my motion about permanently staffing the paediatric ED, you said:

> As health minister, my priority is to ensure that Canberra Hospital provides the safest and highest quality clinical care to children and young people.

The report that you tabled states that there is an acknowledgment within CHS that the current system is suboptimal and creating unnecessary risks for unwell children in the ACT. It also indicates that there have been a number of business cases and alternative models of care put forward previously but not adopted. I am wondering how you can talk about how you are ensuring the safest care, yet this review has suggested that some of these things have not been adopted and it is described as "suboptimal"?

Ms Stephen-Smith: To clarify, because I am just reading the media reporting, the substance of the review has been released. There were elements of the report that were removed before it was tabled. That relates to individuals responsible for specific actions and financial implications—those kinds of things that were quite sensitive or informing budget processes. But the substance of the review has all been released. If you read what has been tabled, that is what the review was telling us.

It was commissioned because of this feedback and understanding that there were improvements that were required to paediatric services at the Centenary Hospital for Women and Children. So this is actually part of the commitment of Canberra Health Services to improve paediatric services. You need to understand the problem before you can address the problem, so this is about really getting to the nub of the problem, talking to the people who are involved and understanding that so that those issues can be addressed. Having said that, I will hand over to Ms O'Neill—now that I cannot remember what your exact question was—to talk about the review and the implementation.

MS CASTLEY: Do you want me to repeat the question? It is: if there have been previous recommendations, why have they not already been implemented?

Ms O'Neill: There has been a lot of work done in paediatrics. A lot of the reviews have happened at individual department or speciality levels. What we need to do is to take a more wholesome view of where we are going with paediatrics. We know that attracting skilled paediatric staff to the territory is challenging. The paediatric workforce right across Australia is depleted, so we need to be quite targeted in which specialties and which models of care we want to progress and develop, and do that in a planned and phased approach. The expert panel that the minister has announced is going to help us do that, not just from a CHS perspective but from a territory perspective. That review was undertaken in 2021. We have already implemented a number of recommendations in that review and we will now continue to work through where we need to take paediatrics and, as I say, do that in a planned and structured way.

MS CASTLEY: At page 74 the Territory-wide Health Services Plan indicated that acute and general paediatrics was not going to increase its service level—if I have got that correct. I am just wondering: is this going to be the case for 2026?

Ms Stephen-Smith: Sorry; I just missed the end of that.

MS CASTLEY: Page 74 of the Territory-wide Health Services Plan.

Ms Stephen-Smith: I just missed the very end of your last sentence. Is that going to be the case for—

MS CASTLEY: 2026. Acute and general paediatrics will not be increasing its service level, so is that going to be the case, looking forward into 2026?

Ms Stephen-Smith: I think one of the early things—well, not one of the early things because we have already invested, in this budget, $4.8 million for a community-based service in neuro developmental service, which Ms O'Neill can talk a bit more about—but the planning for 2024 for the opening of the critical services building is a commitment that within the intensive care unit there will be four paediatric intensive care beds.

One of the things that clearly comes out of that review is a finding that the ACT can sustain a level 1 paediatric intensive care unit, and that would be appropriate for the ACT, but a level 2 or 3 paediatric intensive care unit would not be sustainable for the ACT. I think it is important to have that information out publicly, and the reasoning for

that, because I know that people do express concern about that issue. Ms O'Neill and Ms Freiberg might want to talk about how the service is continuing to expand and improve over the next few years.

Ms O'Neill: I might just also ask Ms George if that reference was actually to role delineation, rather than service expansion. I will answer the rest. I just do not have that report in front of me.

We are looking at what subspecialties we need to grow within paediatrics. As I said, we need to do that in a phased approach. Part of that is driven by the case load. It is really important for these subspecialty services that we have sufficient case load within the territory to keep the staff here. That is part of the retention effort. Nobody is going to come and work here in a subspecialty where they are only seeing five or 10 of that case within a year.

We also know that the evidence is very clear about case load to ensure safe services. That is not just about, for example, the doctors. It is also about all of the support staff. That includes not just the nurses; it might also include the pathology staff in the lab that are dealing with specimens from that subspecialty service. So it really is a holistic picture that we need to look at. Paediatrics will grow. We are seeing increased rates of presentations and bed days for paediatrics. It may be, though, that it is not in acute and surgical services but in some of the subspecialty services.

MS CASTLEY: Regarding the models of care that have been put forward previously, and other paediatric reviews, I am just wondering if you can enlighten me. Was there a paediatric review done in 2015? How often are we doing these? My understanding is that there have been a couple of reviews, all with similar recommendations, and nothing has changed with regard to those specific recommendations. I am wondering: was there a review done in 2015?

Ms Stephen-Smith: My recollection is that we responded to a question taken on notice in relation to previous reviews and inquiries. I do not have it in front of me at this point. I will try and find that. Obviously, none of us were around in 2015 to be able to—

MS CASTLEY: You must have had a handover. There must have been something.

Ms Stephen-Smith: Ms O'Neill may have been in the organisation in 2015. Most of us were not here so would not be familiar with that.

MS CASTLEY: There would be information, a handover—

Ms O'Neill: That is correct. I cannot remember whether it was 2015, but one of the reviews that we did was into the paediatric high dependency unit. As a result of that review we have done some refurbishments in that high dependency unit, as part of the Centenary Hospital for Women and Children expansion program. That has finished and been completed and is operational. We are seeing the benefits of that in terms of one site and better care for children and families in that unit.

There have been a number of other, smaller reviews where we have already acted on those recommendations. What this more recent review did was to have a more holistic

look at where things are at. We will now marry up those recommendations with what is coming out of the territory-wide adolescent and children's health plan and work out what are still the remaining current recommendations.

When we have these reviews done, they are done at a point of time, often by consultants who will have a particular view. Just because they make a recommendation that does not necessarily mean that we will accept that recommendation. We will obviously need to justify why we would not. But there is little value in going back seven years and seeing whether or not we have done those recommendations when we have done more recent reviews that are giving us much more of a contemporary look at what we need to do.

MS CASTLEY: I guess my point is: why keep doing reviews if they have been done and recommendations were not implemented? That is my point.

THE CHAIR: Ms Castley, we will take that as a comment.

MR MILLIGAN: How much of the road map and recommendations for each service have you completed since the last review?

Ms Stephen-Smith: I will let Ms O'Neill and Ms Smitham answer that.

Ms O'Neill: I will need to take that on notice, in terms of quantifying. I am happy to do that.

MR MILLIGAN: Excellent. Thank you.

DR PATERSON: In the Health Directorate's annual report there is a short update on the work underway by the ACT government on improving our community-based alcohol and other drug services. I was wondering if you can update us on the work that is going on, particularly around the Watson health precinct, and where things are at with those projects?

Ms Stephen-Smith: I would be happy to hand over to Ms Lopa to talk about that work.

Ms Lopa: I have read the privilege statement and acknowledge it. Thank you for the question. The Watson health precinct project is going along really well. We are almost at the point of having completed our concept design for the precinct. We have been working really closely with Ted Noffs and CatholicCare on designing their new buildings.

We have STH Architects working with us, who have a lot of experience in doing these kinds of building works. They are really bringing to it a feel for the services that are offered there—really homely and supportive for the young people who use them. Those concept designs are almost complete. We are just at the costing stage, which we will bring forward to the government when that is all complete.

We have been working with the people who work in Ted Noffs and CatholicCare and their management. In the detailed design phase we are going to bring together, with their help, some user groups of people with lived experience. This can often be tricky,

particularly with young people who have experienced mental health or drug or alcohol issues not wanting to come forward and participate in groups. But we are going to use Ted Noffs and CatholicCare to really help us and be the conduit for that so that we are designing infrastructure and services that really meet their needs.

I think I have said before that I am fundamentally uncomfortable, as a middle-aged bureaucrat, designing a building for young people with mental health and drug and alcohol issues and thinking that I know what it needs to be. We need to make sure that we are talking to the people who have used them and are going to use them. So that is going really well.

Parallel to that, we are working really closely with Winnunga on the new Aboriginal and Torres Strait Islander residential rehab. In the last budget Winnunga were given money to start that project. They have engaged a project manager and an architect. I believe it is the same people who they engaged for their Narrabundah build, when they did that. We have been working really closely with them as well to make sure that everything works well together. We have been liaising with Winnunga really closely about how that precinct will operate, making sure that there is good separation between the services that are happening for young people and the services for our Aboriginal and Torres Strait Islander clients.

I do not think Winnunga would have a problem with me speaking on their behalf; I would hope not. I think we are seeing a level of excitement about the culturally appropriate services that will be offered in there and having somewhere culturally appropriate for Aboriginal and Torres Strait Islander people in Canberra and the region to access in their recovery, because it is not one size fits all with these things.

So that is all going really well at Watson. We will be coming forward to government for funding for that in the next financial year and hoping to go out to tender next year to start construction. So that is really exciting.

DR PATERSON: Thank you. And there are proposed upgrades to the Karralika facility as well?

Ms Lopa: Yes. We have been really fortunate. We had some funding that came through both the COVID stimulus and some funding from the commonwealth government from a couple of years ago. We have invested a lot of that in the Karralika facility. We have done major upgrades to those facilities that house families. A lot of the people in Karralika are there for long periods of time, so we have looked at upgrading the amenity of the services there. It is meant to be a home-like environment.

Probably the project that we are most proud of is the upgrading of the backyard at one of our Karralika facilities. It had been closed off for a while because there were hazards with tree roots and those sorts of things. We were able to utilise some funding and go in there and redo the whole yard of Karralika. It is really beautiful. There are tracks for kids to play on. It is green and it is beautiful. We got some funding also from the Riverview Projects group that contributed to that. So there is now a backyard for kids to play in and to help these families on their recovery journey before they go back into the community.

We are also now doing our Karralika in Fadden. I believe we are doing that at the moment. We are doing upgrades to carpeting, painting, bathrooms, all of those things, to help these families really feel that they are valued and to help them on their road to recovery and back into our community.

So we have really been looking at our drug and alcohol facilities. It is the same story across the territory. We have got aged infrastructure. You cannot do everything. We would send the government broke if we tried to do everything. But we have been really targeted. I am really happy that we have been able to do that. Particularly for families and young people, we really want them to be in an environment where they feel comfortable and then can get on with their recovery back into our community.

DR PATERSON: In terms of the planning for these facilities, do you plan what service needs to operate and what requirements they will have and then design the building? How does that work?

Ms Lopa: Yes. I work really closely with my colleague Jacinta George, who is the EGM of health system planning. Her team does a lot of the demand, the modelling et cetera, and then we work with the non-government organisation, if it is a non-government organisation, on what their model of care looks like. Ted Noffs and CatholicCare are funded by the ACT Health Directorate to provide these services. When looking at building new infrastructure, we ask the questions: "Does it need to be bigger? What do we think it is going to look like in the future? Do we just need to build the number of beds that we have now?"

Also, in the case of Ted Noffs, they do some other work that is not funded by government. In their case, they said, "We would love a couple of extra rooms for services that we offer as Ted Noffs that are not funded by government." So we do the service planning, we look at the model of care and then we do the infrastructure planning to reflect that. Sometimes it is parallel. Sometimes Ms George and I are working very closely together as we go through a project. But the way it usually runs is the service planning and the model of care is done and then we get a functional brief, as we call it, and we put it to the architect and we do the infrastructure.

DR PATERSON: Great. Thank you.

MR MILLIGAN: Page 55 of the Canberra Health Services annual report reveals that there has been a seven per cent increase in work, health and safety incidents from last year. From the 2018-19 financial year there has been a 28 per cent increase in incidents. I also note that this period is covered by the Canberra Health Services Work, Health and Safety Strategy 2018-2022. All of this occurred while the WHS strategy was in place. What incidents did you see to monitor this strategy, and what changes have you made each year, given that there has been a large increase each year?

Ms Smitham: Thank you for the question. Workplace health and safety at Canberra Health Services is a really important part of my portfolio of work. I am very well supported, and my team also support the operations in ensuring that we have a safe workplace. There are two components to safety in our workplace. One is around our physical environment and the other is around the psychological safety of our environment. We measure our workplace health and safety incidents across those two.

We look at musculoskeletal injuries and things like that. Our greatest increase is in people tripping and falling on level surfaces, which is a bit of a conundrum, actually, because they are literally tripping over their own feet and slipping and falling. It is a really tricky area to address.

We have also seen an increase in our psychological incidents. That is reflected across health services Australia-wide and, in fact, worldwide in workplaces generally. We have a workplace health and safety management system and we have two levels of structure around that. One is that we have a strong consultative structure, where consultation with the workforce happens from the ward level all the way through to a peak level, so there is very good governance and communication through the safety structures of that.

We also monitor our workforce data. We report monthly and quarterly to a range of different forums about our incidents and accidents, recovery time, lost time—all of that sort of thing. We also do a fair bit of preventative work, so we have manual handling training, we have occupational violence training, and we have early intervention physiotherapy to build core strength and resilience in our workforce that is doing manual handling activities. We do occupational assessments of particular types of work and work intensity. For instance, for the staff that are working in the kitchens and those sorts of areas, we look at the way that they are working and the types of tasks that they do and see if we can change and break up their work intensity. So we do a range of things.

From a psychosocial safety point of view, we have been doing a fair bit of proactive intervention in this space recently. We have just updated and refreshed our risk monitoring around psychosocial safety. We have done some education and awareness with our health and safety reps, and their managers, around what psychosocial safety is, and what the appropriate interventions are. We have also been very well supported by the Chief Minister's directorate in some work they have been doing at a territory-wide level around psychosocial safety and appropriate support tools and interventions, and we are implementing some of the tools that they have suggested.

Our occupational violence program is another key tenet of our safety environment. We did have an increase in incidents of occupational violence this year, which, again, was reflected across the territory as well. We have a range of interventions. We have an occupational violence health and safety program. That involves proactive interventions, training and support, reporting and monitoring. It is quite comprehensive. We were just recently audited. We are independently audited all of the time, and we just recently had an audit that we passed with flying colours.

MR MILLIGAN: Thank you. The report mentions multiple times that a strategy needs to be flexible so that it will be able to identify emergent WHS solutions. Do you think that the strategy has failed to address the issue or that management has not been able to identify the emergent WHS issues?

Ms Smitham: No. I think that we are aware of issues in relation to workplace health and safety. It is quite heavily reported and responded to. We have a team that proactively works at a local level to address workplace health and safety issues and concerns as they are raised.

MS CASTLEY: Ms Smitham, you mentioned musculoskeletal. I note that the strategy calls for all targets to be met by 2022—there is a great little graph here—for a reduction in the incident rate of claims resulting in one or more weeks off work, for at least 30 per cent. Also, for musculoskeletal incidents resulting in one or more weeks off work, you wanted that reduced by 30 per cent. We have seen an increase of 35 and 39 per cent respectively. All the while, the strategy has been in place. I am wondering what has failed here, if there has been such a large increase compared to how you wanted it to reduce.

Ms Smitham: It is difficult to give a precise answer to that, but my view is that the work intensity has increased over the past 12 months and our staff have been busy. My personal view is that that would be contributing to some degree.

MS CASTLEY: Thanks. On page 98 of the annual report it says that insurance has increased by almost $7 million. The footnote mentions that this is because of increases in claims and cost. Does this mean that CHS now has to pay $7 million because the work, health and safety incidents have increased, despite the strategies? I am wondering if you have done an investigation into what the trajectory of that is. It is $7 million this year. Is it $9 million next year? It is quite a chunk of money for our budget. Are we adding that to our budget line? There are three questions there. I apologise. I can repeat them.

Ms Smitham: ACTIA accept our claims and manage our insurance premiums, and they would be best placed to respond to that.

Mr Peffer: I might ask Ms Zagari if she has anything to add.

Ms Zagari: I have read and acknowledge the privilege statement. Ms Smitham is right that ACTIA are best placed to comment. But I would add that the insurance premium increases reflect not just work health and safety claims but increasing claims in the medico-legal arena which we have seen following the emergence of the no fault scheme in the motor vehicle accident space. We are seeing increasing numbers of claims in medico-legal matters that are driving those premiums as well.

MS CASTLEY: So the $7 million is not specific to the work, health and safety responses?

Mr Peffer: No. It reflects the overall increase in premiums. Some of it is about our performance in terms of work health and safety, and quality and safety performance, but some of it is driven by general market forces. As interest rates move up and down, that drives premiums. If you think about what has happened worldwide in terms of the pandemic and the business impact and everything related to climate change as well, they are big influencing factors in what our premium ultimately is, which is driven, a lot of it, by reinsurance activity—indeed, markets over in London. That more or less swings, in no small way, what our premium is year to year.

MS CASTLEY: So this is not a blowout; it is expected and we budget for it to increase?

Mr Peffer: I would not necessarily say it was expected. We do anticipate a gradual

increase in the premium year to year. We sort of budget for that. Of this magnitude, though, that is something that we had not anticipated. It is discussed across government. It has impacted premiums across all government directorates, so it is not just a CHS-driven issue; there are market factors as well. It was perhaps not expected at that level, but, as a result of all of those factors, it has come through at that rate.

Ms Stephen-Smith: In terms of budgeting at that whole-of-government level, every year, when there are significant changes in any of these factors, that is discussed through the budget process, with Treasury, around the extent to which directorates can absorb any increases versus their budgets being supplemented.

THE CHAIR: Thank you, Minister. The time being 10.30, this session now draws to a close. Thank you, Minister Stephen-Smith and officials from Canberra Health Services and ACT Health, for joining us today. For those of you who have taken any questions on notice, could you please provide those answers to the committee secretariat within five working days. The committee will suspend for a short break and we will reconvene at 10.45 am.

Hearing suspended from 10.30 to 10.46 am.

THE CHAIR: We are back for this public hearing of the Standing Committee on Health and Community Wellbeing inquiry into annual and financial reports for 2021-22. We will continue speaking with Minister Rachel Stephen-Smith, in her capacity as the Minister for Health, and officials. I remind everybody, on the first occasion that they speak today, to acknowledge that they have read and understood the privilege statement.

In this session we will deal with not only matters arising from the last session but also Major Project Canberra matters and the Canberra Hospital expansion. I will kick off with the first question. I would appreciate an update on what has happened with the Canberra Hospital expansion over the last 12 months. How much has been built and do we remain—

Ms Stephen-Smith: In two minutes or less!

THE CHAIR: In two minutes or less—and do we remain on track for a completion date as was expected?

Mr Edghill: I have read and acknowledge the privilege statement. Thank you very much for the question. We still have a way to go on the project, but our progress to date has been very pleasing. If you have had the opportunity to be out at the hospital campus recently, it is very apparent that the project is proceeding apace now.

We are in the process of pouring the fifth level of the superstructure, which is great. The stairwells are beginning to reach the top height of the project. We are still on track for the superstructure itself to be completed in the early part of next year, looking forwards rather than backwards. The project, in short, is remaining on track for the previously announced construction completion in mid-2024.

In terms of looking backwards at some of the progress over the last 12 months, the

excavation of the site is now, for all intents and purposes, complete. The connections between the new critical services building and the existing buildings on campus are progressing very well. There has also been great progress in terms of some of the works to connect the building into electrical systems and so forth. As a general statement, we are very pleased with the progress of the hospital to date.

THE CHAIR: We are hearing from other parts of government that the combined pressure points of skills shortage and supply issue shortages are challenging our ability to deliver other infrastructure projects, particularly in the housing space. What is making the Canberra Hospital expansion project so special that, in spite of those pressures, we are still able to meet it on time, to your expectations?

Mr Edghill: Not to make life harder for myself, I would throw weather into the mix there as well, which has not helped any of our projects. We are confident that the project is remaining on track for a few different reasons. Firstly, a significant amount of planning has gone into the construction phase of the project. Our contract partner is a tier 1 national construction firm which has been able to use its networks to draw upon resourcing from other projects if that resourcing was not available here in Canberra.

Of course, using local people and local supplies is our number one priority, but where it has been necessary for our construction partner to move things around, they have been able to do that, given their size and the fact that they are operating across a number of different projects nation-wide.

Also, as part of that planning, there has been a little bit of luck in it, in terms of the worst of the wet weather coming after we had already finished the excavation, and we are in the superstructure building phase. The weather, in particular, has slowed down our construction partner a little, but there has been sufficient allowance at the outset in the ACT government's program for wet weather and other events so that we are still expecting construction to be complete in mid-2024.

THE CHAIR: It sounds like we have prioritised making sure that the hospital is online by mid-2024, but there have been all of these pressures. How has that impacted the budget? I imagine that our arrangement with this top-tier construction company has some buffer, or some accommodation, for some of these extenuating circumstances, but I imagine we pay for that. How has the budget been affected?

Mr Edghill: We still remain within budget. We have a contract which is on the contracts register, which is a fixed price D&C contract, which means that, when we signed the contract in the first place, it was for a fixed amount. Of course, there are variations, as with any contract of that nature, that may be put forward and accepted by the territory, and there are risks that can be encountered. For that reason we maintain, separately to the contract but within the total budget envelope, a territory-held contingency.

It is for that reason, and it is the nature of the contract that we have signed with Multiplex. It is not just about the contract, of course; there has been discipline on the ACT government side, discipline on Multiplex's side, in managing the contract that means, happily, we can sit here today and say that our expectation is that we will deliver the project within the ACT government's budget for the project. Our expectation is that

it is remaining on track, from a program perspective.

THE CHAIR: This will sound really silly, Mr Edghill, and I am not asking you to tell on yourself, but what am I missing? With all of these pressures that we have outlined and that we know are impacting the government's ability to deliver infrastructure projects in other spaces, we are not spending any more money on building the hospital, we are still building it on time and there have not been any delays. But we are seeing delays in other areas. What have I missed?

Ms Stephen-Smith: I think you are right, Mr Davis, and we are starting to see some pressure on this project, as we are on every other project, and particularly around the subcontractors. Mr Edghill talked earlier about Multiplex's tier 1 construction company status, which gives them the capacity to manage those maybe a bit better than a smaller organisation would be able to.

My expectation is that, over the next few months, there will be an ongoing conversation as these pressures flow through, they really start to see the impact, and we really start to see the impact. We are sitting here now, saying, "Okay, this is where we are now," but my expectation is that these pressures will continue to flow through over the next few months. Duncan, is that a fair assessment?

Mr Edghill: Absolutely. Notwithstanding where we are at the moment, that is not to say that there is not significant risk that remains in the project. As the project progresses, the nature of the risks will change. Given that excavation is now largely complete, some of the risks associated with what you might find when you are digging in the ground are beginning to pass, which is good. But now we find ourselves in the world of purchasing the major medical equipment to go into the facility. As we work through that process, there are foreign exchange risks, there are risks associated with shipping costs, and there are risks associated with supply chains and supply times that we are working through.

Why am I being reasonably optimistic here? It is because we know about these things and we are planning in advance for them. Using major medical equipment as an example, whereas on another major hospital project, in ordinary times, you might be putting in your order six months in advance of when you need the equipment here, we are putting in equipment orders 12 months in advance, or further, to help mitigate some of those supply chain risks that you have quite rightly pointed out.

Of course, we then move into a phase of the project where the superstructure itself is complete. But then we have more subtrades on site, so that there is the risk that the minister noted, which is not a Canberra risk but a national risk—a risk associated with subcontractors and them continuing to turn up. We will be facing that risk as we move into the fit-out phase of the project.

We are very pleased with how the project is progressing to date. Certainly, it is a large and complex project, and there is a lot of risk remaining in the project.

DR PATERSON: At the beginning stages of the project, there were some little issues around builders and trades parking in nearby Garran streets. That seems to have reduced. I am interested in how the project is going in terms of engagement with Garran residents

in nearby streets.

Ms Stephen-Smith: Mr Little can speak to that.

Mr Little: I acknowledge that I have read the privilege statement. In terms of engagement with the community, from the commencement of the project we have held regular community consultation, and we continue to do so. Over the last year we have met monthly, until the end of last year; we now meet quarterly. We provide monthly updates in terms of a newsletter that goes out to the group, providing updates on the local impact of the project, potentially, upon the community. We meet regularly with the school and also brief them. We have a regular engagement strategy with them.

In terms of your question about car parking, we do have a dedicated subcontractors' car park away from the site where the subcontractors generally park. There is also a regular shuttle bus that effectively transports them to the site and then back to that car parking area.

MS CASTLEY: Mr Edghill, earlier in estimates I know you said that we are on budget at the moment. You said that it is still the case, so how much has been spent to date?

Mr Edghill: I would have to take on notice, if I may, the exact amount. The invoices should be appearing on the ACT government's invoice register, but I am happy to take the details of that on notice.

MS CASTLEY: Okay, I will check that. Take it on notice. Also you said previously that you expected that, with the post-construction commissioning of the Canberra Hospital, it would be a staged approach, to be finished at some point in the second half of 2024. Can you give us a description of the stages and when exactly we are expecting this to be finished? Will the hospital be finished in June or are we looking at October or November?

Mr Edghill: At a high level, there are two important processes that we are working through in delivering the hospital. The first one is the physical construction component, which is on track, as noted, for completion in mid-2024. We are working through, with our colleagues in Canberra Health Services at the moment, the operational commissioning plan, which is a complex piece of work in itself. That is why we have started so early.

The exact date will, of course, be known closer to the time, once we have worked through some of the construction risks that we have mentioned before, and they have passed. We are actively involved in that operational commissioning process with our colleagues in CHS.

I should have noted, too, that, with the construction completion, we are talking about the critical services building as a whole. There will be some relatively minor works that we need to come back and do once we have moved from the existing emergency department into the new emergency department. Obviously, we cannot do the works on building 2 at the moment until the CSB, the critical services building, is operational. That will continue after the critical services building has opened.

MS CASTLEY: With regard to project reporting, you said that it is starting to look a bit tight in some areas. Are the project reports with regard to risk available or are they part of the program? How are your project managers going with regard to reporting risk, and are the reports flaming red with concern at the moment?

Mr Edghill: There are quite a number of reports that are generated on a regular basis associated with the project. There are reports from our contract partner that come through to ourselves. There are also reports that we generate for our project advisory board. There is a significant amount of internal oversight on this project. We have, as with our other major projects, an independent advisory board, which consists of an independent chair and senior representatives from across the ACT government, including the Health Directorate, CHS and treasury. Major Projects Canberra report on the progress of the project to that advisory board on a monthly basis.

Sitting underneath that project advisory board, we have various committees, including a risk subcommittee, which also meets frequently to assess risk. As part of that reporting to the board, we actively identify which of the key risks—and we prioritise them—we are facing in the project at any point in time. We then provide commentary against those risks.

With those risk reports, we do not make them public because those risk reports and our risk assessments are closely tied to the issue of territory-held contingency, if one of those risk events should arise. For that reason it is more appropriate for those risk reports to be held confidentially by the territory rather than providing them to our contract partner, for example. But in terms of our monitoring and active management of risks, we are absolutely monitoring those.

In terms of whether there are red risks or green risks, of course, it is a mixture of both, and it changes over time. As I noted, probably at the outset of the project, one of our top five risks would have been latent ground conditions—finding hazardous materials, asbestos or unexpected utility services in the ground. That was a high risk for us. That is not a high risk anymore, given that we are basically out of the ground. Now some of the risks that are on our risk register are more geared towards some of those matters that I mentioned before, like purchasing major medical equipment, operational commissioning and so forth.

MR MILLIGAN: My question is in relation to the hydrotherapy services and facilities here in the ACT. In August 2018 your government agreed to work with Arthritis ACT and other parties to maintain appropriate and affordable hydrotherapy pools on the south side of Canberra. Arthritis ACT indicated to Ms Castley and me that they do not receive enough access to hydrotherapy pools for the demand that they have. In addition, the pools require long travel times for our older Canberrans or disabled clients; nor are there big enough facilities close by. Do you think that Arthritis ACT currently have appropriate access to hydrotherapy pools?

Ms Stephen-Smith: I also recently met with Arthritis ACT. Clearly, they are seeing significant demand for hydrotherapy support. We understand the importance of hydrotherapy for people in terms of recovering from acute injury. In the case of most people who are accessing it through Arthritis ACT, it is about maintenance of mobility. There are also mental health and social access issues. There are multiple benefits from

the hydrotherapy supports.

This issue is being experienced by Arthritis ACT on both the north side and the south side. They have been working with University of Canberra Hospital in terms of increasing access to the University of Canberra Hospital pool. They have also expressed concern about lack of access to some pools that they previously could access, including the pool on the south side, at Calvary John James Hospital, which used to be available to them. In my meeting with Arthritis ACT they indicated that they did not currently have access to it. I have spoken with the regional CEO of Calvary and raised that issue with him. I do not yet have resolution of that issue, but I have committed to following it up, and I have done that.

In relation to the construction of a new south side hydrotherapy pool, I will hand over to Ms Lopa to talk about where we are up to on that front. The reality is that, wherever pools are constructed, some people will have to travel to get to them. We have made a commitment in relation to a pool development in Tuggeranong, co-located with the Lakeside Leisure Centre in Tuggeranong, recognising that there are a lot of people in Tuggeranong who need to access this service.

In terms of the existing private hydrotherapy pools and John James, those pools are concentrated in the Deakin area, whether it is the Kingswim warm-water pool, which is not really hydrotherapy, but a lot of people can use that service, or John James. There is not much further south, although Arthritis ACT is using a pool in Calwell at the moment.

I will hand over to Ms Lopa to talk about the construction side of the south side hydrotherapy pool. If you have further questions about Arthritis ACT support and services, Ms Travers, who is acting in that job, will answer. Let us go to Ms Lopa.

Ms Lopa: To reiterate what the minister said around the location in Tuggeranong, when we looked at where hydrotherapy services were located, there is a kids' swimming pool that would be classed as hydrotherapy in Kambah; other than that there are no hydrotherapy services offered in the south of Canberra. A decision was taken to do the new hydrotherapy pool, co-located with the Lakeside Leisure Centre. It will be a fully public hydrotherapy pool, so there will be public access to that pool, and it will also be bookable.

We have been through a process of doing early design of the pool. We have had quite a few sessions with users. With respect to anybody who had contacted the minister with any queries regarding hydrotherapy, we contacted them and invited them to be part of the groups to design the pool. As a result of that, the design changed. They raised issues about needing to go past kids doing swimming lessons and other things in order to access the pool and that they would prefer to have a discrete entry, particularly if someone is disabled and needing to be wheeled past public areas. We have changed our design, and we went to the last budget with a business case and secured the $8.5 million in funding. We are at the point now of going out for procurement, so we are very close. We are finalising our statement of requirements for that procurement and hope to be out to tender very shortly, definitely before Christmas. I want to get that tender out well and truly before Christmas.

We have a project control group that is made up of people from across territory organisations, including sport and rec and property group. Property group will end up owning and running the pool because they own the Tuggeranong leisure centre. That is where we are up to. We are at the procurement phase for somebody to complete the detailed design and then move into construction.

MR MILLIGAN: When is the expected completion date? Are we still talking about June 2024? Also, what are the details in relation to size and capacity?

Ms Lopa: I will take the size and capacity on notice. I do not have that one off the top of my head; I will come back to you on that one. We are still aiming for a 2024 completion date. When we go out for tender, we will put in what our expectations are, but we will also ask for the tenderer to come back with a time line. I am loath at the moment to make a commitment around a time frame that is as detailed as June 2024, because we are seeing the issues that we have spoken about this morning, with regard to construction and infrastructure projects being delayed and those sorts of things. Once we have gone out to market, we will have a much better idea, and we will have a contracted completion date that we can talk to.

MS CASTLEY: With the hydrotherapy pool at UCH, is that fully subscribed every day or is there capacity for Arthritis Australia or other people to come in and use it?

Ms Stephen-Smith: Arthritis ACT already have a number of sessions in that pool every week. I know that the University of Canberra Hospital has been talking to them about the potential to expand that. They have expressed some interest in doing things a bit differently. There are some challenges with some of those things in terms of sharing the pool, in terms of risk and things like that. The pool is primarily used by University of Canberra Hospital as a rehabilitation hospital for patients there.

Mr Peffer: We might have to take on notice the specific question around the rate of utilisation of the pool.

MS CASTLEY: Thank you. I want to know whether there are gaps, and whether the public can use those gaps as well.

Ms Stephen-Smith: My understanding is that it is not available for public booking. There is a pool co-located at CISAC that is a proper hydrotherapy pool that can be booked by the public, and it can be booked for sessions as well. Obviously, as a private hydrotherapy pool, it is significantly more expensive to book, but it is a very good pool that is available in Belconnen. The University of Canberra Hospital pool is really around University of Canberra Hospital patients, both inpatients and outpatients who are getting support from UCH, and those organisations that they work with, particularly Arthritis ACT.

MS CASTLEY: With respect to the business case for the hydrotherapy pool, what is the cost of that?

Ms Stephen-Smith: Is it $8.5 million?

Ms Lopa: Yes. We received $8.5 million in the last budget for construction.

MS CASTLEY: What about the business case?

Ms Lopa: For the operational funding? We are working through now what that operational funding looks like compared to what entry prices might be. Hydrotherapy is very expensive to run because of the temperature that the pool needs to be at. We have some work to do around how much it will cost to run each year, operationally, and where entry prices might sit. We will have to come forward to government with some options for funding before the pool opens—probably in the 2023-24 budget, I would think.

DR PATERSON: My question is in respect of Aboriginal and Torres Strait Islander employment in Canberra Health Services and the Health Directorate more broadly. In the annual report for the Health Directorate it says that the percentage of total staff is two per cent. I believe there is a three per cent target across the ACT public service. What are we doing in our health services to attract, recruit and retain Aboriginal and Torres Strait Islander health workers?

Ms Cross: I think the target of three per cent is to be achieved over a number of years; from memory, it is by 2026, or 2025-26.

Mr Peffer: At some point in the future.

Ms Cross: We are looking in the directorate at every opportunity to employ Aboriginal and Torres Strait Islander staff. We have a couple of areas in the directorate where we have large numbers—the operations of the Ngunnawal Bush Healing Farm, and our partnerships team, which is a unit of Aboriginal and Torres Strait Islander people that support our activities across the directorate. Ideally, though, we would like to see them employed in our mainstream business areas as well. We will be looking at that as part of developing our cultural integrity framework. I am not sure whether Michael Culhane wants to add anything to that general response.

Mr Culhane: I have read and acknowledge the privilege statement. The second part of what Ms Cross was talking about, the cultural integrity framework, is a process that we are embarking on at the moment that is intended to ensure that the directorate becomes more culturally appropriate and culturally attuned to its employees. Also, in terms of the services that we commission from the community, it is about ensuring that those services better target the Aboriginal and Torres Strait Islander members of the community.

There are three or four stages in the process. We kicked off with a survey of all staff, using an Indigenous organisation to benchmark our level of cultural integrity against other organisations. We had a very high level of response to that survey. It was in the order of 50 per cent. I do not have a precise number with me. For this particular survey, it was quite high. We are waiting on that report at the moment, and expecting to get it in the next month or so.

The second part was a series of what I will call workshops, that were offered to all staff, led by an Indigenous consultancy, with a range of Indigenous members. The intention was to educate and lift the level of cultural integrity of employees in the directorate.

That stage has been completed.

The third stage is a series of workshops that will draw on the outcomes of the survey in the report that we have not received yet. We will develop an action plan or a framework that will identify a series of actions for the directorate going forward to make those adjustments to our workplace and assist our workforce to become more culturally appropriate in its dealings with Aboriginal and Torres Strait Islander people, including staff and people in the community.

DR PATERSON: In respect of the actual hospital setting, in terms of cultural safety in that setting, which is quite a clinically prescribed setting, how do you balance those potentially competing interests? What are we doing to ensure that Canberra Hospital is culturally safe?

Ms Stephen-Smith: I will hand over to Mr Peffer, but one of the really positive things that came out of the accreditation process for Canberra Health Services that was called out was the engagement with Aboriginal and Torres Strait Islander consumers and the work that has been done on cultural integrity across the service. Mr Peffer can talk a bit more about that.

Mr Peffer: This is an area where we have had a considered focus for a number of years. A couple of years ago we stood up our Aboriginal and Torres Strait Islander Consumer Reference Group. These were Aboriginal and Torres Strait Islander consumers of the health service. In some cases they were accessing the services on a regular basis for cancer treatment, supporting family members or caring for family members who were accessing the service.

We formed this group. They have been a wonderfully enriching group for the organisation to be able to test ideas, talk to them about what is important about community and how to reflect that in the services or the design of our facilities. The Canberra Hospital expansion is a great example of that. That group has been heavily involved right from the outset, right through the design, to try and create culturally welcoming and safe spaces.

In some cases that consumer reference group has told us, for example, "This is our particular priority, we'd like to see the family room moved within the facility from here to here." There has been feedback on certain areas, with our mortuary being a good example. It had quite a small waiting room without facilities in there. Often we find that our Aboriginal and Torres Strait Islander families come with not just two or three people but 20 people. It is this sort of important feedback that we take on as a health service, and we work to try and improve the services that we are delivering, and to really take ourselves on a bit of a journey.

On top of that we do a series of training for the organisation as a whole. As an executive leadership team, we have been on our own journey, in partnership with Indigenous Allied Health Australia. Earlier this year we had the great privilege of launching, with the chair of our consumer reference group, our statement of commitment, which is a commitment that we have made, as an organisation, to the local and regional community, our Aboriginal and Torres Strait Islander consumers, about the sort of service that we want to be, and how we intend to change and improve continually to do

that.

It was a commitment not just to drive some change and improvement; it was a commitment to do that at all stages in partnership. Certainly, the feedback that we have had from our consumer reference group is that it is an empowered group, it is a demanding group—which is great; that is what we want from it—it is a very opinionated group, and they will be quite forthright in their view of how to construct a service or design a space to change it into a safe and welcoming space.

For us, as an organisation, that is, essentially, one of our pinnacle decision-making committees that we use to guide a lot of the work that we do.

DR PATERSON: In terms of working with culturally and linguistically diverse health consumers in the ACT, do we have similar discussions or reference groups set up to address issues that may be unique to other cultures?

Mr Peffer: Yes, we do. We have a lot of mechanisms that are used within the health service to engage our consumers and, essentially, partner with them, as part of designing a new model of care or services. This was recognised by the commission, as it came through, as part of our accreditation process. Essentially, there is a reasonably high bar that you need to reach to demonstrate that you are involving consumers in the design of care.

Depending on what it is that we are looking at, whether it is a building, a particular service or an area where we have an underserved population, we will look at which community groups or advocacy groups might be best placed to identify consumers or provide a representative to assist us in shaping the design of that service or the improvement.

MS CASTLEY: I have a question about cardiology and ICU reviews. It is on page 146 of the Health Services report. The Johns review that was released occurred in 2020, and it identified areas within the department where culture of the unit was not up to standard. Minister, you mentioned in question time that not all of the recommendations had been implemented from that Johns review. Could you tell me which recommendations from that review had not been implemented?

Ms Stephen-Smith: I will hand over to Mr Peffer.

Mr Peffer: Thanks, Minister. I might have to take on notice the specifics of what came through in that review and what we did implement. My recollection is that, off the back of that review, there were a series of conversations held with particular team members about conduct and behaviour. There was also a bit of a process within the department to look at future planning for the service and what it might look like. I will take on notice the specifics around that review.

MS CASTLEY: Thank you. If the Johns review was 2020, why was Barbara Deegan engaged to do a further review on culture one year later? I think the terms of reference for the Johns review were about culture.

Mr Peffer: Off the back of the Johns review, it was the case that the CEO at the time,

and the executive director of medical services, spent some time in direct conversations with many who had been identified, as part of that review, as generating some of the behaviour that was not acceptable within the unit. There was an opportunity provided to a number of individuals to turn that around, to correct that behaviour.

When the further culture review then was undertaken, our large Better Practice Australia culture review that we do for the entire organisation identified that, in fact, we were not making improvements; we were not making gains in those areas. Off the back of that, Barbara Deegan was engaged to undertake a deep dive assessment within the unit, which provided an opportunity for all team members to come forward to identify what they felt was impacting culture within the team and to identify any improvements that they felt were needed.

That review highlighted and shone a light on certain practices and certain behaviours that, really, we could not sustain as an organisation. They were not in alignment with the our stated values of how we were setting out to engage people and deliver health services at CHS. From there, we progressed to a formal investigation into a number of individuals.

MS CASTLEY: Are they both available, the Johns review and the Deegan review? Are they publicly available?

Mr Peffer: No. There is a level of trust that is required when you engage a department like that, to provide people with the confidence to come forward and provide statements. A number of the individuals who participated in those reviews were not confident to then participate in a formal investigation. That is okay; I understand. But not everyone will be as strident in that respect.

MS CASTLEY: I understand.

Mr Peffer: So, no, they have not been made public. There is a lot of private—

MS CASTLEY: What about the recommendations?

Mr Peffer: No, I do not think they have been.

Ms Cross: The summary of the recommendations from the Deegan review have been provided to the staff, and they are working on them together.

MS CASTLEY: But not the Johns recommendations.

Mr Peffer: From the Johns review there was a slide deck that was provided to the department, given by the reviewer.

MS CASTLEY: Can we get a copy of that?

Mr Peffer: I think that will have a level of detail in it that is specific to individuals.

Ms Stephen-Smith: I think there have been some FOI requests in relation to some of this documentation, so we can have a look and see what is available that has already

been publicly released.

Ms Cross: That is correct; yes.

THE CHAIR: Do we know how many presentations there have been at our public hospitals for dental issues in the last year? Is that data we would collect?

Ms Stephen-Smith: We may have that, but I am not sure we have got it on us at the moment. Ms O'Neill?

Ms O'Neill: No; we would need to take that on notice.

THE CHAIR: Okay; that is all right. Can you tell me what the government has done in the last year to—

Ms Stephen-Smith: Could I just clarify in relation to that: are you just talking about hospital presentations related to dental or are you talking about dental services through Canberra Health Services?

THE CHAIR: No, that goes to my supplementary.

Ms Stephen-Smith: Okay.

THE CHAIR: The raw data, how many people have rocked up at the emergency room with a toothache and other such dental issues, is something that interests me. But, more broadly, what investments were made over the last 12 months to provide free or low cost dental services, particularly preventative dental services, to the community?

Ms Stephen-Smith: There is a public dental program. I will hand over to Ms O'Neill to talk a little bit about it. Of course, one of the frustrations for all of the states and territories in public dental is that the previous commonwealth government continually cut the funding for the dental agreement, which is a national agreement. It is a co-funded service, public dental. The previous coalition government cut the funding a few years ago and then only did 12-month extensions at a time.

So there has been no certainty in funding from the commonwealth, which then makes it very hard for each of the states and territories to plan their public dental services. That is an issue that has been put on the table again, with the new government coming in, to say, "This is something we really need to sort out and have a longer term agreement so that we can plan for certainty of our dental services." Having made that political comment, I will now hand over to Ms O'Neill.

THE CHAIR: Before I go to Ms O'Neill, as I am also a politician I would like to ask you this. There has been a lot of public commentary about the ACT government talking to our federal counterparts about funding arrangements in recent days. Have you or your office made any representations to the incoming health minister about an appetite to engage in that conversation?

Ms Stephen-Smith: Yes. I will take on notice the detail of that, but I think all health ministers have made it clear that it is a priority for us that the dental agreement gets

sorted out.

THE CHAIR: Great. Thank you.

Ms O'Neill: I can make some general comments, but I will have to take on notice the actual data and get that for you. One of the things that we need to be cognisant of with the oral health service is that, by its very nature, it has been one of the services most impacted by COVID restrictions because, obviously, dealing in somebody's mouth increases the potential risk of infection spread with airborne viruses. So it has been one of the services that we have pared back through the lockdowns, but I can get you specific data on what we have actually done.

THE CHAIR: I would like to know that. I would be interested to know if, over the course of the last year, any work has been done to prepare for—as implied in the answer to the question, Ms O'Neill—the demand that there is going to be on the limited ACT government resources in this space. What scope do we have to ramp it up, as restrictions ease and a lot of people who could not afford to get their teeth checked start to come through? That demand will be greater than it has ever been, I would imagine. But tell me if I am wrong.

Ms O'Neill: No, I would not disagree with you. We are constrained in the oral health services by the commonwealth eligibility criteria as well. It is not just an open access scheme. But I can get you full data on the performance of that service and our plans for catch-up work in the next year.

THE CHAIR: That would be great. Thank you.

MS CASTLEY: I have questions about radiation therapy. Page 150 of the annual report says that wait times for radiation therapy are well below the target for the national standards. Emergency treatment starting within 48 hours was five per cent below. Palliative treatment was 32 per cent below, and radical was 20 per cent below. We did an FOI on this and some of the documents said that there were several options to improve the service—for instance, continuing to extended hours, use of shorter course radiation therapy where clinically appropriate, and a couple of others. I am just wondering, Minister, if you can confirm: of the strategies that were mentioned, which ones did CHS use to try and improve those wait times?

Ms Stephen-Smith: I will hand over to Ms O'Neill.

Ms O'Neill: Thank you for the question. The team have used all of those strategies, and our performance against these wait times has been variable throughout the year, particularly with some COVID impacts but also with the changeover to the third new linear accelerator that is now operational. The throughput through that service has meant that our current wait times are within target, noting that the ones published in this report are for the full last financial year.

MS CASTLEY: Okay. I am just wondering: when you chose the options with regard to shorter or single doses, how many patients did that involve?

Ms O'Neill: Single-dose treatments are used predominantly for palliation. This is where

we are using radiation therapy just to relieve some symptoms. It is established clinical practice that single-course treatment is both appropriate and required, so it is not that we have short-changed somebody. With any treatments through this, that is just the way it works for palliation.

MS CASTLEY: Have you reviewed the doses for those patients? I think there are three LINAC machines that are operational. Is the fourth coming online and are there the staff to use that?

Ms O'Neill: Yes and yes.

MS CASTLEY: Perfect.

MR MILLIGAN: Have there been any complaints from patients who use the service, due to the reduction in their dose time or not being able to be treated?

Ms O'Neill: Not that I am aware of. Radiation therapy practice, as with all clinical practice, evolves over time as evidence becomes more and more available, in terms of what is clinical effective. One of the things with radiation therapy is that it is a case of having to balance the risk associated with providing somebody with some radiation versus the benefit to be gained. What we have found, particularly with the new machines, is that people need fewer treatments than they did previously because these machines are much more specific. They deliver the radiation down to one millimetre. Again, it is accepted practice. This is not just something Canberra is doing on its own to try to decrease wait times; it is part of the evolution of the service.

MR MILLIGAN: Okay. Are the hypofractionated treatments used for patients in all categories or are they only used for palliative patients?

Ms O'Neill: Hypofractionation is when we do fewer doses, and that is in the normal curative treatment mode, whereas in palliation they usually only ever require that single dose.

MR MILLIGAN: Okay. Thank you.

Ms Stephen-Smith: Chair, can I interrupt briefly, just to give Ms Castley a reference. There was a freedom of information request in relation to the two reviews in the cardiology division. The number for that—just so that you do not have to open every CHS FOI—is CHS FOI 2122.27, and that is available on the Health freedom of information disclosure log.

MS CASTLEY: Thank you. I appreciate that.

DR PATERSON: Thank you. I really enjoyed reading the ecologically sustainable development section of the Canberra Health Services annual report. I commend you on reductions in natural gas use, water use and waste, and increases in recycling. I am interested in the 21 million litres of waste to landfill from Canberra Health Services, noting that there has been a five per cent decrease in waste to landfill, which is great. Are there key areas of the waste that is created in the hospital where we could potentially see more reductions in waste to landfill?

Mr Mooney: Thank you for the question. I can confirm that I have read and acknowledge the privilege statement. The issue of waste recycling at the hospital, and across all of our services, is something that we are looking at all of the time. As you have noted, we have made reductions. I cannot pick on any specific items because it is changing all the time. We could be looking at organic waste in our food production areas, where we produce a lot of food—1.4 million meals a year, typically. That is an area that we will continue to look at, because that is always going to grow. We are looking at areas where there may be opportunities for recycled plastics that are used in clinical areas. That is something that we are trying to progress as well.

I cannot pinpoint any particular thing. I can say, though, that it is an active focus of the organisation. I think this year we have regained our Actsmart status for the fifth year in a row at Canberra Hospital, and then for the second year in a row at UCH. It is something that we are constantly looking at and are working very closely with our partners on, with our cleaning contractor, ISS, and indeed our clinical waste contractor, Daniels. We know every little bit helps.

DR PATERSON: Thank you.

Ms Stephen-Smith: I think on that "every little helps", it is going to be very interesting to see how much reduced paper use there is with the implementation of the digital health record. The last time I was in hospital there was a folder of paper following me around everywhere I went.

DR PATERSON: In terms of the clinical waste, have there been changes? As there have been improvements in technology, does that create more waste or are some of these improvements in technology reducing our waste?

Mr Mooney: I am not an expert in all of these areas. There are always going to be swings and roundabouts with things like that. Some of the things that we are constantly looking at include re-usable gowns versus single-use gowns and disposables like that. It has to be always treated on a case-by-case basis.

Mr Peffer: I might just add that the consumption of PPE has markedly changed in recent years. The volume of pallets of PPE that we are consuming through the health service has been a marked change from where we have previously been. There has had to be a continued focus on how we adapt and look for new opportunities to prevent things ending up as landfill. That is part of that as well.

MS CASTLEY: Just to clarify, Ms O'Neill, about the complaints with regard to the radiation, were you taking that on notice?

Ms O'Neill: Sure.

MS CASTLEY: Thank you. I have a question going back to workforce. The annual report, in the outlook for 2022-23 with regard to junior doctors and nurse practitioners, says "recruit and train advanced practice nurses and nurse practitioners to our walk-in centres". During estimates we found out that we do not have enough nurse practitioners for each shift. For how many shifts per week do the walk-in centres have no nurse

practitioners on shift?

Ms O'Neill: It is not so much a full shift. What we do is roster the nurse practitioners on what we call through shifts. It is often the hours either side. As you are aware, the walk-in centres are open from 7.30 am to 10 pm at night. Recruitment against those additional positions that we were provided funding for is underway, but there is a little bit of a pipeline to get nurse practitioners skilled, noting that we, through our walk-in centres, are the biggest employer of nurse practitioners. That program is progressing and we are hopeful to have those positions filled in the coming months.

MS CASTLEY: With regard to the walk-in centres, are they managed as a group? If you are the nurse practitioner for Tuggeranong, do you stay there?

Ms O'Neill: No. We manage it as a network. Our staff have been fantastic in working with us. We do it on a voluntary basis. We do not insist that somebody who is living in south Tuggeranong has to work in Gungahlin, for example. But the roster is done collectively across all of those centres.

MS CASTLEY: And do you know exactly how many of those practitioners you need to employ to fill those gaps and what the cost is?

Ms O'Neill: We needed an additional five—

MS CASTLEY: Five.

Ms O'Neill: and we received the funding for that. The last time I checked, we had employed two of those five, noting that we do have turnover, so it gets a little bit confusing. But I can provide you with an update of exactly where we are up to with that.

MS CASTLEY: And the cost too, please. Thank you. And one more, if I may, with regard to workforce and junior doctors? Is there a shortfall of junior doctors in the hospital at this time?

Mr Peffer: There is, against the normal profile that we would run. I would have to take on notice how big that shortfall is. But in our junior ranks at the moment I think we are tracking at mid to high 90 per cent, in terms of day-to-day operations. But I am happy to take that on notice.

MS CASTLEY: Thank you.

DR PATERSON: I am interested in the Canberra Health Services Sexual Health Centre. What assistance will be provided to Canberrans through this service?

Ms O'Neill: I am sorry; I did not hear that.

Ms Stephen-Smith: The Sexual Health Centre generally?

DR PATERSON: Yes. The adult gender specific service to be established for patients aged 16 and over.

Ms Stephen-Smith: So the gender service, not the Sexual Health Centre.

Ms Freiberg: I have read and acknowledge the privilege statement. We have worked on a model of care for the gender services for Canberra Health Services. That is a continual model of care, from paediatrics right though to adult services. There is a component of that that sits currently within sexual health, but we are looking to expand that. Of course, it will need a business case to look at that. We are taking that through the Our Care Committee at this point.

DR PATERSON: And what types of services will that offer?

Ms Freiberg: We have done a lot of work in conjunction with ACT Health and Mr Culhane's team around what is already out in the community. It is not looking to replicate what is actually in the community. It is about the high-end, skilled clinician workforce that we need, so it is more around endocrinology and the sexual health component.

Ms O'Neill: And to ensure that that is provided on a multidisciplinary team basis. There have been services provided but they have been a little bit disjointed. We are bringing this together in this new model of care to make sure that it is contemporary and best practice.

DR PATERSON: Great. Thank you.

THE CHAIR: Can you talk me through the stakeholder engagement that you have done on that work so far? Who has been consulted and how?

Ms Freiberg: Yes. We are working with the team in ACT Health, and working with A Gender Agenda and Meridian. We worked with the team that did the work with KPMG. There were stakeholder workshops that we did, and we attended all of those. We have also been working with our clients that actually use the services within sexual health services, the adult and the paediatric services, to find out what their needs are. We have done a lot of talking.

We have also gone and looked at other services. We specifically went and looked at the Melbourne service, around paediatrics and how they provide that. We looked at other services nationally and how they are provided, to benchmark what we need, looking at what our service currently does around endocrinology and then also mapping what endocrinology does in other services.

THE CHAIR: Do you have an expectation of when you would have a business case prepared for government to consider?

Ms Freiberg: I have got one done now. I have just got to get it through the processes. I do have one done. We are looking at our horizons for that. We have certainly got the first horizon, which we are working on now. That will go through until the end of the financial year. And then the business case will have to go up before that for the next horizon.

THE CHAIR: Tremendous. Thank you very much. Thank you, Minister, statutory

office holders and officials, for your appearance today. For those witnesses who have taken questions on notice, please provide those answers to our committee secretary within five working days of receipt of the uncorrected proof transcript, which you will receive to clarify for omissions and accuracy. If any other member of the Assembly wishes to lodge questions on notice in this area, please get them to the committee secretary within five working days of today's hearings. Today's hearing is now adjourned.

The committee adjourned at 11.45 am.