LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Inquiry into Annual and Financial Reports 2022–2023)

Members:

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

PROOF TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 16 NOVEMBER 2023

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Secretary to the committee:
Ms K Langham (Ph: 620 75498)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 20 May 2013

The committee met at 9.02 am.

Appearances:

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

Health Directorate
Cross, Ms Rebecca, Director General
Lopa, Ms Liz, Deputy Director General, Infrastructure, Communication and Engagement Division
Kaufmann, Mr Holger, Chief Information Officer
Coleman, Dr Kerryn, Chief Health officer
Culhane, Mr Michael, Executive Group Manager, Policy, Partnerships and Programs

Canberra Health Services
Peffer, Mr Dave, Chief Executive Officer
Zagari, Ms Janet, Deputy Chief Executive Officer
Howard, Dr Grant, Chief Operating Officer

Major Projects Canberra
Geraghty, Ms Gillian, Chief Projects Officer
Little, Mr Martin, Deputy Chief Projects Officer

THE CHAIR: Good morning, and welcome to this public hearing of the health and community wellbeing committee inquiry into the annual and financial reports 2022-23. The committee today will examine the annual reports of the Health Directorate, Major Projects Canberra and Canberra Health Services.

The committee wishes to acknowledge the traditional custodians of the land that we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect their continuing culture and the contribution that they make to the life of this city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today's event.

The proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful for witnesses to use these words, "I will take that question on notice," or words to that effect. This will help the committee and witnesses to confirm questions taken on notice from the transcript.

I welcome Minister Rachel Stephen-Smith and all of the officials here today. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. 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. Please confirm, the first time that you speak, that you understand the implications of the statement and that you agree to comply with it.

As we are not accepting opening statements, we will go straight to questions. I will start with a quick one. What is the current waitlist for urology?

Ms Stephen-Smith: I do not think we will have an answer on that today. As I have indicated publicly previously, if we are not able to draw waitlists from the Digital Health Record to provide responses to questions like that at very short notice, I will table an update in the last sitting week of the Assembly, which is only a couple of weeks away, updating the waiting lists that have previously been provided to the Legislative Assembly—an update of the same information that was provided, I think, in May.

THE CHAIR: In the annual report, on page 160, it says that $1,380,784 has been spent on seven specialists. Do we currently have any permanent specialists?

Ms Stephen-Smith: In urology?

THE CHAIR: Yes. That figure—

Ms Stephen-Smith: Could you give the page number again?

THE CHAIR: Page 160.

Ms Stephen-Smith: Of Canberra Health Services?

THE CHAIR: Yes.

Mr Peffer: I acknowledge that I have read and understand the privilege statement.

Ms Stephen-Smith: Me, too.

Mr Peffer: The list of specialists that you will see over those pages at the back end of the annual report are our VMOs, our visiting medical officers. It lists them by specialty and how much they were paid for their services throughout the year. Across surgical and medical specialties, we have a mix of senior medical work force. Each specialty will have a different mix. Some specialties are entirely visiting medical officers; others are entirely senior staff specialists and staff specialists—essentially, permanent employees. It depends on the nature of the work as to the make-up of that work force.

THE CHAIR: How many full-time orthopaedics do you have—full-time equivalent?

Mr Peffer: Surgeons?

THE CHAIR: Yes.

Mr Peffer: We would have to take that on notice. Certainly, with the VMOs that you would see here, the vast majority of them would not have full-time fractions that they are working for Canberra Health Services.

MR PETTERSSON: Minister, how is work progressing on the Canberra Hospital

master plan?

Ms Stephen-Smith: I will ask Ms Lopa to talk about that.

Ms Lopa: Thank you for the question. I acknowledge the privilege statement. As the committee would be aware, we released the Canberra Hospital master plan in 2021, which will guide the redevelopment of the campus over the next 20 years. The first big redevelopment on the campus is underway now, with MPC, CHS and ourselves cooperating on the building 5 development, which is the new acute services building which will open next year.

We have been funded to do work on the next stage of the implementation of the master plan. We are looking at a car park on Yamba Drive, car parking being the number one issue that was raised during our consultation on the master plan. We are looking at a new pathology building next to the new building 5, for an increased pathology service. They are currently housed in building 10 on the Canberra Hospital campus and are fast outgrowing that building. And we will be having extra services come online as a result of the new critical services building.

We are also looking at a new inpatient building. Building 1, which is the tower block, is ageing. It is one of the original buildings from the 1970s. From looking at condition assessments and those kinds of things when we were doing the master plan, it was clear that we needed to build some new inpatient accommodation, so we are looking at those now. The pathology building and building 10, new inpatient accommodation, are currently in design at the moment, to inform a business case to go to government.

MR PETTERSSON: Can you provide further information on how this work fits into the broader health infrastructure program for the ACT?

Ms Lopa: Yes. The government released the health infrastructure update a few months ago, outlining what will be happening in health infrastructure over the next decade, and quite a lot of projects that we will be doing. At the moment we are looking at the two hospital campuses. We are designing a new north side hospital to be built in Bruce, and we have the redevelopment of the Canberra Hospital through the master plan process.

We are also looking at our community infrastructure. The government has committed to four new community health centres in the inner south, Tuggeranong, west Belconnen and northern Gungahlin. We are doing the planning for those as well. We are looking at what services need to be on a hospital campus, what might be on the north, what might be on the south and what might be delivered in the community.

We know that the community, through our community consultation, want as much as possible to have services delivered near to where they live. With car parking being such an issue on our hospital sites, we are examining whether we need to bring people onto a hospital campus to get their treatments, or whether they can be delivered in the community.

We are looking at service planning and infrastructure planning across the territory on our two hospital sites and at UCPH, and looking across the community and thinking

about what we can be doing closer to people's homes. We have quite a large health infrastructure program over the next 10 to 15 years, as we redevelop our ageing infrastructure.

MR PETTERSSON: That is great. You mentioned a couple of times the community consultation that has already been undertaken. Will the community consultation continue?

Ms Lopa: The most recent community consultation we have done is with the Tuggeranong community, or the whole community, but particularly on the Tuggeranong health centre that we will be building soon. That consultation has been fantastic. We have been doing that through Your Say. We have also been doing pop-ups at South Point et cetera, talking to people.

We did quite a large consultation on the north side hospital, and back when we did the master plan. We will continue to involve the community as we go through the design of our facilities, looking at the services that they need and want—backed, of course, by data that we have about the demographic of the suburbs and what the health needs of the suburbs are. We build better health infrastructure if we are involving the community in what we do.

Today we have the first meeting of the ACT Health Directorate's new Consumer Reference Group for all of our health infrastructure. We went out with an EOI for that, and the first meeting is today. That is building on what MPC have done through building 5 on the Canberra Hospital campus—involving consumers in what we build, what it looks like, what it feels like and making sure that we have those consumer inputs from people who are using our infrastructure, and making sure that we get it as right as we can for our community.

Ms Stephen-Smith: Chair, before we move on, my office has reminded me that you asked for some specific information on urology in October, so I have some numbers that are not up to date. Also, to be really clear, these numbers have not been validated due to the time constraints at the time we asked for them. As of 16 October, we were advised that there were 80 urology patients on the waitlist for Canberra Hospital, 466 at North Canberra Hospital and 26 with territory-wide surgical services. At the time there were 230 overdue or long-wait urology patients on the elective surgery waitlist out of a total of 572 patients on the waitlist.

To provide a bit of context to that, about 80 per cent of urology cases are normally performed at North Canberra Hospital, previously Calvary Public Hospital; so that is around 2,000 cases a year, normally. Of course, that was very significantly disrupted by the theatre fires and the loss of some vital equipment, which has now been replaced. The theatres are now open, so normal services are resuming, and North Canberra Hospital will be getting through that. I think we have all recognised that there has been a substantial impact on urology specifically as a result of the theatre fires.

THE CHAIR: Thank you, Minister. Ms Castley, do you have a substantive?

MS CASTLEY: I have a few questions on Calvary. Minister, we know that Calvary

was advised in April 2022 that the government was drafting special legislation to acquire the land for a new north side hospital. Was Calvary also told that this special legislation would terminate the Calvary Network Agreement?

Ms Stephen-Smith: We have been through this many times already, Ms Castley, but I will humour you and repeat the information that has been put on the public record on numerous occasions. The Calvary Network Agreement was tied to the crown lease, so it was, by definition, going to be ceased if the crown lease was ceased. Yes, they were very well aware—

MS CASTLEY: Calvary were told? You actually told them? You put two and two together and—

Ms Stephen-Smith: They were signatories to the Calvary Network Agreement. Prior to the Calvary Network Agreement being negotiated, the previous agreement struck under the commonwealth government, pre self-government, had no end date at all. When it was renegotiated in 2011 as the Calvary Network Agreement, the length of the agreement was tied specifically to the length of the crown lease, which is why they talk about the 76 years. They were very well aware that, if the crown lease was ended, the Calvary Network Agreement would, by definition, cease, and we would need to negotiate a new agreement, if they were to continue running the hospital.

MS CASTLEY: But were they actually told?

Ms Stephen-Smith: Yes, it was very clear in every conversation.

MS CASTLEY: Is there a record of it?

Ms Stephen-Smith: They are also not stupid, Ms Castley. These people run a large organisation. They are not silly. They understand their contracts.

MS CASTLEY: Is there a record of you explaining both to them? Is there a record?

Ms Stephen-Smith: It was clear in every conversation, Ms Castley, that that would be the implication. It was absolutely clear to everybody around the table that that would be the implication. That was part of the reason, in an ongoing way, that their preference would have been to sublease part of the site to the ACT government, precisely because that would enable them to retain the Calvary Network Agreement as it was.

MS CASTLEY: Was this special legislation, the health infrastructure enabling bill 2022, ever actually drafted?

Ms Stephen-Smith: No.

MS CASTLEY: It was never drafted at all? You seemed keen—

Ms Stephen-Smith: No. Again, Ms Castley, that information is on record through the Senate inquiry.

MS CASTLEY: You were never given a draft?

Ms Stephen-Smith: No.

MS CASTLEY: For 2022?

Ms Stephen-Smith: I can hand over to Ms Lopa, who was managing that team.

Ms Lopa: In 2022, we did look at starting to draft legislation, because we did not know how long the negotiations would take, and we did not know whether, if we came to an agreement with Calvary, their preference would be that it be implemented through legislation. But we did not start drafting legislation until 2023, because we really did not know what to put in the legislation until we had come to the conclusion of negotiations with Calvary.

In 2022, we were thinking, "Let's start drafting legislation," but when we sat down to think about drafting it, we did not have anything to put in it because we were still negotiating with Calvary. That legislation started being drafted in early 2023.

MS CASTLEY: There was a brief to you, Minister, to remove the health infrastructure enabling bill 2022 from the spring program. We saw that through FOI. The brief was not released, but there was a piece of information in that FOI. Who wrote paragraph 9 of the brief—that it had been the intention to introduce or debate the bill during the negotiation period? We have information here that there is a response that says:

> Regarding paragraph 9, that it was never the intention to introduce or debate the bill during negotiation period, this is an odd thing to say. Early consideration by cabinet was proposed to ensure that any issues are able to be worked through. Given the complexity and sensitivity, we do not want to be in a position where introduction of the bill is delayed. It is indeed required because there are still issues.

Who wrote that brief to you? It indicated that you did indeed want the—

Ms Cross: I have read and understood the privilege statement. I think we can tell you who signed the brief off, but the process of drafting any brief can involve any number of people contributing and editing. We can certainly tell you who signed the brief off and approved that wording. I am looking at Ms Lopa; I am guessing it was her.

Ms Lopa: It was probably me. I do not have it in front of me, but it probably was me. When we were looking at whether we would go to legislation in the spring sitting, the processes of government mean that you need to put your marker down to go into legislation quite early, to go through all of the processes.

We put it on the spring legislative program in anticipation of those negotiations being done. They were not done. With the wording of the brief, I do not have it in front of me. The intention was never to debate legislation while we were still negotiating, as the minister marked on the brief. I do not have that paragraph in front of me, but it could have just been loose wording.

We prepared and put it on the spring legislative program. We did not start drafting legislation. Indeed, when we briefed up, it was, "No, we're not doing this until negotiations have been concluded," and it was withdrawn from the program. It was really just an early preparation thing to make sure that we were there if we needed to be there on the program, but we did not need to be there.

Ms Stephen-Smith: Ms Castley, just to give the context for my comments, I was conscious that, in the event that we did introduce legislation—and that was in no way determined—there would be complexity around it, and we would need to get substantial advice in relation to how that legislation would be constructed. From my point of view as the minister, I wanted to be confident that, in that eventuality, if we did end up having to act quite quickly, we would be ready to go, which is why my commentary on some of the briefs was a bit of frustration that in fact legislation had not been drafted.

That does not indicate the intention to introduce it, but for me to have confidence, if we did need to do that—whether that was in agreement with Calvary, and that relates to the fact that they would need to get agreement from the Vatican to have that land alienated from the church. It was part of our thinking that they may in fact prefer that we legislate for the transition of the land, effectively in agreement with them and with them continuing to run the hospital. That was one option that we thought might be on the table. They made it clear to us, subsequent to our thinking, that that would not be their preferred option. But, from my point of view, I wanted to be confident that we understood how we would legislate in the event that that came to pass.

MS CASTLEY: Was Calvary ever advised that this legislation, the health infrastructure enabling bill, had been placed on the 2022 spring program?

Ms Lopa: I do not think so. I do not think it was explicitly raised with them, but it was explicitly raised with them that legislation was an option. They were aware of it, but—

MS CASTLEY: But just not on the spring program?

Ms Lopa: Yes.

MS CASTLEY: Were they advised when you took it off the program?

Ms Stephen-Smith: No. These are internal processes of government. While they were not advised, as Ms Lopa has indicated, they were aware that we had authority to prepare legislation. That was clear in that April letter. I tabled in the Legislative Assembly a page from the meeting notes between the Health Directorate, Ms Lopa and the Calvary negotiating team that clearly laid out all of the potential options for the transfer of land, one of which was explicitly stated to be legislation without Calvary's agreement, or compulsory acquisition without Calvary's agreement. So they were aware that all of those options were on the table.

With the people on the other side of the table, the regional CEO is a former senior ACT public servant, so he would have been aware of the processes of ACT government. He would have been aware of how legislative processes occur in the

ACT, that things go on and off the forward program for legislation all the time and that if we had authority to draft legislation, that would indicate that we had a slot on the legislative program. While it might not have been explicitly discussed that there was a slot and then there was not a slot, the people we were negotiating with were very familiar with these types of processes.

MS CASTLEY: Okay. When was Calvary first informed that the government wanted the 25-year modern services agreement?

Ms Stephen-Smith: That was part of the negotiation. It was formally put to them as the government's final position in September, but that had been our position the whole way through, so—

Ms Lopa: Yes—I raised it in my first negotiation meeting with them.

MS CASTLEY: The actual 25 years or just the reduced term?

Ms Lopa: The 25 years.

MS CASTLEY: Is there a record of that anywhere? Is that in the minutes of a meeting?

Ms Lopa: I would have to check. Those meetings were covered by a confidentiality agreement, so I would have to check the records of the meeting and I would have to get some advice around releasing them.

MS CASTLEY: You are sure that everybody understood that 25 years was on the table?

Ms Lopa: Absolutely.

MS CASTLEY: The last actions register released—I have it here; we got it through FOI—shows that the health department was to develop matrices of terms, lengths, options and preferences by July 2022, and it says that the terms, lengths, options and preferences were in progress. Where was this up to at the end of the exclusive negotiations?

Ms Lopa: At the end of the negotiations, Calvary was aware of the government's 25 years. They were always aware that the government's preference was 25 years, and then, at the end of the negotiations, the minister wrote to say this was finalising the government's position of 25 years. I will have to take on notice where the actual matrix was up to, but the government's preference was around the term was absolutely clear in our negotiations with Calvary. It was discussed with them and then it was reiterated in the letter at the end of the negotiation period.

MS CASTLEY: Are you taking this on notice: can you provide me with the documentation, where they were advised about the 25 years?

Ms Lopa: I will take that on notice.

MS CASTLEY: Thank you. I have just one more question, if I can, Chair. FOI documents shows that the government's priority during the exclusive negotiations was to secure agreement to term and termination clauses. The last actions register in the FOI records that the health department and Government Solicitors Office were developing principles to change the termination clauses and that this was in progress. Were these principles developed or communicated to Calvary prior to that so-called final offer letter on 14 September?

Ms Lopa: The discussions with Calvary around termination clauses were during the negotiations. We talked about the Calvary Network Agreement. There was certainly agreement between us, representing the government, and Calvary that the Calvary Network Agreement could be modernised. They also believed that some of it was outdated and we could work through them. Termination clauses was one of those sticking points, around the fact that there was really no termination clause in the agreement. It was a long-term agreement. We had been working through what sort of termination clauses might be in a new agreement.

As we were working through the negotiations, we looked at what a new agreement would look like. We really looked at what a 25-year new modern health contract would look like. They were aware of the government's want around termination clauses, and that was that there were some termination clauses. My recollection is they were open to some of that and not others. They did not want a termination clause where any new government could be elected, for example, and just terminate their contract. They wanted some surety as well. They were discussed throughout the negotiations, but we never reached resolution on it.

THE CHAIR: We will move on to the next substantive. Ms Clay.

MS CLAY: Thank you, Chair. Minister, home birth is a great option for women and birthing people who want to use it. We have had some really good progress on access for that. It is really good to see. We have heard reports of an operational problem. I will describe the operational problem to you. In home birth, it is a requirement that, in the fourth stage of labour, Syntocinon is administered, and midwives are not able to prescribe Syntocinon. They used to get it prescribed by doctors and they are telling us that they are no longer able to find doctors who will prescribe Syntocinon, so the practical implication of that is that people cannot access home birthing, because they cannot conform with the requirement for Syntocinon. Have you come across this problem?

Ms Stephen-Smith: It is ringing a bell with me, but I cannot say I have any detailed knowledge. People are shaking their heads. We might be able to get some information for you before the end of the hearing; otherwise, we can take that on notice.

MS CLAY: That would be excellent, in which case I will tell you the issues. The problem is access to Syntocinon, which midwives are able to administer but cannot prescribe, so they cannot actually get their hands on it. Quite a lot of solutions have been suggested to us. It could be that we could find some doctors who are able to prescribe it; we could perhaps authorise midwives to prescribe Synto—they are able to prescribe some things; or there could be some other system. It has been reported to us as an actual operational barrier at the moment.

Dr Howard: Good morning. I have read and acknowledge the declaration. It is a long time since I was an obstetrics registrar, so I will not claim any particular knowledge of Syntocinon and its use currently, but I would say that we are, as is required, reviewing maternity services' access to continuity midwife models, and in particular where women who enter our maternity services end up delivering and the reasons for that. One of those you have just put on the table, which is that, if people cannot get access to a particular thing for home birth, that may end up with the woman delivering in a hospital setting or similar.

In the ordinary course of mapping out where women are delivering and how they are accessing our services, we will pick up the point that you made and explore that, because obviously that is a significant influence on where women are delivering currently. Our capacity to meet that in a pleasant environment that is not hurried would mean it is an important thing for us to look at.

MS CLAY: Great. Could you take that on notice?

Dr Howard: I could.

MS CLAY: Great—whether midwives are able to access Synto and, if not, what government might do to enable them to access Synto.

Dr Howard: I can certainly answer the first question. The second might be slightly longer.

MS CLAY: Sure. Thank you.

THE CHAIR: Minister, in November 2023 you gave a ministerial statement and said:

> As members are aware, we are making progress on our commitments to new health centres in North Gungahlin, the Inner South, South Tuggeranong and West Belconnen.

When can we expect to see these opened?

Ms Stephen-Smith: Ms Lopa is coming back to the table. We, of course, committed the $16.6 million in the most recent budget. That is for the design and construction of the health centre in South Tuggeranong, which Ms Lopa was talking about earlier, as well as for the further design work on the Inner South and North Gungahlin health centres. We were, in fact, at the Inner South Canberra Community Council earlier this week, a couple of days ago, talking to them about potential sites for that centre in the Inner South, and we also have a potential site identified in North Gungahlin, at Casey, but the government is working through the use of two blocks in Casey. There are a number of directorates that have an interest in that land, but there is also obviously the need for continued housing development. Government is working through where the most appropriate place for the health centre in North Gungahlin might be, but we will be commencing the work on design concurrently. I will hand to Ms Lopa to talk about that.

Ms Lopa: Thank you. We have identified a site in Tuggeranong and the government has committed the funding for the construction of that. We are going through the next stage of design for that. A DA will be lodged in due course and we will look for a contractor to build that. I may need to come back and correct myself on this one, but we think that will be open by 2026-27. As I have said in these forums before, I am always really mindful about not wanting to commit to a time frame 100 per cent until we have had the tender process and the contractor is on board.

Going to the one at Griffith, the Inner South one, as the minister said we went to the Inner South Canberra Community Council this week. There are a number of sites that we are considering for that health centre. You would not be surprised to know that any block that is in the inner areas that is not developed on is usually not developed on because it is difficult. There are some sites and we may need to consider some Territory Plan variations. There are some stormwater issues with infrastructure in the ground. The process for that one will be to do some more site investigations and to land on a preferred site or a final site by next year and then go into the DA et cetera. The early design of that centre has been funded, so we are starting to do the early concept designs for that centre at the moment. We would be looking to go back to government for business case funding, not in the next budget but the one after. I would assume that, at that point, if we are successful in getting funding again, that will be open sometime in 2027-28.

North Gungahlin is in a similar position. We are just waiting to get confirmation of the land. We are also starting to do some of the design works on that. West Belconnen is a little further behind. We are currently looking at whether that will be in Ginninderry or somewhere else in West Belconnen, so we will need to do the land process for that. I cannot give you exact dates of when they will all be open at the moment, but that is pretty much where they are all up to as far as the planning goes.

THE CHAIR: Will there be any urgent-care centres with GPs as part of any of these?

Ms Stephen-Smith: I can say a couple of things. On South Tuggeranong, the aim is to try to get it through to development application in the first half of next year. I would hope, if we can work in parallel in procuring a construction partner, that we would be able to have that open in 2025-26, I think Ms Lopa said it would be in 2026-27, but I am always optimistic that we may be able to do things in parallel and move things along more quickly. The optimistic date is 2025-26, and 2026-27 is the date if the usual construction delays occur.

In relation to urgent-care clinics, the commonwealth government obviously made a commitment through the election campaign to one urgent-care clinic in the ACT, on the south side. Subsequent to the election, there were conversations with the commonwealth about the fact that we have a different model in the ACT, which obviously Senator Gallagher is well-aware of, having opened the first nurse-led walk-in centre. We already have five walk-in centres around the ACT that do almost everything that the urgent-care clinics were intended to do. I have visited one of the priority care clinics in South Australia that is a GP-led clinic, and almost everything that clinic does could be done by nurse practitioners, advanced practice nurses and extended scope physios.

Our view is that we have a great model. Canberrans are used to going to walk-in centres and we could use the commonwealth funding. In fact, we got some additional commonwealth funding to expand the scope of what our current walk-in centres deliver, and then to have five centres across the ACT rather than just one delivering an expanded scope of care. That means things like partnering with medical imaging centres close to the Gungahlin, Belconnen and Tuggeranong walk-in centres, where there is a medical imaging place close by. We would enter into a contract with them so the nurse practitioner could refer someone to get an X-ray, for example, and they could come straight back to get a limb extremity fracture treated in the general area.

In the Inner North, at Dickon, there is no medical imaging centre close by, so the solution is a mobile X-ray which the nurses would be able to use, but someone else would have to read. They have to send the image to a medical imaging specialist to read and get back to them, but the person would not have to go to hospital to get the image and come back.

In Weston Creek, we have a medical imaging centre onsite. Other equipment that is being supported through this includes things like slit lamps for the treatment of superficial eye injuries, particularly when there is a superficial foreign body in someone's eye and they need to get that removed, not having to go the emergency department; and venous Doppler machines to monitor blood flow and identify if there is a blood clot in someone's leg. Again, it something that you might otherwise have to go to hospital for because most GPs do not necessarily have that equipment in their practice. It was our conclusion, with all of that conversation, that almost everything that was being planned to be done in urgent-care centres could in fact be delivered by nurses and nurse practitioners and then, with some extended scope, physio as well in some places.

On that basis, given that we have the lowest proportion of GPs per head of population and already a lot of difficulty accessing GPs, that was the path we went down. Having said all that, Ms Cross might want to add a little bit about the funding and how that agreement was reached.

Ms Cross: I would add two points. Initially, the commonwealth had promised $750,000 for one urgent-care clinic. I think in the end we received over $7 million. By doing it across the five walk-in centres, we actually have a whole-of-system trial. We can look across Canberra by having these centres located across the territory and look at whether that does reduce admissions to the emergency department. If there was just one in Tuggeranong, there would be whole parts of the community that could not access it. Building on the model that we had, doing a system-wide trial and getting extra commonwealth funding to support that were some of the key arguments for going down this path.

THE CHAIR: How long is the commonwealth funding for and will they continue to fund it, or will the ACT government have to step in once that federal funding ceases?

Ms Cross: I think the urgent-care centres are an ongoing measure, whereas there are some others, like the primary care pilots, which are pilots. I think urgent-care centres have ongoing funding from the commonwealth.

THE CHAIR: How much does it cost the government for a consultation with a nurse practitioner, roughly? Do you know?

Mr Peffer: We would need to take that on notice.

THE CHAIR: How many patients who go along to one of these walk-in centres get referred on to GPs? What is the percentage?

Ms Stephen-Smith: Again, we are working through releasing an updated quarterly performance report. At a high level—and it varies from centre to centre and from quarter to quarter—around 80 per cent of presentations are fully treated in the walk-in centre. About six per cent, between five and seven per cent, are referred through to the emergency department, people are advised to go to the emergency department, or in some cases an ambulance might be called.

With the remaining 14-odd per cent, I am not sure that we can say exactly what proportion of that is a referral to a GP. It might involve having a chat with a pharmacist about something. There might be another solution for that. I am not sure that our data is good enough to say exactly when people were advised to see their general practitioner, specifically. Those are the kinds of numbers in terms of being able to be fully treated, being referred to the emergency department or another course of action.

THE CHAIR: How many nurse practitioners do we currently have in the walk-in centres, and is it meeting demand?

Ms Cross: Some of the funding from the commonwealth was to increase the number of nurse practitioners so that they were onsite all of the time, so that, if someone was sick, we would actually have the back-up. Obviously, when there is a nurse practitioner there, you can provide the wider range of services. We would probably have to take that on notice but that was some of the—

THE CHAIR: Take it on notice? Okay.

Ms Stephen-Smith: We had already put in funding to ensure that, over the course of this term, we could get to a point of having a nurse practitioner on every shift in every walk-in centre. Now the commonwealth funding is further expanding that capacity.

MS CASTLEY: Minister, you said that the walk-in centres can do almost everything that an urgent care centre can do. What can't it do?

Ms Stephen-Smith: We will take it on notice, specifically.

Ms Cross: I think there are some prescriptions that a GP can issue that a nurse practitioner cannot. For children under the age of one, for some things you would prefer to see a GP. I think they are some of the key differences.

Ms Stephen-Smith: On children under the age of one, that is a very clear example, where GPs can obviously see babies. We have recently reduced the minimum age for walk-in centres from two years old to one year old, on the basis of the evidence

presented by our nurse practitioners. The nurses did their own piece of work and presented evidence; that was considered through clinical governance and that change was made. We will continue to look at the potential for younger ages. That is obviously not done yet.

MS CASTLEY: Is it a scope of practice issue for the nurse practitioners?

Ms Stephen-Smith: Yes.

MS CASTLEY: You mentioned it seems to be around 14 per cent that possibly get referred to a GP or, as you say, a pharmacist. With that sort of reporting, will you be looking into that a bit more, to understand? Has there been a review into the walk-in centres since they started? Are you going to do one?

Mr Peffer: I can respond to that. We have been through a process where we have shared some data with the Capital Health Network, particularly around the emergency department presentations and the nature of those, as well as walk-in centres and that interface that we have with primary care.

They have done quite a bit of work with our data folk, probably over about 12 to 18 months, seeking to understand that data and share that with their membership—their GPs as well. That is something that we constantly look at, to see whether there are other improvements that we can make.

I will say that quite a number of our walk-in centres have very good partnerships with primary care in the surrounding region when there are those referrals. It is often not a cold referral; it can be a warm referral and a conversation with the practice about what they might be able to do to support a patient.

Ms Cross: Chair, can I slightly correct something that I said? I think the urgent care centres for the commonwealth are an ongoing initiative. Could I clarify that our agreement with them for this first rollout is a three-year funding agreement. Obviously, at the end of the three years there will be some form of evaluation with the commonwealth of the urgent care centres across Australia to see what are effective models and which ones they will renew, presumably.

Ms Stephen-Smith: My office has advised that the federation funding agreement is publicly available on the federal financial relations website.

MS CASTLEY: After those three years, will you check with the federal government as to whether they will continue funding it or will it be something that the ACT government will take up?

Ms Cross: With all of these things, it depends on who is in government in the commonwealth. On some occasions they continue funding agreements and on others they extend them year by year. I really cannot predict that, but the commonwealth would want to look at the urgent care centres that have operated in every state and territory, evaluate which models have been effective and potentially tweak the agreement. We certainly hope they would continue to fund this.

MS CASTLEY: At the end of the day, we are expecting the federal government to continue funding; it is not something that the ACT government would do?

Ms Stephen-Smith: The broader context for this is that we have just considered, within health ministers, and it will go to national cabinet, the midterm review of the National Health Reform Agreement as well. There is a very clear appetite across states, territories and the commonwealth to think more broadly about all of our national health funding arrangements.

The National Health Reform Agreement, which currently funds, effectively, hospital services and some other services that are in scope, was intended to be a genuine reform agreement when it was originally signed under the Gillard government, I think. It has become a hospital funding agreement and it is very difficult, within that agreement, to take a broader scope around innovation in the health system.

We are all very keen to look at opportunities to come to a commonwealth-state-territory agreement that considers the whole health system and an integrated approach to that. When we think about the commonwealth ongoing funding for urgent care clinics, that will no doubt be considered in the context of the broader question of who funds which parts of the health system, from primary care to community-based care and acute hospital-based care, and how all of those funding arrangements work.

MS CLAY: Going back to where we began, with the question on the Conder health hub, have we announced the model of care for that health hub yet?

Ms Stephen-Smith: That has been the subject of consultation with the community. We have said some things already about what those health centres will look like. We have been really clear that they are not walk-in centres in the same way that we have been talking about. They will also not necessarily operate in the same way that community health centres have operated. I expect it will be largely appointment-based care. One of the things we are considering is whether there is capacity for some level of walk-in, drop-in services.

We are looking at the demographics of the particular regions and their use of our existing services. We would look at the data for what services people from south Tuggeranong are accessing, as well as listening to the community about the gaps that they are seeing in care. If you think about an area like south Tuggeranong, it is probably an older community, with fewer very young families than some other parts, like Molonglo or Gungahlin. At the same time it is one of our most socio-economically disadvantaged communities, and there are barriers to accessing health care.

Also, we hear from young people in that community, for example, that they do not travel into the city to access services. Tuggeranong is their home. That is where they access services. Obviously, there is the teen clinic at Mura Lanyon that is run by Directions, and it is a fantastic service. It is about the extent to which there are services for young people that we might want to connect into, and whether that is CHS delivering complementary services or providing space in the health centre for our non-government partners to come in and deliver services there. The Asthma Foundation comes in and delivers childhood asthma services from our site in

Molonglo.

We are putting all of those things into the mix. As we work through the infrastructure development, we are also working through the service design, but none of that is finalised yet. That was a very long answer to say none of it is finalised yet.

MS CLAY: No, that is all good. There was a lot of information there. We have seen the Your Say consultation, which is great. What other practitioners and stakeholders have been consulted or will be consulted on that need for care?

Ms Lopa: We are using the government portal, Your Say. With community consultation, we are doing shopping centre stalls, letterbox drops and those sorts of things, to try to reach as many people in the community as we can. We are aware that not everybody hops on the Your Say website to have a say on something. We are always looking for ways that we can effectively engage those that are hardest to engage, and there are some of the lessons that we have learnt from COVID around engaging with those populations. That is the community consultation.

We are also doing stakeholder consultation, with the Health Care Consumers Association, the ministerial councils that we have and all of our stakeholders that we usually consult with—Mental Health Consumer, Carers ACT and all of our non-government partners. We are doing consultation with them. We do clinical consultation as well. We work with CHS and talk to their experts in the area, the clinicians, their executive directors of areas and the service planners. We talk about how a service might be run and what the logistics of it might be. We bring that all together to make some decisions about what services will be run out of there.

We are having conversations, as the minister said, about what else we can put in them that is not just government public health services. It is about how we can partner with our non-government organisations to give them space to deliver the things that they need, by having flexible space in there. We are also talking about whether we have some community space in some of them. We do not want them just to be a health centre, but actually a hub where the community can access many different types of services.

MS CLAY: Can I get a list, on notice, of the organisations being consulted? Thank you.

Ms Lopa: Yes.

Mr Peffer: Chair, we took a question on notice just before about the number of nurse practitioners. We have 12.35 FTE of nurse practitioners recruited. We have a higher headcount, but some team members work part time. That is across the walk-in centres.

THE CHAIR: Is that meeting demand?

Mr Peffer: We continue to recruit. We have a number of nurse practitioners who will commence in the months ahead. We have a rolling recruitment program in that space.

THE CHAIR: How do you measure whether or not you are meeting demand and

expectation? Do you have a tool or something that you measure this with?

Ms Stephen-Smith: One of the things we look at is waiting times in the walk-in centres, which are generally really good, and less than half an hour. There have been periods where, in the busiest walk-in centres, the wait times have increased. That is one of the things that we monitor, to consider whether we need additional resources or we need to provide information to people. Obviously, it is available on the ACT Health app—what the wait times are at the different walk-in centres across the city, so people can look at it and say, "Belconnen is actually really busy. The wait time is half an hour, but I could pop over to Gungahlin instead and it will be 15 minutes."

MR PETTERSSON: Could the committee get an update on the Watson health precinct?

Ms Stephen-Smith: Ms Lopa is at the table. She can do that for you.

Ms Lopa: Yes, the Watson health precinct, where currently Ted Noffs and CatholicCare are delivering services, is being redeveloped. It was funded in the last budget. We have been through the design process. Ted Noffs and CatholicCare are being rebuilt. It is quite a large site, so we have done a master plan of the site. They are being rebuilt and put into new accommodation. The site is being subdivided to allow for a new Aboriginal and Torres Strait Islander residential rehabilitation service, which Winnunga is designing at the moment.

Things are moving forward really well on that. We have gone to DA on the subdivision of the site and the new buildings. We have a contractor. I think the tender is just about to close. It has either closed or closes, definitely, this month. We will be ready to go as soon as the DA is approved.

The first step in that development will be to rebuild Ted Noffs and CatholicCare, while they stay in the existing buildings onsite, then decant them and demolish the old buildings that are there. Winnunga will start building at the same time, so there will be people left in situ and there will be building happening on either side of them.

Winnunga has a designer, a project manager et cetera on board, and we have been working really closely with them, but they are designing their own facility. We have been working really well and really closely with Ted Noffs and CatholicCare. I think there is a level of excitement about what we are doing there.

The buildings that are on that site are really old and not fit for purpose anymore. They are housing young people who are going through a rough time in their lives, accessing mental health facilities and accessing drug and alcohol facilities. There is a real sense of collaboration and excitement about what we are doing to give better accommodation to the young people who are accessing those services, and all of what comes with that, which is really communicating to these young people that they are worth it. It is about having really appropriate accommodation with access to open space and light. It is a beautiful site at the bottom of Mount Majura, and it is the same with the residential rehab—that connection with bush and country. It is a really special site and a really great project to be doing.

We are expecting to commence construction early next year, when the DAs come through, and we are expecting that construction period to be 18 months to two years. Obviously, they will then decant into the new buildings, and we will be able to demolish those old buildings that are there.

MR PETTERSSON: That is very exciting; thank you.

Ms Lopa: It is.

MS CASTLEY: The RACGP *Health of the nation* report was released yesterday, or maybe the day before, and it showed that, in 2021-22, there were 95.4 GPs per 100,000 of population in the ACT, the second lowest ratio of GPs to population in the country, except for the Northern Territory. This is down from 97.9 per cent per 100,000 of population in 2020-21. The report also found that almost a third of GPs plan to retire in the next five years. Minister, what are your plans to ensure that we have more GPs here in the ACT?

Ms Stephen-Smith: We have been doing a number of things, working with general practice. We hold an annual GP forum where we have the opportunity to listen to GPs about their ideas as to how we can work better with them. We understand that general practice has been a very difficult space to work in over a number of years. COVID has exacerbated that but it has not been the entire cause of it. GPs are seeing a greater level of complexity in their patients at the same time as, under the previous commonwealth government, Medicare benefits were frozen; so their capacity to be appropriately remunerated for the work that they were doing, particularly if they were bulk-billing, was very detrimentally affected. We also know that the ACT is a place where the broader population is relatively high salary. For GPs, the GP salary relativity in the ACT is also something that they take into account.

As to what we can do with them, we have invested about $16 million over the last few years in trying to support GP viability and expand bulk-billing general practice in the ACT. We invest significantly in ensuring that the most vulnerable members of our community can get access to primary care, whether that is people who are homeless, migrants and refugees, young people, and people who may face other barriers to care, such as some parts of the LGBTIQ+ community. That is through initiatives that include but are not limited to the Directions Chat to PAT van, which has been highly successful. We do that in partnership with the Capital Health Network, which manages general practice in the ACT.

Most recently, we have been working with the commonwealth on the Primary Care Pilot, which is specifically looking at how we can partner with general practice and provide financial incentives, with the support of the commonwealth, to enable them to be appropriately remunerated for providing care to people with complex and chronic conditions, particularly those who are frequent presenters at our hospitals, so that not only do those people get better care in the community but also it is actually viable for GPs to provide the kind of care that we know they really want to provide. We often hear from GPs that they want to provide comprehensive, whole-person care and the funding system does not support them to do that, particularly where their patients are from a lower socio-economic group and cannot pay $100 for their appointment. I will ask Ms Cross to talk a little bit about the Primary Care Pilot.

Ms Cross: The Primary Care Pilot will not just be good for the people that participate in it; we are also hoping that we will see improved job satisfaction for the GPs that are involved. That is key to keeping them involved as general practices. We hope to have 15 practices participating over the course of the pilot. We have already had 14 express interest, and we are in the final stages of negotiating the first five agreements, which is pretty exciting. They will start having patients identified, either within their practice or by the hospital, and they will be able to offer them this extended care.

We have had good take-up of specialist services in the hospital that the GP will be able to ring if they want to do a consultation. Rather than the patient having to go to the hospital, the GP, if they are not completely sure, will be able to ring a specialist. We have had good uptake in recruiting additional allied health staff for the community health centres. Again, they will get a priority appointment with an allied health specialist if that is what the person needs. We think that it will result in much better care for the patient.

Going to the issue of 30 per cent of GPs looking to retire or leave the profession, we are hoping that it will give them a better opportunity to do the sort of health care that they signed up for when they became a GP.

MS CASTLEY: An article last month from the Royal College of GPs said that it was a slap in the face to GPs in Canberra when the federal funding did not go to those urgent-care clinics and that Canberrans have been cheated. In light of the fact that we are trying not to go backwards with GPs, what do you say about that? Do you agree with the Royal College of GPs that Canberrans have been cheated, and that it has gone to the wrong spot?

Ms Stephen-Smith: No. I was a bit surprised at some of the language that was used in that commentary. We are seeing, with the commonwealth's urgent-care clinic, the expansion of the scope of the walk-in centres, with five centres across the ACT being able to provide this service rather than one in Tuggeranong.

There was also some commentary there which I think was a bit confusing around GPs providing continuity of care and this being a feature of urgent-care clinics. Urgent-care clinics are not designed to provide continuity of care. They do not do that anywhere else. They are designed as an ED diversion and as a treatment for acute conditions. If there is only one of them, clearly, there will not be continuity of care for anybody who goes to any other practice in the whole of Canberra. Even if they do drive all the way to Tuggeranong from Belconnen to access the urgent-care clinic, they would be seeing GPs from a completely different practice than they normally do.

MS CASTLEY: Is that continuity of care between the nurse practitioner through to the GP? I think that is what they might have been talking about—in one clinic?

Ms Stephen-Smith: One of the things that we have very clearly heard from GPs is that we have a bit more work to do to improve the notes that are sent back to the GP from our walk-in centres. Some GPs really like the relationship they have with their local walk-in centre. They get really good communication between the walk-in centre and them when one of their patients presents at the walk-in centre. Others say they get

the information from the walk-in centre, but it does not have enough context and they do not really know what to do with it. That is good feedback for our walk-in centres to take on board. Others, frankly, are not very happy with the model.

A lot of the commentary, whether it is in relation to this or in relation to other things, comes back to the fact that, while funding for every other part of the health system has been increasing, GPs have seen funding from the commonwealth government frozen and going backwards in real terms. They feel undervalued. At the same time medical graduates are seeing an ongoing increase in the debts that they come out of university with, as the HECS fees—whatever they are called now; HELP fees—increase for them. They are coming out of university with a higher debt. They are seeing their GP colleagues not being appropriately remunerated, and fewer and fewer graduates are wanting to go into general practice.

One of the other things that we have been talking to the RACGP about is how we can support general practice training to see more registrars going into general practice and staying in general practice. When I have spoken to medical students, they are keen to go into general practice. They understand the job satisfaction that it can offer, in giving someone that comprehensive, cradle-to-grave support, but they do not see that it is valued or rewarded within the health system or within the wider community.

I have just opened the report that you were referring to. I think that job satisfaction issue is something that we are seeking to address, with things like the Primary Care Pilot and improving the connection between primary care and our acute services, and particularly our specialists. Again, it has gone from being a community where everyone knows each other, the GP can refer through to the specialist that they know, and they can see their patient getting care, to a much larger system which has much less of a personal relationship and they do not have that level of visibility and connection.

MS CASTLEY: You just said that GPs want more. You had the opportunity to do more with the funding for the urgent-care clinics. We are the only territory that does not run the urgent-care model, yet you are saying that you are trying to address things and the GPs are a bit wild about it. Are you happy that we are the only jurisdiction in the country that does not go with this urgent-care model?

Ms Stephen-Smith: Yes—I think we have chosen the right model for our community. To be clear, that funding would have gone to one practice. Our experience, when we give funding and work directly with one practice—of course, we work with individual practices through our various measures; we work with Next Practice, for example, specifically to support people who are home bound, through one of our programs for enabling people with complex and chronic conditions to get care—is that other practices get annoyed, even if they had the opportunity to apply to be part of that scheme. It is great that we have had so many practices putting up their hand to be part of the primary care pilot. That is fantastic. One of the things that we will get out of that is that we will learn lessons from the primary care pilot that we can then apply across our relationship with all our GPs.

MS CASTLEY: We have the GP payroll tax, the GPs are unhappy about this urgent-care clinic, and we are trying to bring more GPs to the ACT. What is your target and

how do you aim to get there to build the GP community in Canberra? If they do not want to come, for a few of the reasons that I have just mentioned, what is your plan?

Ms Stephen-Smith: I do not think we have a specific target. Obviously, we will want to grow the number of GPs in the ACT and we want to increase the rate of bulk-billing in the ACT as well because we clearly have, far and away, the lowest rate of bulk-billing in the country, across all the primary health networks. The ACT, along with other states and territories, is partnering with the commonwealth through the Strengthening Medicare Taskforce and national cabinet to look at how we can all work together to improve the environment for general practice.

Part of the responsibility of states and territories is to ensure that our services are better integrated and GPs are getting better job satisfaction because they are able to support their patients in that connection between primary, community based and acute care. That is a key piece of feedback that we get from GPs. We need to demonstrate that through things like the primary care pilot and some of the changes that we are making in referral pathways for Canberra Health Services. At the moment, people are sceptical, and I understand that. We need to demonstrate and get some runs on the board around that, but that is exactly our intention.

THE CHAIR: Given that we have three minutes before we take a break, we can start with you, Ms Clay, if you want, when we return, or do you have a question?

MS CLAY: I reckon I can get it in three minutes and not come back.

THE CHAIR: Alright. Good luck. Away you go.

MS CLAY: Thank you, Chair. Minister, we looked in the annual report for information on dental health and we could not find anything in there. I am not sure if we missed it. Can you tell me how much was spent on the adult dental health program in the last year?

Mr Peffer: On the specific amount, we might have to take that question on notice, if you are looking for a dollar value.

MS CLAY: Sure. I have a number of questions on the adult and youth dental health programs. Should I lodge those on notice if you do not have the information at hand?

Mr Peffer: We might be able to help with some of them.

MS CLAY: Great. I will run through them and you can take on notice what you cannot answer. Do you know how many adults received dental care through that program during the year?

Mr Peffer: The amount that we spent in 2022-23 was $11.807 million. I will have to take the number on notice.

MS CLAY: Great. I am also interested in how much was spent on the youth dental health program and how many young people and children received care through that. Will you take that on notice?

Mr Peffer: Yes.

MS CLAY: What proportion of dental health services in the ACT are provided by ACT Health? Out of all of the ACT's dental health services, what proportion are coming through the ACT Health system?

Ms Stephen-Smith: I am not sure that we will be able to answer that question, Ms Clay, because obviously the vast majority of dental services are private, and whether we will be able to find the data that will match up between any data source for the provision of private services. Probably the place we would most likely find it is in Australian Institute of Health and Welfare reporting on health services. You might be able to take a number that is reported nationally, assuming that there is one, and compare that with what we are spending and the number of patients seen through the public health system. We will take it on notice and see if we can provide that information, but I would be surprised if we are actually able to do that.

MS CLAY: Sure. Thank you.

MS CASTLEY: I have a supplementary. You will also probably take this on notice: the current wait list for oral dentures as well—the whole gamut.

Mr Peffer: Okay. We can do that.

MS CASTLEY: Thanks.

THE CHAIR: Excellent. Thank you. The committee will now suspend proceedings for a short break.

Hearing suspended from 10.15 to 10.31 am.

THE CHAIR: Good morning, and welcome back to the public hearings for the committee's inquiry into annual reports 2022-23. Mr Peffer, do you have an update for us?

Mr Peffer: Yes; thank you, Chair. In the earlier session, I took a question on notice about the number of full-time orthopaedic surgeons that we currently have employed. The answer is zero. They are all contracted to the health service under a VMO arrangement. None of them have an employment staff specialist arrangement.

THE CHAIR: Is the government looking at putting people on the books themselves or are they strictly all contractors? Why is that?

Mr Peffer: We have a range of balances across the different specialties. Neurosurgery, for example, is entirely staff specialists. With the employment arrangements for some of the others, there is a mix. Anaesthetics is around fifty-fifty, I understand, and orthopaedics is all VMO arrangements. As administrators, we make employment decisions about the workforce, the work we have got to get done and the nature of that work—so, I guess, the workforce that is available and how they would like to be employed or contracted.

THE CHAIR: Thank you, Mr Peffer. We will go to Ms Castley.

MS CASTLEY: Thank you, Chair. I have some questions about the DHR project. The 2022-23 annual report says, "While our teams and patients benefit from the many positive aspects of a digital health record system, we have some work to do over the next reporting period to realise the great benefits from the data and reporting capabilities." Given what is missing, I would say that is an understatement.

Minister, in budget estimates in July, you said to me, "Yes, Ms Castley, there is data missing in the budget as a result of this. This is a known problem, but there will be annual reports in another couple of months and we are working to ensure that all of that data is included." A large number of strategic and accountability indicators are still not available in this annual report. Data required to produce quarterly performance reports was not available from the second quarter onwards. I feel it has been a bit of debacle.

I note the ACT Audit Office has issued qualified conclusions for the ACT Health Directorate and Canberra Health Services and a disclaimer of conclusion for the ACT Local Hospital Network Directorate due to the large number of accountability indicators not being measured or reported as required by the Financial Management Act. The Director-General of the ACT Health Department and the CEO of CHS have both had to sign statements of responsibility because these accountability indicators were not measured or reported. What do you have to say about this, Minister? I would say that is quite embarrassing for your department. What do you have to say?

Ms Stephen-Smith: I will probably say a few things, Ms Castley. Obviously, I optimistically was expecting that we would be able to report more data in the annual reports than in the budget papers at the time. As I have also indicated, I think then—and certainly subsequently—our data remediation efforts were very focused on ensuring that our national reporting obligations were met, and particularly those reporting obligations that relate to funding arrangements. I will ask Holger, to come up and to provide more detail of where the data remediation project is up to. And I know that Ms Garrett can also speak to that.

So, again, Ms Castley, this is not a new issue. I have been very clear that our primary focus, in terms of bringing that data together was around ensuring that our national reporting requirements were going to be met. That is critically important for the health system. I recognise that you want to see data and that the Canberra people want to see data. We have also had ongoing conversations with other jurisdictions, not just in Australia but also internationally, that have implemented an Epic digital health record system, and this is not an uncommon experience and it takes some time to resolve the data reporting issues out of this system.

But I think we need to keep in mind that the primary goal of implementing the digital health record was to improve the provision of clinical care by our clinicians to our consumers. The data that we released from the 12-month anniversary on Monday clearly indicates that, in that sense, the digital health record is making a substantial difference—

MS CASTLEY: With the other people that have put the Epic system in, is it common that their Director-General for the government department and the CEO have had to sign those statements of responsibility, basically saying that the Auditor-General said that someone has to sign off on this? Should you have also signed a statement of responsibility as the minister?

Ms Stephen-Smith: That is not how annual reports work. Annual reports are the reports of the directorate and so they are the responsibility of the director-general or the chief executive officer. On that note, I will hand over to Ms Cross and Mr Peffer to talk about that process, and then Mr Kaufmann can provide some information about the Data Remediation Project.

Ms Cross: As well as being responsible for the annual report, we are also responsible for the delivery of the project. So I think it is entirely appropriate that it is in our annual report under my signature and that we take responsibility for the lack of data. As the minister has said, though, we have been working very hard on the remediation. We are meeting our national reporting obligations, which are obviously important, not just for funding but also so that that shared data across every state and territory is available. I might get Holger to give an update on where we are with the data remediation—and, as I said, we have been making good progress.

Mr Kaufmann: Thank you, Rebecca. In the July hearings, Mr Peffer explained in detail that the DHR is a very complex system. It supports pretty much all the clinical workflows in the hospitals, and how the clinical workflows are actually used by users is something that we had to experience first before we could do reliable reporting on the data. There are hundreds of fields that can be selected and pre-selected as part of a medical treatment, and not everything has been used exactly as was expected and anticipated. So we needed a couple of months of experience with the data in order to start our detailed reporting and analysis.

That has started now. We set up a data and reporting remediation project, which is now comprehensively providing all the reporting needs we across the system. We have started with the highest priority, and that is the national reporting requirements that we have as a system. We have provided data to the AIHW in accordance with our requirements for this financial year and in the time lines that were required, and we are currently in the process of finalising our reporting to the National Health Funding Body. Again, we are in the required time lines and we are very confident that the data is very complete and clean. Final submission will be on 24 November; so it is upcoming.

MS CASTLEY: Minister, at budget estimates in July you said that there were problems with frontline staff escalating their concerns about the length of time to achieve the robust data reporting to board level. But in January, the DHR program board meeting rejected a request to extend the program's business intelligence and data project. So that part of the DHR program was having problems with external reporting until November 2023. You said that they were not escalated, but they were escalated to a board level; they just were not heeded. Would you say that is fair?

Ms Stephen-Smith: I think what has been clear is that the views of the people who are doing the work on the front line were probably not escalated to the board in the

level of detail and at the level of concern that those frontline staff were experiencing in relation to the potential for data remediation. I am not a member of the project board, so I am not going to speak to that. I will hand to Ms Cross to talk about that.

Ms Cross: Probably the only point I would make is that, although the decision was not to continue with the project board, the decision was to continue all of the work on data remediation. As Holger said, we have set up a team. That was a very strong focus. It was just a decision that we did not need the whole apparatus around the project board, which had really picked people who would help us with the "go live". The chair had gone live with these sorts of systems before. They were not the people that had the detailed knowledge of how we were going to fix the data. So the decision was to continue all of the work on data remediation but not to continue with the project board, as I recall, because the "go live" had been completed.

MS CASTLEY: DHR tracked red every month from January until the project status reports. They stopped in May. But, by February, the business intelligence and data project itself was still tracking red and trending worse, which was placing all the delivery dates for core activity data at risk. It was the business intelligence stream that requested that continuance to the board, is my understanding, but the board decided not to extend that stream. Minister, given how the situation was deteriorating rapidly, did you not consider overturning that board decision? Did you get any information about this? Were you told how badly this stream was tracking?

Ms Stephen-Smith: Ms Castley, I am not going to just simply accept your characterisation of this. I was regularly briefed on the work, and it was a decision of the board. The board was responsible for the decision that it took. I would need to go back and find a date, but concerns were raised with me, and I was asked if I would be happy to attend a meeting of some of the frontline data staff who were actually doing the work on the data remediation, which I did. They had a meeting of some hours, I think, and I attended that for three-quarters of an hour to hear directly from them what their concerns were about the way the project was happening and the amount of time they thought they were going to need to address some of the data concerns.

As Mr Kaufmann has indicated, we knew that there could be some issues—and we have talked before about this—but we knew that we could not know what those issues actually were until after "go live", because it really depends on how people are using the system and whether people are using it in the way that the teams expected them to use it when it was set up and whether the system then in the background works in the way that it was expected to work. So I sat down with those people from across Canberra Health Services, the Health Directorate and, at that time, Calvary as well, probably, and heard their feedback that they were concerned that, frankly, too rosy a picture was being portrayed.

MS CASTLEY: When was that meeting?

Ms Stephen-Smith: I will get my office to look it up. It was earlier this year, but I am not sure exactly when it was. I then immediately, of course, raised that with Ms Cross and Mr Peffer. There were other senior people in that meeting as well hearing that feedback directly. Of course, it was not the fact that I was there that meant that that feedback was being taken on board solely, as that meeting was brought together in

recognition that the feedback was being received and that everyone needed to come together and work through what to do next.

I might actually ask Mr Peffer to talk about how the teams have been brought together. I think part of the challenge was that there were people doing work in the Health Directorate, there were people doing work in Canberra Health Services, and there was a separate team over in Calvary, to my understanding, and there was really a need to bring all of those people together and unite that work.

MS CASTLEY: So it was escalated to you, though, and you still decided to proceed?

Ms Stephen-Smith: When the board makes decisions, the board is making decisions. I am not on that board, and I do not make those decisions. As I have said, when I met with those frontline staff and they expressed their concern to me, I took those concerns on board, and, in my subsequent conversations with Ms Cross and Mr Peffer, very clearly articulated that those concerns needed to be taken seriously. Mr Peffer can talk about next steps.

Mr Peffer: Taking a step back in the considerations of the board, there was an awareness of the board that we had challenges with data. The board had to make essentially a "go" or "no go" decision to live. It had to weigh all sorts of considerations, including some tens of millions of dollars worth of workforce investment to train, prepare and essentially gear up logistically for a deactivation of many systems and a "go live" for the Digital Health Record.

At the time of making that decision, we were aware of the data challenges. Post "go live" and the decommissioning of the project board, that should not be taken to mean that there was a discontinuation of the work that was occurring on data. It shifted between governance mechanisms but at no point did everyone down tools and stop working on data.

Some months ago, however, around the middle of the year, we did come together as leadership teams across the entities and we made a decision that what would give us the best chance for success in the shortest time period would be to combine our efforts and combine our teams and also to then sharpen and simplify the governance that sat over team efforts. We had essentially three separate teams, with completely separate reporting lines into different agencies, or entities, attempting to solve some of the same problems.

We did not have great co-ordination of that effort. I think that showed in the pace at which we were able to resolve issues as they were arising. So we made a decision that we would co-locate the team and bring it under a single line of accountability up through the Health Directorate. That has proven to be very effective in now setting a pace and a trajectory for resolving these data issues. The weight of intellect and commitment, I think, in that team is just unparalleled. They have pulled together as a team and they have served us as a territory incredibly well in being able to produce the submissions that have been submitted to the Australian Institute of Health and Welfare and the National Health Funding Body.

Having said that, we have got a long road ahead for the data capability that we need to

build out. It will be at least another 12 or more months before we have the full range of capability that a system like Epic provides to a health service and health system like ours built and available to be consumed in a way that is going to be useful for our teams but also for the broader public.

MS CASTLEY: Would a continuation of the business and intelligence data project beyond March have ensured that more resources were put towards data reporting?

Ms Cross: Again, the project did continue; it just did not continue under the governance of the project board. As early as February, we were looking at additional expertise and to bring in people who could help us—consultants or people from Epic. So there was absolutely no halt in the program; we just changed the governance mechanism, because, as I said, the DHR program board had been set up for the 'go live", the business transformation and the development of Epic. It was not the right governance mechanism for the data project. As Dave has said, we have moved to a very tight single team that is leading this work. But, from the beginning of the year, even while the project board was in existence, we were looking at what additional expertise and resources we could bring in to work on the data.

MS CASTLEY: With the BIND team—the business intelligence and data team?

Ms Cross: Yes.

MS CASTLEY: With regard to ED data, Minister, in May you said that ED and elective surgery wait times would be a month or so away and in September you told the Assembly that the emergency department data had finally been provided and that elective surgeries were expected to be provided on the time line that was agreed for AIHW, which we have talked about. On ED data, do you have a complete record of the data since "go live" or are there gaps? Have estimates been made in relation to the data?

Mr Kaufmann: Emergency department data was submitted with the Australian Institute of Health and Welfare on 1 September 2023 and elective surgery waitlist data was submitted on 8 September 2023.

MS CASTLEY: Is it a complete picture or have some assumptions had to be made to sort of fill gaps in the data for 12 months?

Mr Kaufmann: That is a difficult question to answer because there is always some modelling that has to be done with the raw data. But the data is as accurate and complete as we think it can be.

Ms Cross: If we look at what we expected the activity to be, the data is consistent with that. I think what Holger is saying is that, even before DHR, there were always some parts of the data submissions where you made some assumptions and included that. So it is not different to previous processes in that it has some modelling within it. I think the main thing is the numbers that are coming out are consistent with what we were expecting.

Ms Stephen-Smith: To be clear on that, there is more modelling and assumption

around the period of "go live" than there would be in a normal year. I think that fair to say. I do not want that to be misunderstood, but it is also normal for there to be that—

MS CASTLEY: How accurate are we sure it is? Is it 50 per cent accurate or 98 per cent accurate?

Mr Peffer: No. The data that has been submitted is accurate. It has gone through an extensive verification process, not just through our business intelligence teams and the analysts—and they pore through all of the numbers in excruciating detail—but also, where there are any questions there has been an elaborate, methodical process that we have gone through with the clinical teams in the emergency department to actually go through individual patient records where there has been a question, when treatment has commenced or what time they might have left the department. So the level of verification on this data is incredibly high.

MS CASTLEY: But there are more divisions than other years. Do we have a percentage on how accurate we think it is?

Ms Cross: I think the best example that I have heard is that, if someone is arriving at the emergency department and being resuscitated, sometimes the entry to the emergency department misses the three-minute rule because they have focused on resuscitating the patient rather than leaving them to go and enter the data. So that is the sort of thing where, because we know the patient came in and was being resuscitated, we are happy to say that treatment was immediate upon entry. So it is not inaccurate; it is just that, if that is what has happened because they have focused on the patient, we make that adjustment.

MS CASTLEY: Of course. No worries.

Ms Stephen-Smith: My officers advised that I met with the DHR data teams on Thursday 9 March 2023 at Canberra Hospital, and it included teams from ACT Health Directorate, Canberra Health Services and the then Calvary Public Hospital, Bruce, and I raised the concerns that had been expressed to me in the joint briefing with the Health Directorate and Canberra Health Services on Tuesday 14 March.

MR PETTERSSON: I was hoping that the committee could get an update on the work that is underway to deliver the new $1 billion northside hospital.

Ms Stephen-Smith: I will hand to Ms Lopa again.

Ms Lopa: Thank you. The government funded the northside hospital in this latest budget. There is over $1 billion provisioned in that budget for the construction of the new hospital. They also funded us for the next two years of design work that would need to happen. We have a concept design for the new hospital. It is a high-level concept design—where we know the services that we want to put in the hospital, how big it will be—which we used as a basis for a business case. We have just gone out for a tender for the next step, which is that reference design and taking that design to the next level.

We are doing a lot of work at the moment. We are getting those contractors in. We

have also got a consultant in to look at the services on the northern block of the Bruce site. That is where Gawanggal is. There are some services being delivered there. We are having a look at those. We will need to decant those before we start construction on the hospital. So we are in there doing assessments of and design for the new facilities, and we are doing some environmental assessments as well. If you can picture that block in Bruce, it is beautiful and surrounded by bushland, but that means that we need to do our due diligence on just making sure we do not have an environmental or ecological impact. We need to know what is in there and how to appropriately treat it.

We are undergoing some extensive consultation at the moment throughout Canberra Health Services, including the staff at North Canberra Hospital, regarding clinical services across the sites and how and what we deliver on the Woden site and what we deliver on the Belconnen site. Ms Zagari and I have been working through that consultation and looking at where the best place is to have services and, as I referred to earlier today, whether a hospital is the right place to have them or indeed whether we should be putting them out in the community. Those consultations will underpin that next stage of design, where we start designing what the hospital will look like. We have also got our new community reference group starting today and they will be having input into that as well.

We have got some early works that need to be done. There is a childcare centre on the site that we are in consultation with. They are on the footprint of where the new hospital will be built. So we are talking to them about building a new childcare centre for them. We have some decanting that needs to happen on the site. There are some offices and some out-patient services that we will need to decant and replace before we can demolish buildings. We are expecting to start construction mid-decade. We are just looking through a program at the moment around that decanting and demolition and how long that might take. But it is moving very quickly.

MR PETTERSSON: That is great. Regarding all the different groups you said you were consulting with, did I miss how you were engaging with clinicians?

Ms Lopa: We are engaging with clinicians throughout CHS and throughout North Canberra Hospital, particularly in thinking about how their services run. We have a really great opportunity because of the decisions that were made earlier this year. We have one clinical service provider across the two major hospitals. We are having conversations about how to integrate those services and have them run across the two hospital sites or whether we concentrate and have centres of excellence at one hospital. Obviously, the Woden hospital is going to stay as the level 6 tertiary hospital at this stage. There are services that will always be there, but we are looking at how to best utilise and integrate all of the services across the two hospital campuses, and our clinicians are really involved in those conversations.

MR PETTERSSON: Wonderful. Thank you.

MS CASTLEY: Minister, I want to ask some questions about the staff survey of the Digital Solutions Division. Throughout the survey there were many references to the fairness of processes to fill positions. Were there any cases of family members, friends or favourite people getting jobs without merit or without proper process?

Ms Cross: I will take that question, Ms Castley. I am not aware of any instances where a proper process was not followed. When we were setting up the Digital Health Record, it was also during the time of COVID. Within that division, as well as having the Digital Health Record we very quickly set up the hotline for the vaccination program. We had huge numbers of staff coming in on temporary contracts to help with that sort of work. Sometimes, if you are bringing people in on a temporary basis, you do not follow a full recruitment process; you can bring people in on short-term contracts.

To my knowledge, they were all done appropriately, but they were not all the normal full recruitment processes that you have for permanent positions. That was the nature of working in that COVID period, both in the Digital Solutions Division and in the Health Emergency Control Centre. We brought in quite a lot of people very quickly on short-term contracts. When you do that, sometimes there are people that other people in the division know. We welcome the fact that we can pick them up quickly and bring them in, but we still go through a proper process in doing that.

MS CASTLEY: Do we know how many cases there were? This was a significant part of the survey and it obviously upset people that there was employment without the proper processes. Is anyone aware of how many cases this occurred in?

Ms Cross: I do not believe there were any cases of inappropriate employment. The other thing which was happening at the end of the year was that we were downsizing from the go-live staffing profile to the business-as-usual staffing profile. There is a range of processes that you go through when you are in that situation. I think it comes under the Secure Local Jobs provisions, where, if people have been in a position for over 12 months, if they have been performing well they have an opportunity to become permanent. We had to go through a process for those people. Once we had done that, we looked at the rest of the staff to see whether they would need to go through a separate process to apply for jobs. There were some people who perhaps felt that meant that it was not a level playing field, but that is just the process that we follow in those circumstances.

We have certainly looked at the feedback. We have changed all of the recruitment processes to make sure that they are following the appropriate arrangements and we have put out a lot of information so people are aware of all of the processes. We have an external person on every panel. I think we are publishing data on the number of people who have applied and were shortlisted—those sorts of things—so we have increased the transparency. I suspect those concerns were perhaps about people not being fully aware of the processes. I am certainly not aware of any cases where it was inappropriate recruitment.

Ms Stephen-Smith: It was the Secure Employment program.

Ms Cross: I had the other one on my mind for some reason.

MS CASTLEY: Did DSD allow a DHR manager to work from England?

Ms Cross: We had a senior person who was critical to the rollout. Her request was put

through, and I approved that so that she could continue working remotely and come back regularly during the project. That was a decision that was put to me for approval. It is not completely unusual. We have flexible working arrangements now. We have people who can work from interstate and, if it is particularly critical that they attend, we can look at doing that while they are overseas.

MS CASTLEY: How long did that go on for?

Ms Cross: I would have to take that on notice, but it was probably for the last six to nine months. I think their partner was posted to the UK and we took the decision that, because they had such a critical role in the DHR go-live, it was appropriate to continue that employment.

MS CASTLEY: And they were paid the same amount while they were in—

Ms Cross: Yes. My recollection is we continued them and we included in the brief that they would be flown back. They were there for go-live, for example, and a couple of other times to maintain contact with the team.

MS CASTLEY: The government paid for their flights back?

Ms Cross: I believe that was part of the arrangement that I approved.

MS CASTLEY: Will you be able to take on notice how much that cost?

Ms Cross: Yes.

MS CASTLEY: I move on to therapy dogs. I know that some measures were put in place to support staff because of their stress levels and burnout. How many sessions were there? How did that work? How many dogs were involved?

Ms Cross: I would have to take that on notice. We had a wellbeing team in place in the directorate that was looking at wellbeing in the COVID response team, as well as in DSD. There was a range of supports available, but the details of the therapy dogs I would have to take on notice.

MS CASTLEY: Thank you. I have heard of therapy dogs for aged-care homes but not for workplaces. How did it come about?

Ms Stephen-Smith: It is not at all unusual in a health environment.

Mr Peffer: We use therapy dogs extensively across our facilities. They are very well received, and equally so by our workforces. It is a simple way to put a smile on people's faces and benefit them.

MS CASTLEY: We can measure that it was definitely worth the time that—

Ms Cross: There is quite a bit of evidence on the benefits of therapy dogs.

MS CASTLEY: For this particular team, that allayed the stress and the burnout that

they were going through?

Ms Cross: I will take it on notice and see what feedback we have, but I think all of the wellbeing measures that were put in place were well received by people. Some people liked one form of wellbeing. If I ran a session and did mindfulness, half of my team would love it and the other half would wonder why we were doing it, so we had a range of wellbeing measures, but I think that they were genuinely all well received.

MS CASTLEY: Can you—you might need to take this on notice—let me know what the cost for the therapy dogs for the DSD group was?

Ms Cross: I do not know that we specifically had them for the division, but I will check for you.

MS CASTLEY: Great.

MR PETTERSSON: Minister, can the committee get an update on the progress of construction of the new critical services building?

Ms Stephen-Smith: Yes. You may not have met Gillian Geraghty, new Chief Project Officer at Major Projects Canberra, who can provide an update.

Ms Geraghty: Thank you, Minister. I have read and acknowledge the privilege statement. Thank you for the question. We are well on track for the delivery of Building 5 at Canberra Hospital. We will have the building complete by mid next year to enable CHS to do their transition, and we will be opening around September next year.

MR PETTERSSON: Could you explain to the committee the steps required to get the building open in that time frame?

Ms Geraghty: Sure. Which particular steps are you interested in—the building steps or the operational steps?

MR PETTERSSON: Both.

Ms Geraghty: We might share the answer. I will ask my deputy to come up as well. I have been in Projects for eight weeks, so he might be able to provide a bit more detail. At the moment we are energising the building. Plant is being activated and operated, and we are also doing deeper works floor by floor. We are well progressed on the construction and we are essentially looking to work through a staged handover of each of the floors.

Mr Little: I acknowledge I have read the privilege statement. I can maybe go back. There are two work streams in terms of completing the building but also aligning it with operational commissioning for CHS. They are running concurrently. In terms of the building completion, as Gillian said, we are working through, effectively, the energisation of each floor. Lights are coming on, units are being powered up, and main plants have been powered up. Units have been spun up and will be online shortly, so the building is starting to come alive, if you like. Concurrent with that, the

team is also working through a completion checklist, effectively, across every floor. We are working our way through to ensure the building is finished floor by floor, and we do that in consultation with CHS.

Aside from that, there are also various working groups made up of both the project team and CHS. We coordinate the provision of the operational commissioning as part of the change management process CHS will go through as they organise the building.

MR PETTERSSON: Amazing.

Ms Zagari: I have read and acknowledge the privilege statement. We are moving into a really exciting phase for us. Commissioning of the new Building 5 is going to bigger than the *Barbie* movie. We are now starting to see a great level of engagement and excitement from the workforce because the building looks real. Every day, somebody will send a photo of the building at a particular time of day as changes happen, and we are starting to be able to bring small teams into the building to see the areas that they will be working in. We have a really closely linked program, working very closely with both MPC and with DSD around the IT components of the building.

We are starting to see medical equipment being delivered and are closing some of the last procurements of significant equipment. There is really good clinical engagement in the opportunity around that. We are finalising a number of models of care, so people are starting to think about what it will mean to work in this sort of environment. It is a really different environment and it will be wonderful for our patients and the community. It is much more therapeutic and it has a modern design. The technology will really support a positive patient experience. We are also working with consumer groups. There is a really structured process of clinical and operational commissioning which involves working with MPC and Multiplex, for the building, to ensure that what is being delivered is what was intended and that it works as intended.

Then there is a significant training schedule moving towards the operationalisation where we bring large groups of clinicians through to start to understand the building and what it is like and to get familiar with the environment ahead of our first patients, with the intended commissioning of clinical services commencing in August of 2024.

MR PETTERSSON: Very exciting.

Ms Zagari: Very exciting.

MR PETTERSSON: Thank you.

MS CASTLEY: I have a few questions—

THE CHAIR: A supplementary?

MS CASTLEY: Yes—on the Canberra Hospital expansion plan, to piggyback on that. In 2021-22, regarding the Major Projects budget, I asked a question in estimates about the almost $40 million increase. Originally, the Major Projects budget was expected to cost $549 million over four years and now the total project costs $661 million, which is an increase of $112 million. I understand that some of the costs would have

increased, obviously, due to inflation and supply difficulties, but have there been any major cost blowouts which have caused a 17 per cent increase in just over two years?

Ms Stephen-Smith: There have been some scope changes which were publicly announced and funded through various budget measures. I will hand over to Mr Little to talk about those.

Mr Little: Thank you, Minister. As the minister has said, there were a number of additional scope areas added to the project and funded separately. They include the fit-out of the shelf spaces. When we entered into the contract with Multiplex, we had the benefit of creating a range of shelf spaces within the building for future fit-out. They are being fitted out now, as we speak, and will be available next year when the building comes online. There is also an increase in the CSSD area, which is the sterilising services area. Again, that is to provide greater flexibility in services. Aligned with that also is the opportunity to take the lessons learned out of the pandemic and effectively provide a pandemic overlay across the building so that it could be available for use in future pandemics.

MS CASTLEY: Great.

Ms Stephen-Smith: I think the hybrid theatre was an addition as well.

MS CASTLEY: Has the implementation of DHR meant that you have had to spend additional money? If so, what have the additional works been and what was the total cost?

Ms Stephen-Smith: The funding that you have in front of you does not reflect that. However, we are currently doing some work in relation to additional ICT costs, partly related to the complexity of the Digital Health Record implementation and partly related to other matters, to ensure that all of the ICT systems can be implemented in a timely way and be fit for purpose. As we have worked through the commissioning process, we have recognised that some additional equipment purchases would be helpful in making a smooth transition from the spaces that the services that will be moving into the critical services building currently occupy. We do not have any figures to put on that at the moment—we are still doing that work—but, to be transparent about it, that is coming and there will be some additional costs associated with that.

MS CASTLEY: I understand that the wi-fi that was installed in the new critical services building was not compatible with DHR and the correct technology has to be retrofitted. Is that correct?

Mr Little: I do not believe that to be correct.

Ms Stephen-Smith: No.

Mr Little: The wi-fi system that is installed in the building is contemporary.

Ms Geraghty: We might take that on notice, just to validate.

MS CASTLEY: That would be great. Thank you. That is it for Major Projects.

THE CHAIR: Thank you. Ms Castley, on a substantive?

MS CASTLEY: Yes. Thank you. I have some questions about the 2023 workforce culture survey. How much money has been spent on increasing workforce engagement with Canberra Health Services' biannual full workplace culture survey since the last full survey, in 2021, roughly?

Mr Peffer: Are you talking about the cost of the survey itself or are you talking about the engagement from the survey?

MS CASTLEY: What it costs—the increased cost to get engagement in the survey.

Mr Peffer: I cannot give you a number on that and the reason for that is that, on the back of the 2022 survey, there are thousands of responses. Every team is going on a separate but aligned journey around culture, and, team by team, there are different requirements that we have had to work on. For some managers, for example, it could be that what is most useful to the team is to have a regular team meeting each week to catch up on the news and understand what is going on and what is coming next. It is very hard for us to then cost that out across hundreds of areas and different facilitates to determine the investment that we are making in terms of increasing engagement. What I will say is that I had notification yesterday, I think from BPA, who are undertaking the current culture survey for us. It has just closed. It closed on Sunday just past, so a couple of days ago, and participation was up above 50 per cent. More than 5,000 team members participated in that survey.

MS CASTLEY: Forty-nine per cent, and the target was 50 per cent?

Ms Stephen-Smith: No. Mr Peffer sent an all-staff email today that indicated to staff that the final result was 53 per cent.

MS CASTLEY: I have the dashboard in front of me and it says 49 per cent. Am I reading the wrong one?

Ms Stephen-Smith: It is hard to know how you could have a dashboard in front of you for a survey that has not been reported on yet, so I think we are talking about different things. The one that we are talking about is the one that has just closed—the BPA survey that has just closed across Canberra Health Services.

Mr Peffer: Ms Castley, what that might refer to—

MS CASTLEY: The dashboard is online.

Mr Peffer: We had a dashboard that was regularly updating for our culture champions. We had a number of team members, who self-nominated from across the organisation, that were going to be the champions in their workplace to encourage and aid participation in the survey. What was not captured on that dashboard is all the paper surveys that were distributed to food services or security or wards people and that sort of thing. Those paper surveys have all been collected. The 53 per cent that I

just mentioned to you captures all data—not just what was on the dashboard that was being updated but also a number of paper based surveys.

MS CASTLEY: I look forward to seeing it. Great. Thanks.

THE CHAIR: Mr Pettersson, on a substantive.

MR PETTERSSON: Thank you. Minister, the annual report says that the ACT government has been working with pharmacists to expand their scope of practice to enable them to prescribe antibiotics and the pill. What is that trial expected to cover and has it commenced?

Ms Stephen-Smith: I invite the Chief Health Officer to talk. You might have seen today or yesterday that it was announced. It is an ongoing part of the New South Wales trial. New South Wales Health and the University of Newcastle are running this trial and have kindly enabled five ACT pharmacies to participate.

Dr Coleman: I have read and acknowledge the privilege statement. As the minister indicated, we have been allowed to join the New South Wales trial. New South Wales is running a quite intensive trial that has co-collaborators across New South Wales. The intent of this trial is to actually reproduce a little similarly of what happened in Queensland, to look at how we could best integrate pharmacists into our medical system around offering prescribing functions. There were some criticisms or some concerns that we heard about with the Queensland trial. While there were positives, there were concerns about: how do we not fragment care using this; how do we make sure that the data that we are collecting is showing us improved or similar outcomes and not unintended consequences; how do we use the systems that we have to actually give us the best possible continuity of care? Also, in particular with the UTI trial, there are concerns about the potential for antimicrobial resistance to be further pushed in this way. The collaborators on this New South Wales trial are looking at all those questions and are doing very intensive monitoring. I think it is over a two-year period.

We have five pharmacies—I will double-check that period for you and get back to you on that—who are participating in that. We started with the urinary tract infection trial. There are rigorous processes that support who can actually do that and how that would occur. I have an update for you. I can tell you how many people we have had through. As at 10 November, participating pharmacies have completed 147 UTI consults, with strong demand and really positive feedback received. It reports the service is utilised most frequently in the evenings and on weekends, which makes sense, and, from 16 November, which is today, they have officially launched the oral contraceptive pill.

There are also some concerns about making sure that we allow the use of the oral contraceptive pill to be really appropriate, so again there are rigorous procedures and processes around that. People have to already have been on the pill, they can only be using the pill for contraceptive purposes, not for other purposes such as the management of acne, and there needs to be a regular check-in with their GP into the future as well.

I do not have any more information that I can give you at the moment, but we are

checking regularly with the researchers in New South Wales who are collecting the data. We are obviously working hard to support our pharmacies and pharmacists in this process through our Acting Chief Pharmacist, Amanda Galbraith. All the data that we are collecting is going to be useful into the future. I am looking for an end date for you. I hope Amanda will be listening and can shoot that through to me.

MR PETTERSSON: I am glad you immediately went there, because that was going to be my first question: when does the trial end?

Dr Coleman: I have it somewhere in front of me. Bear with me.

MR PETTERSSON: Are there any other low-risk medications that are on the horizon for this type of trial?

Dr Coleman: I am aware that New South Wales is looking at expanding to some other medications, in particular medications for skin conditions. There are two major issues we are considering when we are exploring this. The first one is about making sure that we can do it safely with the type of medication that we are choosing. The second one is making sure that the system that sits around that is integrated and allows us to produce more continuous care and maximise the scope of practice for everyone involved so that we have an efficient model. One of the main concerns for a lot of us is that there are numerous systems out there. How do we use DHR in the future to actually create one access to this health record that everybody can use in a way that is really safe?

MR PETTERSSON: This enables pharmacists to supply these medicines. Are there pharmacists that do not want to take up this new ability or is it a situation where, if the trial is successful, people could expect every pharmacy to be providing this?

Dr Coleman: It will be up to individual pharmacists to do that. At the moment, the Pharmacy Council is looking at what some standards and prescribing standards might look like from a national level. That will be really useful because that will allow us to have consistent training for pharmacists across the board. At the moment, everybody who is participating in the trials themselves has to provide their own training standards, their own training guidelines and their own training programs. We are looking at having that ability moving forward. But, as with any private practice, they can choose to be involved in what they are most comfortable with or what they consider is within their own scope of practice.

MR PETTERSSON: Interesting. Thank you.

Dr Coleman: The UTI end date is July 2024 and the ACP will be for 12 months from 25 September 2023. We have still quite a bit of time to go.

MR PETTERSSON: Yes. Interesting. Thank you.

THE CHAIR: Ms Castley, a substantive?

MS CASTLEY: Yes. Before I go to my substantive, could I just clarify something with regard to the Calvary questions on notice? Can the department confirm on notice

whether Calvary was explicitly told that the special legislation would terminate the Calvary Network Agreement? And can you also confirm on notice whether Calvary's lease on land could have been voluntarily transferred to the government without cancelling the network agreement? I would just like clarity around those questions on notice.

Ms Stephen-Smith: Ms Castley, yes, Calvary was told that the cessation of its Crown lease through any mechanism would inevitably cease the Calvary Network Agreement because the Calvary Network Agreement time line was tied to the end of the Crown lease.

MS CASTLEY: I am just asking if you can tell me when and where they were told that.

Ms Stephen-Smith: When the Crown lease ended, under any circumstances, the Calvary Network Agreement would automatically come to an end.

MS CASTLEY: I understand. I am just asking you to tell us when and where they were told that.

Ms Stephen-Smith: And Calvary well understood that.

MS CASTLEY: Just let me know a date if you could, please.

Ms Stephen-Smith: That has been known to them since they signed the agreement in 2011. They have understood that that is the time line for the Calvary Network Agreement. They signed the agreement.

MS CASTLEY: I am asking you: in this negotiation period, did you specifically clarify with Calvary—take it on notice whether it is yes or no—and in what meeting—

Ms Stephen-Smith: I do not understand how I can possibly answer that question, Ms Castley—for me to sit in a meeting or to write a letter to them saying, "If we end the Crown lease, the contract we have with you that is tied to the Crown lease will come to an end." It makes no sense that I would have explicitly put it in those words, because everybody at the table understood that that was the case and it was the topic of ongoing conversation repeatedly over many years, before we even started this particular conversation. I have absolutely no idea what you are trying to get at and what gotcha moment you are trying to achieve here, but I cannot take the question on notice in the form that you have asked it because it does not make any sense. It does not make any sense.

MS CASTLEY: But it does to the people that were involved, so—

Ms Stephen-Smith: If the people who were involved would like to write to me and ask me when I thought that they did not know that would be the implication—if I was ever under any illusion that they did not know that would be the implication. But how they could have been under that illusion—I do not understand.

Ms Cross: I think it was in all the discussions we had with Calvary. I do not think there was any time when anyone did not think that was the case. That is probably the best I can do. All the conversations were predicated on everyone understanding that the lease of the land and the network agreement were completely linked. That even goes to before the negotiations. It would have been when we were discussing the contract, the Cavalry Network Agreement, and the management of that contract. It was a known fact, and I do not think there was ever any suggestion from anyone at Calvary that they did not understand that link.

MS CASTLEY: If the land had been voluntarily transferred, would that have necessitated termination of the Calvary Network Agreement?

Ms Cross: It would have terminated by virtue of the fact that the lease no longer existed—yes.

Ms Stephen-Smith: Yes—which was, as I said earlier, one of the factors in Calvary's preferred position, which is clear in the papers that have been released under freedom of information. Their preferred position was that the ACT government sublease the land rather than the Crown lease transferring to the ACT government. That was part of the reason that was their preferred position.

Ms Lopa: Minister, I might also add that the negotiating team from Calvary had their internal counsel, who worked for Calvary and has since left. He had worked for Calvary for some time, including on negotiating the Calvary Network Agreement, so he was well aware. He had the most knowledge out of anyone in the room about how that Calvary Network Agreement functioned. Their outside legal team is the Sydney lawyers that they use. The lawyer that was part of their negotiating team actually drafted that agreement. So they were very well aware throughout the whole negotiation what the consequence of any termination of a Crown lease would mean, and, as the minister said, that is why their preferred position was to sublease, because it would not impact the contract.

MS CASTLEY: I would like to ask about the elective surgery centre—the abandoned promise regarding the University of Canberra. I have sent you a question on notice and the response, No 1336, was about the feasibility work for this abandoned election commitment at UC. Labor's 2020 election announcement said that a re-elected Labor government would begin work with the University of Canberra for the centre to be operational in 2024-25, at a cost of around $21 million.

The elective surgery centre was under consideration for just over a year, from late 2021 to January 2023. I see that there were several clinical and project staff that had spent some time looking at this project for just over that year and that $2,500 was spent on consultants to do a feasibility study. What was the brief for the staff and how far did that project get?

Ms Zagari: The staff involved were looking specifically at the amount of theatre capacity in the territory across the forward years, with consideration of the new build of the critical services building in particular and the additional theatre capacity that that would add. The assessment that was undertaken was around the time line of additional capacity coming on board, the length of time it would take to build an

elective surgery centre and knowing that, ultimately, there was a north side hospital plan in the territory infrastructure master plan.

With the additional theatres coming online in the critical services building next year, the additional theatres that would have been delivered by this project were no longer required. Therefore the expense of a new build was not warranted when there was an assessment against projected demand. That is where the clinical staff involvement was, in mapping projected surgical demand against theatre capacity.

MS CASTLEY: It was really looking at why it should not be delivered?

Ms Zagari: No. They were very much looking at whether it should be delivered as opposed to it not being delivered. It is that balancing equation around surgical capacity, total workforce and what is the most efficient way to deliver the total number of surgeries, with consideration being given to those things, and particularly the available workforce in the territory and how we maximise the most efficient use of that.

MS CASTLY: Minister, it was a $21 million commitment that Canberrans took on board; they believed you, and you only spent $2,500. That is all that you committed to looking into this commitment. $21 million is what you promised. Wouldn't you have tried to put a bit more money towards it so that Canberrans got what they thought they were getting?

Ms Stephen-Smith: I will make a couple of points about what Canberrans thought they were getting. I do not know that very many people had actually focused on this particular commitment. Put it this way: I have not received a single representation from anyone, prior to us making the announcement that this project was not going ahead, asking me about it. I have never received a question from the opposition asking me about it. This was not—

MS CASTLEY: I bet people on the waiting list were pretty excited to hear about it, though.

Ms Stephen-Smith: I suspect they only heard about it when it became clear that we were going in a different direction, actually. I am pretty sure—and we can check the record—that the opposition never asked a question about this particular election commitment until it became clear that we were going in a different direction.

I have had excitement from people about our community-based health centres. One of the things that we have indicated, in relation to the north Gungahlin centre—and some of the others, but particularly north Gungahlin—is that we will look at the potential, and we still need to do the work, for procedures to be done on a day surgery basis in that centre. Having day surgery capacity in Gungahlin would be good. Again, we still need to do the work on that, but that is one of the considerations.

As Ms Zagari indicated, in the same time period we were working through what our north side hospital commitment would look like. We had obviously committed to the redevelopment of the north side hospital prior to and during the election—a commitment that I do not believe the Canberra Liberals firmly made during the

election. Certainly, the Canberra Liberals did not commit to anything in relation to additional surgical capacity for elective surgeries, despite making a commitment to a completely unachievable number of elective surgeries.

We had also worked, through that time, on additional and stronger partnerships with our private hospital partners. Through the period of the 2020-21 year, through what is now called Operation Reboot, there was a boost in the number of elective surgeries delivered through our private hospital partners. We also had a growing awareness of what their capacity was and how we could work with them to help meet our elective surgery targets.

The final thing I would say is that, as we were finalising this decision in government, and as was indicated in the response to the question on notice, the project was closed in January 2023. That is post the Calvary Public Hospital theatre fire. We were very conscious of the need to ensure that energy was focused on getting those theatres back up and running, and that was where we needed to focus our energy.

This facility was never due to be open in this term of government. I think you or Ms Zagari mentioned that 2024-25 was the completion time line in the election commitment costings. We recognised that we needed to focus our energy on how we could use our private sector partnerships, ensure that the Calvary hospital theatre complex, now the North Canberra Hospital theatre complex, came back online as quickly as possible, understand what volume we could put through that complex, and plan for how we would use the additional theatres coming online through the critical services building to ensure that we were using, as Ms Zagari said, all of our human resources as best we possibly can, and planning for the future of day surgery and procedural capacity out in the community and in our health centres.

MS CASTLEY: Don't you think it shows contempt for your electors that if they do not follow up—

Ms Stephen-Smith: No, I do not, Ms Castley.

MS CASTLEY: with complaints then something that you promised is not going to happen? Just because they do not follow up, it does not matter; you can promise anything.

Ms Stephen-Smith: No, Ms Castley; I do not agree with that at all. The reality of being in government is that, when circumstances change, you have to look at how you can deliver on your objectives in a way that most effectively uses taxpayer money, and that is what we have done.

We have seen, across our entire infrastructure program, escalating costs. While that project was costed at $21 million in 2020, we know that construction costs have escalated substantially since then. This would be a more expensive project, and we have concluded, looking across all of our suite of infrastructure commitments, that it would not be the most efficient and effective use of taxpayers' money to achieve the shared objective that we have of increasing elective surgery across the system.

I think taxpayers want governments to responsibly consider every step they take and

most efficiently and effectively use taxpayers' money to achieve the actual outcome that they are interested in.

MS CASTLEY: But you only put 2½ grand towards this so-called important $21 million project. It seems that it was not a priority in the first place. $2½ thousand to look into it is not a lot of money.

Mr Peffer: I might add to that, Ms Castley. We had a range of experts, particularly internal, including surgeons, having a look at this project. I do not think it is fair to characterise that as the full spend. There was considerable time that people spent working on this, looking at the numbers, assessing, analysing and projecting forward, to come to some advice around the feasibility or otherwise.

MS CASTLEY: There was a consultancy contract that CHS awarded to GHD Pty Ltd in May 2022 for elective surgery centre and endoscopy expansion feasibility, at a cost of nearly $700,000. Can you talk to me a bit more about that? This is obviously different.

Ms Zagari: The GHD consultancy was engaged to look at the opportunities around expanding endoscopy services, particularly at the Canberra Hospital site. We know that the facility that currently houses endoscopy needs to expand, given the demand on those services and the need to be able to provide additional procedures.

GHD have worked closely with our clinical workforce to identify how we will do that post the opening of the critical services building. There is an opportunity in the space that has been vacated to be able to provide more room for endoscopy.

MS CASTLEY: Do you know the value of the works being considered?

Ms Zagari: I will come back with the precise amount that was awarded in the previous budget. It was $8-point-something million, but I will come back with the exact figure.

MS CASTLEY: Great; thanks.

THE CHAIR: You can come back on that one, if possible.

Ms Zagari: Yes.

MR PETTERSON: Minister, can the committee get an update on the work that is underway to make abortions more affordable in the ACT?

Ms Stephen-Smith: Yes, absolutely. As our commitment indicated, we have enabled people who have an unwanted pregnancy in the ACT to be able to access both surgical and medical abortions with no up-front costs—free of charge up-front. We have been working in partnership with Women's Health Matters to deliver that commitment.

The initial contract was with MSI to deliver surgical abortion. They are the primary surgical abortion provider in the ACT, and also for them to deliver medical abortion

through this program while we worked with primary care GPs to see who was interested in participating. Mr Culhane can come to the table and talk about where we are up to on that.

Of course, the environment has changed a little bit as well. At the time that we made the commitment, GPs had to be registered to prescribe and pharmacists had to be registered—I do not know whether that is quite the right word—effectively to dispense MS-2 Step for medical abortions. The commonwealth arrangements have changed. The Therapeutic Goods Administration has changed those arrangements, and we are working through the implications of that for the ACT and what it means for the program.

Mr Culhane: I have read and acknowledge the privilege statement. There are a few elements to the abortion measure that the government has funded. In one of those elements, we have funded the Women's Centre for Health Matters to pilot a reproductive data fund project that involves GPs, chemists and pathology services. There is the option to sign up to that program and provide data to Women's Health Matters in exchange for funding. One of the conditions of that is that they provide free services at the point of service provision for abortions.

At the moment we have one clinic; one general practice has signed up for that process. We are expecting another general practice to sign up in the next week or so. We have a couple of chemists who are dispensing, with another chemist interested in providing those services. Capital Pathology has also signed a contract. Women's Health Matters is working with other imaging services as well to provide those services.

One of the other elements of it was that Women's Health Matters was progressing a communications package. It is working with their consumer network to complete that work.

MR PETTERSSON: The annual report mentions that there was a discussion paper and a round table. What was the feedback or the result of that consultation?

Mr Culhane: We funded, as I recall, Women's Health Matters to work with us on that discussion paper. Women's Health Matters hosted the round table. The directorate participated as part of that, along with a bunch of their stakeholders. It was centred on trying to get a clear understanding from consumers and affected people of what sort of services were needed and what the issues and barriers were with access to services at the time. That informed a report that was provided to government.

MS CASTLEY: My question comes under the women and children banner. With the early pregnancy service, can you talk to me a little bit about that? How is it staffed? Is there an ultrasound machine in the unit? If a woman who is pregnant comes in, is there the ability to do an ultrasound while they are there onsite, in the unit?

Ms Stephen-Smith: I will get Dr Howard to talk to this.

Dr Howard: There is no ultrasound unit in the actual room where the patient would be looked after as an inpatient, but there is the Fetal Medicine Unit ultrasound group and our main department radiology group. It depends on where the person would

present and what the presentation symptoms were, as to who would do the scan.

MS CASTLEY: How many beds or treatment spaces are there? What does it look like?

Dr Howard: There is an area of a ward that has been allocated as the early pregnancy service. It has a number of beds. I think it is two that we use routinely, but I would need to check that, to be sure.

MS CASTLEY: I know we chatted earlier. We had our briefing—

Dr Howard: Correct. We did; yes.

MS CASTLEY: —and at that stage it was five days a week staffed. Is it still five days a week?

Dr Howard: It is. It does not mean that the service is not provided over the weekend.

MS CASTLEY: Right.

Mr Peffer: Ms Castley, sorry; it is three.

MS CASTLEY: It is three days?

Mr Peffer: Three treatment spaces.

MS CASTLEY: Three treatment spaces; great.

Can I keep going under the banner of women and children?

THE CHAIR: Yes.

MS CASTLEY: On the gynaecology, oncology, I noted you had a ministerial statement in November talking about increased services and that Dr Leon Foster has been brought on. I am just wondering: how many surgery hours does he get?

Dr Howard: I will take that on notice in terms of the lists that are allocated.

MS CASTLEY: Yes, I am interested in understanding impacts. It is great having him here. Did he get more surgery hours than was originally talked about a couple of years ago, and how many women are still needing to travel to Sydney? Could you let me know what that list would look like.

Dr Howard: So, we do have a phased clinical service plan that looks at a two- to three-year horizon in terms of provision of gynae-oncology and what the capacity to do that would look like.

MS CASTLEY: Is there a breastfeeding clinic for new mums currently running?

Dr Howard: I am sure there would be, but I will have to take it on notice.

MS CASTLEY: Could you also take on notice how long that would last for. Is it just while they are in hospital? Is it after they go home? And how many people go through that unit? I just want to understand the impact of what the needs are, because I know that babies may be tongue tied. Does that encompass all of that?

Ms Zagari: I cannot answer specifically but there is this clinic. I do know that our lactation consultants and our midwives will visit new mothers actually in the home, and help provide a wrap-around service which includes assistance with establishment of feeding post discharge. As well as lactation consultants seeing women in the hospital, that care extends beyond there, so the midwives are skilled in that area.

Mr Peffer: It is also a service that is provided through our MACH clinics, and the community health centres as well.

MS CASTLEY: If a baby is tongue tied, do we have any information on for how long, or how many of those a year are born, or—

Ms Zagari: We could come back on notice with numbers if they are available. As for how long, it would depend on the needs of the individual family, actually, as to how long was required to support that feeding.

MS CASTLEY: Sure.

Dr Howard: As Mr Peffer has offered, the maternal and child health team has an extensive footprint in the community and interfacing with the hospital following the birth of the child, so it will look at the child and the mum, obviously, as a—

MS CASTLEY: As a whole?

Dr Howard: Yes.

Ms Stephen-Smith: In addition, obviously there is the QEII Family Centre as well for those people who need to stay for a period of time to get that in-patient support. They would be able to access QEII.

MS CASTLEY: Right. So, onto speech pathology. How many children use the service for speech pathology? I believe it is up to seven years old—is that correct? Do we have stats on how many kids go through that program?

Dr Howard: Not at hand. I would have to take it on notice.

MS CASTLEY: I think it is about five sessions for children over three, but if you could just give me, on notice, a bit of information about that I would really appreciate it. Finally, I move on to women and children, with regard to obstetrics and gynaecology. We have training midwives coming through. I just had a representation from someone who was concerned. If the training accreditation for that department has been redacted—or whatever is going on there at the moment; I know we are working on that—will that impact midwives or is the training accreditation purely for doctors?

Dr Howard: The accreditation through RANZCOG, the college, does not cover midwives specifically. Whether that impacts on midwifery training or not, I could not give you a definitive answer. Kellie Lang may be able to.

MS CASTLEY: Do the trainee midwives know this? I think there is some concern that they are unsure. They are on the ward. They are doing their training, which is great; there is no problem there. Someone has contacted me. They are just a little bit worried about whether this is going to impact them at all. I do not know whether some communication might need to filter down to the trainee midwives.

Dr Howard: Absolutely. Happy to look at the communications processes we are using. If I may, we are not contemplating losing training in that facility. Under the current requirements, we are reporting as required and have met what we need to do at this stage.

MS CASTLEY: Okay. Thank you.

THE CHAIR: Mr Pettersson has a substantive question.

MR PETTERSSON: The Albanese-led government is developing a national climate change and health strategy. What work is underway in the ACT to support that?

Ms Stephen-Smith: I think Dr Coleman is the right person to speak to that, but I can say that at the health ministers' meeting last week in Perth, Ged Kearney was there. She is the Assistant Minister for Health and Aged Care, who is managing this development of the strategy at the commonwealth level. It is expected to be released in December, and states and territories were all very supportive of that. Our ongoing work will now be able to be done in the context of having a commonwealth government that is committed to recognising the intersection between health and climate change.

Dr Coleman: Thank you, Minister. As the minister mentioned, we are very keen to see the final national plan, which will really help us to work through how we can best utilise the ACT-specific resources in our focus. What is probably really important to mention is that a lot of the things that we need to do in climate change really need a national and commonwealth lever to be pulled. Liz and I will share this. Liz will be able to talk a little bit about some of the emissions reductions scope of what we are doing in the ACT, and I can touch a little bit on the adaptive mechanisms.

We have done a fair bit of work so far to collect information on what is happening in the Health Directorate and across the health services at this point in time. The plan is to pull that all together, and then to be able to produce an action plan, post release of the commonwealth survey, that talks to the things that are already underway, as well as those things that we need to prioritise to deliver over the next little while in that action plan.

I think there is a lot of stuff that we already do that actually has an intersection with climate change from an adaptation perspective. We are particularly interested in our vulnerable communities. They are the ones that are going to be impacted the most by

what we are doing. Particularly post-COVID in my area, we have learned a lot of lessons about how we best engage with, communicate with, and work with those vulnerable and high-priority populations. We are very busy working with those communities and with our other stakeholders across directorates to make sure that we can engage and work with those to minimise the impacts of climate change on those communities.

We might well see this summer season some further impact of having heat increases, so we have updated our heat stress plan and our heat response, and have actually been going out quite proactively to our communities to ask them to go and see their GPs to be aware of what they might need to do. I think these are the things that are already occurring from an adaptive perspective, but we have actually done quite a bit in our emissions reduction space, and Liz is probably best placed to talk to that.

Ms Lopa: Thanks, Kerryn. What we are really mindful of is that our health services in Canberra and around the world are a significant contributor to carbon gas emissions, just because of the size of our hospitals, et cetera. One of the things that we have been doing in the ACT is turning to all-electric hospitals. Building 5, the critical services building that will open next year, is all electric. It is the first all-electric building of its type. Obviously, in the ACT we get electricity from renewable sources, so that is a really great achievement as far as decreasing the emissions.

The Canberra Hospital master plan for that 20-year renewal of the campus, sets out steps to becoming carbon neutral, as far as what our infrastructure is producing. Every building that we will be doing, include the new northside hospital, will be electric buildings. They will not have gas in them. That is a big step. Other states and territories are a little behind us in that. The new Women's and Children's Hospital in South Australia is going to be all-electric, but I understand that South Australia does not have 100 per cent renewable electricity as yet. But that is where we are moving in the infrastructure space. We are also looking, every time we do our normal repairs and maintenance on our buildings, at replacing boilers, HVAC, and all of those things, with electricity.

The next step—and what we have been talking about and what Dr Coleman is referring to—is looking at supply chains of things and how we procure things in our health system, and making sure that the people or the companies that we procure it from have zero emissions strategies, et cetera, as well. But that is not something we can go alone on in a market as small as Canberra. We will really need a national approach to looking at some of those issues.

The NHS over in the UK has done some amazing work on their procurement strategies and things that they are doing to make sure that the companies that they are getting medical equipment from, and medicines—the pharmacy companies—are committed to zero emissions as well. There is quite a bit of work that we can do in this space, but we are actually also quite a bit further ahead of a lot of other jurisdictions, because of our 100 per cent renewable electricity, and the infrastructure works that we are going through.

Dr Coleman: I think the only other thing I would mention in that space is that we are working really closely with our jurisdictional colleagues to learn as many lessons as

possible, particularly from an adaptive techniques perspective. There is a number and range of options in which we could go, and learning and actually leveraging off their experiences and the tools and resources they have, is going to be really important for us in the ACT, aligned contextually with our own community.

MR PETTERSSON: Amazing. Thank you.

THE CHAIR: Ms Castley.

Ms Zagari: I have that answer on the endoscopy investment. It is $8.537 million.

MS CASTLEY: Thank you. I have some really brief questions about the radiation council report in the annual report. There were four incidents: repeat exposure due to equipment failure, and incorrect procedure for two patients. I am just wondering: the equipment failure—what was that about? Is it because the machines are ageing? Can you tell me about those incidents? It is on page 449.

Ms Cross: Ms Castley, is this in the ACT Health Directorate report?

MS CASTLEY: Yes.

Ms Cross: I think the radiation council covers a whole range of facilities and organisations, not just CHS. My recollection is they were all minor in nature, but I am not even sure they were at CHS.

MS CASTLEY: Can you confirm?

Ms Cross: We can get some further information for you.

Ms Stephen-Smith: We can get that on notice.

MS CASTLEY: Thank you. Is the new MRI machine plugged in and working? Do we know how many scans it has done?

Ms Zagari: It is plugged in and working, and I will try to get the number of scans, or at least an approximation.

MS CASTLEY: Thank you. Radiotherapy treatment is in the CHS report, page 172. Can you tell me what the staffing levels are in the unit, and are any treatments being delayed due to staff shortages?

Mr Peffer: I will have to take that on notice in terms of the actual workforce profile. I am not aware of any delay to care that is being provided. I think the scheduling of the treatment is around the available workforce, but I might have to take that on notice.

MS CASTLEY: Okay. Have any of the staff raised concerns over the ageing equipment?

Mr Peffer: Not that I am aware of, but let me take that on notice and just confirm

within the organisation.

MS CASTLEY: Also on notice, then, could you let me know how many CT scanners there are at Calvary.

Mr Peffer: Just one.

MS CASTLEY: One?

Ms Zagari: At North Canberra Hospital?

MS CASTLEY: Yes; sorry. Oh my goodness—it is such a habit!

Ms Stephen-Smith: We do it all the time.

MS CASTLEY: I think that is as much time as I can squeeze in.

THE CHAIR: Any other questions on notice? You have 60 seconds.

MS CASTLEY: I have a few on aged care.

THE CHAIR: You can put them through.

Ms Stephen-Smith: I would like to come back to a question we took on notice earlier in relation to scope-of-practice differences between nurse practitioners and GPs. We will come back on notice, but what we might do, if that would be helpful, is to table some information around nurse practitioners' scope of practice. It is going to be hard for us to explicitly list everything that a GP could possibly do that cannot be done in a walk-in centre, but I think we also need to recognise that everything a GP could possibly do also would not be able to be done in an urgent care clinic.

When you think about things like more complex urinary tract infections, the nurse practitioners and nurses might be able to support someone with a less complex issue; they might need to go to a GP for a more complex one. There will just be those nuances. We will do our best to respond to the question on notice, but just to say that we are not probably going to be able to provide an apples-to-apples list.

MS CASTLEY: That would help the GPs. I know they have concerns about the UTI, so if there was one onsite, that would allay some of those concerns, because they enjoy working with the nurse practitioners.

Ms Stephen-Smith: They have also said to me they would much rather have a nurse practitioner talking to a patient about a UTI than a pharmacist, which is their view.

MS CASTLEY: That is right, and they do enjoy working together.

THE CHAIR: Very good, ladies and gentlemen. I would like to thank the minister and officials for attending today. I would also like to thank broadcasting and Hansard for the work that they have done. If you have taken any questions on notice, please provide your answers to the committee secretary within five business days of

receiving the uncorrected proof. If members would like to put any questions on notice, please upload them to the parliamentary portal as soon as practical, and no later than five business days after the hearing. This meeting is now adjourned.

The committee adjourned at 12.01 pm.