LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2008-2009

(Reference: Appropriation Bill 2008-2009)

Members:

MS M PORTER (The Chair)
MRS V DUNNE (The Deputy Chair)
MR M GENTLEMAN
MS K MACDONALD
MR B SMYTH

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 21 MAY 2008

Secretary to the committee:
Dr S Lilburn (Ph: 6205 0490)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents relevant to this inquiry that have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

APPEARANCES

ACT Health..**313**

The Committee met at 9.00 am.

Appearances:

Gallagher, Ms Katy, Minister for Health, Minister for Children and Young People, Minister for Disability and Community Services, Minister for Women

ACT Health
Cormack, Mr Mark, Chief Executive
Guest, Dr Charles, Chief Health Officer, Population Health Division
Reading, Ms Jenelle, General Manager, Community Health
Thompson, Mr Ian, Deputy Chief Executive, Clinical Operations
Foster, Mr Ron, Chief Finance Officer, Financial and Risk Management Branch
Bassett, Professor Mark, Director, Medical Appointments and Training Unit
Vickerstaff, Adj Professor Joy, Acting Chief Nurse
Brown, Dr Peggy, Director and Chief Psychiatrist, Mental Health ACT

THE CHAIR: Welcome to this hearing of the Select Committee on Estimates 2008-2009. I am sure that those that are sitting at the table and everyone else behind you are familiar with the yellow card. Do you understand the privilege implications that are contained in it?

Ms Gallagher: Yes.

THE CHAIR: Thank you very much. I move:

> That the statement be incorporated in Hansard.

The document read as follows:

> The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the Resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings. Before the committee commences taking evidence, let me place on record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it.
>
> Parliamentary privilege means special rights and immunities attach to parliament, its members and others, necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.
>
> While the committee prefers to hear all evidence in public, if the committee accedes to such a request, the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly. I should add that any decision regarding publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing.

THE CHAIR: Minister, did you have some opening remarks that you would like to

make?

Ms Gallagher: Yes, I will make a few opening remarks. To begin, I thank the committee for asking us to appear. We look forward to it. As you can see, we are all sitting here ready and willing to answer all of the committee's questions.

This budget is a fantastic budget for health. It has got a number of recurrent initiatives which are very important in terms of continuing to improve our public health system. It has got the very significant allocation of capital money to begin our investment in our complete overhaul of public health infrastructure. You will see that many of the recurrent initiatives go to areas of need such as increasing our bed base and our capacity to provide inpatient services at both hospitals.

There is more money for mental health, again continuing our annual investment in mental health services, and, of course, in other areas of growth: our older person services, cancer treatment, continued demand for elective surgery, which continues to grow every year at a significant pace, and services that support our acute systems such as palliative care services. And there is money in this budget to start our funding of corrections health at the Alexander Maconochie Centre. We have also got some interesting initiatives, including the ACT's first public sleep studies laboratory and our design or our scoping for how we get our primary care walk-in centres up and running, which again is going to be a very important element of the redesign of our health system.

On the capital side—this is work that I started perhaps 18 months ago but it had been going on in terms of the planning in health for a period longer than that—we have been working very hard on plans in a whole range of areas in health. Part of that has been scoping future need. Out of that work, it became clear that incremental change at the hospital or within public health is no longer sufficient to meet some of the challenges. Adding 20 beds here and there every year is not going to meet some of the demands that we were seeing that were coming out of that planning work that was done under ACT Health, and particularly in Megan Cahill's area, over the past few years.

Eighteen months ago we commissioned some work—it was funded through the second appropriation—and that work is almost complete; it is not at the final stage. But what we needed to do this year was get that work up and running.

What that told us was that, across the board, over the next 15 to 20 years, we would see a 60 per cent increase in demand across a whole range of services not just in terms of our beds but in terms of cancer services and the amount of surgery that we will be needing to perform. Really we needed to think outside the square about how we were going to manage that and how we were going to make it work. And we were given the opportunity of a lifetime here.

We have been told the health tsunami will hit us in eight to 10 years. This starts off an eight to 10-year plan. From where I sit, I feel very lucky that we are sitting here eight years out and not four years out, having to do something that takes eight years when we know the demand is going to come in four. So the timing is right; it is perfect, actually. Cabinet has agreed to the details of future demand and we have kicked it off

with this first $300 million investment in redesigning our health system.

It kicks off a number of projects, including the women's and children's hospital, which is not unimportant in terms of the services that we offer women and children in our public health system but it is also strategically important in that it allows us to decant a number of areas within the existing hospital to proceed with the next stages of this program.

The budget also provides funding for the construction of our adult mental health precinct. That includes not only the acute inpatient unit but also the secure unit. The budget funds a new intensive care unit at Calvary Public Hospital; it funds a neurosurgery suite; it allows us to construct more beds at the Canberra Hospital to be in place over the next year or so; and we meet with the board on the surgical assessment and planning unit and construction of an additional 24 beds.

Importantly, the work has shown us that we cannot and will not be able to meet the demand if we just look at the hospitals; we need to look outside that. So there is a component in there for community health, including a new community health centre in Gungahlin, at a cost of $18 million, and an additional $5 million to really refresh and redesign our existing health centres. The work has shown us that our community health centres are really well located where they are but I think it has also shown us that perhaps we could use them a bit better.

We will be looking at what other services we can offer out of our community health centres and we will be very keen to get our primary care walk-in centres up and running. The scoping work for that this year will help us but it is envisaged that the first primary care walk-in centre would happen in Tuggeranong. We can talk about that initiative through the course of the morning.

There is also money in this budget for the mental health young persons unit to move to the design stage. It is envisaged that that would go on the Bruce site next to Brian Hennessy House. That is quite an important area, too. It is not at a critical stage yet but we will need an inpatient facility for young people in the future. That will be looking to cater for young people as young as 13 up to, say, 25.

There are also significant proportions of the capital program to go to project definition planning and overall scoping and management of the next stages of that work. Cabinet has agreed that this work will, in the end, once it is delivered, be in excess of a billion dollars. Those large amounts of money are defining the future stages, staging it, getting a project manager in place, really nutting down the planning, consulting with all the people we need to consult. They certainly look like significant proportions of money but it has to be seen in the context of a 10-year plan in excess of a billion dollars. I think that explains those allocations.

But it is very important that we get that work right, from the beginning, because this is the most significant public infrastructure project undertaken since self-government. It is incredibly important that we are able to continue providing the health services we provide whilst managing a 60 per cent new build on the Canberra Hospital site. So you can see the challenges involved there, and we need the expertise and we need all those decisions up front so that we enable this to go as smoothly as we can.

It is a very exciting budget for health and it is certainly a budget that is not necessarily going to help this government or governments in the near future. But certainly in 10 years time, when that health tsunami hits our community, I imagine whoever is in the Assembly at that time will be acknowledging the efforts of this Assembly in making sure that we move forward with a plan for the future.

THE CHAIR: Thank you very much, minister. We are going to spend approximately half an hour, hopefully, on the overview area. Then we are going to go to output class 1.1, which is acute services.

MR SMYTH: Is it possible to have a little bit longer for the overview?

Ms Gallagher: Will we do an hour on the overview?

MRS DUNNE: Yes, I think that is a good idea.

MR SMYTH: Yes, I think so.

THE CHAIR: We will do from 9.15 to 10.15 and then check how we are going, if that is all right. There are a lot of general questions. I just left a breakfast where the speaker, the ex-director general of health in Queensland, said that, in her opinion, all the hospital systems throughout Australia were facing what she called an avalanche as far as ageing was concerned.

MS MacDONALD: As opposed to a tsunami.

THE CHAIR: As opposed to a tsunami. She also said that, in her opinion, there was no hospital in Australia that was equipped to cope with that. Obviously you believe this budget is actually addressing that issue. I was particularly interested in what we are doing as far as chronic illness and ageing are concerned.

Ms Gallagher: I did not hear the comments but I think probably the analysis is pretty accurate. I think the pressure is evident not just across public health but also across the entire health system. If you ask your GP whether they have got any free appointments they are pretty well going to say no. You ask the private hospitals how many spare beds they have got—

THE CHAIR: I do not think she was directly talking about only public health.

Ms Gallagher: It is across the board. The health system is operating to near full capacity now. That is why I see this as a very exciting opportunity. We have a younger population, we have a healthier population. We are seeing some of the pressures that are being seen in other jurisdictions now, jurisdictions close to us, for example. We are lucky in that we are not seeing that level of stress yet but we know, from the work we have done—the $1.2 million allocation in the second appropriation to do this—we have to take expertise on board to do this very detailed modelling of what demands our health system is going to see next year, the year after and growing out to 2022.

I think we are in a position where we know what is coming but we had the time to get it right. And that is what this budget starts doing. We have been doing it every year. By the time the 25 extra beds funded in this budget are replaced, there are going to be 172 extra beds across our public health system. So we have been doing that every year, building our capacity, increasing our services.

But what we can see coming over the next eight to 10 years is that that 20 to 25, 30 beds a year is not necessarily going to be enough. We have to keep doing that but we have to look at other ways of managing demand. And that is increasing our services in our community health centres, for example. We are going to be increasing our prevention and management of people with a chronic disease in our community. And we are going to have to do things. We have to really have a look at how our hospital system works and make sure that the whole public health system is more integrated and there are more opportunities for care outside the hospital itself. And that is what this work sets us up to do.

THE CHAIR: Once an older person enters hospital—and they have complex needs, do they not?—is there money in this budget to help deal with those more and more complex needs that older people have or is that planning for the future?

Ms Gallagher: Last year, we opened MAPU. It is making quite significant improvements. If you look at one of the indicators on access block for older patients coming into the hospital—they traditionally are the people that spend a long time in the emergency department—their needs are complex; they need a number of doctors to come and assess them; they may be an orthopaedic patient but they may have other medical concerns, which means that finding the right bed for them may be difficult. And that is why we see the level of access block for older patients higher than for those that are younger.

We opened MAPU and we are seeing the access block figures come down for that age group. And that has, I think, created enormous capacity. If you talk to the emergency department staff, I think they will agree that in that model we are able to take an older patient and get them to a ward and have the assessments occur there. And then they move to other areas of the hospital or they are discharged.

I think there is a lot of discussion nationally on how to deal with the older patient. Some of our discussions on this in relation to the Australian health care agreement are very much focused on this group. In the ACT, by 2032, 25 per cent of our population is going to be over the age of 65; so it is very critical for us that we work out how we are going to manage our ageing population and look after them appropriately. It is an area on which we are having quite intense negotiations with the commonwealth and we are looking at the whole interface between aged care facilities and the hospital.

This budget does have money—in fact, just over $4 million—for increases to the older persons service, which I think we have seen every year since the subacute opened. And that is for an expanding range of different services. The equipment loan service is seven days a week. There are things like that where we are better able to meet the needs of the older patient. But this is a matter of concern for us in how we meet the needs and that is why we need to have those discussions with the commonwealth and look at how we better interface with aged people's

accommodation and the journey to the hospital or staying out of the hospital.

MR SMYTH: Minister, you are the health minister and you are also one of the two shareholders for the territory in Actew. What information have you been given of the impact of the power station on the health facility which is 660 metres from the boundary of the proposed power station and data centre? And how will you ensure the health of the residents there should the data centre go ahead on the Macarthur location?

Ms Gallagher: I have received some correspondence on that, not just in health but in disability, and I am taking advice on both of those areas.

MR SMYTH: So what have you done to protect the residents?

Ms Gallagher: I have taken advice on all of the issues under the health and disability portfolio.

MRS BURKE: But were you not warned about this?

Ms Gallagher: As you know, the community consultation period is underway and it is appropriate that I take advice during that period. No decision has been taken.

MRS BURKE: Were you not notified before that? It is a major project. If we can let people know about road bumps in Fadden, why can we not let people know about a major facility that may impact on their health?

Ms Gallagher: I am taking advice on it, as I have said.

MRS BURKE: Now.

Ms Gallagher: No final decision has been taken. So it is appropriate that, during that consultation phase, I, as minister, take advice and I am doing just that.

MRS BURKE: That is appalling.

Ms Gallagher: I am sorry to have appalled you.

MR SMYTH: What information has ACT Health been given or has it obtained about the design and operation of the centre and its impact on residents at large and in particular the residents at Rose Cottage?

Ms Gallagher: I might let Mr Cormack answer that on behalf of ACT Health but I think the process is underway for those discussions.

MR SMYTH: Yes, as I have heard you say several times.

Ms Gallagher: I think it is appropriate that agencies have discussions. I am aware that they have across my portfolio. No, I have not seen any firm advice on it. But I am sure that is on its way to me.

Mr Cormack: I just agree with the minister's statements. Advice has been prepared and will be made available to the minister and to the other authorities as appropriate during the consulting process.

MR SMYTH: When was ACT Health first made aware of potential impacts on people arising from the activities—

Mr Cormack: I will have to take that one on notice, Mr Smyth.

MR SMYTH: Alright. What conclusions have been made about these impacts? Specifically, what emissions are anticipated from the power plant, and how do these emissions compare with what is normal and/or safe?

Ms Gallagher: I think the Chief Minister has been pretty clear. If, under the work that is underway and the assessments that are underway, it does not meet those safe guidelines, the project will not proceed. But those assessments are underway.

THE CHAIR: Okay. Ms MacDonald?

MS MacDONALD: Yes—

MRS BURKE: Sorry, chair, I just have a very quick supplementary to that. I am just mystified. This is such a major project. When was ACT Health first notified of potential possible impacts upon health in the community? Did ActewAGL talk with the Chief Minister, talk to you, minister, or talk to the health department? Have there been discussions around this before it was presented to the community?

Ms Gallagher: It is too early. It is a community consultation. The consultation has not finished; the government has not made any decisions. The assessments have not been completed, as far as I am aware—

MRS BURKE: Were you aware though? Were you aware of what was going on?

Ms Gallagher: The potential health concerns, it has not reached that point.

MRS BURKE: Surely that is the first point to consider in a major project, which may have—

Ms Gallagher: So you decide all that before you undertake the studies, do you?

MRS BURKE: You are the minister; you should be across this, surely.

Ms Gallagher: Well, I mean, your logic is just not there; it does—

MR SMYTH: The PA and the DA have been lodged—

MRS BURKE: I am sure Mr Gentleman was put on the spot at the public meeting.

MR SMYTH: The preliminary assessment and the development application have been lodged.

Ms Gallagher: Yes.

MR SMYTH: Attached to those were a string of documents.

Ms Gallagher: Yes, I am aware of that.

MR SMYTH: One of those documents from Bassett Consulting Engineers looks at the acoustics. There are other documents about the output from the smokestacks of nitrous oxide-based emissions. Has ACT Health commenced reading, assessing or reporting on those reports that have been placed on the website?

Ms Gallagher: Yes, they would have started reading and assessing. Have they reached a final position? Has that advice reached me? No, it has not.

MR SMYTH: Right. Mr Cormack, when do you expect to be able to be in a position to give the minister that information?

Mr Cormack: Once the necessary work is complete, and I cannot give you a date on that at this point in time.

THE CHAIR: Okay.

MR SMYTH: Alright. You have taken on notice when that work commenced?

Mr Cormack: Sorry?

MR SMYTH: You have taken on notice the day you first became aware of this and the work commenced?

Mr Cormack: I have taken that on notice, yes.

MRS DUNNE: Minister, as a shareholder, were you briefed about the project before the DA?

Ms Gallagher: There was a meeting, which I was unable to attend, but the cabinet was briefed. I was not at the meeting.

MRS DUNNE: Were you briefed as a shareholder?

Ms Gallagher: No, I was not briefed as a shareholder, but I have received correspondence, I am sure.

THE CHAIR: Ms MacDonald?

MS MACDONALD: Good morning, minister; good morning, officials. My question does not relate to the proposed gas-fired power station at all. Last night I had the opportunity to open, on behalf of the Chief Minister, a conference for Audiology Australia. I appreciate that this might be a question which should go directly to the Canberra Hospital, but it was raised with me that Canberra Hospital does not employ

directly an audiologist and that they actually contract out. Given that, at the moment, we have one in six Australians who suffer from hearing impairment, and that is estimated to go up to one in four by the year 2050 given that we have an ageing population and we have concerns about the ageing population, I was wondering if there was any work being done on looking at hearing issues within ACT Health and the health system generally.

Mr Cormack: The Canberra Hospital has commenced some work in relation to further equipping of a sound-proof facility, sound-proof booth, for the establishment of audiometry services. I am just getting advice on the anticipated completion date of that, but that was in response to a number of representations that had been made to me from the ear, nose and throat surgeons. We have responded to that, and I would like to be able to hopefully advise you when that facility will be completed and the arrangements that will be made to source the necessary expertise to provide that service.

MS MacDONALD: Thank you.

THE CHAIR: Mr Gentleman?

MR GENTLEMAN: Thanks, chair. Good morning, minister and officials. My question relates to the priorities in budget paper 4 at page 145. One of the priorities there is strengthening the workforce against current and anticipated nursing and midwifery allied health people workforce shortages. I think all sectors in the ACT are heading towards future shortages, and many have current ones. I understand the nurses' EBA is now complete. Can you tell us a little bit more about what you were able to achieve there and then talk about what you are doing to try and strengthen these workforce areas?

Mr Cormack: I am happy to answer those questions through you, chair. In relation to the nurse's EBA, it is correct, it was a very good outcome for all parties. We were able to secure greater flexibility in terms of rostering and part-time and full-time arrangements and shift lengths and the consultation processes required to vary those, so that was terrific. We were also able to incorporate into the agreement the classification of an assistant in nursing. That is in place in a number of other jurisdictions and, of course, assistants in nursing are well established in the private and non-government sectors and also the aged care sector. That is certainly a very important part of future development of our workforce.

We do need to be able to look at the range of responsibilities that individual professional groups provide. By that, I am talking about the scope of practice for medical officers, nurses, allied health professionals and assistants. By incorporating the assistant in nursing into the collective agreement for public sector nurses, we anticipate being able to respond, in part, to the pressures on our workforce by relieving registered nurses and enrolled nurses of some of the lesser skilled aspects of their current range of duties. That is a very important part of the agreement.

Just to cap off your question on the agreement, the third key component was to ensure that we have a more refined workload monitoring tool for use in nursing across both of our public hospitals. That is in recognition that, as the minister outlined in her

opening address, the demand on health care is increasing, particularly with the hospital side of things. We have seen some of the highest levels of activity. That does potentially cause additional demands on our workforce, so we need to be able to look at ways of measuring workload demand and adapting our staffing to respond to that. That is a response to one of your questions.

The second question really goes to the heart of what the budget will provide in terms of workforce initiatives in the future. The minister outlined in her opening comments a projected increase in overall demand for public hospital and healthcare services of the order of 60 per cent or more. What we do know, particularly in the area of nursing and allied health and, to a certain extent, in medicine, is that simply projecting forward a 60 per cent increase in staff using the current ways of doing things is not necessarily going to be sustainable, nor is it going to be achievable.

In the last couple of budgets, and in this budget in particular, we have invested in a range of workforce initiatives. Those initiatives look at the roles of allied health workers, such as physios and others, and at expanding their scope of practice. They also look at the roles of assistants in allied health. They build upon our successful and wide-ranging approach to attraction and retention through scholarship initiatives. So it is an important strategic investment in this budget, and it is outlined in budget paper 3 under the workforce initiatives. I am happy to respond as required.

MR GENTLEMAN: Thanks, Mr Cormack. What is the time line for nurses to complete their training period before they are fully qualified nurses?

Mr Cormack: For a registered nurse it is a three-year degree. We have an extensive graduate program in both our public hospitals where we take on a large number of new graduates. We support them with supervisory and mentoring nurses, clinical development nurses, and we support them particularly in that first-year period where they need to consolidate and acquire a number of new skills. Roughly it is about three years from commencement of tertiary training to the end of tertiary training. Of course, our approach is to encourage lifelong learning for our health professionals, so it is intensive support in the first year and then ongoing professional development opportunities right through to postgraduate level certificate courses and postgraduate degree courses for our nurses.

MR GENTLEMAN: Thank you.

THE CHAIR: Okay. You had a supplementary, Mrs Burke?

MRS BURKE: Thank you, chair. Just in relation to workforce issues, what were the results of ACT Health's 2005 and 2007 workplace culture surveys? Of course, you know, as I do, the surveys are searching questions about attitudes and practices in the workplace. There have been persistent reports from nursing staff of corporate culture fear and reprisals if they offer constructive criticism of ACT Health and if staff speak out. Can you tell me what the results of that survey showed and what is being done to address such issues as this culture that seems to be still pervading in terms of fear of reprisals?

Ms Gallagher: I will let Mr Cormack answer the detail. We can give you some detail.

I think the workforce culture survey showed improvements in nearly every area from the last survey. There is a mound of information we can give you, but it is also restricted information from a commercial point of view from the group that do the survey for us.

MRS BURKE: Are they not done anonymously, though, minister? I do not think names were attached, from what I have been told.

Ms Gallagher: It is not about the people who fill it out; it is about the commercial interests of the company that do it for us. I have had a good look at this workforce culture survey, and I am pretty pleased. All of the indicators are going the right way, but there is still a way to go in terms of improving workforce culture. I think that is not unusual for any large organisation.

MRS BURKE: Were they published online for the health professionals to see?

Ms Gallagher: My understanding is that each area was given a debrief from their directors, a pretty frank and open debrief, about what was found. There have been a number of workplace meetings—I think Mark did a few—to talk about the general themes. Can you add to that?

Mr Cormack: Yes, I am happy to add to that. This is the second workplace culture survey that we have undertaken. We did the first one in, I think, August 2005. This one was undertaken in August and September 2007. With respect to the survey format, as the minister identified, a commercial company provides the services; we have a contract with them which specifies the use, publication and reuse of that information. It is benchmarked across a large number of other public sector organisations, both large and small. We fit into the category of a large organisation—public sector, private sector and not-for-profit sector. It enables us to compare ourselves against like organisations on a number of attributes. The minister identified the feedback to staff. The short answer is that there is not a published report that is available for staff. However, we have undertaken a range of feedback sessions. I have undertaken a number at the organisation-wide level.

MRS BURKE: Were they well attended?

Mr Cormack: They were very well attended. The survey enables us to move from the overall picture, which is the one I focused on, down to the picture of the varying division levels. My executive colleagues have provided feedback to their work areas in relation to how their staff went in the survey.

I will go to just a couple of headline points; this is outlined in advice that I gave to staff in an email to staff. Between 2005 and 2007, there was an overall shift of 10 percentage points in the positive direction in the overall engagement of staff and how they felt about their workplace. That compares well with our benchmarking partners.

This survey identifies 77 quantitative attributes that it looks at, so it is quite a detailed piece of work. Seventy-four of those showed statistically significant improvements over the two-year period of the survey. These include implementation and performance management, optimism about the future of the organisation, trust in

senior management and pride in the organisation. The major areas are as follows. The staff agreed that we are setting very realistic performance objectives with our employees; we are reviewing employees' progress against those objectives; there is a lot more assistance to help employees plan their personal and professional development; and we measure employees' performance against their expectations. We also conduct a range of annual performance reviews. We focused on those areas after 2005, and it was very pleasing to see that, when we resurveyed staff, those are the areas that showed quite significant improvements from one survey to the next.

In terms of what we will be doing from this survey, we will be continuing our work on performance management. The staff identified that we need to work on a concept called the problem pipeline, which is getting in early rather than allowing problems to build and escalate. There is a lot of work going on there. There were issues raised around addressing bullying and harassment. That was raised last time. We put in place a range of policy changes—a range of program and education changes—to assist in promoting teamwork, communication and strategies, and also modelling a zero-tolerance approach for inappropriate behaviour. An emphasis on change management—again, we have put a lot of work into managing projects and change programs over the last two years. The final area is about leadership and management development for our staff.

The other area around bullying and harassment was that the major finding in relation to what staff are feeling was inappropriate, harassing, violent behaviour from patients and from relatives and visitors. That was the key problem. It was a far more significant problem than bullying and harassment in the workplace. Unfortunately, that is an international trend. I was in the UK last year and spent a bit of time in the NHS having a looking at a number of their service development programs. One of the single biggest problems they face is inappropriate behaviour by patients and relatives towards staff. They have got very assertive, very structured programs to discourage that sort of behaviour. We are developing and implementing responses to that sort of behaviour in our own system—within the context of the ACT, but not necessarily the NHS, which is a different system.

That is a bit of a summary as to what the survey found and how we fed it back to people. It is part of an ongoing program of work for me and my senior colleagues.

MRS BURKE: Finally, do you know if it is true that people were offered the opportunity to be put into a raffle for theatre tickets or cinema tickets if they attended either to fill out the survey form or to come and hear the results of that survey?

Mr Cormack: With respect to one of the criticisms from the 2005 survey, we got around 50 per cent of employees responding. That is pretty good for a survey, but some of the feedback we got was, "Well, you had only a 50 per cent response rate; it is not truly representative." As part of the program's improvement in 2007, we did offer a raffle for some cinema tickets for people who filled out the form. So yes, that is true.

MRS BURKE: Did you not find it disappointing that people just would not want to—well, anyway.

MS MacDONALD: It is human nature.

Ms Gallagher: I think the important thing to realise is that the whole reason you undertake a workforce culture survey is that you want to continuously improve your workplace environment. I guess the motivation behind actually doing it is to constantly improve and respond to staff concerns. In order to do that effectively, it is not unusual to want to increase participation rates, particularly when it had been a criticism in 2005.

MRS BURKE: My feedback is that they did not bother coming because they thought that nothing was going to change. Maybe I will talk to you separately on that issue, minister.

Ms Gallagher: If I could just add this, my experience is that people do take part in it. I am not sure of the participation rate in this; I think it was greater than 50 per cent—

Mr Cormack: Just under.

Ms Gallagher: They are interested in providing feedback, and it is pretty frank feedback.

MRS BURKE: They are more interested in the outcomes actually working. My feedback is that there are things that are not happening. Is that true?

Ms Gallagher: No, I would not say it is true. The information we get from these surveys enables you to respond. If you did not do them—across the board as an organisation it is more difficult to respond comprehensively across the board. Issues can be resolved in individual workplaces, but this is a very important tool. I am pleased that staff have participated in it. We want to see that increased, but we are doing it every two years; it is not mandatory that you do it.

The motivation behind this is good and genuine. From the results that I have seen, we have been able to respond. You can see things across the organisation, but you can also see things in individual workplaces. That gives you the information to respond in a confidential way so that staff feel comfortable about it. On a large part there are, but that is not to say that there are no individual staff who still feel that problems are not being addressed. I say that every year. In an organisation the size of health it is very difficult to have 100 per cent happy staff.

MRS DUNNE: I want to go back to the notion of the confidentiality of the workforce survey. Minister and Mr Cormack, you said that there is a contractual agreement with a private company who runs this sort of survey; presumably they run them for a number of organisations. I am really concerned that you run a major survey like this and that the only information available to the survey participants and to the general public, as opposed to the policy people in the organisation, is what is revealed by the policy people in the organisation. It seems to me that, without revealing the organisation's presumably patented techniques, you should be able to provide public information about the content and the results of the survey.

Mr Cormack: In response to that, you are right: there are agreements we have with a

commercial organisation that restrict the distribution and publication of that information. But there are a couple of other important points to identify here and acknowledge. The first one is that when we approach staff, they basically get a letter from me—every one of them; it is the same letter, of course—at the beginning of the process. But it does guarantee confidentiality and—

MRS DUNNE: Confidentiality of their identity—

Mr Cormack: What it says is—I do not have the text in front of me—"Your information is provided to us on an in-confidence basis"—and it outlines what it will be used for. There is another key consideration here. We do make the information available at the appropriate work levels. When the information comes back from the survey, I give an overview, but we also make information available at the individual work unit level. That is so that managers can work with their staff and say, "Well, look, these are some of the trends that were identified; let us see what we can do to put programs in place to improve that."

It is not helpful and it is not in the public interest to have people potentially identified through the publication of information which undermines the trust that we value very highly in engaging our staff in this process. It potentially identifies areas, work areas and individuals unfairly and inappropriately. This is an internal survey; it was always meant to be an internal survey. It is a way to help us to work with our staff to improve the workplace and to improve their satisfaction. That is best done in the context of a relationship between employer and employee that commences with a commitment to confidentiality. It is for that reason, and the other reasons, that it will not be published.

MRS DUNNE: On that subject, first of all, Mr Cormack, do you think that you could provide for the committee a copy of the letter that goes to staff and points out those things?

Mr Cormack: Certainly.

MRS DUNNE: I think you draw a false dichotomy between revealing identifiable information about individuals and work units and providing information to the public, who have a keen interest in the administration and the running of the largest public hospital in the territory. Most people in the territory are concerned about the welfare of workers in the hospital, because they see that they are very important. They are highly valued; they are highly regarded. If there are issues of workplace concern and if there are places where you can point to significant improvements in the way that people approach their work, it is a benefit and in the public interest to know that we have a happy staff if that is the case—or that there are areas where there can be improvement or areas where you can demonstrate where over time there has been improvement.

I am cognisant of the commercial proprietary interests of the provider; I am cognisant of the individual confidentiality of individuals and discrete work areas. But there are also macro levels which I think are in the public interest. You should be looking at publishing.

MRS BURKE: Particularly as the minister identified that a lot of bullying, for

example, comes from the general public. Maybe that makes—

MRS DUNNE: That needs to be identified—and also because there is a notion that the Stanhope government came into government saying that they would not hide behind commercial and confidential—

MR SMYTH: On that issue of aggression towards staff, you said that there was a worldwide trend of this occurring. Has anybody done any work to identify what the cause of the aggression is? Is it factors outside the control of the hospitals or is it frustration with the system? Has anybody, particularly here in Canberra, done any work to identify particularly the cause of the aggression here in the ACT and come up with solutions?

Mr Cormack: We have certainly done a lot of work on identifying solutions. These solutions come from the literature that researches the very sorts of issues that you are talking about. Part of the solution is being very clear in a policy sense about what you will accept as appropriate behaviour from patients and visitors. We do have that policy framework. The second issue is to assist staff in a range of training programs. We have rolled out a program called Carm; it is about assisting staff to recognise signs of agitation, concern, distress and aggressive behaviour. It provides them with a set of tools and guidance to be able to manage and de-escalate that sort of behaviour.

MRS BURKE: Could you give the acronym of Carm for Hansard?

Mr Cormack: I will give you the acronym as soon as I look it up, Mrs Burke. I will give it to you momentarily.

MR SMYTH: What is the cause of the aggression, particularly here in Canberra? You said you have come up with a solution. What is the cause?

Mr Cormack: I do not know specifically what the cause is. All I know is that this is a national and international trend and we are responding to it according to what best-practice approaches are identified in the literature. We have not done any specific detailed research in the ACT that says, "Why did you pick that ashtray up and throw it against a staff member?" We did not do that sort of research. We draw upon an established body of research and guidance in programs to be able to come up with the responses that we have recommended.

MR SMYTH: Can you give us some references that I might look at. The question for the minister is this: if we have come up with some solutions but we have not done the specific work in the ACT, will you direct the department to do some research in the ACT?

Ms Gallagher: When this issue has been raised with me, I have come from very much a point of view of protecting staff and making sure that we respond appropriately. In the budget last year or the year before, there was additional money for security guards. We looked at it in terms of some of the lighting and general safety around the campus in responding to some of that. But I do not disagree that it would be a good idea to have a look at whether or not we could find out information from some of these very difficult visitors and patients. In the scenarios I have seen, it would

just be the icing on the cake to go and say to them, "Why did you do that?"—to say, as they are being frogmarched out, "Why did you do that?" But I am sure there is something we could come up with to have a look at it.

MRS DUNNE: But the thing is that it seems to me that, while empowering staff to deal with difficult clients is an important factor, unless you can actually pinpoint with some accuracy why people are losing it—it could be that they are just bad tempered; it could be that they have been there for eight or 10 hours beside a bed waiting for someone to be treated and they have been told 15 different contradictory things. I have been in that situation, and it tends to fray the nerves of the most saintly. You really need to look at what are the myriad causes and, in addition to empowering staff, how you can minimise the occasions when someone is told 15 different lots of contradictory information that may drive them over the edge.

Ms Gallagher: The point you go to there is the point that we are doing quite a bit of work on, around communication within the hospital. When I look at some of the complaints that come to me and feedback I get, it is not necessarily about the standard of care or even necessarily the timeliness of care. It quite often goes to the point of communication about what is going on, where you are going to next and who is going to do what to you.

MRS DUNNE: And why.

Ms Gallagher: I have asked health to have a look at that across the board—about how we can do better. Because staff in the hospital are so busy, I am not sure that it is something that we can ask our nurses and doctors to do. If every nurse had a bit more time, some of those communication problems would not arise. I have asked about the idea of having communication staff within the hospital wearing a different coloured T-shirt—this was my idea: that they wear a different coloured T-shirt—that says, "If you have a question ask me." But when we worked through that, they do have to have medical training of some sort, because usually the questions are going to be medical. We are exploring this; I am just not sure the answer is always as easy as putting extra people in to answer people's questions. I think you are right; I think a lot of the stress for patients comes from not having all the information before them in a way that they can understand.

MRS BURKE: On that, minister, just to jump in very quickly, it has been suggested to me that—would you contend this as well?—there may be a need to look at the triage staffing arrangements, for example lack of maturity in some of those people that are presenting or being presented with these multiple problems from the public.

Ms Gallagher: Whose lack of—sorry, I do not understand?

MRS BURKE: The staffing of triage has often been put to me—

Ms Gallagher: In the ED?

MRS BURKE: In the ED. It has often been put to me that they are maybe inexperienced or young by years, not able to have the extent of life. Would you comment on that?

Ms Gallagher: I think there are two interfaces in the ED. There is the triage where you come in. Those nurses are specifically trained for that job. It is a technical job. We move people through that to get experience, but you do need experienced staff. So whoever is on triage is trained and experienced. The next interface is the admission or the person you go to hand your Medicare card to. I am not sure of the title—admissions officer, is it? I have certainly had some feedback around improving customer service in that area, and we are responding to that.

The triage is always going to be difficult. We have had a look at this independently. We had some people come down to have a look at how our triage was operating and whether it was meeting the standard set. The word back from that was that it was and that people were being triaged appropriately. Again, it is around information. People do not necessarily understand what category they are being triaged at; they do not necessarily understand how many people are before them or come after them. They may be triaged higher; they get seen before them even though they do not look as unwell.

I am not sure that there is an easy answer to addressing some of the concerns people have around triage. My focus was to make sure that the triage was happening appropriately, and we externally checked that. We have responded with waiting room nurses—and also paediatric waiting room nurses in the paediatric waiting area, which I believe started construction this week or will start in the next week. That is not only to check how people are going, but also to provide that communication and hopefully address some of the concerns that people have.

THE CHAIR: I am going to go to Mr Gentleman because he has been waiting for quite a while. Ms MacDonald has a question too. Then I am going to allow Dr Foskey to have a question. I know that she is not a member of the committee, but she does have to leave shortly so I will let her have a question.

DR FOSKEY: I will stay as long as it takes.

MR GENTLEMAN: Minister, I want to go to the strategic indicators. They start at page 149 of budget paper 4. There are 12 pages of strategic indicators. There are 23 indicators listed in here. All of them seem to be trending very well, but I want to go to one on page 152, and that is the proportion of the ACT population diagnosed with circulatory disease in comparison to the rest of Australia. It is just slightly up—less than one per cent, but up on the rest of Australia. I wondered if you had looked at what factors may be contributing to that.

Ms Gallagher: We might ask the Chief Health Officer, Dr Guest, to come to the table.

Dr Guest: The prevalence of circulatory disease in the ACT is consistent with other Australian jurisdictions. We have, customarily, problems with small numbers in the territory and it is frequently the case that you will see that of late it is slightly above or below, but the difference here in the ACT is not statistically significant. The other point to make is that circulatory disease correlates with socioeconomic status, and here in the ACT we are slightly above the rest of the country, so it is not surprising that you would see this slight difference, but it is not statistically significantly

different when you allow for differences in socioeconomic status.

MR GENTLEMAN: So you would suggest perhaps that the slight rise over the rest of Australia is more to do with diet than—

Dr Guest: No. I would say that when you remove the other factors—the socioeconomic status, the diet, the education, the levels of intake of dietary factors, as you suggest—when you allow for all of that, we are the same as everybody else.

MR GENTLEMAN: My other question, minister, was still in relation to strategic indicators, and it goes to page 156, strategic indicator 18, and that is persons aged 12 to 17 who smoke regularly. You have a long-term target of five per cent, which is very good. What impact do you think that will have on the health system when you are able to achieve that target?

Ms Gallagher: We are just about to undertake the next survey, the secondary school survey, which is where we get this data from. We have put in a range of programs to reduce the uptake of young people smoking. When you look at some of the impacts on the health system, smoking-related diseases are still the largest killer, of preventable illnesses in Australia. You can understand, when you extrapolate that, the impact it would have on our health system, from cancer services to our cardiac services. So, of course, we would want to see this continue to decrease, because the health-related cost of smoking is enormous. It is right up there with obesity and chronic diseases such as diabetes.

MR SMYTH: As a supplementary to that, your tobacco legislation: how is the consultation going on it and when do you intend to bring it back to the Assembly?

Ms Gallagher: Bring it on for debate? I have asked for some further work to be done, really around point-of-sale displays. I have met with a number of the stakeholders. I have received a number of letters. I do not know if they have already done it, but health protection have been invited to go out and have a look at what the impact would be on some businesses. Once that is finished, I will have another look at it. I would like to proceed with point-of-sale display bans—I think it is the right thing to do—but I am mindful of the effect on a number of small businesses if it proceeds as it is now.

I think the tobacconists are the ones that would really suffer, so I need to have another look at it. At the meetings I have had with them, they have offered some other areas to look at, which I have undertaken to do as well. So, rather than bulldoze ahead, I want to get it right, as right as I can. At the end of the day there still may be disagreement, but if we can go together on the journey, I would prefer to do it that way.

MS MacDONALD: I am interested in the proposed women's and children's hospital, which is mentioned on page 171 under capital works in budget paper 4, as well as on page 54 of budget paper 5, the infrastructure budget paper. Can you talk a little bit about what sorts of services the women's and children's hospital will provide and where the services are going to be coming from. I understand PaTCH is supposed to go into the new women's and children's hospital.

THE CHAIR: Can you explain that, please?

MRS DUNNE: Paediatrics at the Canberra Hospital.

MS MacDONALD: Thank you; I was not sure of the acronym. Do you have an idea of where you are going to put it—located on the campus, or is that yet to be determined?

Ms Gallagher: The idea is that it goes at that end where the current maternity entrance is, but it is built out from there. The idea is to co-locate, as you say, a number of services, so it does include really all women's and children health: gynaecology, maternity, PaTCH, the NICU, the special care nursery, some increased ambulatory treatment areas and an increased number of delivery areas. What we want to do is pull it all together, improve the environment but also increase capacity. With the NICU redevelopment there will be 12 NICU cots and 18 special neonatal intensive care cots. That is an increase—I am not sure of how much, but quite a bit—

Mr Cormack: It is about 50 per cent.

Ms Gallagher: It is about a 50 per cent increase in the NICU and it will be a similar increase in the delivery areas, a similar increase in ambulatory care treatment areas and an increase of 12 per cent in special care cots. So it will be larger and, hopefully, with the co-location of all those services, a better service for women and children.

The other important aspect of this is that it does allow us to move forward with the next stages of the redevelopment in a decanting sense. Some responses to our announcements around the redevelopment have been: is women's and children's health the number one thing you need to do? I have had some feedback around that—as you would, because people want to see some improvements in their own area faster. I would argue, yes, it is important that we do this from a women's and children's health point of view, but a secondary issue is that it does allow for a more organised movement of the next stages of the redevelopment.

MS MacDONALD: Mrs Burke was on the committee in the last Assembly when we looked at the continuity of care, the "pregnant pause" report that came out; I am still opposed to the title of the report, but anyway. One of the things that we did was to go into where the premature babies are. It was such a small area and quite overcrowded. Will that be taken into account?

Ms Gallagher: The NICU will be completely redeveloped.

DR FOSKEY: Could you just say what NICU stands for.

Ms Gallagher: The neonatal intensive care unit. It will be completely redeveloped. I do not know whether the size will be doubled, but around that, because I have visited that area too and it is very difficult for parents. There is no privacy and babies are dying next to babies that are struggling to live. It is a very difficult environment in just the privacy and the size. The equipment is getting bigger than it has ever been. It really does need a much bigger space, and this will allow that to proceed. They are all very excited about this, the staff in the NICU.

MS MacDONALD: Just one final thing: I know I have taken up a little bit of time with this, but it is a large amount of money being spent on it. We have heard this before, but the other day I met somebody who about four years ago had had a child who was in the NICU area, although I do not think it was called that back then. There was talk of encouraging parents, when they could, to have the child with "skin-to-skin" contact and that sort of thing, but there is just no room for the parents. Will there be—

Ms Gallagher: All of that has been looked at. There need to be private areas; the areas around the cots need to be bigger. At the moment, once you put a cot with a parent on either side, you really are next to the next baby. So all of that will be addressed, yes.

THE CHAIR: You have got a supplementary, Mrs Dunne, and then we will go to Dr Foskey.

MRS DUNNE: Actually, I have got two or three supplementaries, so I will ask them all together. You mentioned the word "decanting" and I was wondering if somebody could tell us what that meant.

Ms Gallagher: Nothing to do with wine!

MRS DUNNE: Yes, I presumed that we were not serving wine in the NICU! Could you, minister, give more of a rationale? You touched on that people had questioned you as to whether this was the most appropriate priority. You are not just relocating services—you are expanding some. I know there are women's and children's hospitals in other jurisdictions, but can you explain the rationale for creating a subset of the hospital which is called a women's and children's hospital?

Then I have a personal question: does the adolescent ward go with the women's and children's hospital, and what would happen to facilities that are being privately subsidised, like the Ronald McDonald House facilities; presumably if the paediatric ward moves from level 5 that would move as well?

Ms Gallagher: Yes, it is an expansion of services. There will not be enormous expansion in the number of paediatric and maternity beds, and that has been supported by that work, the planning work that has been done. I think the idea is to have 50 paediatric beds and 45 maternity and gynae beds. The big expansion will be in the NICU and in the ambulatory care area, so more day type procedures, including day stay beds. There will be an increase to about 50 treatment areas, so that is a 30 per cent increase in non-admitted patient treatment areas; a 50 per cent expansion of the NICU; and a 12 per cent expansion of the special care cots. If you talk to women's and children's doctors, there is a strong desire to be co-located in a purpose-built building and to have streamlined access for parents and for expectant parents. The adolescent ward, I am told, will be part of it.

This has been driven by what a lot of parents I have spoken to who have come through the hospital have told me. We are looking at improving entry to the hospital without going through the emergency department, particularly for "frequent flyer"

parents and children coming to this area, those people that come a lot, whom we expect and we know. We will never be able to sustain a women's and children's hospital on its own on another site in a community our size, yet I want to give it the importance that it deserves in terms of how we provide our services. It is not "cute" to call it a women's and children's hospital; it will be a separate building, although linked to the rest of the hospital on that site, but this will give it prominence. It could have been called a centre of excellence, but I think that means nothing to people. When I was looking at it, I said, "Could we call this a women's and children's hospital, to give it that prominence and to make sure everyone understands that this is where women's and children's care happens; that it has a separate entry and exit and so people coming there do not have to bother themselves with the rest of the hospital." That was behind the idea of it.

Decanting: maybe I have just picked up that term in all the work I have been reading. It is not about wine; it is about freeing up space. As we move some of those services out to that new building, it allows for the reorganisation and use of that space to occur to allow the rest of the hospital to be redeveloped.

MRS DUNNE: I have forgotten the numbers, but you said there will be 40 or 50 maternity beds and paediatric beds. If you are doing obstetrics, they would be, for the most part, general medical or surgical beds—not necessarily?

Mr Cormack: No, they are not now, and they never would be. Obstetric beds and gynae beds are specialist beds.

MRS DUNNE: Sorry, gynae beds are specialist beds; they are not just normal medical or surgical beds.

Mr Cormack: Correct, yes.

MRS DUNNE: So there is a gynae ward in the hospital.

Ms Gallagher: Yes.

MRS DUNNE: And that would be moved there as well?

Ms Gallagher: Yes, that is right. So we are not stealing beds from other parts of the hospital and putting—

MRS DUNNE: So how many gynae beds will there be?

Ms Gallagher: There are 45 maternity and gynae, so I guess that is flexible, depending on what the needs are. This will be done in the design. It is less about more beds, because the demand is not there for more beds, in this area; it is more about more appropriate space. One of the issues that I have had raised with me, and that people would be aware of, is women who have miscarried having to be on the antenatal ward where they spend the night listening to babies crying. That is something that we want to be able to address, so that there is more privacy and more choice for the nurses about where they locate people. At the moment, in the current configuration, we cannot really respond to that in an adequate way, and we will be

able to in this new building.

THE CHAIR: It would be the same for women who had a stillbirth too?

Ms Gallagher: Exactly. Those areas can be extremely happy places in the hospital and they can be extremely distressing, and at the moment we juggle that. The nurses on the ward do the best they can, but it is still not ideal.

MRS DUNNE: Could you, on notice, minister, perhaps give us some of the projections for the current bed allocations for those categories, but also the projections that show the demand?

Ms Gallagher: Yes, I am sure we could do that.

MRS DUNNE: I take your point that there may not be increasing demand. The other question, with your indulgence, Madam Chair, is: when you considered a women's and children's hospital, did you consider moving it to the Calvary campus because nappy valley has moved to the north?

Ms Gallagher: Everything was in the mix. I do not know whether it was specifically considered. It is difficult. I was asked, when I went out to Calvary, did I think of having a paediatric unit at Calvary and a few other questions. I guess it is economies of scale and the need to be, if we need to, near the tertiary services that Canberra Hospital offers, such as the helipad for CareFlight or intensive care facilities if they are needed.

We have got paediatric intensive care at Canberra Hospital. We do not like to use it too much, because we do not have the specialty there. If we need it on a short-term basis for children older than those that can go into the NICU, we do use the intensive care facility as they move out. We cannot sustain two units.

At the moment, the Canberra Hospital has all those other add-ons which Calvary does not have, which we would have to then re-create at Calvary. We would have to have a helipad, we would have to have paediatric intensive care. We do not have those at the moment and we do not have the numbers to support two units.

But I did say to Calvary, when we were out there, that I think we do need to look at paediatric emergency, because they are getting more and more paediatric patients coming through their ED. They can then be transferred to Canberra if they need to be admitted. Some of the special neonatal cots will go to Calvary as well, I understand.

Mr Cormack: Yes, the special care nursery.

MR SMYTH: The women's and children's hospital represents a third of the money you have put aside for the expansion of health services to help you to cope with the health tsunami, but you just said there is not an enormous expansion in the number of beds in the women's and children's hospital.

Ms Gallagher: It is $90 million of the first $300 million.

MR SMYTH: Yes, I appreciate the number. But is this not catch-up and better delivery of services rather than an enormous expansion of services to cope with the tsunami in regard to the women's and children's hospital?

Ms Gallagher: In terms of women's and children's health, we are building what our projections tell us we need to build. This is not a large area. This is not the biggest growth area. You are right. It is $90 million of what, in the end, will be in excess of a billion dollar program. I think $90 million out of $300 million looks different to $90 million out of a billion dollars. But it is an area of pressure, I think, for the community that uses it. It does need to be improved. The NICU itself, as we have just gone through, needs a comprehensive response.

There are those issues on how we deal with increasingly complex gynae patients and obstetric patients, how we offer them the environment they need. The expansion in bed needs will happen in other areas of the hospital, although this is a significant increase in non-admitted treatment areas. For babies, it is a big expansion, a 50 per cent expansion of what we offer babies at the moment. If you have got a sick baby in our NICU, you end up in Sydney or Brisbane or somewhere else. Creating a 50 per cent increase there will reduce the number of patients that have to go interstate, but it also means we can provide opportunities for interstate people to come to a state-of-the-art NICU as well.

MR SMYTH: Again, by those statements that we are currently sending people interstate—

Ms Gallagher: If we have to.

MR SMYTH: I understand the need for that. That does confirm that this is really catch-up to match existing need; it is really not taking a huge step forward for the future.

Ms Gallagher: No, I disagree. I think it is a huge step. We can deal with the maternity and gynae patients now and do nothing about this if we want. The beds are there. At different times of the year—I think after Ramadan and September—those areas are usually pretty full, but at other times of the year there is capacity. From my point of view, it is about making a fantastic facility for women and children, expanding services where we need to, and, more appropriately, responding to the complexity of patients that we see.

We could do nothing. We have chosen not to and I think it is a great thing for Canberra that, when this Assembly passes this budget, this Assembly will be saying, "We want a women's and children's hospital in Canberra," mindful of the fact that we could not support one on its own in a separate site like other cities. I think it is a mature response. And I hope that, in years to come, if I look around Canberra when I am doddering around in my wheelchair, going to my nice new aged care unit that will have popped up somewhere, I will see that and I will be proud of some of the decisions that this Assembly has taken. I think this will be one of them.

DR FOSKEY: I have got many questions, but I will start off with a general one. I understand that the items in this year's budget are based on a more comprehensive

forward plan. I am interested in the rollout for primary care walk-in centres, especially in the context of the one expressed criticism of the Health Care Consumers Association, when I asked them how they felt about the plan, that primary care has been largely forgotten in this budget. That was a point that was also made by the Youth Coalition and ACTCOSS. Could you please advise why primary care has received significantly less funding than other areas, the time frame and the terms of reference for the scoping study that is funded in the budget?

Ms Gallagher: Sure. I should begin by saying that we are not an enormous provider of primary care health services. That is an area where the commonwealth is providing, through GPs largely. But we have our community health centres and our allied health teams in particular. I understand the health care consumers' view. I think they have had this view of every budget since I have been health minister and that is because the acute end gets the big dollars. When it costs you $1.2 million to fund one intensive care bed, everything else pales not into insignificance but it looks a lot less. The $2½ million going to critical care capacity—

DR FOSKEY: Is that because primary health care is cheaper per capita?

Ms Gallagher: Nothing is cheap in health, but acute and critical care is very expensive. The $2½ million to critical care capacity buys you two intensive care beds. But this really is a step, a foot, into the primary care area for us. As I said, we are not huge providers of primary health care, and I know the health care consumers have a view on that. They think we should be.

DR FOSKEY: Who is?

Ms Gallagher: GPs.

DR FOSKEY: That is one aspect, yes. I do not want to get sidetracked.

Ms Gallagher: It is really the primary care walk-in centres, if it gets up and running, and the reason that we did not fund a full walk-in centre in this budget is that I just think we need to be sensitive about the discussions on how we make this work, because it is an area that particularly doctors will be very interested in. The idea is to have these facilities, the walk-in centres, as nurse-led facilities, whether we use our nurse practitioners or our advanced practice nurses. That is how they run overseas and I would really like to get the support of the doctors in the model that we move forward with, rather than just start something that puts other primary healthcare providers offside.

So the work this year will be just to consult, discuss, liaise with existing primary healthcare providers about the best model to get up and running, because, look, if I get the support of the healthcare providers for this then the chances are they will be a lot more successful than if there are disagreements and if GPs do not refer to walk-in centres. I mean, we actually need them to help us and say, "If you get sick later tonight, go to the walk-in centre down the road and have a chat to the nurse." The idea is to try and keep people out of our emergency departments.

DR FOSKEY: Yes.

Ms Gallagher: In the model we are looking at, and as I said, the indication is that we would really like to start this in Tuggeranong, so that we would have out-of-hours, extended hours, care provided by a nurse practitioner, perhaps, and a team, depending on what the demand is, to provide services around a number of agreed protocols. They would not be able to do everything, but they could look in your kid's ear and see if they had an ear infection, they could offer emergency contraception if you needed that, they could suture you if you cut your finger. There would be a range of agreed protocols that the doctors particularly would agree to that we would use and in a way it benefits us by not having them troop in to Canberra Hospital or Calvary. The idea, if it has got legs, is to have one as part of the Gungahlin Community Centre as well.

MR GENTLEMAN: Tuggeranong is a great place to start.

Ms Gallagher: I am sure.

THE CHAIR: As a supplementary to that, the extended youth services would be in the primary care area as well, would they not?

Ms Gallagher: Yes. We fund a number of non-government organisations to offer some of those primary healthcare services.

THE CHAIR: Yes.

Ms Gallagher: But ACT Health, under the ACT Health banner, is not a huge provider of primary care services. In a way, I prefer to look at these walk-in centres as almost outposts of the emergency department, so they link in to the emergency department. If someone comes to the walk-in centre and they need to go to the emergency department, the nurse will be able to ferry them off or give the ED a call and say, "This person is coming with their baby and they need to be seen." That is how I would like them to work, in an integrated fashion. But I do think there are some difficult discussions to have with the workforce around how this model should work, which is why we are taking this year to see if we can get agreement around the model and the way forward.

THE CHAIR: Mrs Dunne has a supplementary and then we will go back to your next question, Dr Foskey.

MRS DUNNE: On the subject of primary care, minister, and providing for a range of services outside emergency departments, and especially out of hours, did you in the budget contemplate extra funding for the West Belconnen Health Cooperative as a means of addressing some of those issues in the disadvantaged area?

Ms Gallagher: I have agreed to provide some money, not under the Health portfolio, because I think you will find if money is provided under the Health portfolio for subsidising of a private general practice facility, even as a co-op, it will set the GP land off. I did consult with a number of GPs, including the Division of General Practice and the AMA, over our response to the West Belconnen Co-op. As you know, discussions around it have been going on for some time. I then spoke to the West Belconnen Co-op around wanting to support their work, but the difficulty the

government has found, under the Health portfolio, was with subsidising one GP and not subsidising another. A number of GPs would welcome a $200,000 subsidisation from the government as well. In fact, that was requested from a number I spoke to who said, "Well, we would do very well if you would give us that same level of subsidy."

My response to the west Belconnen group was, "I will fund a portion of this"—I think they asked for $170,000, from memory—"but I will do it under my community services hat and I would like you to use that money for the other services to be provided at that site." They do not want it just to be a GP; they want it to have other aspects—allied health, perhaps child protection and social workers, and things like that. They said they would be happy with that; they could then use the commonwealth money—

MRS DUNNE: Which is not forthcoming?

Ms Gallagher: Well, the latest letter I got from Roger Nicholl was that it is still under consideration—$200,000 to fund the GP site—which I thought was more appropriate considering the commonwealth currently provides incentives and subsidies to GPs. I think it is a very dangerous move to use the ACT health budget to subsidise a GP service, because it will not be welcomed by every other GP in town, and that is the decision I took. They only ever asked me for $170,000—I think it was just under $200,000.

MRS DUNNE: It was about $200,000, a little less.

Ms Gallagher: I have agreed to provide that money. I think that was done in May or March last year.

MRS DUNNE: But, since then, the other $200,000, roughly, which is outstanding to get this GP and allied health clinic off the ground in west Belconnen has not been forthcoming.

Ms Gallagher: There has been a final decision on it, has there?

MRS DUNNE: Well, there was no money before the change of government, and at the moment the commonwealth is—

Ms Gallagher: Yes.

MRS DUNNE: It is contemplating what it will do with its regional partnerships money et cetera.

Ms Gallagher: The regional partnerships, yes.

MRS DUNNE: Although the ACT agreed to fund that money last year, and that is welcome, we are still another—how long is it, chair, since this has been going on?

THE CHAIR: The steering committee was formed before the last election.

MRS DUNNE: We have seen four years, a lot of community work, and still no GPs out there.

Ms Gallagher: I guess what I am trying to explain to you is the difficulty in the health budget for funding a GP service. If that happens, you will have angry GPs in this city, and that is something I am trying to avoid. It has been made very clear to me that that will be the case. I am trying to do whatever I can to support the co-op model—I think it is a good one—and I think there is a role for government to provide them with support for some of the other services that want to provide out there, and that is where I found the money.

If they want me to consider more money for that in light of the $200,000 not being made available, I would look at that, but I will have to draw the line on funding a GP. I cannot do it, because there are too many GPs stretched and under financial pressure with loans and practice costs that they are currently funding themselves who would see that as a very unfair response from the government and would equally seek a similar response for themselves. If there is a change of government in October, that would provide the next government with a significant problem.

THE CHAIR: Dr Foskey.

DR FOSKEY: Another general question. This morning we heard the AMA come out with a critique of the extension of the Medicare levy threshold. I was just wondering, given the potential ramifications, whether you, minister, were consulted when the federal government was coming up with that policy and whether you believe there will be any impact on the ability of the ACT to provide health services, either positive or negative?

Ms Gallagher: In relation to whether we were consulted, no, we were not, but that is not unusual. I did not consult the commonwealth over our budget; they do not consult us over theirs. It had not come up in discussions around the health care agreement, so it was, as it was to everyone else, news to me in the budget.

DR FOSKEY: Good news?

Ms Gallagher: I think it is obviously good news for some families who do not feel the need to take out private health insurance. I think it is hard for us to work out how this is going to impact, because we have the highest private health insurance rate in the country but the lowest use of it. People do not use it as much—

DR FOSKEY: We are profitable.

Ms Gallagher: They come to the public health system, perhaps because of a lack of private choices or whatever. We know that from all the national data. What I have said is that we will watch it over the next 12 months to see if there is an impact that we can attribute back to this decision. If there is, we would be looking for the commonwealth's assistance in that. I have heard some people say that there is an element of cost shifting here and that people will now come to the public hospital where the states and territories pick up the cost for all of the care where previously the federal government has done that through the rebate and through the cost of

pharmaceuticals and things like that. I think we just have to watch it.

The other thing for me is that we never saw an exodus from the public system. When the incentives around taking up private insurance were really pushed and people did take up private health insurance at a very quick rate, we never saw an exodus from the public system. It is just a very hard one to judge, but we are watching. I think all the other jurisdictions are watching too.

MRS BURKE: I have a supplementary to that, chair, if I may?

THE CHAIR: Yes, Mrs Burke.

MRS BURKE: Following on from that, minister, on 19 May you said on ABC radio what may seem to be a contradictory statement, because you did say you noticed the predictions are worrying. As you have just said, there was no great shift from the public hospital system when incentives were given. The alarming thing is, according to PricewaterhouseCoopers, more than 900,000 Australians will ditch their private health insurance, which is double Treasury projections.

Ms Gallagher: Yes.

MRS BURKE: Then you said, that whilst you were worried about the predictions, you noticed that on the surface it would not have a great impact on our public hospital system. You cannot have it each way.

Ms Gallagher: That is why I am saying it is difficult. I do not think, on the data we have seen and the experience we have, that it will have an impact, but I cannot predict into the future. That is what I am trying to say here. Based on what we know and what we have seen in the past, I cannot see that it will have an enormous impact, because our public health demand has been growing and growing and growing. There has been no decrease because of private health insurance. If there are going to be people opting out of private health insurance to this degree, the question is whether it will impact on the public health system. My honest answer to that is I do not know. It would not appear so, based on previous experience, but, if it does, we need to keep the door open to say, "Look, you know, you took this decision. We have seen the big growth. We need to be compensated for it."

MRS BURKE: Where are those negotiations up to at this point? Hopefully, you have gone in all guns blazing to the federal government.

Ms Gallagher: Sure. The health care agreement has been rolled over until July next year. The COAG decision is that the agreement should be finalised by the end of December, so those negotiations continue. The COAG working groups are also having a role in the health care agreement. I can guarantee you that we are going in for the best deal for the ACT that we possibly can.

MRS BURKE: In your best judgement, then, you say trends are worrying but it will not have a big impact. That is where you stand on this? You do not think it will be a big impact?

Ms Gallagher: The data from PricewaterhouseCoopers, the analysis, that is worrying to me if it is predicting double the exodus. But you could also say that the people who are not going to take out the private health insurance are the young and the healthy, in which case—

MRS BURKE: But I pick you up on that too, because they play sport and they get fairly hefty injuries which would impact—

Ms Gallagher: Yes, they could. But the healthy and the well are not really the drain on the public health system.

MRS BURKE: No; that is a given.

Ms Gallagher: The cost comes from those ageing patients and people with chronic disease. That is the burden. So, if the people who are not taking out the private health insurance are the ones who are not going to cost us a lot of money in the next five years anyway, we may not see a big impact. But it is hard for me; I am just honestly saying to you that I do think it is going to have an impact, but, if it does, I want to be compensated—the ACT should be compensated for it.

MRS BURKE: So that is your summary of how you are going to deal with that? You just have to wait and see and you will—

Ms Gallagher: Well, what else can I do? I cannot go to Nicola and say—

MR SMYTH: Yes, you can.

MRS BURKE: Yes, you can.

Ms Gallagher: I can in six months say, "Look, we have seen this big increase of people and it is largely attributed to that. Here's the data."

THE CHAIR: You have got to have data.

Ms Gallagher: I have not spoken to Nicola herself, but I have made a number of public statements, as have other jurisdictions. In fact, Nicola Roxon has said the same thing: she expects this to be part of the negotiations that we are currently having.

MRS BURKE: Just finally, you have seen increases in the number of public hospital presentations. How are you going to be able to distinguish the lines between that steady increase, and how would you apportion that? You will not be able to, I guess. Will it not be a case of you then perhaps trying to get the federal government to bail you out of a situation that we should be managing at a territory level?

Ms Gallagher: No. We try to best predict where we will see growth, and over the last two years we have seen growth in the acute area of around six per cent per annum. There are good, effective ways; health economics and health modellers have very effective ways of predicting growth and attributing that growth to whatever. There are tools that we would use to isolate that. But I do not think the commonwealth is going to come and bail anyone out who cannot justify the claim for increased resources. I

think the commonwealth understand that they need to put more money into public health. I think they are certainly already starting to do that, but it is not as if there is a blank cheque and away you go. That is not the way.

MRS BURKE: So that is not a failing of the states and territories, you do not believe?

Ms Gallagher: What is not a failing?

MRS BURKE: The federal government contributing more to health. You do not believe that we are mismanaging the system in any way?

Ms Gallagher: No, certainly not in provision of funds, which is the issue that we are negotiating under the health care agreement. Every publication which reports health expenditure will show that the states have been growing their health budget at probably just under 10 per cent per annum.

MRS BURKE: But we are more inefficient than other states and territories, or at least we are one of the most inefficient.

Ms Gallagher: If I could just answer your question about whether it is the states and territories that are letting it down rather than commonwealth. We know that, around the country, the state and territory health budgets have been growing at just under nine per cent and there have been decreases in the commonwealth's funding. I am not sure what the percentage is.

Mr Cormack: It has gone to under 40 per cent of contributions. It was certainly above that before; it was closer to a 50-50 split. But over the last healthcare agreement it has come closer to 40-60.

Ms Gallagher: And in relation to whether we are more inefficient, our costs are certainly higher, but they are coming down.

MRS BURKE: What are they at now?

Ms Gallagher: The last official published data that I saw was 115 per cent, coming down from 120 per cent. As you know, we have set ourselves a target of 110 per cent—that was two budgets ago—in five years.

MRS DUNNE: On Dr Foskey's question, minister, you said that it would be hard to see what the impact would be. Access Economics, in their report that has come out today, said that it may be hard to see a big impact because the people most likely to leave are what they call the Clayton's members in private health insurance, the young people who have got minimal cover. But as the community rating goes up and we see more people leaving because the premiums would go up—Access Economics predict by up to 70 per cent—that has a cumulative effect of driving up the community rating as more well people leave. Then you will also not see in the long term—and I suspect that you are right—an impact this year or next year; it might take a while for that impact to come in.

What are you doing here in the ACT to encourage people who have private health

insurance to use their private health insurance? If you are saying that maybe there are not enough choices for people, what are you doing to encourage people to use the private system and therefore take pressure off the public health system? We are paying for it, but we are not using it. Is that what you say?

Ms Gallagher: That is right. We have got a number of strategies in place because it is good for public health if people do use their private health insurance. The most effective strategy is on the ground, being asked to use it, when you come to the hospital. We do rely on our staff to ask—and certainly staff are asked to ask people—whether or not they have used their private health insurance.

Another strategy we have done is, in our elective surgery letter—and I was a bit worried about this because I thought it looked a bit tricky by half—we have added a sentence or two, advising them that if they use their private health insurance they may be able to have their surgery sooner in the private system. As I said, I was a bit worried. We did that about—was that about a year ago?

Mr Cormack: No, it was about six months ago.

Ms Gallagher: Six months ago. I was a bit worried about that because I thought it looked like me trying to halve our waiting list or something, and I was worried that people would get offended at our putting that in a letter. But I have not had one response back from having it included in the letter. We just have to see now whether or not more people are choosing to go in the private system.

MRS DUNNE: I honestly do not know the answer to this, but is there a role for you, as the Minister for Health, to encourage private providers to provide a more cost-effective package for people? A lot of people actually do the sums and say, "Yes, I've got private health insurance, but my out-of-pocket expenses are going to be this much. Therefore, it is really a matter of rationing one way or the other. Either I pay a large sum of money to have this service provided privately or I wait and have it provided in the public system."

Do you think that, as part of a means of encouraging people to use their private health insurance, we should be looking at working with the private providers, the private doctors, the private hospitals, and the private health insurance organisations, to provide the consumers with a package, where there is not quite so much out-of-pocket expense and that that out-of-pocket expense is predictable?

Ms Gallagher: I would not see it as part of my role. It may be something that the federal minister, who has more relations, statutory and otherwise, with private health insurance, may have more appropriately. It is difficult running a public system. Everyone is entitled to come and be treated in the public system, regardless of whether they have private health insurance or not. I am reluctant to do anything more than we are already trying to do on the ground on that. We are trying to gradually increase our private uptake.

I know, from some of the doctors' views of the redevelopment of our hospital, that they are saying to me, "Make sure you build, in the new part, large and private rooms so that you can actually offer patients, if they use their private health insurance, a

private room." I think that does help a bit but, aside from that, probably the majority of the new beds in the new hospital will be single rooms anyway, for infection control reasons and otherwise.

At the end of the day, I think it is difficult, because private hospitals need to make money. We see how expensive running a hospital is. Then they have to get that money.

MRS DUNNE: You do not see that you have a role to do away with the disincentives?

Ms Gallagher: No. I honestly do not think it is my role but I do think we need to—

MRS DUNNE: We could possibly debate that but this is not the day.

Ms Gallagher: Yes. I think we do need to increase—what is our private health usage, do you know?

Mr Cormack: It is 5.6 per cent of admissions to a public hospital that are covered by private health insurance, against a backdrop of 55 per cent of the community that actually have private health insurance. But I think that underscores the minister's previous point that it is already pretty much at rock bottom when you compare the ACT with the other jurisdictions and that is, in part, because Canberrans choose—

MRS DUNNE: How does that compare with other jurisdictions?

Mr Cormack: It is lower.

MRS DUNNE: Could you provide us those figures? On notice is fine.

Mr Cormack: I can give that to you right now. The national average is 7.8 per cent. Obviously, some states are high. New South Wales, I think, is the highest.

DR FOSKEY: Is that possibly a judgement of the systems as well?

Mr Cormack: Yes.

DR FOSKEY: People choose the public health system, even though they can afford an option. They are actually claiming faith in the system. I would just take that as a claim and look for more money federally, basically.

Ms Gallagher: We would like to get it to the national average. We would like to get our private health usage up to that.

MRS BURKE: That is a good point and I think there is a fine balance between all of these issues that are facing us. Certainly to increase private health insurance is the way to go. How are you going to combat, therefore, what the commonwealth are trying to do at the other end, to give more people the option to opt out? Are you going to be tackling that with Nicola Roxon and say, "Revisit it"? There is a balance somewhere in between. I guess that there are 100,000 and 150,000, respectively, for singles and couples. Maybe it is just a bit too hard; maybe we do need to lower it

again. Have you thought about that? I do not know whether you have.

Ms Gallagher: I think what we saw under the commonwealth funding decisions on health in the last, say, five years was that enormous amounts of public money went into the private health insurance rebate. An enormous amount of money, billions of dollars, went into funding the private health insurance rebate. If we can get some of that money back into the public system, that is what I would prefer and that is what I will be keeping an eye on in case we do have increases in our presentations and we can attribute it to this decision. Instead of funding the rebate, which they will not have to do for a number of people now who opt out, that money should come back into the public system, which is where people are choosing to come.

MRS DUNNE: There is not going to be very much money if you believe Access Economics.

MRS BURKE: No. It has put you in a bit of a predicament, I would suggest, because, as you said on ABC, you were very surprised at the commonwealth doing that; it was almost like you did not know about it.

Ms Gallagher: Yes, but that is what budgets are about.

MRS BURKE: I would have thought that they should have consulted with the states and territories before making such a big decision again.

Ms Gallagher: I would be surprised if any government consults with other governments on their budget decisions.

MRS BURKE: Confidentially, I mean, with the ministers.

Ms Gallagher: I have never done it.

DR FOSKEY: Your budget would have less impact on the federal sphere than theirs has on ours.

Ms Gallagher: I know, but the same rules apply on cabinet confidence and those decisions and how those decisions are made, regardless of the size of the cabinet.

MRS BURKE: So it was a complete surprise hen?

Ms Gallagher: Yes. I have already said that. It was news to me, the same as other elements in the budget. As I said, our budget was a surprise to them.

MR SMYTH: We spoke to the corrections minister yesterday. One of the questions was: what is the provision of health services for the prison and how much will it cost? Under the act that we passed, these services will be provided through the health budget. Can you outline how much money there is in this year's budget for services to the prison and what a full year is worth? What services will be provided and how does that impact in terms of doctors, nurses and others?

DR FOSKEY: Can you add "who will provide them?"

MR SMYTH: And who will provide them?

Ms Gallagher: I was just having a look. It is in the budget papers, at 377. It is just under a million dollars for this year—and that is to get it up and running—and then it grows a little bit in the outyears. The idea is to have nursing services on site at the Alexander Maconachie Centre for 14 hours a day, which is more than I understand is offered at the remand centre at the moment. I am not sure whether there is someone who can more adequately explain the service model.

Mr Cormack: Before Ms Reading takes her place, the amount appropriated in budget paper 3 is the additional cost.

Ms Gallagher: On top of?

Mr Cormack: Yes, it is not the total cost.

MR SMYTH: Could you tell me what the total cost is?

Ms Gallagher: Sorry, I misunderstood your question.

Mr Cormack: We can give you the precise detail on that on notice, if that is okay.

MRS DUNNE: Could you break that down by what is provided at Belconnen and what is provided at Symonston?

Mr McCormack: We will give you the breakdowns that are available to us. I am not sure that it goes down to everything.

Ms Reading: At the beginning of 2007, we recruited a staff specialist who has expertise in prison health. His name is Dr Michael Levy. Since that time, we have been transitioning with our key partners in DJACS to enhance the health services that we will be providing at the Alexander Maconochie Centre. They primarily relate to an extension of the general nursing services, with an extension of the times that we are actually providing those services.

We have a sound core group of VMOs who are providing general health clinics; that will continue. We have an increased focus on dental services in the jail. We also have a purpose-built facility to provide those services. That will also give us the opportunity to provide a full range of treatment care to prisoners housed at the Alexander Maconochie Centre.

Currently we provide emergency services to prisoners on remand, but that is not fulfilling the full range of health care and it is a major issue for prisoners. We will also be having a significant increase in pharmaceutical services on site, particularly around opioid replacement therapies. We will also be having an increase in mental health services, with psychiatry and nursing.

As I said, we have been working closely with our partners in DJACS. We have a very committed team and a firm planning cycle for how we will start to commence the

assessments. In fact, we have started commencing assessments from 120 prisoners that will be coming from New South Wales so that when they arrive we have engaged in the assessment process and can try to provide a level of service that they can expect in the community. We will also have a focus on commencing with some surveillance of population health in terms of communicable disease. And we will be looking at having a firm program to assist with transitioning into the community.

DR FOSKEY: Will you be using any of the community health providers—for instance, Winnunga Nimmityjah and other providers—or will the services be directly through ACT Health's various services?

Ms Reading: We will be working very closely with Winnunga. Clearly, there is a representation of the client group—an over representation, actually—at both the Alexander Maconochie Centre and the new Bimberi centre. We have specific expertise by Dr Peter Sharp from Winnunga, who continues to provide those services currently. We will enhance the level of service provision that he provides in both centres when we commission. We have got a bit of a lead-in time, which will give us an opportunity to commission and decommission the Quamby services and slowly build ourselves up to provide the best model of care that we can.

DR FOSKEY: So the model that you talk about applies to Alexander Maconochie and Bimberi.

Ms Reading: Bimberi as well, yes.

MRS DUNNE: And the PDC as well?

Ms Reading: The periodic detention centre employs separate medical services.

DR FOSKEY: Through corrections?

Ms Reading: Not through ACT Health.

MRS DUNNE: Why is there that disjunction there? If, legislatively, Health is providing services to Bimberi and Alexander Maconochie, why is it not providing them to the PDC?

Ms Reading: I would appreciate taking this on notice so that I can get you the appropriate information, because my focus has been on the health services.

THE CHAIR: That is fine; we will take that one on notice.

MR SMYTH: So we will have one doctor full time and devoted to the prison?

Ms Reading: We most definitely have. He is in charge of a multidisciplinary team. That is also complementing a range of other medical specialist services that we will be providing there as well as general practice services from VMOs.

MR SMYTH: The nursing workforce—14 hours a day. How many nurses will be on-site 14 hours?

Ms Reading: We will be increasing the nursing staff, but we are having a change around of shifts—rotating shifts, starting from 7.30 and increasing to a 14-hour shift. For our nursing services, general health services will be increasing by three FTEs. There will also be an increase in the mental health nursing service by a further two. So it is an extra five staff in nursing services.

MR SMYTH: So general nursing plus three will go to a total, therefore, of how many FTEs?

Ms Reading: We have currently got five.

MR SMYTH: So you will have eight nurses.

Ms Reading: Yes, we will have eight nurses providing the service. And that is just for Alexander Maconochie.

MR SMYTH: And how many in mental health services currently?

Ms Reading: Currently we have one mental health nurse; we will be increasing by another two full-time equivalents.

MRS DUNNE: That is for AMC. What is going to happen? What is the staff profile in Bimberi?

Ms Reading: Because there is a smaller group of young people at Bimberi, we will be increasing our nursing services by one full-time equivalent—and the status quo for the mental health services.

MRS DUNNE: And the status quo is what at Quamby?

Ms Gallagher: A part-time position.

Ms Reading: Yes, a part-time position.

MRS DUNNE: What is the current nursing establishment for Quamby?

Ms Reading: We share. We do rotate some of those staff through Quamby. We have a full-time equivalent at Quamby.

MRS DUNNE: Just one FTE?

Ms Reading: Yes.

MRS BURKE: Can I make one very quick point? Did you say 14-hour shifts for the GP at AMC?

Ms Reading: No, this is the nursing service.

MRS DUNNE: It is a 14-hour spread of service?

Ms Reading: Yes, shifts covering 14 hours.

MR SMYTH: But the shift will cover 14 hours.

Ms Reading: It will cover 14 hours.

MR SMYTH: One person will do a 14-hour shift.

Ms Reading: No; we will have a range of shifts.

MR SMYTH: In regard to the fit-out, major surgery will be taken to the hospital, I take it, as per normal?

Ms Reading: Yes.

MR SMYTH: Dental will be conducted on site?

Ms Reading: It will be conducted on site; we have a purpose-built facility.

MR SMYTH: What other facilities are there? Minor treatments will be conducted on-site?

Ms Reading: Yes, by the general practitioners providing visiting medical officer services.

MR SMYTH: As per a GP clinic.

Ms Reading: Yes.

MR SMYTH: Drug and alcohol rehabilitation?

Ms Reading: Yes.

MR SMYTH: What services will be provided?

Ms Reading: We currently have expertise via general practitioners. They are prescribing general practitioners, so they have expertise in that. We also have non-government organisations providing therapeutic and group work. There is also access by the services that are provided in our alcohol and drug program now.

DR FOSKEY: Could you provide the names of the MDOs that are providing therapies?

Ms Reading: Can I take that on notice?

DR FOSKEY: Yes.

Ms Reading: Can I retract "therapy"? They are providing group work and support.

MRS BURKE: Therapeutic goods and services, did you say?

THE CHAIR: No, she did not.

Ms Reading: Therapeutic services will be provided by a health professional.

MR SMYTH: In regard to–

THE CHAIR: We are going to a break, Mr Smyth.

MR SMYTH: I can finish this if you like. Mental health services—what percentage of patients are considered to have mental health problems?

Ms Reading: Could I also provide that on notice? I would confer with my colleagues.

Ms Gallagher: I think you are doing the assessments now, aren't you?

Ms Reading: Yes. We do have a mental health team that do those assessments, but the percentage of patients were detainees, so I could not provide that.

THE CHAIR: It is five past.

MR SMYTH: And what was—

THE CHAIR: Mr Smyth, we are stopping here.

MS MacDONALD: You never give up, Brendan, do you?

MR SMYTH: I just want to finish the point.

THE CHAIR: No, we are stopping. It is five past 11. I am letting the minister go to her morning tea break. I have released the minister and everybody else. I ask the members to stay behind for two seconds while we make a decision about our timing. Thank you very much, minister and officials.

Meeting adjourned from 11.05 to 11.37 am.

THE CHAIR: We had some discussions about continuing on through the overview until 1 o'clock, the lunch break, and then going on to 1.1 and 1.2, but, because there is a need to do 1.3 today, we will do overview till 1 o'clock and then we will do 1.1, 1.3 and then 1.2.

Ms Gallagher: Thank you very much. Mr Cormack has some questions that he can answer.

Mr Cormack: Yes, in relation to the question about the audiology services, I confirm that we do currently employ an audiologist on a sessional basis for the newborn screening program. We will expand the sessional availability of audiology services once the booth and equipment are installed. That is anticipated to be completed within three months and, depending upon the final demand that will emanate from the

completion of that work, we will then reassess the amount of audiology hours we need, whether it is sessional, part time or full time.

In relation to what does CARM mean, I am advised that CARM is not an acronym; it is the name of the training course but it is spelt CARM. That is what threw me and I apologise for that; but I can tantalise you with another acronym that is under that program, and that is PART, which is the professional assault response training program, and that is another part of the way we equip our staff to deal with de-escalating behaviour in the workplace.

THE CHAIR: I was sharing with the minister during the morning tea break how I could have done with that myself as a registered nurse at some stage—

Ms Gallagher: Or the patient could have done with it, I think, Mary.

THE CHAIR: or the patients could have done with it.

MRS DUNNE: I do not know that we should dwell on the chair's deep dark past as a—

THE CHAIR: No, we will not.

MR SMYTH: Minister, I understand you gave some briefings to the staff at Canberra Hospital and Calvary on the capital redevelopment program. Was there a PowerPoint presentation or documentation that went with that?

Ms Gallagher: Yes, there was.

MR SMYTH: Is it possible for the committee to receive a copy of that?

Ms Gallagher: Yes, I cannot see why we cannot provide it.

MR SMYTH: You have got $300 million over the next four or five years for works primarily at the Canberra Hospital and you have said today that over the next 10 years $1 billion will be spent on developing the hospital system in the ACT. It has been put to me—and I do not know whether it was a wish or a hope or a fear—that, in effect, building 1, the main tower building, will be ultimately demolished. Is that what is being proposed?

Ms Gallagher: I do not think it is. I think in the overall plan the idea is that that will be used for more administrative; is that right?

Mr Cormack: The main tower block at Canberra Hospital: in the preliminary planning that we have done—and of course there is still more detailed planning to be completed—it is anticipated that a portion of that would be for administrative staffing but the major part of the tower block would be reconfigured for subacute inpatient accommodation. So it will remain a ward block, but it will be reconfigured to bring it up to contemporary and future standards in relation to single rooms, space of rooms and those sorts of things. So it will be quite significantly refurbished.

MRS DUNNE: I appreciate that there is only preliminary thinking about how to spend this billion dollars over this period of time. In this preliminary sense—I am emphasising "preliminary" because I do not want someone to come back in three years time and say, "You said on this day"—what is your thinking about what the campus would look like in 10 years time? Where are the operating theatres going to be and where are the acute beds going to be—that sort of thing—and their proximity?

Ms Gallagher: Essentially, the major rebuild would happen on what is known as building 3, so the flat bit—

MRS DUNNE: That is that long, flat one that goes out to Hindmarsh Drive?

Ms Gallagher: and that would be created into a new tower block. That would contain the acute ward areas and operating theatres, intensive care; all of that would be within a new tower block.

MRS DUNNE: So what happens to the existing operating theatres that are in the wavy building? It probably has a technical name.

Ms Gallagher: The new part of the hospital, yes.

Mr Cormack: The conceptual design at this stage is to articulate that with the new tower block, so we largely retain the existing operating theatres, but through an articulation process with the new tower block we will be able to refurbish the operating theatres, expand and create new operating theatres and create an articulation with like a hot floor concept, which would pick up on ICU, HDU et cetera.

MRS DUNNE: Okay.

Ms Gallagher: This map in the back of that book that we put out on budget day does not show you the tower block but that shows the creation of precincts within the campus.

MRS DUNNE: I do not think we saw that during the budget—

Ms Gallagher: You have not seen this?

MRS DUNNE: No.

Ms Gallagher: I have been giving it out to everyone. Sorry.

MRS DUNNE: Not to members, though.

MS MacDONALD: I have got a copy. Would you like to look at my copy?

Ms Gallagher: I thought it got handed out with the budget papers.

MRS DUNNE: No. It certainly was not in the budget box.

MR SMYTH: Perhaps you could provide a copy to the committee and distribute it

around the Assembly?

Ms Gallagher: Yes. I am very sorry about that. There was no secrecy around it. This gives you a map which shows the creation of precincts and the creation of a hospital street et cetera within the TCH grounds, trying to better use the space we have got and make it more pedestrian friendly, in a sense so that people who have to go to the cancer area do not have to deal with the rest of the hospital. They can go to unique precincts within the precinct.

MR MULCAHY: How many more parking bays will you have under the new plan?

Ms Gallagher: The new multistorey car park, which will start construction around November this year, will create 1,400.

MR MULCAHY: So it should take a lot of pressure off the neighbourhood streets in Garran?

Ms Gallagher: Yes.

MR GENTLEMAN: My question relates to infrastructure expenditure as well, minister. On budget paper 5, page 54, there are some new fundings for a surgical assessment planning unit. Can you tell us what benefits you hope to bring to the ACT community with that expenditure?

Ms Gallagher: Sure. The surgical assessment and planning unit is going into an area that is largely taken for administrative uses at the moment within the hospital; it is near the emergency department. It is quite a large space but we continue to evict administrative people, even though they have a very important job to do, from areas that we think can be better used for clinical purposes. It follows on from the MAPU, the medical assessment and planning unit.

MS MacDONALD: So this will be the SAPU?

Ms Gallagher: Yes. We look at reasons why people may have long stays in the emergency department. While we have alleviated some of the pressure around medical beds, the pressure is now for surgical patients, so this is built on that same model—a short-stay area, a ward area, where people can either get in, get their treatment and go home or come into that unit and get moved to another area within the hospital.

It is going to be very closely located to the existing emergency department, and it is something that we can do straightaway. It is part of the 10-year plan, but it is something that we can have up and running, I think, in the next 14 months or so. Once the refurb is done, we can have it up and running and create that additional bed capacity, another 16 beds, which is on top of the 25 beds that this budget funds as well.

So we have funded in this year's budget 20 acute beds, three cancer beds and two critical care beds. If we add them onto the other beds, we are heading up now to well over 800 beds—about 830 I think—which is a significant increase, and we know that it helps us meet some of the demand and pressures we are seeing in the emergency

department.

MR GENTLEMAN: Do you expect people will go straight to the SAPU?

Ms Gallagher: At the moment they will come into the emergency department but MAPU is linked by a screen to the emergency department so they can see when people come in. It might say "72-year-old woman" with question mark, question mark for what the diagnosis is or treatment is. The staff from the MAPU can ring the emergency department and say: "She looks like she would be eligible for one of our beds. We will come down and bring her up straightaway." They can come in that way.

The SAPU would work on the same model. They would be linked in, they can see and remove patients—go down there and physically take them up.

MRS BURKE: Does that have an impact on the emergency medicine unit beds?

Ms Gallagher: Has it had an impact?

MRS BURKE: Will it, because we will be keeping people there much longer than the suggested 23 hours, and you have said that that is fine. In the overall scheme of things, is this going to impact upon that—those beds used being used primarily and specifically for what they are intended for?

Ms Gallagher: I think it adds to our capacity. From my discussions with emergency department staff—and I have recently been there again—they are very strict about what patients get admitted. They have to fit certain criteria; otherwise, that unit would not work because, if there was pressure in the emergency department, it is a place where you could just move people. So they are very strict about who goes to that unit. This will enhance their ability.

MRS BURKE: So it means they will not be staying there longer than the 23 hours; patients have been reported to have been staying there too long.

MRS DUNNE: It becomes a little difficult. We have got the ED, the EMU, the SNAFU, the—

MS MacDONALD: No, no, there is no SNAFU; you just put that in.

MRS DUNNE: The MAFU, sorry. Would it be possible to perhaps provide the committee with a sort of—

THE CHAIR: List of acronyms.

MRS DUNNE: No, not just a list—more a mud map. How do these things fit together and how are people articulated through these systems? You do not necessarily go through all the gates and so on. That would be useful.

Ms Gallagher: I am not sure how—we can talk you through it—

MRS DUNNE: It is hard to talk through—

Ms Gallagher: Everyone comes to the emergency department from there. The surgical assessment and planning unit is not up and running yet, so nobody goes there because that does not exist; that is funded in this year's budget. When you are in there, you are assessed as to where you go. You may go to a ward, if you need admission. So there is a group that do not need admission but we are talking about the group that do need admission. If they are a paediatric patient, it is obvious they would go to the paediatric ward.

The medical assessment and planning unit takes, primarily, patients where it is not clear where they should go; either they are complex medical patients or they are elderly but they have a medical issue that compounds that. They might have multiple doctors involved in their care. There may be pressure in other wards.

MRS DUNNE: So it is entirely medical?

Ms Gallagher: Yes. For example, if the oncology ward is full and the medical assessment and planning unit has beds available, it may take that patient for a short period of time before they move to the oncology ward.

MRS DUNNE: So is it possible that somebody might not necessarily come into the medical assessment ward and that they may, from time to time, service an overflow from other medical wards?

Ms Gallagher: They, again, have pretty clear criteria about what patients they can and cannot take. The idea is to have a short-stay ward of 72 hours, I think, before you either go home or you go to another area of the hospital. But I could not say whether at times, if the hospital is full—it is full today, it was extremely full yesterday and the medical assessment and planning unit is full—that they have not got patients there that would normally have gone to another ward. We are using every bed that we can possibly use today because the hospital is so full. Calvary is full, too, and so are both the private hospitals. I do not know what is happening at the moment.

MRS DUNNE: The SAPU?

Ms Gallagher: The surgical assessment planning unit will take surgical patients.

MRS DUNNE: We had an instance recently, minister, where somebody needed orthopaedic work done and they were in and out of the emergency unit for quite a lengthy period of time. I had constituent representation, Mrs Burke did, and I gather your office did. That sort of patient might go in and out of surgery and be dealt with and then sent home rather than going into an orthopaedic ward or something like that?

Ms Gallagher: Yes, if they do not need to.

MRS DUNNE: Yes.

Ms Gallagher: Or, if they need a longer stay, they could go from the emergency department to the surgical planning unit, which essentially is just a ward, and then have their surgery. If they need, then, to have a longer stay in hospital, they would

probably go to the orthopaedic ward, if it was an orthopaedic matter.

MRS DUNNE: Yes, I was just using that as an example.

Ms Gallagher: But surgical patients is the area. Now that we have addressed some of the long stays in the ED of medical patients, it has now created quite a clear contrast with the surgical patients, who are not always able to get on to a ward to await their surgery in a timely fashion.

THE CHAIR: Mr Smyth, you said you wanted to go back to something where I cut you off.

MR SMYTH: In regards to the infrastructure, how will you deliver this infrastructure over the next three or four years and over the next 10 years, given the government has got such a poor record of delivering health infrastructure? For instance, the step down geriatric facility took six years. The mental health facility was announced in 2005 to open in 2008, and we are yet to see a plan let alone turn a sod. I note on page 170 of budget paper 4 there are a significant number of rollovers for small and medium sized projects. How can we have any confidence at all that you can actually deliver this?

Ms Gallagher: I do not agree with your statement leading into the question. I think ACT Health has got a very, very good record of delivering large projects and delivering on time and usually within budget. We have set ourselves an enormous task; I do not disagree with that. But we have to deliver this, and any government in power has to deliver this program—it is not just our government—otherwise we are all going to be in a lot of strife in 10 years. We will deliver it, as we delivered the linear accelerator project, a huge project. That $30 million project is opening in July, on time and on budget.

MR SMYTH: There is $44 million in 2008-09 and in 2009-10 there is $94 million. I put to you that there are a number of projects—

Ms Gallagher: Which number are you reading from?

MR SMYTH: Budget paper 5, page 33.

Ms Gallagher: I am sorry, I have got my two working documents; I did not bring the budget papers with me. Page 33?

MR SMYTH: Yes. For instance, $90 million for the women's and children's hospital. How much of that has been done? Are there plans? Is it ready to start? When will it commence? When is it expected to open?

Ms Gallagher: Part of the appropriation for the women's and children's hospital is to fast track the forward design work. You can see across here it is $4 million being provided to ensure that we are doing that on time. I think when you go through the reasons for the rollover and you go through those individual projects that you have talked about, the mental health project has been talked about for a long time, but this is the first year that we have actually provided the money to actually move to the construction phase. We have spent the year doing the design work, so I do not see that

that is a delay around delivering a capital work.

MR SMYTH: If you go back to Mr Corbell's original announcement in 2005, it was to open in 2008, and you have just admitted yourself this is—

Ms Gallagher: Yes, sure, but that ignores some of the issues that you are very well aware of, Mr Smyth, around disagreement about what type of facility—

MR SMYTH: So why would the government make the announcement in 2005 if it was not ready to roll?

Ms Gallagher: Well, that was all those discussions. I do not think Simon knew when he made that announcement how strongly the consumers and the people who were going to use that facility felt about an appropriate type of facility. I have said before, I have spent over a year talking to them about how we best deal with this, including saying, "Instead of providing the construction money in last year's budget, how about we just provide the design money so that we can keep you on this journey as we move forward to getting agreement." Now we have got it we are making the money available, and I do not see that there will be—

MR SMYTH: The design money has been rolled over, has it not?

Ms Gallagher: Some of that money has been rolled over, yes.

MR SMYTH: Well, there is $2 million against the acute in-patient, and there is $1 million against the secure adult, and it has all been rolled over?

Ms Gallagher: I think that is not that the work has not been done but that the bills have not been issued and so payments have not been made. It is not necessarily a sign that the work has not been done. The work has been done; it is continuing to be done. That is simply a statement, in that instance, of where bills have not been paid. We roll money over and you pay them when they come in. I can get Ron Foster to talk about some of the other projects, but I do not think that you can say in the health area that they have a bad record on delivering capital works. I think they have got a good record.

Some of the delays, as I said, are not down to inability to manage a project and construct it; it is around other issues in health, which we deal with all the time and which are largely around consultation and involvement around the project as we move forward. A large proportion of this $300 million is put aside for all of those next stages: definition planning, consultation, moving forward with everybody before we make the next allocation next year, which we will, or which the government of the day will have to make.

Mr Cormack: If I could just add to the minister's comments. The capital asset development plan is an overarching blueprint which really provides us with the framework for the development of all of our sites. A number of the items were rolled over in order to complete the overarching site plans. I mean, you would not want to put the car park in the wrong place by not working out what the overarching site plan was for the TCH campus. A number of those delays, or rollovers, are for precisely the

right reasons—that is, to make sure that the money that is invested in creating already approved infrastructure projects fits in with the plan that takes us through to 2021 and 2022. That work–

MR SMYTH: Surely when the bid is made to cabinet that work has already been done?

Ms Gallagher: No, it was not, and I have already explained that in relation to this. The adult mental health and the secure mental health and the neonatal intensive care and the multistorey car park, in fact, were all bids from the previous budget in order to get it ready for forward design. It was around budget time last year that I asked for this overarching plan to be commissioned, and it was funded in the second appropriation. Naturally, it was at that point where I actually asked the question about what happens when we cannot fit another 20 beds into TCH. Just from being a layperson walking around, I could see there is a limited amount of space, and I had a discussion with Mark about how we needed to look at this. We commissioned some work, and that did impact on those four projects in the forward-design capacity.

When the NICU went through the budget process, which was December-January 2006, we never envisaged a women's and children's hospital and that the NICU would be part of that. We funded design work around redesigning the area that they were currently in. As soon as we started on the capital asset plan we put that on hold because we saw what we were going to get, which was a bigger picture. In fact, we have moved the neonatal intensive care unit into another place in the hospital. That has delayed some of that work. It is unfortunate, but it is a better outcome; it will be a better outcome in the long run.

MR SMYTH: Well, for instance, the work Mr Corbell did before you became minister, has there been any money wasted or design work discarded on the project that Mr Corbell envisaged as opposed to the project that you will deliver?

Ms Gallagher: No, because for mental health it was always envisaged that that would go up in that back part of Yamba Drive and Hindmarsh Drive, so not to my understanding.

MR SMYTH: So the actual forward planning, the design for the facility started when? It was announced in 2005 to open in 2008, so when was the actual design—

Ms Gallagher: The forward design started in last year's budget when the money was appropriated for it.

MR SMYTH: Okay.

THE CHAIR: Mrs Dunne.

MRS DUNNE: You gave the example of the NICU and putting those changes on hold. We have just made a big investment in radiotherapy.

Ms Gallagher: Yes.

MRS DUNNE: Are we sure that that is not going to end up being moved in the process?

Ms Gallagher: No way. We have built a massive $30 million bunker there.

MRS DUNNE: It is a great big hole in the ground, yes.

Ms Gallagher: It is not any more; it is a very nice building, but it has a great big hole in the ground. In fact, that has fed into—

MRS DUNNE: This is not a very user-friendly map, really, and the colours do not match, but it is over there in that bit. It does not—

THE CHAIR: I do not think Hansard can transcribe that, Mrs Dunne.

Ms Gallagher: It is the white bit.

MRS DUNNE: It is the white bit, thank you.

Ms Gallagher: Yes, and that would be the cancer centre.

MRS DUNNE: So that would become a cancer centre.

Ms Gallagher: So when we build the integrated cancer centre, that will be around that facility.

MRS DUNNE: Okay. So that is the core.

Ms Gallagher: Yes, that is fine. In fact, that has been the start of this overhaul. When someone looks back at this in 15 years and asks what was the first bit that was done, it really is the linear accelerator that kicked off all the rest of this work.

MRS DUNNE: Because it is a bit of a warren at the moment, but, yes.

Ms Gallagher: You should have a look at the new building; it is fantastic, the new cancer area.

MRS DUNNE: Yes. Getting there at the moment is a bit of a challenge, but yes.

THE CHAIR: Mrs Burke?

MRS BURKE: Thank you, chair. Minister, on 2 May, this year, a member of the public reported a number of serious breaches of health and safety regulations in the wards and corridors of the Canberra Hospital. As you all know, a WorkCover inspector issued a prohibition notice on 1 May, which required the builder to rectify breaches before the work could continue. I make mention of this and allude to BP4, page 145, looking at the eight stated objectives of ACT Health. Three key ones that stand out in relation to this matter are: improved patient safety and quality of care; keep staff safe and healthy; manage environmental risks to ensure the safety of all people on ACT Health premises.

Minister, what are you doing, considering the ongoing works at Canberra Hospital, to minimise the risk to patients from this building work inside the Canberra Hospital, particularly those with heart and respiratory conditions and those with visual impairment? Why were patients allowed to be covered with concrete dust in some cases and subjected to high levels of noise from concrete drills being used in the same ward?

Mr Cormack: I am happy to take that question, through you, Madam Chair. In relation to your first question, which is how we are going to ensure that in implementing this infrastructure development program we do look after the workplace safety of staff and obviously the safety of patients and visitors. You will see in the breakdown of the major infrastructure program that there is a significant amount of funding there for both project definition planning and also for phase 1 clinical services redevelopment.

MRS BURKE: Could you define "project definition planning"?

Mr Cormack: Project definition planning is really recognising that there are various stages. With any capital project, there are various formal stages that we go through. The first stage is to identify the needs for the service and that is a preliminary service planning exercise.

The second stage is the development of a service plan and, certainly over the last couple of years, we have spent a lot of time and effort getting our service planning right. That helps you shape up the way your services are going, to respond to the needs that you identified in the first phase.

The third phase then is a procurement feasibility plan, or a PFP. The PFP enables us to translate, in an indicative sense, the service planning into a business case that identifies broadly what objectives we are proposing, how those objectives will be met, what are the means by which it will be delivered and what are the indicative costs. It effectively enables us to prepare a business case.

The next stage, which is the project definition plan, is a very detailed and intensive program of detailed design. It involves, obviously, a lot of input from architects, engineers and cost planners and it also articulates a plan to secure the staffing and the necessary resources and the costing thereof. So with any major construction project, even though it may be called different things in different industries, the PDP or the project definition plan is the final detail blueprint upon which you then go out to tender in terms of designing and constructing buildings.

It is a key component of the $300 million that has been appropriated in this budget, and the PDP will enable us to finalise the women and children's precinct, do the detailed design on the cancer centre, the tower block, the operating theatres, the community health centres and the work at Calvary; so it is a very important piece of work. In that phase, and in fact in the phase before that, we will address the important issues of being able to safely continue to provide services to the community while we are undertaking construction work on the site.

MRS BURKE: Do you believe that has failed in this instance that I am referring to?

Mr Cormack: I believe that there was a minor matter.

MRS BURKE: It was not minor. They were actually issued with a notice, which is probably—

Mr Cormack: And it was withdrawn the next day.

MRS BURKE: That was after weeks.

Mr Cormack: The action by WorkCover was an appropriate response, based on the details that they had received. We worked with them the following day and it was literally resolved.

MRS BURKE: Who is watching the contractors as they perform? Some of the matters that were raised include grinding machines being used on concrete floors, carpets being pulled up with no effort at containment, no isolation controls, hazards such as leads and electrical tools lying in corridors, a gas bottle being used in a public area, no signs until after the complaint by a member of the pubic notifying the name of the construction firm. Do you think that is satisfactory building works in progress?

Mr Cormack: If those were substantiated, there would be a problem but most of them—

MRS BURKE: They were, because they were given a notice to shut down, were they not, to cease operations on that?

Mr Cormack: And once those were investigated in detail, the actual problem was much more minor than you have outlined. It was rectified literally within a day and work was able to continue. There was an issue—

MRS BURKE: I do not accept they were minor works.

Mr Cormack: There was an issue with the supervision of the subcontractor by the head contractor. We have taken that matter up with them as part of our responsibility and we have an undertaking that that sort of incident will not occur again.

MR MULCAHY: Was public safety ever at risk during the works that were—

MRS BURKE: I need to finish my line of questioning.

MR MULCAHY: I had a supplementary. Was public safety ever at risk during this process?

MRS BURKE: Chair, I have not finished my question.

THE CHAIR: You can come back in a second.

Mr Cormack: The advice that I have received is that there was no risk to public

safety or patient safety during the process.

MRS BURKE: Can I put this to you: you have just said that there were not major issues. I totally rebut that. The prohibition notice under section 155 of the Occupational Health and Safety Act, as you would well know, is the strongest rebuke that can be issued. If there were minor issues, the works would continue; the builder would have been monitored further.

I do not accept your explanation for this. I think it is far more serious than you are making out. Nurses have called the opposition hotline. Members of the public called because they had family members in that ward at that time. And it has happened on other floors throughout the hospital.

MR MULCAHY: Chair, could I ask that the number of complaints that Mrs Burke cited be tabled, for the committee's interest?

MRS BURKE: That is not part of the question.

MR MULCAHY: I thought it was.

MRS BURKE: No, it is not.

Ms Gallagher: I will respond to that. It is probably more appropriate that, if you are going to launch quite a vicious attack, you do it to me and not a public servant. But what I would say is that a number of allegations were made. WorkCover responded appropriately in that instance. What they do as a matter of course is issue a prohibition notice. They issue that whilst they undertake an investigation.

That investigation was undertaken. I think the level of those allegations was not substantiated. But there were issues that were identified that needed a response and that response was given.

You have to understand that these issues are taken extremely seriously. Building work goes on all the time at TCH. It is a very important area that management has to control, monitor and respond to. For example, I am aware of a number of incidents where a dangerous or hazardous situation has occurred. I think ACT Health are one of the best-placed agencies to respond to that. And they do, mindful of staff and patients' safety. That is at the forefront of their mind.

I think this case sounds extraordinarily dangerous as you have read it out. But, from advice to me, when the matter was investigated, it was not nearly as serious as those initial allegations appeared. WorkCover supported that by removing the prohibition notice the very next day.

MRS BURKE: You referred to a vicious attack. My concern here is for the safety and wellbeing of patients and their visitors.

Ms Gallagher: I know that; you say it all the time. Part of me believes it.

MRS BURKE: Why did the hospital management not ensure that the builder

contracted was observing high standards of health and safety regulations, given ACT Health's stated objectives to ensure safety of patients, staff and other people within the hospital?

Mr Cormack: My response to that is that when the matter was brought to our attention we acted immediately. We have contractual arrangements with the head contractor which specifically outlined those particular requirements. On a contractual arrangement, that is what we do. We have a contract in place; we monitor that contract. If there are alleged breaches of that contract we act on it immediately and that is what we did.

MRS BURKE: Who monitors the works continuing?

Mr Cormack: There is a contractual arrangement between the head contractor and our business and infrastructure unit which oversees a multiplicity of minor and major works that are going on at any one of our facilities across the ACT at any one time.

MRS BURKE: Is it not true that complaints were made to you many days prior, possibly a couple of weeks prior? Why were those complaints not heeded at the time?

Mr Cormack: I am not aware of any complaints that were raised days or weeks earlier.

MRS DUNNE: Could you check?

Mr Cormack: I am happy to do that. As I said, I am not aware. I am certainly happy to check but what I am saying is that, when we received the concerns and complaints that I am sure you received as well, we acted to investigate them and take corrective action as appropriate. And that is what we did.

MRS BURKE: Were they from nurses, patients or all of the above?

Mr Cormack: If you want the detail, I am happy to provide you with the detail.

MRS BURKE: If you could, thank you.

THE CHAIR: We will take the rest of this on notice if you do not mind.

MR MULCAHY: I had one of the children ill this morning so I missed the first part. Could I ask the minister some questions on the strategic indicators. If you look at strategic indicators 1 and 2, you fail to meet your own target of strategic indicator 1. There was a failure to meet five out of the eight of your own targets for strategic indicator 2. Could you provide us some advice as to why that has happened?

Ms Gallagher: On strategic indicator 1, emergency department access block, I will try to do it in a way that answers your question. We have set these targets when our performance is worse than they are.

MR MULCAHY: Does it not mean that, if your target is not achieved, it soon becomes even worse?

Ms Gallagher: We are trying to improve our performance every year. With regard to the emergency department access block, I am not sure how many years we have been reporting this. I do not know; I am relatively new.

Mr Cormack: It commenced in 2005-06.

Ms Gallagher: Yes, it is a relatively new indicator. I think it was well into the 30s—30 per cent.

MR MULCAHY: You are saying that the target you have got was a bit ambitious, basically?

Ms Gallagher: We want to get there.

MR MULCAHY: It was only 25 per cent.

Ms Gallagher: Access block a couple of years ago was 40 per cent. It has been coming down every year. We have set ourselves the target of 25 per cent this year. We have got it down from 40 per cent to 28 per cent and we were aiming for 25 per cent. Hopefully we can achieve that this year. The long-term target is to get it down to 20 per cent.

MR MULCAHY: Do you think you will get it down further in the next fiscal year?

Ms Gallagher: I think so. With the extra beds that we are putting in through the last budget and this budget, that essentially will address access block to that level. I believe 25 per cent is achievable once we have those beds in and operational.

MR MULCAHY: What about indicator 2 where four out of five did not meet the target?

Ms Gallagher: I am sure there is someone with a greater mind than mine that can go through these. I thought we all did pretty well on these.

Mr Cormack: In terms of indicator 2, the target is 0.7 per cent, 0.8 per cent. The target remains 0.7 per cent. That is very, very low. That would be barely statistically significant, the difference between the two. So that is what we would be looking at.

MR MULCAHY: Is there any amplification you can provide us with as to what leads to these scenarios or is it too hard to generalise?

Mr Cormack: Sorry, I did not quite get that?

MR MULCAHY: The re-admissions issue?

Ms Gallagher: What would lead to that?

Mr Cormack: There could be a range of factors that could lead to an unplanned return to the operating theatre. That could be related to co-morbidities in the patient. It

could be a subsequent relapse unrelated to the original condition. It is an indicator that says, "This is something to look out for. An unplanned return to the operating theatre is something you should look closely at." It is certainly not to say that, of itself, it is a bad thing. When you complete an operation, particularly a major, complicated operation, you do the best that you possibly can, given the circumstances available with the patient.

If it is a complicated condition, you may well have an unplanned return to the operating theatre. That is part of a normal range of expectations for that condition. But what we do try to do is look at that level, keep it at a target that we believe is consistent with what other organisations are striving for and, if we fall below that—in other words, the return rate is unacceptable or is significantly higher—then it is something that we look further at.

MRS DUNNE: Why, in the fourth of those, the hospital-acquired infection rate, have you changed the indicator? I suppose it is still a percentage but it has been represented differently as percentages opposed to one per thousand. If you change those, why not change the others?

Mr Cormack: I ask Mr Thompson to answer that question.

Mr Thompson: It is simply a presentational issue.

MRS DUNNE: Yes, I realised that.

Mr Thompson: Less than one per thousand is the same as 0.1 per cent. Our feeling on this one was that there are two issues. One, this is an indicator that does get quite a lot of attention and we wanted to make it as readable as possible, and our feeling was that it was more readable to have it as less than one to a thousand than 0.1 per cent. It means exactly the same; it is just a presentation issue.

MRS DUNNE: I know it is entirely a presentation thing, but it causes me to scratch my head—why you have got all of these presented as a percentage and therefore why isn't the number one, rate of unplanned return to hospitals, in a less than seven per thousand?

Mr Thompson: It is about the extent to which this one, as compared with others, gets asked about; it is to make it more readable and understandable.

MRS DUNNE: Mr Cormack, you said in answer to Mr Mulcahy's question that, for instance, the 0.8 per cent rather than 0.7 per cent may not be statistically significant. What are the statistically significant figures for this area? What is the tolerance in which you say that is not statistically significant?

Mr Cormack: I will provide that for you on notice.

MR MULCAHY: Can I just ask a question which might need your dentist specialist? At page 151, as I read it, the DMFT rate for children is running higher than the Australian average in the ACT, which is troubling. I know there is a trend that is starting to emerge in this regard, but obviously we are deteriorating at a quicker rate

than the Australian community. Is there any comment you can give on that? Is there anything that you are doing to try and address that issue?

Mr Cormack: I might ask Jenelle Reading, who is the general manager of community health and is responsible for our public dental program.

Ms Reading: I would like to get some more specific information for you on this issue out of session. However, this data is not necessarily accurate. I am not quite sure how frequently this is collected but I think it is every few years.

Ms Gallagher: 2002.

MR MULCAHY: Can I just make a comment: I have talked to some of the leading specialists in this field and, if anything, it is getting worse—not just here but Australia wide. And I believe there are factors that are causing this, in the way people are giving drinks and so forth to kids. I just wondered what the territory is doing to try and address it.

Ms Reading: We have a dedicated service to young families in Canberra. We have a child youth dental health team and we have very good access to services for families and young children under the age of 14.

MR MULCAHY: Is that proactive or just reactive—

Ms Reading: No, it is proactive.

MR MULCAHY: So you are actually getting material into the schools or the childcare centres?

Ms Reading: We target very carefully childcare centres. We do a lot of education to families in facilities—young mothers groups and the like. We offer a free program, called first smiles program, so that the parents can come in and orientate their children with a chair, opening their mouth, the assessment and providing good oral health practices. We are very integrated with higher risk areas in alcohol and drug programs, with mental health clients where the maternal and child health nurses can make appropriate referrals to our service. There will be a significant focus on younger children and a team program with the commonwealth dental health program that is about to be rolled out nationally.

MR MULCAHY: Do you have the material about the hazards of non-fluoridated water?

Ms Reading: We could definitely provide material.

MR MULCAHY: Is that in your educational material or not?

Ms Reading: I would have to provide that level of information for you out of session.

MR MULCAHY: If you have any available, I would be happy to see them.

Ms Reading: Yes, we would be happy to provide that.

MR GENTLEMAN: It is a past debate, Mr Mulcahy.

MR MULCAHY: But it is actually coming back as a problem because, as Ms MacDonald indicated, bottled water is contributing to this problem.

Ms Reading: That is right. That is one of the education issues that are put across with the dental therapists that provide this information. It is very important that your child receives adequate water from a tap, not milk and coke in a bottle. It is a very high needs area that, deservingly, does get the attention that it requires in the ACT. But at a national level there will be an increased focus.

MR MULCAHY: If you have any current data, it would be really helpful if that can be sourced.

Ms Reading: I would be very happy to provide that.

THE CHAIR: Mr Gentleman, you have a supplementary on this?

MR GENTLEMAN: The Council of Australian Women made a presentation to the committee last week and discussed this very issue. They made a suggestion that perhaps the government should think about going back to school-based dental services. I remember mine at Ainslie primary; it was a horrible experience. But they made that suggestion and asked us to—

Ms Gallagher: I think you will only hear more about dental health for young Australians. We do need to keep an eye on how we provide those services. As Ms Reading said, we have an excellent service available, essentially a universal access service for children, littlies and up to the age of 14, publicly funded, which I am not sure is available in every other jurisdiction to the level that we provide it. It is good but I agree that in the future we will have to do more around this.

THE CHAIR: I am going to go to Ms Macdonald. Do you have any more strategic indicators you need to ask about, Mr Mulcahy?

MR MULCAHY: The only other one was strategic indicator 18. My question is: since it appears from the 2008-09 budget that youth smoking data for 2004 has been available for quite some time, I am just wondering why the 2007-08 budget did not report this data and adjust its target for 2008 for strategic indicator 18 accordingly?

Ms Gallagher: We have adjusted the target down to five per cent. This information only becomes available through the secondary students alcohol and drugs survey, which we do every four years, I think.

MR MULCAHY: Isn't it 2004 that it has been available?

Ms Gallagher: The nine per cent? We are just about to do it now, though.

MRS DUNNE: So that means you have done it in 2006 and you are about to do it

again.

Ms Gallagher: We might take that on notice. That may be where we get the five per cent target from. I will check. I know we are just about to go out and do the next survey, which should give us a better idea of where we are at.

MRS BURKE: I have a question while we are around those pages, on page 149, bed occupancy. Here we see that bed occupancy refers to the percentage of adult overnight acute medical and surgical beds in use, which provides an indication of the efficient use of resources available for hospital services. The estimated outcome received for 2007-08 was 91 per cent bed occupancy, with a stated target of 90 per cent bed occupancy for 2008-09. The target—what seems to be on the never-never—is 85 per cent bed occupancy.

In the AMA's *Public hospital report card 2007*, published in October last year, they stated unequivocally:

> A shortage of beds manifests itself in a dangerously high bed occupancy rate. An Australasian College for Emergency Medicine study has shown that an occupancy rate of more than 85 per cent (on average over the year) risks systematic breakdowns and extended periods of 'code red', which put patient safety at risk.

Is the description, minister, of this indicator then extremely deceptive, suggesting that a high rate of bed occupancy equates to an indication of the efficient use of resources available, rather than a dangerous level of overcapacity, which leads inevitably to bed block and the inability of the hospital to readily admit patients to wards where they can be properly treated?

Ms Gallagher: I think the strategic indicator supports exactly what the AMA are saying. It says "reaching the optimum occupancy rate for acute adult overnight hospital beds" and we are trying to bring that down to 85 per cent.

MRS BURKE: How?

Ms Gallagher: More beds, replacing the 114 beds that were taken out and putting in more beds.

MRS BURKE: So staffing is not a problem with those beds?

Ms Gallagher: No, staffing is not a problem with those beds. All the beds that are funded are staffed.

MRS BURKE: And you are not worried or concerned that staff are doing double rosters, coming back, called back—

Ms Gallagher: What is your question? Is your question around occupancy rate or around staffing?

MRS BURKE: It is around bed occupancy; if you have not got the staff, how can you have the bed occupancy?

Ms Gallagher: But the occupancy rate being high would indicate that you had got staff, because you have got to staff the beds.

MRS BURKE: Two different issues. In that regard—

Ms Gallagher: They most certainly are.

MRS BURKE: Yes, they are, so how you are you bringing down the bed occupancy to 85 per cent?

Ms Gallagher: The answer to your question is more beds, Mrs Burke. More beds mean your ability to have vacant beds, so that when you have people needing to come into those beds you have got beds for them to fill. The only answer to that is beds. Coming off that, though, yes, in order to have beds, you need to have staff to staff those beds, because it is not actually the bed itself; it is the staff. At the moment, for example today, I would say our hospital bed occupancy rate is probably around 99 per cent, as in every other hospital in Canberra, and we are staffing the hospital to that level. But the only answer—

MRS BURKE: I am concerned—

Ms Gallagher: Yes, it does concern me a lot, but we need to respond to the amount of admissions. The emergency department on Monday saw, I think, 170 people, of which 50 were admitted—to a hospital that was almost virtually full. So, yes, it is not ideal and that is why it is so important that we do the work that we are talking about and that we increase our bed capacity, which is why you will see in this budget, as it has been in every single budget since we were elected, additional beds to deal with the health needs of our community. And at the end of this budget we will have increased our bed base by 172 beds and we will exceed 800 beds across our two public hospitals, and that will assist us in bringing down our bed occupancy.

We have also put in place bed management meetings, which are held every day. Everyone is focused on making sure those beds are used as effectively as possible and bringing down, as I said, that occupancy rate to the long-term target of 85 per cent.

MR MULCAHY: I just have a last one on the strategic indicators. Minister, I omitted to ask you this earlier: in relation to strategic indicator 21, which is obviously a very topical issue, although you achieved your targets under triage categories 1 and 2, categories 3, 4 and 5 were not met and I am just wondering if you can provide an explanation on that, and also what you would propose to do differently this year to ensure the targets for waiting times in the emergency department are met in 2008-09?

Ms Gallagher: There has been a big effort put into improving our timeliness, as you say, in categories 3 and 4. I am pleased that over the past year we have seen continued improvement in both 3 and 4 and maintained our performance around categories 1, 2 and 5.

The answer is multifold really. It is making sure that we are using our emergency department as efficiently and effectively as we can. That relates to things such as

access block and moving people through in a more timely fashion once the decision is made to admit them. We have implemented fast track, which is particularly helpful for category 4; they are treated essentially in a different way from categories 1, 2 and 3, because most in categories 4 and 5 will not need to be admitted to hospital. That has really been the reason behind some of the improvements in category 4.

Category 3 is our most difficult category. We are seeing improvements, but we need to see more improvements. That is really because again, even in the latest quarter, we have seen a 23 per cent increase in categories 1 and 2. They get seen first. In category 3 some still quite unwell people are the ones that wait. I went on a recent visit to the emergency department and spoke to a number of doctors there. That is the area that we need to not take our focus off; they are the ones that are still quite unwell but are having to wait longer because of the increase in categories 1 and 2 that we are seeing.

MR MULCAHY: How are you going to fix it this year?

Ms Gallagher: I would love to say that in a year I could fix this and turn it around. It cannot be done in a year. We have almost full staffing in our emergency department, for the first time in probably a couple of years. I think they are funded for 11 doctors and we have got about 10 of them in place. At its lowest point, we were down to around 50 per cent staffing in terms of our doctors available.

MR MULCAHY: When you say that it cannot be done in a year, does that mean that the target is not going to be achieved?

Ms Gallagher: I think the target is important. We need to keep those targets there and remain focused on them. Ideally, that is what we want to be delivering. But I cannot sit here and say that in a year's time the health minister will sit here and be meeting that target. From my experience—I have been there two years—we have invested more money, we have employed more staff, we have put fast track in place and we have added new beds, but our presentations keep increasing, the seriousness of the presentations keeps increasing, the admissions to hospital keep increasing and we are just not seeing that large jump.

MR MULCAHY: Do you need more front-line medical staff or a bigger area?

Ms Gallagher: Part of the CADP planning—the capital planning—is to build effectively double the emergency departments at both Canberra and Calvary hospitals to provide around 50 in-patient beds at Canberra Hospital.

MR MULCAHY: And obviously staff will escalate to meet that?

Ms Gallagher: Yes, we will have to staff that.

MRS BURKE: Have you considered doing exit surveys for those people presenting who do not wait? We know that that was a bit of a problem. It fluctuates. We do entry surveys for people by way of them being admitted and going into triage. What about doing exit surveys? Have you thought about that? If you are going to go before treatment—

Ms Gallagher: Maybe that is something that we should do. My guess is that the answer would be that they did not want to wait or they had got sick of the wait. But maybe that is something we can do. The did-not-waits are coming down; there is a 15 per cent decrease in the did-not-waits in this quarter. I am really pleased with that; it shows that we are getting to more people in a more timely fashion. But I have to say that the hospital is so stretched every day that ringing people who did not wait for treatment is probably down the list in terms of resources and availability; the staff are extremely busy dealing with the people who did wait. Maybe it is something we can look at as a special project or something outside the hospitals.

MRS BURKE: Can I just ask something on notice very quickly? I have just had word that the prohibition notice that we were talking about—can you check for me to see if that has been revoked or withdrawn?

Ms Gallagher: Sure. I understood it was.

MRS BURKE: I have heard that it has not been. I just need you to verify that for me.

Mr Cormack: Our advice is that it has been withdrawn and was withdrawn along the lines of what I mentioned before, but I am more than happy to double-check. Normally I am notified of such matters; I am unaware of any—

Ms Gallagher: Unless it has been reissued.

Mr Cormack: If something has been reissued, I am unaware of that.

Ms Gallagher: I have not heard that it has.

MR MULCAHY: Just one last thing on emergency: when will you do the expansion of the two emergency departments?

Ms Gallagher: That will be very early on in the 10-year plan. That is what this year's project definition planning and staging works have been funded for, but it is earlier rather than later.

THE CHAIR: Ms MacDonald.

MS MacDONALD: I want to go to pages 75 and 76 of budget paper 3, where you are talking about the cardiac catheter lab and the sleep lab—the labs that are proposed. I was wondering if you could provide information on what will be provided with these labs. Also, can you tell me what titrate therapy is—in the sleep lab.

Ms Gallagher: I do not know if I can tell you that. I am sure that there are other people that can expand on this, but essentially it is to upgrade the second cardiac catheter lab at the Canberra Hospital to meet the demand for that service. Again, it is envisaged that demand for this will have approximately 15 per cent growth. We have one cardiac catheter lab already operational; this is to position us to deal with the demand in growth.

MR GENTLEMAN: This is quite a good story, though, isn't it? If we were to go

back—I mentioned this when we were talking about ambulance and paramedics yesterday—

MRS DUNNE: You could at least be subtle, Mick.

MR GENTLEMAN: I am saying that overall, if we were to go back 20 years, these people would not get to the hospital; they would not survive from the paramedic trip. Now they are; we are able to treat them and get them back home.

Ms Gallagher: Yes, sure. I think we have an excellent cardiac unit here in the territory.

Mr Cormack: Titrate means to adjust.

MS MacDONALD: Adjust—adjust your sleeping?

Mr Cormack: That is correct. No, your therapy—is that right?

MS MacDONALD: It says "titrate". I do not know what it means.

Ms Gallagher: I think you are right.

Mr Cormack: Sorry. I did find the wording. I had not quite heard it. It says "to diagnose, and titrate therapy". So you diagnose and you adjust it.

Ms Gallagher: But the cardiac service we offer is excellent and this will enable us to meet that future growth.

MRS DUNNE: In terms of future growth, one of the essentials in meeting future growth is issues relating to workforce.

Ms Gallagher: I thought we answered that question right back at the beginning.

MRS DUNNE: We have a whole lot of people in things, but it is actually matching the staff—the doctors, the nurses and the other technicians—to do the jobs. What are we doing in relation to that? There are gaps that we are all aware of. How do we make sure that we are matching people up, that we have the best people we possibly can and that we keep them?

Ms Gallagher: The work that is being done running alongside the capital work—this has been an issue as we talk to stakeholders. There is the line: "Well, you can build all these lovely buildings, but if you do not have staff you are not going to be able to deliver services."

MRS DUNNE: You need something more than machines that go ping.

Ms Gallagher: Yes. The last thing we want to have is a situation where you have nice buildings and no-one to work in them. So running alongside this work—in fact probably starting before this work—the clinical services planning was well underway, which has a very significant focus on workforce.

Part of the answer to it is going to be the diversity of the health workforce. We need to diversify. There is going to have to be assistance in nursing to help nurses. There are simply not enough doctors and nurses in the world to staff the way hospitals and health systems have traditionally been staffed. We are already starting. In fact, we are well placed with our allied health, multidisciplinary teams, allied health assistants and assistants in nursing, with a better role for the nurse practitioner and the advanced practice nurse.

There are going to be new health roles as e-health rolls out and new technology rolls out. There will be a new health worker—a health technician. We have already got assistants in nursing in our EBA with our nurses, as we have in those other areas of the nursing workforce. That gives us opportunity. Do we need registered nurses to make the beds for people and make sure people have had lunch when someone else can do that?

That work is well underway. I remind the committee that we have been increasing our workforce, particularly through our beds, in every budget. We have been increasing our mental health workforce and our broader health workforce in every single budget. We have been managing to do it. In the last 18 months, we have recruited 87 new doctors to the ACT health system.

MRS DUNNE: But it is not just the numbers. It is about making sure that you have the people with the right skill set to fill your gaps.

Ms Gallagher: Yes, that is right.

MRS DUNNE: But there are gaps. There are gaps in plastic surgery, facial surgery—

Ms Gallagher: There are no gaps there any more.

MRS DUNNE: There are no gaps there any more?

Ms Gallagher: No. We would like more plastic surgeons, if you know anyone that wants to work in the ACT.

MRS DUNNE: I would be marrying my daughters off to them.

Ms Gallagher: But they can still work.

Mr Cormack: If I could just add something, the medical appointments and training unit was established as an initiative of the 2006-07 budget. The MATU's role—

Ms Gallagher: As opposed to the MAPU. It is the medical appointments and training unit for recruitment for doctors.

Mr Cormack: Its job is to do precisely that. It is to work across the organisation to identify current workforce requirements in the medical area—objective workforce requirements—undertake detailed recruitment initiatives and exercise to source those. As the minister said, it has been very successful. There have been 87 new positions

filled, 41 of which were brand-new positions we did not have before.

If you go to budget paper number 4, page 146, under "Employment Level", you will see that there has been significant growth in employment in the ACT health system as we have responded to demands. That is not to say that they are not without challenge; that is not to say that it is easy. But we do not open services that we cannot staff, and we run our workforce program in tandem with our capital program and our annual budget cycle.

THE CHAIR: You had a supplementary, Ms MacDonald?

MS MacDONALD: Yes. You were talking about the issue of e-health. When the Health Care Consumers Association appeared before us last Friday, I asked this question as well, because we were talking about the changes in technology. I think I have heard you say before, minister, that we know that people are going to be having home diagnostics going on in order to try and avoid a lot of what is happening within the hospital—to try and deal with it. They will be coming in and we will need somewhere to plug them in and all that sort of thing. I have a question. My question to the Health Care Consumers Association was about the costs around this for the devices. Is it sufficiently advanced that it will be accessible to people or is it just going to be in the domain of the rich who can afford it?

Ms Gallagher: I think already you can get quite a number of personal devices that are quite cheap to take your blood pressure and do all that sort of stuff. In the future we expect people to have greater access to a whole range of more technical apparatus that they might want to hook themselves into. The issue for the health system is how we build a health system that is able to use that information when people turn up with it, and also the huge costs. E-health will cost the Australian health system billions of dollars—and quite rightly; there are a lot of good reasons for that cost.

This is something that health ministers are looking at nationally. I think it is fair to say that Australia is probably lagging behind other jurisdictions in our take-up of e-health technology. Something that will be a very significant part of the project definition planning for the new hospitals and the improvements at Calvary would be building a system that can cope with the new technology—that integrates new technologies a lot more easily.

That will mean larger rooms with more power points, I imagine—and at greater cost. But the machinery and the technology that are becoming available in health are changing all the time. It is expensive, but ultimately it provides significant improvements for patients' safety and quality of care. I think our neurosurgery suite will be the start of that. We are going to build a state-of-the-art neurosurgery theatre complete with MRI and things that move so that patients do not have to move for further tests as they undergo their brain surgery.

We are well poised. Yes, it is going to be incredibly expensive, but it is going to have to be done. I think it has to be done across the country so that, if you turn up at Brisbane but you are normally a patient in Canberra, there is some integrated way that we can use the information Canberra has for Brisbane. Some of the efficiencies that will be found through e-health really have to occur under a national umbrella.

THE CHAIR: Is the digital breast screening part of that process?

Ms Gallagher: It is. It is a small part, but it is part of modernising the system and improving it—moving it from analog to digital.

MRS BURKE: Chair, I need to advise the committee—

THE CHAIR: Just a minute. I am sorry, you are not a member of this committee, and Mr Smyth has a couple of questions he needs to ask before some of the officials leave.

MR SMYTH: Just on the balance sheet on page 175 of budget paper 4, minister, I notice the receivables have blown out from an estimated $22 million to a $41 million outcome at 30 June this year.

Ms Gallagher: Sorry, I am catching up. Page 175, is it?

MR SMYTH: Yes, 175, BP4, the second line, the receivables?

Ms Gallagher: Yes.

MR SMYTH: The estimate in the paper was $22 million worth of receivables. I note that it is 85 per cent higher than expected at $41 million. Is there a reason for this?

Ms Gallagher: I am sure there is.

MR SMYTH: And what does it consist of?

Ms Gallagher: With the numbers that big, it has to be from our colleagues over the border.

MR SMYTH: Mr Foster cannot get away from this without answering at least one question.

Mr Foster: I understand we are finishing at 1 o'clock.

MR SMYTH: He is looking at his watch there a bit.

Ms Gallagher: I think it is largely the New South Wales cross-border issue.

Mr Foster: It certainly is that, and it relates to the arbitrated outcome that we have had with New South Wales. It goes back a number of years, and so this reflects us recognising revenue that they owe us and they have not yet paid us.

MRS DUNNE: So that is back pay?

Mr Foster: Associated with back pay for 2005-06, 2006-07 and an estimate for 2007-08.

MR SMYTH: Okay, but if you go to the next column, the plan for 30 June 2009, this

year it was meant to be $22 million and next it is going up to $36 million, which is about a 65 per cent increase. Is that for the same reason? Is that just because New South Wales are bad payers?

MRS DUNNE: I think you can say yes.

Mr Foster: It is related to the same issue. Those numbers will adjust as we get a better payment pattern from New South Wales following the results of the arbitration.

MR SMYTH: How long would it take to establish a better payment pattern?

Mr Foster: The arbitration process has led to them recognising they have to pay us more, and we expect that they will now start paying us more on a monthly basis than they have paid previously. They have been paying us on a monthly basis that relates to the agreed payments that would go back to about 2004-05. They have not increased their rates of payment on a monthly basis to reflect the higher activity and the higher price that has now been agreed. They are catching that up.

MR SMYTH: But in 2010, 2011 and 2012 the receivables issued were about $22 million, but for the three outyears it seems to have been static at about $31.368 million. Why are we accepting a 50 per cent increase? Do they pay interest on that, and why does New South Wales not pay on time?

Mr Foster: We do not charge interest. Why do they not pay on time? Well, there is a process to be followed in relation to an acquittal process for each year, and that takes up to 12 months, the acquittal process to confirm the data. The figures will change, as each year we do the budget you get better performance going on. I am not too worried about those outyear figures. I do not think we should be out there saying that New South Wales are bad guys in regard to this. We concentrated on the 2008-09 year, and the following years will be adjusted in subsequent years.

MR SMYTH: Okay. Minister, on page 174, the second-last line, the total ordinary expenses, the estimate for this year was $801 million. I have in mind your commitment to try and limit health growth to eight per cent or less so that, to quote the Chief Minister, we live within our means.

Ms Gallagher: Yes.

MR SMYTH: I notice that the budget for next year, 2008-09, is $888 million, or an 11 per cent increase over the budget for this year.

Ms Gallagher: Yes.

MR SMYTH: Why have you not been able to live within your means as dictated by the Chief Minister?

Ms Gallagher: We are living within our means. The formula that ACT Health agreed in terms of living within a growth envelope, which was actually 6.4 per cent, came out of the 2005-06 budget and was predicated on pretty complex modelling of what we expected growth in certain areas of health to be. We were expecting growth in acute

services to grow at three per cent per annum. What we have seen since the 2005-06 budget is that acute service has grown at six per cent per annum, not three per cent, and the formula has been adjusted accordingly.

I have said, and the Chief Minister has accepted this, that we will live within a growth regime that pays for what we deliver, and we are delivering double what was expected in terms of acute services. It is unclear whether that growth will continue at six per cent. I hope that it does not, but it has continued at six per cent for the last two years. You will see in the budget papers that it makes an adjustment to the health-based funding of $23 million—that is the activity that we have delivered that was not included in that growth formula.

MR SMYTH: What is the percentage now? If you have changed the formula from—

Ms Gallagher: It is about 8.9 per cent. That was the growth. Once we have had this base adjustment and our current initiatives, that is where it is at at the moment. The commitment to restrain was twofold: to restrain growth but bring down our costs. We are bringing down our costs; it is just we are overdelivering on activity, and that is just driven by the people that walk in the door.

MR SMYTH: Is the expectation now that, instead of trying to live with eight per cent, at least we will live with nine per cent or less?

Ms Gallagher: It is hard. The commitment to bring down our cost to 110 per cent of benchmark remains. Now that this base funding adjustment has been made, the growth formula has not been increased to nine per cent. You will see in the outyears that it increases at the agreed level of whatever it turns out.

MR SMYTH: But on one stage you are planning for the health tsunami, and we are putting an enormous amount of work into capital works.

Ms Gallagher: Yes.

MR SMYTH: That would indicate that you do not believe that the growth will ease.

Ms Gallagher: But it has been growing at double what we expected it to grow in two years. The health tsunami, we know, is going to come in 10 years. We will have to adjust our growth accordingly based on activity. I think that is a more realistic way of operating.

MR SMYTH: Yes, but that is not what the government committed to two years ago when the target was to live with eight per cent growth or less.

Ms Gallagher: As I said, that target set in that budget was to restrict growth to 6.4 per cent, but it was based on a particular level of activity, delivering a particular amount of cross weights. We have been doing double that. You cannot expect to be increasing that at double the growth that we are expecting and live within that funding envelope. What I have argued is, yes, we will bring down our costs. That helps us, and it is clear in these budget papers that we are still doing that, but—

MRS BURKE: How are you doing that, minister?

THE CHAIR: Just a moment.

Ms Gallagher: Just a minute. The growth formula needs to be funded based on the work that we are delivering. Yes, it is more than what we originally intended, but, as I said, we could not predict the growth that we have seen.

MR SMYTH: Could you provide, if you have not got it with you now, the committee with the rate of growth over the last five years for acute services?

Ms Gallagher: In terms of activity delivered?

MR SMYTH: Percentage growth.

Ms Gallagher: Yes, sure.

THE CHAIR: I would also be interested to see where that activity came from—across the border or from the ACT, if that is possible.

Ms Gallagher: That usually remains pretty static at around 25 per cent.

THE CHAIR: In terms of whether it is growing or not, is it growing?

Ms Gallagher: It is growing as well, but it is maintaining at around—

THE CHAIR: It is maintaining the same percentage?

Ms Gallagher: Yes.

THE CHAIR: I was just interested to know whether we were getting additional demand from New South Wales. Okay, so—

MRS BURKE: So it is growing, but how are you bringing the costs down? I just wanted to clear that up.

Mr Cormack: I can clear that up.

MRS BURKE: You are growing, but you are trying to bring costs down. Can you answer that?

Mr Cormack: We are growing by producing the unit of production at a marginal cost. So we produce extra cost growth separations at a lower unit price. It is the unit price that forms the basis of the benchmarking against which we are compared. The minister is talking about growth and activity, which the government has recognised in this budget, but there is a cost element as well, which is how much it costs per unit of production. That is coming down from over 130 per cent to 115 per cent in the last published AIHW figures, which is what we go on. We are confident that we will be able to continue that downward growth—

MRS BURKE: What areas are impacting upon that downward trend?

Ms Gallagher: It is looking at a whole range of things across the system: how you purchase things, how you run your operating theatres, how you manage your leave accruals; the implementation of different flexible shift arrangements. Some people want to do 12-hour shifts; some people will want to do less. It is a whole range of strategies. It is more about efficiency rather than not doing things; making sure that we are trying to do things as efficiently as possible. We recognise that we have not been the best performing jurisdiction on that level in the past. As Mark said, we have brought it down from 130 per cent to 115 per cent. We are hopeful that this year's data, when it is published, will show another reduction and that we will reach 110 per cent, which is the target that I signed up to as health minister.

THE CHAIR: Thank you, minister. We will go to lunch now—

MRS BURKE: Chair—

THE CHAIR: No, I am sorry, we are going to lunch. We will come back at 2 o'clock, minister.

Ms Gallagher: Okay, thank you.

Meeting adjourned from 1.01 to 2.04 pm.

THE CHAIR: We are in output 1.1, acute services.

MRS DUNNE: I have some questions which sort of go back to this morning—to something that we did not quite finish this morning—but they do relate directly to acute services. That is the workforce planning. Mr Cormack started to talk about the work being done by the MATU, the medical appointments and training unit. Could somebody give me an exposition? You pointed to gross figures increasing, but what are you doing to ensure that you are matching staff with need and you are filling the holes and ensuring that those holes stay filled? Welcome, Dr Bassett.

Mr Cormack: I am happy to respond to that and then I will pass it on to Professor Bassett, who manages the day-to-day process. The assessment of need begins with our planning process. Using the budget paper 3 initiatives as an example, the second cardiac catheter lab was identified as a need. We then go through a process of developing a proposal. Part of that process of developing a proposal is to identify the range of staff that you need for that particular service. Once we have identified that, then, for medical recruitment, because Professor Bassett's unit looks after only medical appointments and training, it really falls into his unit. For other areas, it will be the particular line area of the department that will determine that.

MRS DUNNE: So allied health is not being done by the MATU?

Mr Cormack: No. That would be done by the particular service unit. In this case, it is the Canberra Hospital that is doing that. They will draw upon the expertise of our allied health adviser if there is a particular skill set that is required; otherwise, they would simply recruit according to the number of different sorts of allied health

workers—or, in the case of nursing, the nurses that are required for that sort of unit.

MRS DUNNE: So you would need nurses who had some postgraduate specialisation in doing angiograms, angioplasties and things like that?

Mr Cormack: You would be looking for—

MRS DUNNE: Using that and using the cardio—

Mr Cormack: I will talk about nursing. I will leave the medical side of it to Professor Bassett. On the nursing side of it, you would look for a range of skills, experiences and qualifications that would be required to safely staff that from a nursing point of view. You may start with a very experienced core and over time offer further on-site training or you may send people away if there is a specific technique that is required. Fortunately, in this case we already run a cardiac catheter service; we are just really doubling the capacity. Without wishing to devalue it, it is probably more of the same skill mix that we have already got there. Perhaps Professor Bassett can talk about the medical appointment side of things.

Prof Bassett: As the chief executive has indicated, the medical appointments and training unit—we call it MATU—began operation in August 2006. Its role is a strategic approach to medical workforce management. It is not just about increasing the overall number of medical staff in the agency; it is about identifying areas where there is a weakness in clinical service delivery, and working to fill those gaps.

Very often, the weaknesses will be there for historical reasons and may be quite complex. They would show up, for instance, in terms of inability to cover the roster with the required number of specialists. It may be that the range of procedures that are offered is not considered to be as broad as it should be. There may be complaints coming from clinicians, and even perhaps from patients, that there are particular issues. Those areas get identified. There is also the ongoing clinical service planning that we take into consideration.

MATU's role is to work with the chief executive and with Megan Cahill's group to fill those gaps. This has several components. We set out to recruit the best people that we can. We use a whole range of recruitment procedures, including agencies where required. But we are required not only to fill those gaps, but to fill those gaps with qualified personnel that meet all the mandated requirements by the Medical Board and the various colleges. We have to select the best people that we can. We have certainly improved the processes for recruitment and appointment in the last few years. We have a much more rigorous approach to it. We certainly meet and exceed national standards in this area.

There is another component to this, and that is the education and training of junior doctors. Very often our best solution to weaknesses in specialist cover is actually to grow our own within the territory. That cannot just happen overnight. It does not happen by just appointing junior doctors. You need to have accreditation for the training of those doctors, and that is a very rigorous process. We have achieved accreditation in a number of areas where we previously did not have it, and we either achieved or renewed accreditation in the last couple of years. So there is work around

accreditation. There is work around improving the actual education, training, supervision and assessment of junior doctors. At the same time, there is a national—

MRS DUNNE: That would be done in concert with the colleges?

Prof Bassett: That is done in concert with the colleges and the Institute of Medical Education and Training in New South Wales, which is our postgraduate medical council equivalent. That is usually an extensive process. It is not just a bit of window-dressing; it really means that we have to make substantive changes in the environment in which we educate and train junior doctors. We have done a lot of work around that in the last few years.

As you have heard, since MATU got underway we have made a total of 87 specialist appointments, and of those there are 41 new positions. In the past three years, we have also increased the number of junior doctors by 31 per cent—that is counting all junior doctors from interns up to registrars—which is a very significant increase.

MRS DUNNE: Are the 41 new positions essentially to fill gaps in services provided?

Prof Bassett: Yes, that is correct, and to fill gaps as services expand or as it becomes clear that there is a need for another specialist in that area—or in the development of new services. For instance, ophthalmology is a very good example. There has been a major development in terms of ophthalmology in the territory in the last two years, and that ultimately benefits the local community.

MRS DUNNE: When you are recruiting doctors, are these staff doctors, VMOs or a combination?

Prof Bassett: There is a combination. Those numbers that I gave you actually are a combination. In fact, of that 87, 49 were full-time staff specialists, 10 were part time, 22 were visiting medical officers and six were career medical officers. We have a mix. It depends very much on identifying the particular duty statement—the particular duties that the doctor is going to be doing and whether there is a significant private sector component that we would envisage that the doctor may wish to be involved in. It will come back to the particular service that we are trying to build.

THE CHAIR: And choices for doctors.

MRS DUNNE: And choice of the doctor?

THE CHAIR: Individual choice, yes.

Prof Bassett: Yes. We do not have an ideological approach to it. We are out to get the best people that we can and to appoint people to contracts that they are satisfied with so that they will stay in the territory.

MRS DUNNE: On the issue of staying in the territory—I will try and be brief—is part of the problem that the highly specialised areas may not have the population base to support doing particular procedures on a really regular basis? Doctors in Sydney might perform particular procedures every day; they might do it once a month here or

once a week. Is that an issue?

Prof Bassett: Yes. It is always going to be an issue in a relatively small jurisdiction. As technology advances, some judgement will need to be made about the quantum of work that would be required to support a particular clinical procedure. That work comes under the medical and dental appointments advisory committee, which I am the chair of. It is about determining what is called clinical privileges or the scope of clinical practice. It also relates very much to the clinical service development planning that goes on prior to that stage. To summarise, it is scientific process, if you like. It has some scientific process to it. It is not just a willy-nilly sort of thing that is based on some whim of a doctor or group of doctors that they should be doing such and such. It comes back to what is needed in the territory and what is cost effective in terms of how we can best spend the dollars.

MRS DUNNE: After you have appointed these 87 doctors, where are the gaps that you are working on at the moment?

Prof Bassett: Right now, we are still working on emergency department, plastic reconstructive surgery, oromaxillofacial surgery, ophthalmology and anaesthesia. I might say that the gaps there are relatively small in each of those; we are really finetuning the workforce at the moment. We have made some very big gains in the past two years.

MRS DUNNE: Plastic and maxillofacial surgery have been a contentious issue.

Prof Bassett: There has been a lot of work done in both of those areas in the past 18 months, with some very good achievements.

MRS DUNNE: And you have made appointments—or are you looking to make them?

Prof Bassett: We have made one full-time staff specialist appointment to oromaxillofacial surgery and there are further appointments in the pipeline. We have made two appointments in plastic and reconstructive surgery and the chief executive has given the approval to make further appointments. Right now I have a recruitment process underway for one worker or maybe even two workers over the next 12 to 18 months.

MRS DUNNE: So it is a very long process as well?

Prof Bassett: Yes. These processes take time. It can take six to 18 months to recruit. It depends very much on the type of person. If we are seeking an Australasian trained plastic and reconstructive surgeon who, in succession planning, would be suitable for a unit director role, that is quite a big appointment and that would take quite a lot of time to do.

THE CHAIR: I have a quick supp around the neurosurgery area. With the new area that you were talking about before, minister, will we need to recruit additional specialists for that area?

Prof Bassett: Yes. We have already done that. We have made two very significant appointments in neurosurgery. Both are staff specialists—full-time staff specialists—of very high calibre. Those two people have been appointed in probably about the past 15 months, 18 months. We did lose one of our visiting medical officers back to the private sector at around that same time and we began recruiting again to fill that position.

I have to say that the visiting medical officer who was uncertain about where he wanted to work has actually applied for a position that we advertised, and we are very pleased about that. I would predict that we will come back to a very strong position in neurosurgery, with filling that position. Right now we are in a very sound position and we are going to get stronger.

THE CHAIR: Mrs Burke, you had a question?

MRS BURKE: Minister, you probably know that the inevitable question is going to come up. I wanted to have an update from you in terms of the oral maxillofacial surgery operations—excuse the pun—at both Calvary and Canberra, particularly at Canberra Hospital. I know that you have had one surgeon recently installed there, and I know that Mr Bassett has mentioned plastics and reconstructive. Could you give the committee an update on OMFS and any appointments that have to be made or are in the pipeline? They were mentioned, I know, some time ago. Where are we up to?

Mr Thompson: As Professor Bassett said, we have recently appointed a full-time OMFS surgeon. He is now working in collaboration with the plastic and reconstructive surgeons at the Canberra Hospital. That service is operating very effectively and is comfortably meeting community needs. I am not aware of any concerns that have been raised about the quality and service capacity since the most recent appointment.

However, a single surgeon is not where we would like to leave the service. That is what Professor Bassett was alluding to. We are in the process of looking at further recruitment action or further appointments to assist the surgeon we have appointed. That is at the Canberra Hospital. At Calvary Hospital there has been an OMFS service for several years now. That service is still performing well and we have got no immediate proposal to change that.

MRS BURKE: Minister, I have an issue in terms of Mr Thompson's response. I am led to understand that plastics and reconstructive have said that they will not do manual fracture or surgery work.

Ms Gallagher: They will not?

MRS BURKE: They will not—considering it too high risk. What would your comments be on that?

Ms Gallagher: You have heard from the plastics?

MRS BURKE: I have just heard information that has come to me to say that—

Mr Cormack: That is not our advice.

MRS BURKE: Apparently plastics and reconstructive have said that they are concerned about having to do lower jaw fractures and mandible work because it is too high risk. Is that not true?

Ms Gallagher: I certainly have not heard that. It has not been raised with me. In fact, I happened to come across one of those surgeons the other day.

MRS BURKE: So similar—

Ms Gallagher: I presume it would if they had significant concerns.

MRS BURKE: That is why I ask. I do not know how true it is.

Ms Gallagher: I have not heard that.

MRS BURKE: I have heard that they are concerned about the implications that perhaps plastics and reconstructive are not—now that you have your new OMFS surgeon on board, and my concerns come to him as well, he may be fairly overloaded in the amount of work he has. That is probably another story altogether.

Ms Gallagher: We have other alternatives, which we were using before his appointment.

MRS BURKE: The other thing that was suggested to me was that, because of this lack of surgeons in plastics and reconstructive and the volume of work that the current OMFS surgeon has, there are patients who are literally lying in beds, waiting in wards. How true or untrue is that? Do you know?

Mr Cormack: We do not have any evidence of that.

MRS BURKE: Would you be able to find that out and confirm with the committee?

Mr Cormack: I am happy to find that out, but I am pretty sure that it does not happen.

THE CHAIR: Mrs Dunne said that she thought that the first half or second half of her question had not been answered.

MRS DUNNE: After Dr Bassett had finished, Mr Cormack, you were going to expand on what was happening with nursing and allied health in terms of a specialised workforce.

Mr Cormack: Perhaps I might ask Adjunct Professor Vickerstaff to join us.

Prof Vickerstaff: The question was about our ability to develop a specialised nursing midwifery workforce.

MRS DUNNE: And allied health as well, I presume.

Ms Gallagher: But you are just talking about nursing?

Prof Vickerstaff: I can respond for nursing.

MRS DUNNE: Okay. It is really about nursing. Using the example, which Mr Cormack thought may not be the best possible, the cardiac catheter laboratory, you have to go and staff up a new laboratory. You have got cardiologists, then you need the nurses and the technical people to go with that. What sort of process do you follow, and how does that fit into the normal recruitment?

Prof Vickerstaff: We would use a combination of our own in-house expertise and educational and training facilities and external providers. If I go first to our internal capacity and speak about our staff development unit, we are a registered training organisation. We work very closely with our local nursing and midwifery board to understand what competencies are expected. Of course, that is based on working with our clinicians, understanding what work will be undertaken and what level of staff that we need. Of course, we will always need a mix of skilled staff. You need people who are highly skilled to scrub and work at the high-tech end and, of course, there is a gradation of skills to people who undertake the more routine tasks that would be undertaken for any area.

The raft of skills that are needed in any high-tech cardiovascular situation is well known to us, and we are able to provide in-house training. However, we work very closely also with our local universities and colleges as well as other universities who provide ongoing courses to ensure that all of our staff are facilitated and encouraged to undertake post-registration qualifications. We have a very generous scholarship program; we allocate $500,000 a year to enable nurses and midwives in the ACT to obtain post-registration qualifications, and we support that very strongly.

MRS DUNNE: In supporting that, in addition to the money for the courses, does that include the capacity for people to take time out of the wards to do that training?

Prof Vickerstaff: Yes, absolutely. There is a raft of initiatives that are based around professional development leave. We will pay upfront people's registration fees for the universities. That is deducted by fortnightly payrolls, but certainly it includes quite specified and quite generous time out of the workforce. We also provide on-the-floor clinical development nurses, who are experts in that clinical area. They work side by side with neophytes or less experienced people in that clinical area.

We are very concerned about and very supportive of people experiencing other areas if they wish to do so without the need to commit. For example, if we take the excellent example of the cardiac catheterisation laboratory, we would encourage people from other areas who expressed a wish to try that area to see if it is one in which they would like to develop their careers, to do so in a supported fashion, but then revert to their earlier areas should they find that it is not an area of their particular passion. That way we make sure we have got the passion and the commitment and the competency base for people to be in areas.

MRS DUNNE: Thank you.

THE CHAIR: You have a supplementary, Ms MacDonald?

MS MacDONALD: Yes. It relates to the ability to attract midwives to the Canberra midwifery program. As I understand it, midwives go into the delivery suite, but they are not necessarily attracted into going into the CMP. There has been a definite demand but shortage of places within the CMP itself in the past.

Prof Vickerstaff: Yes, I think it is a very interesting area. I guess about the only relationship between the delivery suite and the CMP is that babies arrive, because the midwives have a very extensive raft of accountabilities and responsibilities in the CMP. Of course, they do in the delivery suite also, but they are a little different. One of the ways that we believe that that will be satisfactorily addressed is with the commencement of the new bachelor of midwifery program due to start next year. That will focus on training midwives, not on nurses who then wish to add midwifery as a skill. Perhaps a different mental set of people who see themselves practising a little more autonomously than major tertiary hospital delivery suite midwives might happen.

However, interestingly we have some resurgence of interest, and that is demonstrated in a very high participation in the international midwives symposium which is happening about now in Glasgow. We are actually presenting some papers there around that thing. There is a resurgence of interest, and I think the very high value that ACT Health and the people of the ACT place on the Canberra midwifery program is one stimulus to attract and retain midwives in that program.

THE CHAIR: Mr Gentleman, you had a question?

MR GENTLEMAN: Thank you, chair. My question is in regard to elective surgery. Minister, I wonder if you could just give us an overview on what results you have been able to achieve from previous investments in elective surgery?

Ms Gallagher: Thanks. The government has invested heavily in elective surgery. I think the latest count is $33 million or $34 million invested in additional funding for elective surgery over the term of this government. What it has allowed us to do is commission all our operating theatres. They are operating for extra hours of the day; they are operating on weekends if they are needed. It has allowed us to increase our throughput by around 2,000 procedures a year. So, 2,000 more people are having their surgery performed this year than in 2002, so that is essentially what it has paid for.

The list seems to be remaining static, despite those increased statistics as to elective surgery, so it sits around 5,000. I think we have seen additions to the list go up by about eight per cent this year. The last figures I saw were, I am trying to recall, 4,700 removed from the list and 4,702 added to the list. It was something like that.

THE CHAIR: Like painting the harbour bridge, really?

Ms Gallagher: Yes, but we have seen additions to the list increase by eight per cent. The list is remaining flat. Our long-wait patients are coming down. I think we are down to around 850.

Mr Cormack: It is 817.

Ms Gallagher: There are 817 patients who have been waiting more than a year for their surgery. That has come down—

MR GENTLEMAN: What sorts of surgery are involved for those who are in long waiting?

Ms Gallagher: It would be a whole range, across the board.

Mr Cormack: It tends to be non-urgent surgery, so it can include some orthopaedics—

MRS DUNNE: That is hip replacements?

Mr Cormack: Yes, hip and knee replacements. It can include ophthalmology, although we are getting that down pretty significantly. Plastics and some aspects of neurology can also be on that list. Another significant component of our long waits is ENT.

THE CHAIR: That is ear, nose and throat, is it?

Mr Cormack: Yes, I am sorry, Madam Chair, ear, nose and throat surgery.

MRS DUNNE: So what sort of ear, nose and throat surgery would we see in the long-wait stuff?

Mr Cormack: That can be myringotomies, which are middle ear procedures and the insertion of grommets, it can be tonsillectomy and adenoidectomy, those sorts of procedures.

MR GENTLEMAN: You were answering the question there, minister, and you said that the hours of operation for the theatres are longer. What were they before? What were the hours?

Ms Gallagher: I will check, but I think it is eight till five in theatres.

Mr Cormack: Yes.

Ms Gallagher: We added an extra hour; they were closing at four. We have extended them until five, and I think there has been weekend work that is required particularly for orthopaedics.

Mr Cormack: Yes, we have added additional weekend sessions for orthopaedic non-elective. That is a very high-volume specialty, so really for more than the last year we have been running additional weekend sessions just to keep the flow of patients turning over. It has been very busy.

Ms Gallagher: Because of the increases we have seen in emergency surgery, some of this growth in demand will go there—juggling. On any given day at Canberra Hospital five of our theatres are being used for emergency surgery, which impacts on

our ability to deliver elective work. We are discussing with the commonwealth around their capital funds that they have announced in the budget for elective surgery, their blitz money. We have got the $2.5 million to do extra procedures by 31 December this year, and we are on target for that. We are pretty much operating at full capacity now, and that was recognised by the commonwealth in their allocation to us. They accepted that the $2.5 million they gave to us was really all we could deliver with our current theatres.

At Calvary, three of the theatres are used for the private hospital. We are at full capacity with the public theatres we have. We have three at Calvary and 10 at Canberra Hospital. We have extended hours and weekend hours. There is very tight management of the sessions. We really are almost at our limit now. Again, that is part of the capital asset development plan, but also in the shorter term some of our discussions with the commonwealth.

I should say that our emergency surgery is, I think, the best in the country. I am pretty sure that in the last AIHW we were the best performer in access to emergency surgery. Of our category 1 patients, 96 per cent of them are seen within 30 days, and that small four per cent may be for other reasons. We perform very well in those areas. We would like to see those long waits come down, and they are coming down. They are heading in the right direction, but they will take a bit of time to get through. If we can get some extra support from the commonwealth in relation to capital, I think we will be well positioned to really move forward on the elective list and make sure that people are not waiting too long for their surgery.

MR GENTLEMAN: So with that capital that you are hoping for, would that go towards more theatres?

Ms Gallagher: Yes, it would go to theatres, and theatres in the short-term run and in the long term.

THE CHAIR: Mr Smyth has a supplementary for this.

MR SMYTH: What is the elective surgery waiting list at the end of, say, April?

Ms Gallagher: At the end of April, I am not sure if we have got that figure.

Mr Cormack: No, we have not.

Ms Gallagher: It is around 5,000.

MR SMYTH: Do you have the figure for the end of March then?

Ms Gallagher: The end of March, I imagine we have.

Mr Cormack: I do not have that with me, but it is—

MR SMYTH: You do not have it? You have come to health estimates knowing that I would be here and you did not bring the end-of-March figures for elective surgery?

Ms Gallagher: I will tell you: it is around 5,000. It might be 4,973 or 5,007. We will find the exact number.

Mr Cormack: I will answer it before you leave, Mr Smyth.

MR SMYTH: That would be good, Mr Cormack. Just in regard to the actual provision of figures, we have had trouble in the past year because of ACTPAS. Is ACTPAS now fully operational?

Mr Cormack: Fully operational.

MR SMYTH: Fully operational?

Mr Cormack: Yes.

MS MacDONALD: Sorry, what does that acronym stand for?

MR SMYTH: Patient administration system.

MS MacDONALD: Yes, thanks for that.

MR SMYTH: So all of the problems that we had encountered previously with ACTPAS have been resolved?

Mr Cormack: That is correct.

MR SMYTH: Was that done at extra cost to the territory?

Mr Cormack: No.

MR SMYTH: Operationally, at any stage, we can pull off data? At any stage now, data can be drawn from the system to answer inquires and manage the hospital?

Mr Cormack: Yes. It is a fully functioning, modern, reliable, robust system that we had a difficulty with in the implementation phase. I think that is a matter of previous discussions. But it has proven to be a very reliable, robust product that will set us up well for the electronic health future that we are entering and will continue to develop.

MR SMYTH: But on 21 May it cannot tell you the elective surgery waiting lists at the end of April?

Ms Gallagher: We can.

Mr Cormack: We can. I just have not got it in front of me.

Ms Gallagher: We will get the figure for you.

MRS BURKE: Does that mean, on the back of hearing that, that we will now be able to adopt those performance reporting requirements to give greater accountability to the commonwealth?

Ms Gallagher: That is across the whole system. It is not just in relation to the whole public hospital system. I have said from the beginning that we have no trouble with accepting those. We may be on par with Queensland in terms of the information we report but we report pretty much everything. I cannot imagine there is anything else that we can report publicly that the commonwealth would ask us to.

MRS BURKE: On that, have you seen the FOI reports that come through to the opposition? Some of it is gobbledygook, frankly. Maybe you and I need to have a separate discussion about that.

Ms Gallagher: I am sure you just get the reports you ask for.

MRS BURKE: I do. I think we need to talk about that, though, in terms of some of the information that is or is not provided and that is not clear.

Ms Gallagher: In terms of how you can interpret it.

MRS BURKE: Being able to interpret it, of course.

Ms Gallagher: It is difficult to interpret.

MRS BURKE: For a layperson, it is of little value.

Ms Gallagher: We do try to make quarterly performance reports easily readable. And they would be based on that information.

MRS BURKE: You are happy for perhaps more and fuller accountability if the commonwealth requests it?

Ms Gallagher: Sure. I think it is the only way. My own view is that the only way to have good community support for your health system is if you are reporting. I think the commonwealth has taken this on board. I think it needs to be across the board. They will involve the private hospitals in that as well.

MR SMYTH: In regard to the elective surgery lists, if there are 5,000 people waiting for elective surgery, has there ever been any work done as to whether or not other sections of ACT Health pick up their care in the interim? If there are more people on elective surgery waiting lists, is there a greater pressure on community care, for instance?

Mr Cormack: Generally speaking, no. Most of the people who are long waits have been assessed clinically. That is not to say that a person waiting more than 12 months for a hip replacement, a knee replacement or a lens procedure is not experiencing some discomfort or difficulty and, in some cases, pain. But we are certainly not aware of any additional burden that is being picked up by other parts of the health care system as a result of those long waits. We are very concerned, as the minister is concerned; hence the very significant investment of funding. We want to get those wait times down to the lowest that we can possibly get them.

MR SMYTH: Is there any work, therefore, done to determine what the cost is to the commonwealth of long-term waits on the elective surgery waiting lists, say, through pharmaceuticals or other parts of the health system?

Mr Cormack: We do not do that work.

MR SMYTH: Has the commonwealth, do you know?

Mr Cormack: I am not aware of any work the commonwealth has done on that. In the past, they have not taken a great deal of interest in the economic or social costs of people on long-term public hospital waiting lists.

MR SMYTH: Has anybody else taken that interest and are there any reports about it?

Mr Cormack: I am sure that there have been some health economic studies undertaken on that, but I do not have those at my fingertips.

MR SMYTH: Does someone in the department have access to that knowledge and has that knowledge been brought to the attention of the government?

Mr Cormack: I am happy to take that on notice and provide you with whatever information is readily available to us in relation to the economic cost of people on extended waits on the elective surgery waiting list.

MR SMYTH: You did say economic and social. Economic, you can do; social, at the same time?

Mr Cormack: Social is a bit more difficult to quantify. We draw that from the general literature relating to the social consequences of poor health. That is a whole other discipline of research endeavour, but we are happy to pick the eyes out of that.

MRS BURKE: Minister, I would like to ask you about a much-raised issue with me—and I have raised it probably with you before now—in relation to hospital supplies. You might be able to tell the committee how supplies in the public hospital system are organised and why we, as an opposition, are still getting calls from nurses, through the health hotline, complaining of a lack of supplies. I refer to things like pillows and panadols—and not just icy poles but that has cropped up again—and oxygen masks falling on the floor and not being replaced. Maybe that is as much to do with staff shortages on that particular shift.

In one instance at least, we have heard of a piece of equipment about $100 in value having to be taxied at huge expense from Sydney. I cannot give you more details on it. I just wondered whether you had heard about it. It is quite extraordinary that we would be doing that. I guess the whole issue circles around hospital supplies, those basic things.

MR GENTLEMAN: It certainly is quite extraordinary.

Ms Gallagher: It is difficult, I guess. I am sure Mark can add to this. We have looked at this, based on your raising it and people raising it through you answering your

phone in your office. The Auditor-General has had a look at it. I think the issue for me is whether or not there is a funding problem about supplies and people have been asked to tighten their belts and things like that—whether that is the cause of it.

We have had a look at all of that, and it is not the case. Mark can go through how they order it but, to the best of my knowledge, there should not be any shortage of supplies at the hospital.

MRS BURKE: I agree, but there is.

Ms Gallagher: That is not to say that at particular times they may be running out of a particular thing. But, in terms of ordering, there is a process that we go through. There is a planning stage, and it is pretty closely monitored. As I said, the Auditor-General had a look at it—and she had a look at it pretty closely—and found that our systems were appropriate for the job they were trying to do.

I talk to nurses, too, at different moments on different shifts. At the end of a busy day or something, people might look around for something and it is not there. That does not say to me that there is a systemic failure in terms of supplies or funding for supplies in the hospital. As closely as I have looked at it and as closely as Mark has looked at it, that is not the case.

In relation to the $100 equipment ferried from Sydney, I would not know where to begin with that one. I have not had it raised with me and, short of knowing other details, it would be difficult to respond to that.

MR SMYTH: On that issue, could you explain how shortages are brought to the attention of management and how the chain might work?

Ms Gallagher: Yes. I was going to hand over to Mark.

MR SMYTH: How is the failure to have the appropriate material available at the end of a shift or at any time during a shift brought to the attention of management?

Mr Cormack: Typically, in any ward area or service area you have got a standard stock list and an impress is maintained. Typically, there is a staff member, a manager, whose responsibility is to maintain stock levels at the agreed levels. So that work is done routinely. We have some stocks available from local warehouses but, increasingly, supply chain is managed on a much more sophisticated basis these days; there is a lot more emphasis on just-in-time ordering, where appropriate. And there are benefits in doing that. A routine part of management is to keep those stock levels up.

If a staff member notices that a stock level is low, is below the prescribed level, they will initiate the necessary ordering process to replenish that stock. As the minister said, there will be times when we run out of stock and if we do run out of stock they will try to get it from an adjacent service area or adjacent ward area.

I do not know anything about the example that you are referring to, the $100 item. If the $100 item is required clinically and we do not have it locally available, we most

certainly will taxi down a $100 piece of equipment if that is the difference between providing an appropriate, safe clinical service and not providing a service. That is not the way we deal with things routinely; we have much more formalised supply chain arrangements in place than that. If we run out, we will source the supplies. It is an emergency service that we operate and we place patient safety very highly and we will do whatever we can to source the stock that is required if it is not available locally.

MRS BURKE: A supplementary to that refers, in part, to post-operative pulmonary embolisms. We have had reports to my office in regard to prophylaxis being not supplied and people being told, "You will have to wash the one that you have got," and so on. We followed that through. I am not sure whether I have told you, minister, but obviously all of these complaints or issues that have been raised with me I am giving fully to the Health Services Commissioner. I am hopeful that is coming back to the minister in a more orderly form. I hope that the system is going to work. I am concerned about that.

At page 148, it says that post-operative pulmonary embolism provides an indication of quality of care and the effectiveness of the hospital system in meeting needs of patients, as pulmonary embolisms are to some extent avoidable through the use of appropriate prophylaxis. That was my whole issue as well on basic supplies and equipment.

Mr Cormack: We believe that all of our basic supplies and equipment are maintained at an appropriate level. We are more than happy to follow up on any specific identifiable issue that you would like to bring to our attention. From time to time, we do experience national shortages of things like Clexane, which is the subject of a nationally coordinated action.

MRS BURKE: Sorry, what is Clexane?

Mr Cormack: Clexane is a heparin product and it is used as a sort of blood-thinning product for a range of medical and postsurgical conditions. We are part of a nationally coordinated response to some shortages that have been determined due to some supply issues emanating from China, I believe, and we have got a plan in place to manage those supplies until such time as regularity and consistency of supply are maintained or restored on an international basis. That may be what you are referring to.

MRS BURKE: The strategic indicator here says that you already know the problem and you think you know why and it is because it could be avoidable through the use of appropriate prophylaxis.

Mr Cormack: That is right.

MRS BURKE: So does that mean they are not available?

Mr Cormack: No, not necessarily.

MRS BURKE: So are there occasions when the appropriate prophylaxis is not

provided?

Mr Cormack: I am not aware of any. I am happy to have a further look at that. But I am not aware of any specific situation where that has not happened.

MRS BURKE: But you have identified it as being a problem here.

Ms Gallagher: No, it is just one of our performance reporting measures. It is about reporting how effectively your hospital is performing.

Mr Cormack: That is right.

Ms Gallagher: And that is a strategic—it is not about—

MRS BURKE: Sorry, minister; it says here "to some extent avoidable through the use of appropriate prophylaxis".

Mr Cormack: That is right; it is good treatment.

Ms Gallagher: That is right—the strategic indicator. If that goes up, that is a lesson that you are not doing—

MRS BURKE: Page 148.

Ms Gallagher: That is why we keep an eye on it, just as we keep an eye on everything else. So, yes, they happen, but this is the level, and if they go up we need to be looking at that. But it might not be around supply; it might be around something else.

We had a look at how our emergency department was operating, and one of the things that the reviewers told me was they were absolutely astounded at the amount of supplies and the quality of supply that we have on offer in our hospital; for example, supplying nappies and other things to parents who may be in there, which are things that are not offered in other hospitals. I am not using that to say we are great, but I am saying that we have had people come and have a look at this and say, "This is really good. Your systems, your stocks and the quality of what you provide is excellent and would not be seen elsewhere."

MRS BURKE: That is interesting. Nurses have said to me, "We've been told we've only got 100 pillows"—I do not know what all that means, and that was recently—or, "I can't give you another oxygen mask."

Ms Gallagher: Do they need more than 100?

MRS BURKE: I do not know. I have no idea.

Ms Gallagher: Maybe they only need 40 and they have got 100.

MRS BURKE: No. Somebody wanted a pillow and was told: "We can't give you one. We only have 100 and they are all gone."

Mr Cormack: We have already started looking into that particular issue. We are not aware of the circumstances of the case; something has appeared in the *Canberra Times* today. We will look into that.

MRS BURKE: I have not seen the *Canberra Times* today, so you are telling me something now.

Mr Cormack: It sounds very similar to what you are referring to. We will look into that and we will follow that up. As far as I am aware, there is no pillow restriction; there is no per pillow allowance.

MRS BURKE: I am very pleased to hear it.

Ms Cormack: We provide pillows and prophylaxis to all those who need them. That is the way we run our service.

MR SMYTH: Just on that strategic indicator 3, I notice Canberra met its target of one per cent but Calvary seems, at two per cent, to be struggling. Is there a reason for that?

Mr Cormack: We are happy to give you some advice on that. We report this in our public performance reports and there is a rider on that: because of the lower number of admissions at Calvary, you get a little bit more variability. But I am happy to provide you with a more detailed response to that.

Ms Gallagher: If you need one.

MR SMYTH: If there is more to it. To go back to part of your earlier answer, you said you will freight things down from Sydney urgently if necessarily. Is it possible to find out on how many occasions that would have happened in the last 12 months and at what expense?

Mr Cormack: We will have a go at it.

MRS BURKE: Or from elsewhere. If you are aware of it, there must be a record of it.

Mr Cormack: We bring down stuff from Sydney routinely as part of our supply chain. So differentiating between those that are because we have run out at very short notice as opposed to regular supplies is a pretty significant piece of work. But I am happy to make that inquiry if that would assist the committee.

Ms Gallagher: Mr Cormack has a number of answers to questions taken earlier.

THE CHAIR: Sorry, I meant to ask Mr Cormack when you first came down—I got distracted, or we both got distracted, and I forgot to ask you—for those questions on notice. So would you mind giving them to us now.

Mr Cormack: In relation to the WorkCover notice, I confirm the previous advice that the notice was put on at 4.00 pm on 30 April and was removed, revoked, at 9.00 am

on 1 May.

THE CHAIR: So 4.00 pm, in the evening?

Mr Cormack: And revoked the next day.

THE CHAIR: The next day, at 9.00 am?

Mr Cormack: Yes.

Ms Gallagher: It has not been reissued.

Mr Cormack: It has not been reissued; there is no current action there. In relation to Mr Mulcahy's question about strategic indicator 18 of budget paper 4, page 156, the graph presents the most recent data from ASSAD, the Australian Secondary Students Alcohol and Drug, survey. The last survey, 2004-05, showed the prevalence of smoking at nine per cent and a target of five per cent was set. The 2008 survey is about to be undertaken, after an interval of approximately three years.

The third issue relates to people waiting around in the hospital with fractured mandibles. We have made inquiry and we are not aware of any issue with patients with fractured mandibles waiting around in the hospital, experiencing unnecessary delays. However, I would say that at times of extreme peaks in activity people do wait in hospital for surgery and those waits can extend for more than a day or two in some cases, but we are not aware of any specific instances of fractured mandibles. We are happy to investigate any cases where further detail is provided.

In relation, Mr Smyth, to the elective surgery waiting lists, it is 4,954 in March 2008, 4,988 in April 2008.

MR SMYTH: Thank you.

Ms Gallagher: Can Mr Thompson answer one of Dr Foskey's questions?

THE CHAIR: Yes, of course.

Mr Thompson: You asked which NGOs were currently operating, assisting in service provision at the corrections facilities at Quamby. The NGOs that are currently providing services are Gugan Gulwan, Ted Noffs, Directions ACT and Winnunga, and at Belconnen Remand Centre and the Symonston Temporary Remand Centre it is Gugan Gulwan, Directions ACT, WIREDD—and if you want me to say what WIREDD stands for I would have to take that on notice—

DR FOSKEY: It is the women's information referral and education on drugs, or something like that.

Mr Thompson: ADFACT, which is the Alcohol and Drug Foundation of the ACT, and Winnunga.

DR FOSKEY: So that is current but not future arrangements?

Mr Thompson: We would expect that they will continue to provide these services.

MR SMYTH: On page 148, strategic indicator 4, hospital acquired infection rates, I notice there have been some articles in the *Sydney Morning Herald* recently about—I am not even going to try to pronounce it—the MRSA virus.

MRS DUNNE: Methicillin-resistant staphylococcus aureus.

MR SMYTH: All right. I read somewhere that in New South Wales and the ACT 43 per cent of golden staph specimens were found to have MRSA compared to the national average of 31 per cent. Is there a reason that it is so high in the ACT?

Mr Cormack: My advice is that it is not as high; in fact, the ACT has quite good infection control rates. I am not aware of the particular piece of research that you are referring to but I am happy to provide you with a response to that. The advice that we have, certainly from Professor Collignon and the infection control unit, on the work that we have done in the past and that we will continue to do, is that our rates are pretty good.

MR SMYTH: So do we know what our rate is?

Mr Cormack: I would be happy to take that on notice and provide you with a more definitive answer.

MR SMYTH: The information I think came from the federal health department's *Communicable diseases intelligence* journal.

Mr Cormack: Yes.

MR SMYTH: I believe that countries overseas—places like Sweden—and in Australia, Western Australia, have gone on quite aggressive campaigns to rid hospitals of MRSA as best they can. Is that needed here and is it likely to happen here?

Mr Cormack: It certainly is. It is an international issue of great prominence. We will certainly continue to give it the priority that it deserves. We have got a very strong team, particularly at the Canberra Hospital. They provide consulting services across both hospitals. It is a matter of the greatest concern to us. We will continue to put in whatever effort and resources are required to get it under control.

MS MacDONALD: Can I ask a supp to that, please?

THE CHAIR: Ms MacDonald first.

MS MacDONALD: The issue of infection rates within the hospital has been raised before: Mrs Burke has raised it and I made inquiries about it. It is my understanding that it is not mandatory to report the levels of staph.

Mr Cormack: That is right.

MS MacDONALD: And other bacteraemia infections. So it is a bit difficult to know what we are actually faced with. Are there any discussions going on at a national level in terms of reporting mechanisms on that issue?

Mr Cormack: I could ask Dr Guest to provide us with the national context of notifiable diseases and the status of that. We offer 100 per cent blood testing in the Canberra Hospital anyway, so whether it is mandatory or not we have a very comprehensive testing regime in place that many of the other jurisdictions do not have. Perhaps Dr Guest could inform us about how things become notifiable diseases and what the national thinking is on this.

Dr Guest: The question of notifiability of disease really arises in relation to infections, particularly, and other conditions where the local public health unit would take action. Hospital-acquired infections do not report to the public health unit here—nor is there much enthusiasm to get them to report to public health units around Australia—because the action is taken by hospital infection control staff on site. That is why there is no particular agitation coming from the Population Health Division, or the communicable disease intelligence network that Mr Smyth referred to before, to make a hospital infection formally notifiable.

MS MacDONALD: But, if you do not, is it possible to, say, get MRSA and go home without it actually being detected by the hospital in the first place?

Dr Guest: Theoretically it is possible. In practice, that does not happen.

Ms Gallagher: I should say too that, in our planning work for the capital infrastructure, it is envisaged, as part of that $1 billion plan, that the majority of beds within wards will be single rooms. That is how hospitals are being built around the world. The other day I spoke to the intensive care director, who had just been up to visit the new intensive care unit in Westmead. She was telling me that it is an absolutely massive space and every one of those beds is in a single room, to deal with these sorts of issues. I think we are well placed to be able to respond in a building and infrastructure way with this plan, and it is largely around single rooms.

MRS BURKE: I want to pick up something Mr Cormack said.

THE CHAIR: Excuse me, Mrs Burke—

MRS BURKE: Sorry, I thought I was next.

THE CHAIR: Mrs Dunne has a supplementary. You did ask for one.

MRS DUNNE: Yes, I did. I thought I was after Jacqui.

THE CHAIR: No.

MRS DUNNE: On the issue of single rooms, this was one of the issues that I recall was pointed out by Dr Collignon—that we had gone out of single rooms, that there are a lot of two and four-bed wards.

Ms Gallagher: Yes.

MRS DUNNE: And not very many single rooms.

Ms Gallagher: That is right.

MRS DUNNE: He did make the comment that a lot of the existing single rooms had been turned into offices—that is my recollection—so we are actually moving back into the single-room configuration.

Ms Gallagher: Yes. That has certainly been the design of the new building. I did answer a question on notice about this from Mrs Burke and can happily report that this government has not converted any of those single rooms to administration purposes; that was all done under the previous government. It is one of those happy questions on notice you sign. And we are now resuming them at as fast a rate as we can.

MRS BURKE: Do you mean all the rest are unhappy, minister?

Ms Gallagher: Pardon?

MRS BURKE: Do you mean all the other questions are unhappy?

Ms Gallagher: No; it was just one of those ones that give you a little smile. It is quite rare in this job.

THE CHAIR: Do you have a supplementary on this area?

MRS BURKE: Yes. I am not sure if Dr Guest needs to come back, but on that *Communicable Diseases Intelligence* journal the research showed that New South Wales and ACT hospital patients are 25 per cent more likely to have an antibiotic-resistant type of golden staph bug than patients in the other states. Linked to that, too, that research shows that about half of the clinical staff are still failing to wash their hands each time they look at a new patient. What is being done to try and up the ante on this whole thing? I note and recognise the work of Professor Collignon in this area.

Also, I have heard of examples of nurses entering or returning to the system and not being given a physical demonstration of how best to wash hands. Perhaps that might be something that you are looking at or can look at, and, along with that, how regularly are we checking things like soap dispensers, which I know to be really dirty underneath? How far are we with any or some of this?

Ms Gallagher: Every bed has one of those pump packs of disinfectant that you rub—

MRS DUNNE: The alcohol disinfectant?

Ms Gallagher: Yes—that you rub on your hands. We had a campaign around washing hands. The nurses were wearing badges that said something about "Have I

washed my hands yet?" or "Ask me whether I washed my hands" or something to that effect. So there has been quite a concerted effort under the leadership of Professor Collignon and some of the infection control nurses, who do a fantastic job to educate and remind staff. For the large part, the nurses do an excellent job. Outside the intensive care unit there is again a pump pack for visitors. Before they even enter, they have to wash down their hands and stuff before they walk in.

So there is a big effort on that in the hospital. I do not know about nurses returning to work. I imagine they do go through an induction program around that on the ward. I cannot imagine that they would not, because it is now such a prominent part of the day-to-day workload for nurses—and visitors as well.

MRS BURKE: Would there be any move then to, for example, publish score cards for the ACT's public hospitals in order to drive home the necessary reforms in infection management?

Mr Cormack: We publish quarterly. We publish a range of indicators around—

Ms Gallagher: I think the chapter heading is "How safe are our hospitals?"

Mr Cormack: We have published "How safe are our hospitals?" every quarter for the last three years.

MRS BURKE: Is that in—

Ms Gallagher: In the quarterly performance reports. It is only the title. It is one of those chapters towards the end of the report. It says, "How safe are our hospitals?" It goes through hospital-acquired infection, unplanned returns to theatre. Some of it is a bit more than the strategic indicators here.

The best thing to do is constantly remind visitors and staff at the hospital about the need to wash hands and have appropriate hygiene plans in place. I know that it happens in the paediatric area. If someone has got a gastro bug or something, toilets are cordoned off for that family to use; no-one else is allowed near. Again, with ageing infrastructure, it is difficult to always have 100 per cent control over these things, but I think staff do a very good job day to day.

THE CHAIR: Mr Smyth is going to ask one more question on this output class and then we are going to go to the next output class.

MR SMYTH: I want to go to page 164 of budget paper 4, the accountability indicators. I notice that for the cost-related patient separations this year you have included the target for mental health cost-weighted separations. If you take the 2,400—which is what I think is listed in the notes at the end of mental health output—off that, at 2,400, are you actually planning in-patient activity to do less next year than you have done this year?

Mr Cormack: No.

MR SMYTH: Am I misreading that?

Mr Cormack: Yes, you are. The underlying growth rate is three per cent. If we are looking at 1.1, the underlying growth rate is about three per cent that we are projecting once you adjust for the cost weight changes in the mental health separations.

MR SMYTH: So the 2007-08 target of 73,400 includes the 2,400 mental health cost-weighted seps?

Mr Cormack: Sorry. Yes, it does, but it is not in the estimated outcome.

MR SMYTH: It is not in the estimated outcome. So the growth this year is 76,000 cost-weighted seps against a target of 70. It is not in the estimated outcome?

Mr Cormack: No.

MR SMYTH: But it is in the target. So if we take 2,400—

Mr Cormack: It is in the 2008-09 target; that is right. It is about a seven per cent difference once you do that.

MR SMYTH: That is the point I was trying to make. Your actual outcome this year is seven per cent.

Mr Cormack: That is right.

MR SMYTH: But you are estimating only a three per cent growth for next year?

Mr Cormack: That is right, yes.

MR SMYTH: What is that based on? Are you underestimating it? If it is growing at that rate—

Mr Cormack: I think the minister made this very clear in her opening statement. If you look at growth over the recent longer term, you are talking about growth rates of around two to three per cent—less than three per cent. In the last two years we have seen growth rates of six per cent. We do not believe that it is necessarily going to continue at six per cent per annum. We have no reason to believe that.

MR SMYTH: Do you have a reason to believe that it will not?

Mr Cormack: The long-term average—which is really what we look at; we do not just look at blips from one year to the next—in our population projections are indicating a growth of about three per cent. We got that wrong. We did get that wrong; there is no question about that. That is a risk. But we have to look at the longer-term trend, and the longer-term trend does not support continuing to project forward a six per cent growth rate into the future. There is not the evidence to support that.

MR SMYTH: What is the cost of an average cost-weighted separation these days?

Mr Cormack: It is about 4,000, 4,400. I am looking to my colleague; I can get that for you momentarily.

MR SMYTH: That is okay. And has that gone down?

Mr Cormack: The rate of growth per cost-weighted separation has moderated significantly. We indicated before that we were running at about 30 per cent above the national average. We have now pulled that back to about 15 per cent. The data that we have available to us indicates that the rate of growth in the cost per weighted separation is moderating.

MR SMYTH: All right. Is it possible to get the cost of the cost-weighted separations over the last five years?

Mr Cormack: Of course it is. It is published in the Australian Institute of Health and Welfare hospital statistics, and we are happy to provide you with a summary of that.

MR SMYTH: That is fine, thank you.

THE CHAIR: We will go on to the next output class, which is 1.3. We are skipping to that and then coming back to mental health. Do you have a question, Dr Foskey?

DR FOSKEY: Yes, I have a question on this. I am asking a question about community health and the dental area. Provision for public dental health services, has been included as part of the community health output and mentions only ensuring timely access to public dental health in cases of emergency need.

Ms Gallagher: We are on budget paper 3, are we?

THE CHAIR: Which page?

Ms Gallagher: I know you are on output 1.3. I just cannot—

MR GENTLEMAN: It is page 165 of BP4.

Ms Gallagher: Thank you.

DR FOSKEY: How much will actually be allocated specifically to public dental services, and what measures is the government undertaking to address the need for preventative dental services, particularly for the socially disadvantaged members of our community?

Mr Cormack: We might ask Jenelle to talk about the second part of the question, through you, Madam Chair. We might take the first one on notice. We are going to publish a degree of detail, but we are happy to make that available to Dr Foskey.

THE CHAIR: Thank you.

DR FOSKEY: Assume that we are talking about reducing waiting times for people in

the public dental health system. I am also interested in knowing whether there is an extension of services to public dental health clients, too, because there is a narrow range of services offered to public dental patients.

Ms Reading: Dr Foskey, could you please outline your question again?

DR FOSKEY: Yes. What measures is the government undertaking to address preventative dental health services, particularly for the socially disadvantaged members in our community?

Ms Reading: Preventative dental health, the parameters of that are quite broad. Clearly, it is about community education, good oral health hygiene and the foods you eat, but it is also timely access to care. There are also preventative health measures provided when people actually come in for treatment services, where they may well have a sealant or they may well be provided with health promotion by the dental officer. Again, that is about maintaining the basic standards of oral health care that will ensure that they continue their full course of treatment and be maintained until they are recalled to access the service again.

From a commonwealth perspective, we would be looking at having a more targeted approach to preventative health care for the key target groups that we have talked about this morning in terms of younger children and a team plan. The teenage population are probably the most at risk in that you get away from packing their lunch and they are given lunch money and that is when they access the Coco Pops and everything else that is available at school canteens. Hopefully we have got healthy school canteens, but they access those things on the way home from school or the like.

DR FOSKEY: I have heard evidence that infants' teeth are very badly affected by, for instance, a lot of fruit juice in bottles, which is a bit of a measure that some parents use.

Ms Reading: What is the evidence? Are you asking me that?

DR FOSKEY: No, I have said that that is the case, and that is a very early and important stage to educate people about their children's teeth.

Ms Reading: It certainly is.

THE CHAIR: We had this question answered this morning, Dr Foskey.

DR FOSKEY: Did we?

THE CHAIR: Yes, quite extensively.

DR FOSKEY: We are talking preventative dental—

THE CHAIR: Yes, that is what we had.

Ms Reading: I am happy to inform you that we do have a dedicated children's dental service. There is very opportune access to that service, and we do have targeted

programs for prevention.

DR FOSKEY: In terms of improving public dental services, what are the objectives? Are they to reduce waiting times? Are they to increase the range of services? If it is the latter, to what?

Ms Reading: I know that we have made extraordinary efforts to reduce our waiting times for access to services. We have certainly made extraordinary gains over the last 12 months. We have halved our waiting list numbers. We need to balance that with the complexity of the clients that are accessing our services. We have some client groups that require more frequent recall. We might have people with a disability; we may well have people with chronic illness that are higher risk groups. It is balancing those with the general community who are eligible to access our services as well.

We have made really strong gains in that area. We owe that performance to two things: firstly, our ability to maintain excellent working relationships and partnerships with private providers; also, our telephone triage system, which has been very effective in ensuring that emergency services are provided in a timely way. We have to balance between those people who are a true emergency and those who can go on the restorative waiting list. That provides the dentists that work with us the opportunity to have that shift away from the ongoing provision of emergency services so that they can actually get on with the business of restorative care and finish a full course of care.

THE CHAIR: Mrs Burke, you have a supplementary?

MRS BURKE: No, I have another question on page 165.

MRS DUNNE: I have a supplementary on dental, if I could interpose.

THE CHAIR: Yes.

MRS DUNNE: We have spoken a lot this morning about young people, Ms Reading. People in the aged care sector, one of the things that they are most concerned about is the provision of dental services. That would include dentures and the like. What are the ongoing services that are targeted to the aged in the community, and is there anything in this budget for that? There is certainly nothing in the commonwealth budget that relates to provision of dental services for older people?

Ms Reading: The first thing is that we do have a domiciliary service to aged care facilities, albeit that we would certainly welcome the opportunity to enhance that service. With your comment about the commonwealth dental health plan, we are currently negotiating and are part of the discussions around finalising policy and targeting services to individual needs of states and territories. The targeting and funding arrangements for the ACT with other states and territories are yet to be finalised.

Our needs are very different to those of New South Wales, Queensland and Western Australia where there are huge issues with rural and remote areas. We do not have those problems. It gives us the flexibility with the commonwealth dental health

program funding that is imminent to be able to target services to areas where we could be doing better.

MRS DUNNE: Correct me if I am wrong, but I thought that most of the commonwealth dental health program funding was for the teenage group and that the program of the previous government for people with chronic conditions and older people is being phased out and the books are closed on that.

Ms Reading: I beg your pardon?

MRS DUNNE: The previous program, called the chronic something or other—

Ms Reading: That is with the Medicare arrangements?

MRS DUNNE: With the Medicare arrangements.

Ms Reading: Yes.

MRS DUNNE: The books are closed on that. I think they closed at the end of March or are about to close.

Ms Reading: Yes.

MRS DUNNE: So no-one else can go into that program. In addition to there being no-one able to go into that program, the people who are in that program have funding to have the full course of service?

Ms Reading: If they are eligible to use the services in ACT, they will get access to care, without a doubt. If they are a primary holder of a current Centrelink card, they will get access to care.

MRS DUNNE: Under the commonwealth scheme, for which the books are closed, or are you filling the gap?

Ms Reading: Under ACT government access to services.

MRS DUNNE: Sorry?

Mr Cormack: Sorry, just to clarify, there is a different question being asked.

MRS DUNNE: Yes.

Mr Cormack: I think Mrs Dunne is referring to the cessation of the commonwealth Medicare benefit for dental under chronic disease.

Ms Reading: Yes.

MRS DUNNE: When did that cease, Mr Cormack?

Mr Cormack: I do not know.

MRS DUNNE: My understanding is it is ceasing about now, and there are some doubts as to whether the people who are already in the scheme will actually get their full course of service that they anticipated.

Mr Cormack: I think the answer to that is that we will follow that up, but it is really a commonwealth issue. I think what Ms Reading is identifying is that we are able to provide a certain package of services for eligible people, which is a different answer to the question that you are asking. I am happy to follow up on that. I do not know the technical answer to it.

MRS DUNNE: ACT Health is providing some of that service through the chronic—

Ms Gallagher: I think it is done privately. In fact, it is all just a private provider service.

Mr Cormack: We are not involved with it.

MRS DUNNE: It is a private provider. It is an arrangement between the commonwealth and—

Mr Cormack: Correct. So we do not have to follow that up?

MRS DUNNE: No.

Ms Reading: Sorry for the confusion.

MRS DUNNE: I was working under a misapprehension, sorry.

THE CHAIR: Mrs Burke, and then Ms MacDonald.

MRS BURKE: Thank you, chair. Remaining on page 165 of budget paper 4, item "i", the proportion of clients discharged from public hospitals to a community health program who have had a completed discharge plan—I have raised this before publicly—I notice that the target for 2008-09 is not applicable given that strategic indicator 23 now replaces that. When you look at page 159 of budget paper 4, indeed, it now shows a target of 75 per cent. Some 80 per cent of people who leave hospital do not need a plan while the other 20 per cent do. How are we going to achieve that, given that we were struggling to achieve even 30 per cent previously?

Mr Cormack: I am happy to answer that question. I guess the issue of discharge planning has always been a challenge for public hospitals. There is no question about that; there is a whole literature out there published on it. ACT Health's response has been to adopt the 80-20 rule, which is to recognise that you really should be focusing on the 20 per cent where you need to get the discharge planning right.

In looking at accountability indicator 1.3 "i"—which, you are quite correct, we have discontinued for 2008-09—we recognised that it was not necessarily hitting the target in terms of the client group that we were focusing on. We have actually got three indicators in discharge planning that we are focusing our energies on. One is strategic

indicator 17, which is in a different output class but they are still patients within hospital. We are getting pretty close to 100 per cent compliance on that. They are the riskiest group of all. They are the clients of the Aged Care Rehabilitation Service.

MRS BURKE: What percentage of that 20 per cent would that be, do you think?

Mr Cormack: **W**e are recognising them as part of that more troublesome group in terms of the ones we—

MRS DUNNE: You mean that in a nice way, do you not, Mr Cormack?

Mr Cormack: Yes, in terms of the work that is required.

THE CHAIR: Work intensity.

Mr Cormack: Indeed, the complexity. They are a significant component of it. They are older people or people in our rehabilitation programs. We are close to 100 per cent compliant on that. In relation to the replacement indicator for 1.3 "i", which is strategic indicator 23, that recognises that there is a second group of clients who are not necessarily part of that included under strategic indicator No 17, and that is people who have been in hospital for more than 30 days. If you have been in hospital for more than 30 days, generally speaking you have a pretty complex, multifaceted admission. That is the group that we are focusing on. There is a third group, which is in mental health. I draw your attention to output 1.2 "i". We have an indicator in there which focuses on the importance of follow-up for mental health clients discharged from hospital.

What we are really doing is focusing our discharge planning effort on those three groups. I do apologise; I wish I could withdraw from the record the word "troublesome"—the most complicated group of clients. That is where we are focusing the greatest effort. When you look at those three groups in particular, you are probably going to pick up most of the 20 per cent that we are focused on.

MRS BURKE: Do the ones with longer than a 30-day stay come in that category?

Mr Cormack: That is right.

MRS BURKE: Going back to my original question, how are we going to be able to reach a target of 75 per cent if we are currently reaching only 30 per cent?

Mr Cormack: We are using the same sort of strategy. It is a different group of clients, to start with. We will be using the same sort of successful strategy that we have got for strategic indicator 17 and accountability indicator 1.2 "i".

MRS BURKE: I am sorry; now I am confused.

Mr Cormack: I think you are asking me how we are going to achieve it.

MRS BURKE: I am, but output 1.3 at page 165, item "i", refers directly to strategic indicator 23. It has nothing to do with the other strategic indicators on discharge

planning that you have said—

Mr Cormack: Actually, it is, because—

MRS BURKE: Maybe it is not very clear in the budget papers.

THE CHAIR: Over the afternoon tea break, perhaps the officials could have a look at those indicators and then come back to you with some kind of answer—rather than us trying to clarify it now?

MRS BURKE: That would be good. Thank you.

MR SMYTH: If you are going to go away and look at it, I note that 30 per cent of the people are discharged to a community health program. How many people are discharged to a community health program?

Mr Cormack: I do not have that information.

MR SMYTH: If 30 per cent get a completed discharge plan, how many is that? How many completed discharge plans are done?

Mr Cormack: I do not have that information at my fingertips at the moment. What I am saying is that we have had difficulties with accountability indicator 1.3. The main difficulty is that it is not necessarily focusing our change and reform efforts on the most in need group in terms of discharge planning.

MR SMYTH: I understand that, but I would like to know how many people are discharged from hospital to a community health program. Then we can work out what 30 per cent of that is in terms of just the raw number of discharge plans. And in indicator 23, you want 75 per cent of the 20 per cent, so can we find out how many that is in terms of number of plans.

Mr Cormack: Yes—how many patients we have who are discharged with a length of stay longer than 30 days—

MR SMYTH: And we want 75 per cent of that—

Mr Cormack: We are happy to do that.

MRS BURKE: That was my original question, which I am still confused on, because "i" at 165 refers directly back to strategic indicator 23.

Ms Gallagher: We are sort of changing.

Mr Cormack: We are refocusing.

Ms Gallagher: We are refocusing the indicator. It is not measuring the same thing. That is the difference.

MRS BURKE: If we can have a breakdown or disaggregation or whatever—

Ms Gallagher: Yes.

THE CHAIR: We will leave it at that. That will come on notice and that will answer this question.

Meeting adjourned from 3.30 to 4.00 pm.

THE CHAIR: Mrs Dunne has remembered what the supplementary was.

MRS DUNNE: It is not that I had forgotten what my supplementary was. I was able to clarify it, with the help of some blood sugar. I would like to go back to strategic indictor 23 and the discussion that we were having about strategic indicator 23 and accountability indicator 1.3 "i". Even with the blood sugar, it is still unclear, which is why I am asking the question. The discontinued indicator is the proportion of people who are leaving hospital to go to a community health program. Mr Cormack, why is it the case that people who are going to a community health program—why was the indicator not 100 per cent? Surely people going in these sorts of circumstances would have to have some sort of discharge plan.

Mr Cormack: The issue comes down to again this discussion we had about the 80-20 rule. I am using that in a general sense: I am not saying precisely 80 versus 20, but the 80-20 rule. There is a good literature base to this. The 80-20 rule says basically that 80 per cent of people who come in and go home from hospital have very uncomplicated, simple discharge arrangements that do not require a formal detailed discharge plan.

We are really talking about a group of clients—patients, roughly about 20 per cent—that we need to focus on. That is really what we are saying. The indicator that we are deleting has been in for only a short period of time. We found that it was not really addressing the issue of patients who needed a more formalised discharge plan. It was addressing a proxy set of patients. To answer the question from before, to the end of March 2008 from the beginning of the financial year the number is 17,338 patients. That is more than 20 per cent. So it was not a targeted indicator. For completeness, we actually achieved a completed discharge plan for 29.1 per cent of those, which is just a tad short of the target of 30.

The point is that it was not really getting at the complicated patients that we wanted to focus our efforts on. What we have done in this year's presentation is identify a more targeted group of patients, and that is those with a length of stay longer than 30 days, which generally means that they have had a complex episode of care. Again, using some current figures just provided to me, to the end of April 2008—so that is a 10-month period—922 people fit into that category. Over a full year, that would be about 1,100 people with a stay of longer than 30 days. They are the group that we really want to focus our efforts on in fixing up the discharge planning issue. That is why we have changed the indicator. We want to aim for the highest possible level of performance with that particular group. If we do not handle their discharge well, or as well as we can, they are at greater risk of not having the best health outcome. That is the explanation for it.

MRS DUNNE: I see your point about the previous indicator being quite wide and that now you cast it in a much narrower way. But are we preparing discharge plans for people who stay less than 30 days?

Mr Cormack: Yes. There are two other groups. They are both picked up under other strategic indicators. One is on strategic indicator 17. That is in a different output class but they are still patients who go to hospital and get discharged. That is a group that we want to pick up and focus on. We are aiming for, I think, 100 per cent on that one—strategic indicator 17. We are going pretty well with those. They are the ones we really want to focus on.

MRS DUNNE: Yes.

Mr Cormack: There is another group, which is accountability indicator 1.2 "i", which is the mental health group. They are another group where you really want to make sure that their discharge is as well coordinated, planned and documented as you possibly can. We are coming at the overall discharge planning issue by addressing indicators in three output areas.

MRS BURKE: Going back to my original question on page 159, can you break those down to percentages? We know that 80 per cent of patients discharged do not need a plan. We therefore say that 20 per cent do. You have now targeted three groups; you have broken that down. What was the percentage of that 20 per cent for each grouping? Would you have any idea?

Mr Cormack: I will be able to provide that to you.

MRS BURKE: Thank you.

Mr Cormack: I can give you one group, which is the length of stay longer than 30 days; that is about 1,100.

MRS BURKE: Right.

Mr Cormack: I will give you the numbers for strategic indicator 17 and output indicator 1.2 "i".

MRS BURKE: Thank you.

Mr Cormack: That will get us a bit closer to answering your question.

MRS DUNNE: Once we get outside those three groups of people, are there discharge plans for anyone else?

Mr Cormack: There are discharge processes in place for most patients, but in terms of a formalised detailed discharge plan, as I said before, we focus on the 20 per cent group. They are the ones we have developed indicators for.

MRS DUNNE: Do those three indicators cover the whole of that 20 per cent group?

Mr Cormack: I do not think they cover the whole of the 20 per cent group.

MRS BURKE: That is what I am asking.

MRS DUNNE: I think that was Mrs Burke's question.

Mr Cormack: I guess the point is that our indicators do not cover the whole of everything we do anyway; the indicators are meant to indicate issues that we need to focus our performance improvement efforts on. We could come up with another 20, but we would spend more time counting and collecting data for indicators than actually improving discharge. We tend to focus on a manageable group of indicators.

MRS BURKE: How are you going to manage reaching your 75 per cent target in that 30-day group?

Mr Cormack: By adopting similar processes to what we have done with strategic indicator 17 where we are getting nearly 100 per cent—that is, through concentrating reform efforts and management efforts on the most complex group of patients—that is how we will do that. It is through policy changes, it is through education, it is through data collection and it is through good management practices. That is how we will do it, which is how we did it with strategic indicator 17.

MRS BURKE: Sure, but previously I was on page 165 at 1.3 "i" and they were all grouped into that and we were having difficulties being only able to reach a target of 30 per cent.

Mr Cormack: Yes.

MRS BURKE: I am just wondering, now we have got them separated: you are telling me it is going to be more efficient and you are confident you can reach your 75 per cent target?

Mr Cormack: Yes, for those three indicators. I am sure we will do a lot better than what we have done with this group.

MR SMYTH: So overall will there be more discharge plans done, the same number of discharge plans done or fewer discharge plans done?

Mr Cormack: There will be a far greater emphasis on discharge planning and a more comprehensive range of indicators available against identified targets to measure our performance and success in discharge planning.

MRS BURKE: This aggregated information will be useful.

MR SMYTH: But overall will there be more, the same number or fewer discharge plans done?

Mr Cormack: I cannot tell you that specifically, but I can say that we will be aiming for very significant high-stretch targets in those three specific areas, which compromise the most complex of dischargees that we have. As to the mathematical

formula of that, I am happy to take that on notice and provide a reconciled table for you.

MS MacDONALD: I am interested to know about what would be in the refurbishments of the community health centres. We did not do this before, did we?

THE CHAIR: No. The minister mentioned them but I do not think we had an explanation of what the refurbishment would actually mean.

Ms Gallagher: The idea, I think, is to upgrade some of the facilities, to look at perhaps Belconnen and Phillip and whether there are opportunities for additional services in the future. That is probably part of a second piece of work, not part of the $5 million upgrade. That $5 million essentially will allow us to modernise the existing centres—maybe look at streamlined reception; I guess just an easier patient journey through those centres. If, say, the walk-in centres are feasible at Tuggeranong, it will involve setting up a walk-in centre in the Tuggeranong Health Centre—it is very well located; in fact, all of our health centres are very well located—and then the Gungahlin centre. We are just finalising a suitable block of land for that facility, but that as well would be a purpose-built facility, potentially with a walk-in centre as well. That is an $18 million new construct, though, so that is more.

The idea, and $5 million will get us going, is to invest in the infrastructure we have got, bring it up to standard, look at what services we can offer there—more efficient use of, for example, reception areas—and begin the process of integrating them more effectively with the hospitals. That will be part of that initial work. But I think we have got a bit more discussion to have about the community health centres as we roll out this plan, and some of that work in project definition and planning will assist us on the future use of those facilities. For example, I think in that little book you have got there, the Belconnen and Phillip one—

MS MacDONALD: It says new refurbished community health centre and wellness centre for both of them.

Ms Gallagher: Yes. The wellness centres are the ones that we would look at having, potentially in the future, some additional services offered from there that may now be offered in the hospital but could be offered in another site as well, with closer links to the hospital.

MS MacDONALD: As you said, they are well located, so it would make it easier for transportation as well. It is not as though Canberra Hospital and Calvary Hospital are dramatically out of the way, but there is that additional bus ride out of the town centre.

Ms Gallagher: It is also changing the mindset, I think, of having our hospitals being the only point where these services can be offered. That is where perhaps the walk-in centre will help us, if there are opportunities for early diagnostic work of some order to happen in one of them. We could not do it at every one because that would just be ridiculous; you would just be getting these little mini sites and they would be very expensive and not very efficient. But I think the idea is that we could have two polyclinic-type centres and they would be best located at Belconnen and Phillip, which are already, location-wise, close to the hospitals.

MS MacDONALD: Would the nurse practitioners be located in some of those centres?

Ms Gallagher: I think there is opportunity there to use nurse practitioners. One of the biggest constraints on the nurse practitioner is the ability to prescribe and order tests outside of the hospital environment, because they do not have those rights. That is an issue that we are all talking with the commonwealth about, because it is all very well to train these professionals, but then to really constrain their ability to use these skills is not the most effective use of them. So, if in the walk-in centres we are really setting up an outpost for the emergency department, there are ways that we can support that increased role for the nurse practitioner, under the auspices of the hospital.

MRS DUNNE: I am going to ask a question which will probably display my ignorance: what is a wellness centre?

Ms Gallagher: I just went through that. You were not listening? It is really the opportunity to offer some increased services over and above what we offer at the community health centre now, possibly early diagnostic work that we currently—

MRS DUNNE: But there is no primary intervention at any of these health centres? You do not have GPs on?

Ms Gallagher: No. For example, if we had a clinic, run by one of our doctors from the hospital, where they could visit—I am trying to think off the top of my head; maybe a fracture clinic—

MRS DUNNE: So you do not have to hobble all the way to the hospital?

Ms Gallagher: Yes, that is right. If we could offer something there, with our existing staff—what I want to see is a better link between the community health facilities and the hospital, so it is not that some are in hospital land and others in community health land, to better integrate them. The idea—perhaps this has to be defined this year—is to enhance the roles of the Belconnen and Phillip community health centres, as they are quite close to hospitals already, so we could use staff effectively. We would not want to see them across all of the community health centres, but there is the opportunity to just change the need for everyone to go to hospital for particular things, if there are things that we can offer in more adequate facilities.

One of the issues at the hospital at the moment, as we increase beds and staff, is an increasing lack of space. If we are going to upgrade our community health facilities in part of this first $300 million, and there is some space available, we should be looking at some of those services that do not really need to be in the hospital and whether they can be offered in these two locations. That is all it is, with the idea of better integrating the system. They may have a different name; that is what their name is at the moment.

MRS DUNNE: Sounds a bit New-Agey.

Ms Gallagher: Nothing New Age about it.

MR SMYTH: On page 165, indicator "a", number of opioid treatment clients with a management plan: is somebody receiving opioid treatment on the methadone program?

Ms Gallagher: Yes.

MR SMYTH: How can you get onto that program and not have a treatment plan?

Mr Cormack: I think what I might do is ask Ms Reading to respond to this question about this indicator.

Ms Reading: This relates to a care plan that is coordinated by the doctor or the specialist that sees the clients. It has shifted from a medical intervention to a care plan where there is a range of multidisciplinary services available to these clients. So it is about having a coordinated plan for the management of their health care needs. It may well be broader than just receiving treatment services.

MR SMYTH: Sure. But how do you get onto the program if you do not have a management plan? The existing indicator has a number. The replacement indicator will have a percentage, which says the target is 90 per cent of people with a plan. Surely you have to go through an assessment and have a plan before you can—

Ms Reading: You certainly do. I will give you an example of what may well be the gap with the 90 per cent. If an alcohol and drug program client comes in, the staff specialist assesses them. It is an emergency intervention or a clinic that has not allowed a full assessment and work-up of their needs. There would be a medical assessment, there would be a clinical notation and it may well be that it is not until the client comes back the next week for a full assessment and coordination of their care that the care plan would be appropriately worked up.

MR SMYTH: Okay, so you are saying that at any time there might be as many as 60 patients who have not had a care plan?

Ms Reading: It is not about the fact that they have not got a care plan; it is about the fact that they have a clinical notation based on their first representation to the doctor and it is about the review and the work-up of what is required for the appropriateness of their care.

MR SMYTH: But nobody would get into the program unless it was the intention to give them a care plan?

Ms Reading: They have a full clinical assessment by the staff specialist; that is one part of their treatment, and the second is coordinating the appropriate care needs that they may well require apart from the medical intervention.

MR SMYTH: So why isn't this indicated 100 per cent?

Ms Reading: It may well be that we will achieve 100 per cent. We have shifted from a 90 per cent to a percentage for next year.

MR SMYTH: But what you have said is they have some sort of assessment in the interim; while they are having their care plan put together, they might get their first dose. But surely that means that everyone who starts will have a care plan?

Ms Reading: Everyone that has started on a dose of their medication has had a clinical assessment and a clinical notation by the medical officer.

MR SMYTH: Okay, but to receive ongoing doses will they have to have a care plan?

Ms Reading: They would have a full assessment of their care plan needs when they access the medical service again.

MR SMYTH: Minister, is it the objective of the government that everybody on the methadone program have a management treatment plan?

Ms Gallagher: Yes.

MR SMYTH: Okay. So why isn't this indicated then 100 per cent?

Ms Gallagher: You could ask that about any indicator really—why isn't everything 100 per cent?

MR SMYTH: But, if they are going on the program and they are staying on the program, if I am hearing Jenelle right, they have to have a treatment plan.

Mr Cormack: It also recognises that you can have people on for a short period of time. It also recognises that some clients can come in from interstate for a period of five weeks, six weeks on another—as the minister said, we could aim for 100 per cent on absolutely everything and have a perfect health care system, but the reality is that, if we can achieve 90 per cent in this area given the variations in the client group, we think that is a very good level of performance on our way to 100 per cent.

MR SMYTH: So how many interstate patients would we issue methadone to?

Mr Cormack: I do not know off the top of my head.

Mr Thompson: I can say that the methadone program routinely, particularly around periods like Christmas, provides services to people who return to the ACT to visit family, relatives, friends and so forth, and that is done on a referral basis from interstate providers for a defined period of time. They need a daily dosing program and they do need to get onto our program. The point that Mark was making was that logistically over the Christmas period developing a management plan for a client like that can be extremely difficult, particularly if they are coming on referral from another provider.

MR SMYTH: I accept that, but surely in the other jurisdiction they would be on some sort of treatment plan?

Mr Thompson: Quite possibly, but we can—

Ms Gallagher: I think we are reporting here about ACT Health.

MR SMYTH: Okay, if we are reporting about ACT patients—

Ms Gallagher: Is this really an issue? We have set a target of 90 per cent but we want to achieve 100. We may achieve 100. Every one of the clients is being seen, is being assessed. Dealing with this complex client group, I would imagine a 90 per cent target is pretty good.

MR SMYTH: What is the exposure and liability of ACT Health then for issuing methadone to people without a proper treatment plan?

Ms Gallagher: We are not saying they do not have a treatment plan. This is a management plan; it is a different thing. They are all seen by a doctor, they are all assessed and then they are given an appropriate dose, whatever that may be, and they are seen every time they come for their dose. So I do not think you can say that they do not have a treatment plan in place. They do. This is talking more broadly, as I understand it, about the care plan which takes into consideration a whole range of factors.

For example, with the new service we are starting with IMPACT, that may be part of the care plan; that is that they have young children that we would like to keep an eye on. It is a broader piece of work. It is not around the treatment necessarily or singularly; that would be a part of it. There are other elements to it and, as I said, I think 90 per cent is pretty good.

MRS DUNNE: So what is the difference between a care plan and a management plan?

Ms Gallagher: I think I have just explained. Sometimes we get stuck on these things in estimates. I think this is a good target to set. If 100 per cent is achieved next year, that is great; we can up the target.

MRS BURKE: You have said everybody will have a plan. Why are we not aiming for that? That is the simple—

Ms Gallagher: This is about a management; this is changing the focus from just around their dose to the whole person and their care plan. Some people may not want to participate in that, I would imagine, knowing some of the people—

MRS BURKE: So they would get methadone if they do not—

Ms Gallagher: I do not know that we could make a care plan a mandatory requirement of treatment on the opioid program. I would imagine we could.

MRS BURKE: A treatment plan is part of a care plan, so we would still give them methadone if they did not want a care plan?

Ms Gallagher: If they were eligible, medically and clinically approved for treatment

on the opioid program and we wanted to broaden that out to have a care program that encompassed a whole range of areas that they did not want to be part of, I do not know that we would be able to say that, therefore, they do not get their methadone, because—

MRS BURKE: Which plan number are you referring to? Are you referring to a care plan or a—

Ms Gallagher: The care plan, which is what this indicator is about.

MRS DUNNE: No. This one is about a management plan. The words I was saying—

Ms Gallagher: The management plan is what Jenelle has referred to as the "care plan" and that is different to the—

MRS DUNNE: That is what I asked—what the difference was—and you said you had explained it, and now you say they are the same.

Ms Gallagher: I did.

MRS DUNNE: No, you said you explained it and now you say they are the same.

Ms Gallagher: I did. The treatment and assessment is done by the doctor on entering a service and that happens for everyone; everyone has to go through that. So they all get one of those. Then we are now saying, instead of just having that, we would like to implement a management plan/care plan and we would like 90 per cent of clients on the program to have one of those.

What I am now saying is that, if somebody did not want to have a care plan or management plan but still wanted to use the dosing service, I would imagine that we could not withdraw one because they did not want to take the other. We could encourage, we could support, we would hope. I think that is probably reflected in the target—that you will not get 100 per cent of people saying, "Yes, we would like to be part of a broader approach rather than just coming and getting our methadone." I know some people for years just want to show up, get their dose and go home—and they live very happy, wholesome lives. But there are others that we probably envisage we can support a bit more widely—for example, with children.

MRS BURKE: Is that not part of rehabilitation where you would want people on to a care plan? You are saying you do—

Ms Gallagher: Some people will not want to be rehabilitated; that is the whole thing with methadone. It is a maintenance program; it is to maintain a level of methadone for them so they can conduct their normal lives. A large number of them do not want to be rehabilitated. We may have personal views on that, but for people—

MRS BURKE: No, it is a personal choice; that is right.

Ms Gallagher: It is a personal choice and, if that is the case, they might be holding down a job and living a very busy life and they will just want to come and be dosed;

they will not want a multidisciplinary care plan put in place to look at every other aspect of their health—and as a public health provider I am not sure we can force them to.

THE CHAIR: Mrs Burke, you had a question on a new area. After that question, I immediately want to go to mental health, because we need to do that.

MRS BURKE: Thank you very much. I know that the minister has been very gladly working with me on eating disorders, and thank you for the big question on notice and for the response. Do you think current programs dealing with eating disorders appropriately and adequately address the wide range of complex problems associated with eating disorders, otherwise known as ED, or eating disorders not otherwise specified, otherwise known as EDNOS?

Ms Gallagher: I have had a pretty close look at this, as has health; I understand and acknowledge your interest in it. Based on the numbers that we are seeing, I think we are offering what we can offer. I think a lot of the criticism is around the lack of an in-patient facility here. To some extent, that is addressed in this budget with the design allocation for a young person's mental health in-patient facility, which is looking at the provision of a 20-bed facility for young people between the ages of 13 and 16, and then 16 and 25. That might be slightly wrong; it might be 13 and 18 and 18 and 25. I am sure someone will correct me if I am wrong.

A proportion of those beds would be made available for people who have an eating disorder. That is going to be designed this year. The way that we have been doing it is that the construction costs will then be in the next year. It is important that we get that in-patient facility up. But we cannot support an eating disorders in-patient facility here. We just do not have the numbers. We see this in a range of areas—for example, burns, transplants, paediatric intensive care. There are a number of areas where we just do not have the numbers, and could not get the workforce—going back to Vicki's discussion earlier—to support that sort of intervention. I understand that it is extremely difficult for families who are going through that, and for the individuals who have to travel interstate.

MRS BURKE: I was going to say that my issue is not really about a medical solution; it is about a non-medical solution, which is what we are being told now. What would be your view on that? I refer, for example, to the fact that the national mental health data set does not collect data on eating disorders and specific outcomes. Would you be in a position to do more about that, so that we did collect data?

Ms Gallagher: Yes, sure.

MRS BURKE: Can we then look more broadly in the ACT and undertake to do a study of collecting such data? I think people are not coming to what we have got now because it is simply a medical solution.

Ms Gallagher: The eating disorder program, as much as it can, does try to be flexible, with a non-medical approach. In fact, it is staffed by a number of non-medical staff. I have asked that we have a look at how that is operating and the flexibility within it to meet individuals' needs. Some are saying that they do not like cognitive behavioural

therapy; they want another type of therapy. We cannot be everything to everybody, but as to whether there is genuine inflexibility in the program, I have asked that we have a look at that to make sure that we can respond as best we can. When this young persons mental health unit is set up, that will give us some more appropriate choices, if people need to come in and have some in-patient services before they need more medically-based services. Now, the only in-patient service we can provide for young people—normally it is young people, but some older people—is when they get so medically unwell that they end up in hospital for other reasons, for their medical unwellness, not their mental unwellness.

MRS BURKE: Are you happy to look at the national mental health data set?

Ms Gallagher: Yes, sure.

MRS BURKE: Thank you, minister.

THE CHAIR: We will now go back to 1.2.

MR GENTLEMAN: Minister, I take you to budget paper 5, page 53. There are four groups of new expenditures there within mental health. Could you go through each one and tell us what you would like to see achieved with each of those expenditures. The first one is on the adult mental health in-patient facility.

Ms Gallagher: With respect to the adult mental health in-patient facility, as you can see, that money is for the construction of a 40-bed unit at the Canberra Hospital. This will replace the existing PSU, which, as everyone would know, has been less than acceptable in terms of accommodation. With respect to the secure mental health unit, there will be the construction of a 15-bed secure unit, which is a service we have not previously provided in the ACT but which is one that we have needed. We certainly need it now and there has been the odd individual case where we have needed it before, and this is in response to that. At the moment we do look for solutions interstate, if required, and this will certainly go some way towards relieving some pressure in this area.

The mental health assessment unit is to be constructed near the emergency department at the Canberra Hospital. I think it is about a five or six-bed unit, and it will allow for more appropriate intervention in dealing with those patients presenting to the emergency department as a separate group. It will allow them to be assessed and then, if appropriate, to be moved into the in-patient facility, to go home or to have some other treatment option.

We have just discussed the young persons mental health unit. That is to design the facility. It is envisaged that we would do this next to Brian Hennessy House in Bruce, but we have to go through the necessary work around that. I think it would be a nice place to have one, in terms of the environment.

MRS DUNNE: Is that why there is that blue oval thing?

Ms Gallagher: Yes. It is a blue oval thing but you will notice there are lots of trees there. I am saying that is where we would like to put it, but we need to go through a

consultation phase around that.

MR GENTLEMAN: With the assessment unit, you said this is where people will come from ED.

Ms Gallagher: When they present to ED, they will be able to be streamed into this area if they are a mental health client.

MR GENTLEMAN: My question was about the presentation to ED. Will these be people who come along themselves or could they be brought by other groups?

Ms Gallagher: They could come by ambulance, by one of our community teams, the police, or they could present themselves—whatever way they come, and they come at the moment. It is just that they are assessed currently in the ED and then moved, say, to the PSU. This would give us the opportunity to have a specialised assessment unit and remove them out of the mainstream emergency department.

MR GENTLEMAN: How long would they stay at the moment in emergency?

Ms Gallagher: Not too long. I could not give you an hour figure.

Mr Cormack: We have a target. One of our strategic indicators is that 10 per cent of mental health presentations to the emergency department would wait more than eight hours. In other words, 90 per cent should be admitted or discharged within eight hours. So we do try to avoid people staying for extended periods in the emergency department, irrespective of their condition. Obviously, with mental health patients, there are special needs, and that is why we have responded with the mental health assessment unit, which provides us with a more specialised environment to be able to cater for those acute presentations of people with mental illness to the emergency department.

MRS DUNNE: First of all, can I congratulate you on the vision of the mental health assessment unit. From the experiences I have had with people who present themselves to ED when they are having episodes, sometimes the service is quite mixed. It often depends on whether there are vacancies in the PSU. I congratulate you on the vision for that, and I hope that it works. I want to ask a financial question. There are expenses here which are other than depreciation.

THE CHAIR: What page are you looking at?

MRS DUNNE: It is page 53 of BP5. So there is the capital expenditure, there is depreciation, which is obvious, and there are other expenses. What are those other expenses? Are they staff expenses? If so, why are they in the capital column?

Ms Gallagher: There is a good answer to this.

Mr Cormack: There is a good answer on its way from Mr Foster.

MRS DUNNE: There are a couple of others. There is the Aboriginal and Torres Strait Islander drug rehabilitation facility, which was in the second appropriation bill, and

also the expenses with mammography. There must be some sort of recurrent expenditure; therefore, what are they and why are they here?

Mr Foster: The mental health figures relate to a net increase in the cost of repairs and maintenance for these facilities, as determined by Treasury and provided to us. It is a simple recognition that a new facility like this will have higher repairs and maintenance costs than the previous facility. In relation to procurements, it is new money towards maintenance costs.

MRS DUNNE: Okay. Thank you.

MR SMYTH: Minister, you stated some years ago that the government's intention is to get to 12 per cent of funding as the required amount of funding for mental health overall. How are you going on your journey?

Ms Gallagher: I think at the end of this budget it is about 7½ per cent; so we are—

MR SMYTH: That is appalling.

Ms Gallagher: Is it?

MR SMYTH: Yes.

Ms Gallagher: I will have to check your figures; I do not trust you. My advice is that it is around 7½ per cent. I do not know what else we are counting in there. It is hard. I said at the time that we would increase our health budget—and we are increasing the mental health budget all the time—but it is 12 per cent of a larger pie every year. So it is an aspirational target which I would like to meet. But we have set ourselves both. The NGOs want it by 2012. I said that is what we would like to see and that is what we are aiming for and working towards.

But, as the health budget itself grows bigger, it is a bigger challenge. We have had a 143 per cent increase in mental health now. The budget is up to about $66 million, I think, from $27 million.

MR SMYTH: It is $64 million, according to the papers.

Ms Gallagher: We are counting something else other than you. We are counting the early intervention money, I think. They got split out of the output classes.

MR SMYTH: How much is in the early intervention money?

Ms Gallagher: It is another output class, at 1.7 or something.

Mr Cormack: It is $2.234 million.

Ms Gallagher: And that data is counted in there as part of the 2005-06 budget.

MRS DUNNE: Which output class is it in?

Ms Gallagher: I think it is 1.7

Mr Cormack: It is 1.7.

Ms Gallagher: It is the percentage in 1.7.

MR SMYTH: It has gone up by $9.3 million this year. What exactly will it be used for and what results are you expecting from it?

Ms Gallagher: The $9.3 million, yes, that is the mental health growth and promoting recovery and—

Mr Cormack: Yes, it is the initiatives outlined in budget paper No 3, plus there is a reassignment of on-costs apportioned to the mental health program. We have also done a similar exercise with the Capital Region Cancer Service and aged care and rehabilitation. Historically, most of the overhead costs and on-costs were all grouped under outputs 1.1 and 1.3. We have just done some reapportionment of those to reflect the appropriate relativities.

MR SMYTH: And how much does it represent of the $9.3 million?

Mr Cormack: $3.8 million.

Ms Gallagher: What do we get for that initiative? There are different components in that. There is the expanding of the better general health for people with a mental illness, which we currently run. There is an expansion of that very successful program. There is a proportion that will go to improving access for community support for mental health clients—I think that is around $1.2 million—and an enhanced capacity for the mental health sector. Some of that will go to community organisations; some of it is about increasing staff in Mental Health ACT.

MR SMYTH: A subject that needs to be treated carefully is suicide rates for people who have been identified with mental health issues and are under care. I know some of this is still subject to coronial inquiries. Is it possible to get the numbers for the past five years?

Mr Cormack: We will take it on notice.

MR SMYTH: Is it possible to get the numbers for those not under care in the ACT?

Mr Cormack: We will have a look at that.

MR SMYTH: In relation to the health precinct, I notice you have got some money for the forward design. I have to say there is always a great deal of mirth in my office when we see “forward design”, because I have never understood why you would have backward design. In relation to the mental health young persons unit, you have got money for the planning.

Ms Gallagher: That is for the design, yes.

MR SMYTH: When would the government intend to actually build the facility?

Ms Gallagher: My normal practice is: design, one year; construct, the next.

MR SMYTH: I notice that you have actually got depreciation against that. Does the cost of design depreciate? Therefore, is there a figure somewhere else?

Ms Gallagher: I am sure there is, again, a very good reason for why things like this appear in the budget.

MR SMYTH: I know that paper gets old and brittle and it needs to be treated carefully, but how can you depreciate it? I am sure there is a cost to CAD, but I want to hear the technical explanation.

Ms Gallagher: We will take it on notice.

MR SMYTH: I look forward to reading that one. Again, the timetable is likely to be when?

Ms Gallagher: As I said, the design potentially could be difficult. I do not know whether the location is going to be an issue. We have not really tested that yet, so that will become clearer through the year. If that work can be done this year, then whoever is in government next year will need to be looking at providing capital.

MR SMYTH: I promise we will continue it for you.

Ms Gallagher: Thank you. I, of course, hope to be able to continue it myself.

MR SMYTH: I would be happy to swap places so that you could ask me how it is going next year. How much is it expected that would cost to build? You must have some idea.

Ms Gallagher: It would be a 20-bed facility. Going on the construct of the adult facility, at 40 beds—it is pretty rough; looking at that, that is $23 million—I would say you would not get out of it for under $20 million. You do not get out of anything for that.

MR SMYTH: It is a neat number. Is there any reason why the—

Ms Gallagher: There is absolutely no science to that at all; that is just my thinking.

MR SMYTH: Exactly and that is why I said it is a neat number. Is there any reason why the youth facility would be located adjacent to Calvary; yet the other facilities will all be on the Woden precinct?

Ms Gallagher: The thinking behind that—and there is a very strong view in mental health, both in the public sector and in the community sector—is to not co-locate adults and children and young people together. As I said about the location, I am just not sure how this will go—and we will of course need to consult with the local community—but it is a piece of land that we have that we could use. We currently

have Brian Hennessey there; there is Hyson Green there; and there is 2N.

MR SMYTH: That is not co-location; that is just in the same facility? Brian Hennessy is there.

Ms Gallagher: It is not co-location but there are a number of psychiatrists who work, say, in Calvary's private offices and who would probably be seeing some of these young people; there is 2N at Calvary. There are a number of services there and there are opportunities there, I think. And we do not want to have it at TCH. It is a nice location, I think.

MR SMYTH: Why not put it all at Calvary, then, if it is a nice location?

Ms Gallagher: What, put the whole—

MR SMYTH: Yes, put all the facilities there.

Ms Gallagher: I am not sure there is enough land at Calvary when we look at what else we need to do at Calvary. We need to build up Calvary Public Hospital as well.

MRS DUNNE: And find some car parking.

Ms Gallagher: Yes, and some car parking. Once we have done that, there just would not be the land available. And, again, putting it all there ignores the fact that there is a pretty strong view that you do not have them all in the one place.

MR SMYTH: The committee heard on, it must have been, Monday afternoon one of the mental health groups suggest that there should be a greater focus on community-based programs and not necessarily on facilities. What is the strategy in regard to dealing with people with mental illness in the community rather than in facilities, and what effort will we make to keep them out of facilities?

Ms Gallagher: I think we have got a pretty good record on mental health. I understand that recovery and support happen in the community and often the inpatient services are the ones that deal with acute episodes of care. But we have to also understand that Mental Health ACT provides a large amount of its services in the community as well as funding community organisations to support recovery and support for individuals. I think this budget increases the per cent of the budget spent on community care to over 12 per cent. We have increased it every year. I think the mental health groups are after 30 per cent.

MR SMYTH: Thirty per cent, yes.

Ms Gallagher: So we have got a bit of a way to go before we meet what they are after. We have got some discussions with a number of the community organisations on accommodation and management of some community-based accommodation options which we will continue this year. This budget does have, again, a proportion of money that will go to community organisations. We have been increasing their funding as much as we can.

MR SMYTH: What percentage is spent on community based?

Ms Gallagher: I think it is about 12.1 per cent.

DR FOSKEY: I notice that there is no specific mention of dual diagnosis in this budget. Could you please advise me as to whether funding has been allocated; or, if not, when it will be?

Ms Gallagher: I will have to call Dr Peggy Brown.

Dr Brown: There is no specific funding in this budget to enhance the co-morbidity or dual-diagnosis services, but in last year's budget there was enhancement of funding for training of mental health professionals. Part of that has already gone towards training around dual diagnosis. I cannot give you the exact number of clinicians—I can give you that on notice—but we have had staff trained, and they are then undertaking placements within drug and alcohol clinics. We are building not only their skills base but also the relationship between the mental health services and the drug and alcohol services.

DR FOSKEY: When you say they are placed in services, are they placed in the drug and alcohol services?

Dr Brown: Yes, here in the ACT.

DR FOSKEY: What are your observations about the number of people who could be classified as having co-morbidity or dual-diagnosis issues?

Dr Brown: That depends on the setting. In the inpatient setting, the numbers as to who would be regarded as having dual diagnosis are as high as 70 to 80 per cent. In the community the numbers are less. We actually do have a flag on our record system that indicates that at least one-third of the community clients have co-morbid issues.

DR FOSKEY: Okay. So do you feel that the money allocated last year was adequate, or do you foresee that the next budget could perhaps make another allocation to this or some other aspect of treatment?

Dr Brown: I think it is fair to say that around the world this has been a subject that has been looked at quite closely—that is, what is the best model to address this need. Do you actually have dedicated dual-diagnosis services or do you attempt to ensure that, regardless of where people present, the workers have the skills to ensure that they can access the appropriate treatment? Last year we were part of a group that hosted a forum with two international experts who came to Canberra. Very clearly, the message from them is that you upskill your workers, so that regardless of where the dual-diagnosis clients present they are directed to the appropriate treatment. That is basically what we are aiming to do—upskill our staff with training and placements so that if dual-diagnosis clients present to mental health services, we can work collaboratively with our drug and alcohol colleagues and ensure that appropriate services are delivered.

DR FOSKEY: Could you give us numbers of people who have the training and

whether there are more people in line for training?

Dr Brown: I can certainly provide you with that. I am sorry, I do not have it with me.

DR FOSKEY: Would it be your aim to train all the mental health workers?

Dr Brown: That would take time. The training, I can tell you, goes over 16 days. It covers a range of subjects and is followed by a 10-day supernumerary placement at one of a range of services. That is recurrent funding that we have for enhanced training, so we will be aiming to increase the percentage of staff trained over successive years.

THE CHAIR: Dr Brown, in response to Dr Foskey, what is it you were going to take on notice?

Dr Brown: The number of actual workers trained.

THE CHAIR: Okay. Ms MacDonald has a supplementary.

MS MacDONALD: Could you actually provide the percentage of the workforce that those numbers would make up so that we have got an idea of proportionally how many people are actually getting that?

Dr Brown: I can do that. This is additional training to what we already provide, and we do, of course, already have a worker who is a resource for our existing staff who will provide specialist opinion and then back up ongoing support and education.

MS MacDONALD: That was going to be the basis for my question, because surely there is a need for ongoing training in this area, given that you have new people coming in who have been trained in this area. Ultimately, some of them will leave the service, go interstate, retire, go on maternity leave, do whatever it is that they are doing, so you lose that skill set to a certain extent, so you have to have that ongoing training.

Dr Brown: Yes, we have that capacity already. As I said, the training that we have commissioned this year will be ongoing as well.

THE CHAIR: Did members have one last question?

DR FOSKEY: I can ask another. Are you evaluating that as you go to make sure it does do what the international experts promised it would?

Dr Brown: We have not actually developed a formal evaluation framework for that as yet. As I indicated, we do monitor the percentage of our clients who have dual diagnosis as part of our standard monitoring of the service. We do undertake satisfaction surveys, but that is not specific to the dual-diagnosis clients. That is perhaps something that we could give further thought to.

DR FOSKEY: Yes, it would be interesting to know if it works.

THE CHAIR: Okay, so I will think we will finish there, because it is one minute to five.

MRS DUNNE: I am sure that you have got time to ask one question and somebody to answer it.

THE CHAIR: Well, it has got to be very quick.

MR SMYTH: I am intrigued, minister, that, on page 164 of budget paper 4, item "f" under output 1.2, psychogeriatric services bed days were very accurately estimated to be 4,424 but we only delivered 2,500, which is only 56 per cent of that. Is there a reason why it has been so low against the target?

Ms Gallagher: Yes, it has been the difficulty of recruiting appropriately skilled staff to that centre. I understand only 13 beds rather than the 20 that are funded were able to be staffed over that time. But the 20 beds are staffed now, I understand. No?

MR SMYTH: No?

Ms Gallagher: Maybe I read somewhere that said—

MR SMYTH: So the target for next year of 4,400, that is likely to be achieved, or is staffing an ongoing problem?

Ms Gallagher: You might have more information on that.

Dr Brown: The target for next year is based on an average of 13 beds open with a length of stay of around 40 days on average. This year, we started when the unit opened with six beds and increased. We got to a maximum of 16 beds being open, and then we ran into difficulties with the nursing recruitment. It has actually had to be scaled back, which is why we did not achieve the targets, because we had planned to get up to the full 20 beds being opened from about—

MR SMYTH: This is the facility at Calvary?

Ms Gallagher: Yes, the psychogeriatric part.

MR SMYTH: Just on the existing number of staff, that will deliver 4,400 bed days?

Dr Brown: At the moment the unit is operating with 10 beds open, but the projection for next year, the target for next year, is based on 13 beds. I guess we are anticipating that over the 12 months we will go from the 10 that are currently open up to 16 to 20.

MR SMYTH: Okay, and just in items "d" and "e"—

THE CHAIR: It is 5 o'clock, Mr Smyth.

MR SMYTH: I know it is hard to answer quickly, but there are some dramatic increases there in the number of services to be provided. Will you have the staff available to provide those?

Dr Brown: I am sorry—

MR SMYTH: Older persons' services and children and youth services.

Dr Brown: I think you will find that they reflect the level of services that we have achieved this year.

MRS DUNNE: They are this year's; they are just reflected in those.

MR SMYTH: Sorry, all right. But the dramatic jump this year, what has caused that?

Dr Brown: I would like to say we are working very hard.

MR SMYTH: Now that you are working very hard, is that why the public accompanies?

Dr Brown: I think the demand is there, and the service has responded to the level of demand.

MR SMYTH: It is a 25 to 30 per cent jump. What is the level of unmet demand?

Dr Brown: I do not think we have an easy way of measuring that.

MR SMYTH: In your opinion, is there unmet demand still out there?

Dr Brown: I think there is probably always unmet demand if you look at the epidemiology of the studies that have been around that subject, yes.

THE CHAIR: Okay, so we are at 5 o'clock—

Ms Gallagher: Sorry, chair, could we just—

THE CHAIR: Yes, we are stopping now.

Ms Gallagher: Yes, stop, but Mark has just got a couple of answers we can slip in.

THE CHAIR: Yes, fine, thank you.

Ms Gallagher: Thank you.

Mr Cormack: In answer to Mr Smyth's question about the cost per case, this is just the separation for the ACT, it is $4,380 including depreciation and $4,250 excluding depreciation in 2005-06.

MR SMYTH: Fine.

Mr Cormack: I was asked a question, I think it was from Mrs Burke, about whether there were any reports of incidents regarding the minor works in the days and weeks prior to the incident on 30 April. No, there were no formal incidents reported by our

management or by our risk management system or OHS reporting systems.

I was also asked a question—I am not sure whether it was from Mr Smyth or Mrs Burke—on how many occasions in the last 12 months have we sourced supply from Sydney. The answer is we currently have 98.6 per cent of our delivery stock delivered, once requested, for routine replacement of impress stock delivered on time against an industry standard of 95 per cent.

There was one incident four years ago where renal fluids were delivered in a taxi truck from Sydney as a special request for a particular patient. However, occasionally suppliers will fly items to the hospital if they have not been able to meet the deadline.

THE CHAIR: Thank you very much for that. Thank you, minister, and thank you Mr Cormack.

Ms Gallagher: See you in the morning.

THE CHAIR: Yes, 9.30 in the morning.

MR SMYTH: Do you want to start earlier?

Ms Gallagher: Yes, I hear that was your idea.

MR SMYTH: Do you want to start earlier, 8.45?

THE CHAIR: No, it is 9.30 in the morning and we are going to—

MR SMYTH: I asked for it—

THE CHAIR: Excuse me, Mr Smyth, could just be quiet for two seconds? We are going on to 1.4.

Ms Gallagher: Output 1.4 tomorrow? So we have finished mental health, have we?

THE CHAIR: We have finished mental health.

MR SMYTH: No, no, I can—

THE CHAIR: We have finished mental health; we are going to 1.4 tomorrow.

MR SMYTH: We could always have more mental health.

THE CHAIR: Then we are going through to 1.7, so 1.4 tomorrow minister.

MR SMYTH: You are no fun, chair.

The committee adjourned at 5.03 pm.