LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND DISABILITY

(Reference: Annual and financial reports 2003-2004)

Members:

MS K MACDONALD (The Chair)
MS M PORTER (The Deputy Chair)
MRS J BURKE

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 21 APRIL 2005

Secretary to the committee:
Ms T Carling (Ph: 6205 0129)

By authority of the Legislative Assembly for the Australian Capital Territory

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

The committee met at 2.01 pm.

Appearances:

Mr Simon Corbell, Minister for Health and Minister for Planning

ACT Health
- Dr Tony Sherbon, Chief Executive
- Mr Mark Cormack, Deputy Chief Executive
- Mr Ron Foster, Chief Finance Officer
- Ms Laurann Yen, General Manager, Community Health
- Mr Brian Jacobs, General Manager, Mental Health ACT
- Mr John Mollett, General Manager, Canberra Hospital
- Ms Vicki Williams, Calvary Public Hospital
- Dr Paul Dugdale, Chief Health Officer and Executive Director, Population and Health Division
- Mr Doug Jackman, Director, Human Resource Management Branch
- Mr Owen Smalley, Chief Information Officer, Information Services Branch
- Mr Ian Thompson, Executive Director, Policy Division

Healthpact
- Ms Kerrie Arabena, Chairperson
- Ms Sam Moskwa, Director

Community and Health Services Complaints Commissioner
- Mr Philip Moss, Commissioner
- Ms Roxane Shaw, Principal Investigations Officer

THE CHAIR: I declare open this public hearing of the Standing Committee on Health and Disability, which is inquiring into the 2003-04 annual reports. This afternoon, the committee will be taking evidence in relation to the annual reports of Healthpact, the Community and Health Services Complaints Commissioner and ACT Health. For the benefit of those present, I point out that this is a public hearing and a Hansard transcript of the proceedings will be made. There will be a break for afternoon tea from 3.00 to 3.15 pm, although yesterday we were a bit more flexible and pushed it back a bit for convenience. We may do that today, depending on how we are going.

Answers to questions taken on notice and additional information should be received by the committee no later than Friday, 29 April 2005. Witnesses should understand that these hearings are legal proceedings of the Legislative Assembly, protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal action, such as being sued for defamation, for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

I welcome Mr Simon Corbell, the Minister for Health, and the officers accompanying him. When officers are called to answer a question for the first time, I request that they state their full name and the capacity in which they appear. Please speak clearly and directly into the microphones to assist the Hansard staff recording the proceedings. For your benefit, Mr Smyth, and that of Dr Foskey when she comes down, I indicate that

I will be giving precedence to members of the committee with questions. Minister, would you like to make an opening statement?

Mr Corbell: Thank you, Madam Chair. I do not have an opening statement to make. My officers and I will be happy to answer any questions as best we can.

MS PORTER: On page 9 of the Healthpact report there is reference to the community funding program. The report does not indicate—at least I cannot find it—which programs were funded for a single year and which ones were multi-year projects. Would it be possible—perhaps this question needs to be taken on notice—to clarify for me which ones were for multiple years and which ones were for a single years? Perhaps in future reports you could delineate those in such a way. The other thing I would like to know, if possible, is which of the projects which were funded for one year would have preferred multi-year funding but were unable to be funded in that way. Perhaps that is something that you will want to take on notice, minister.

Mr Corbell: I will ask Ms Arabena to answer that question. It is an administrative matter for Healthpact.

Ms Arabena: That is a question that we would like to take on notice. We do have all of that information in the office and we keep very good records of those sorts of questions. We would like to be able to answer it later.

MS PORTER: Thank you. I have a supplementary question. One of the grants was to the Canberra Racing Club for the sum of $10,000 for a project described as "Diabetes 'Reduce your risk, eat Healthy'". Would you please advise me how that sponsorship of a race meeting actually delivered in one or more of the board's seven focus areas?

Ms Moskwa: That particular group's restaurants, canteens and fast foods were changed, offering healthy nutrition options. They had a smoke-free message. That was on days and in written pamphlets; it was ongoing in the area. They are the only two that come straight to mind. I can give you more information, if you would like more.

MRS BURKE: Thank you for being here today and thank you for the opportunity to ask you questions. I guess mine starts at the end. It is about the staffing profile in your report. I note that you do not seem to have any males. Is the sector one that does not attract males? What do you see as the problem in terms of the staffing levels?

THE CHAIR: To which page are you referring?

MRS BURKE: Page 61.

Ms Arabena: Gender inequity is, of course, something that I have found to be prevalent across the health and welfare sector generally, but Healthpact is one of a number of health promoting organisations in the ACT and we have improved our lot by having at least one male involved in the staff, who is sitting behind you. We actually have a very good representation of men. I cannot believe that I am sitting here saying it, just quietly; it is usually about representing women.

MR SMYTH: I think that it is fabulous.

Ms Arabena: Thank you very much. We have a very good representation of men on our working groups and committees and also on our board. I believe that there are some men somewhere in the health promotion unit.

MRS BURKE: Maybe this is a call to those who are listening to these proceedings.

Ms Arabena: Certainly, it is equal opportunity employment. Recruitment strategies are followed through appropriately. I would love to be able to encourage more men to take up health promotion.

MRS BURKE: There was no sting in the question. It was just an observation. I just wondered whether there were any particular reasons that you could not attract men.

Ms Arabena: It is not about issues of efficiency. It might be around pay rates, health promotion and the private community sector. I think that there might be some issues there that come up as a point of interest.

THE CHAIR: On page 10 of the report you refer to the health promotion awards. Can you outline how successful these awards are in promoting health programs?

Ms Arabena: I will answer part of the question and then refer the rest of it to Sam Moskwa, if that is okay. I first became aware of health promotion in the ACT at a small awards evening of approximately 50 people in a small building. It was just a Healthpact awards night and it was specifically within the group that were able to access from our budget. It has now moved to the convention centre, with over 300 people attending just the dinner, but it is around health promotion activity across the whole of the sector.

I think that there are at least six contributors to the awards evenings now. They are not so much around how much health promotion is being done, but a recognition of the effort of the community sector in promoting health for all across the ACT. I for one am very pleased and proud to be involved with it. I think that rewarding people who do good work for not a lot of pay and make incredible innovations in health that stop late hospitalisations and get people thinking around health promotion activities, particularly when people are younger, is a good investment. I think that it is a very good thing that the minister supports that.

Ms Moskwa: There is a mentoring component. When a particular project is showcased, groups can be inspired to contact other groups to see how they had such great success and work through it. People do contact each other. Messengers, the Tuggeranong community arts program which received awards for excellence, has gone on with pathways to other departments. The awards recognise excellence and also can be useful for groups wishing to network and then find other sustainable pathways.

Ms Arabena: Do you know how many people were nominated for the awards and how many were given out?

Ms Moskwa: This year there were 56 nominations and 11 awards. This year—I think it is a great move—health promotion is everyone's business and there are more parts of

health being part of the health promotion awards.

THE CHAIR: Having been to one of the earlier awards nights and then later as they have grown, I commend Healthpact for the work that it has been doing. They have been growing admirably and it has been doing great work. I am not sure whether you are aware that your awards night this year will clash with the ClubsACT awards night, which is a bit unfortunate.

MS PORTER: On page 10 of the report there is reference to a detailed scoping report for the development of the Healthpact research centre for health promotion and wellbeing. Are you aware of the findings of the studies conducted by Richard Eckersley at the ANU School of Epidemiology and Population Health which demonstrate the relationship between happiness and wellbeing and volunteer involvement? If so, what part of this research has been incorporated into the research that has been conducted? Have you been aware of that and has it been used?

Ms Arabena: I had the opportunity to work with Richard very closely when he and I did a presentation on life matters at the Australian National Museum around community building and resilience, Richard's emphasis on looking at health being to establish a happiness indicator. It was a pivotal point around recognition of the word "wellbeing" and what it actually means. When you start to unpack it, Richard's work and that of other like-minded people became very valuable to the establishment of the set of principles and values and what we will be looking at through this research and evaluation centre.

I am very pleased to say that it is going to be launched on 10 May. It has been established at the University of Canberra. They have also been able to make contributions to the centre. With the development of the centre, we are going to look retrospectively at all of the work that has happened through Healthpact initially, but other health promotion activities across the ACT as well. I am very excited about it. I think that it is an Australian first. There are very few places which are putting priority on wellbeing. I think that it is going to form an incredible foundation and evidence base for future work in this region and possibly will be able to be replicated in others.

MS PORTER: I echo the point that it seems to be something that people are not paying enough attention to and I congratulate you for that.

Ms Arabena: Thank you very much.

THE CHAIR: On page 17 of your report you refer to the human resources strategic plan. Can you give us an update on the progress of this plan?

Ms Moskwa: It is still in a draft form. I have been on leave for four months and my assistant director has been on a year's leave, a commonwealth employee going overseas for Australian business. I apologise.

THE CHAIR: No, that is okay.

MS PORTER: I am still on my favourite subject of volunteers. On page 11 of the report you mention that over 2,000 volunteers contributed to the success of the 9th Australian Masters Games. Do you have details of the number of hours that the 2,000 volunteers

contributed? You may need to take that on notice.

Ms Arabena: Not only that, but I believe that the volunteer programs had been initiated elsewhere but were enhanced through the whole program and have been taken on as a mechanism for the masters games in South Australia. So they took the whole volunteer package and will look to implement it over there. I believe that in the closing ceremony for the masters games they were all out on the parade ground marching around, 2,000 of them, and there was a huge milk carton there. I do not know what the relationship was. Yes, I do, it was about the sponsor for the whole lot. They just had a great time. It was an incredible community building opportunity. I really enjoyed being part of that, too.

THE CHAIR: Sorry, what was the milk carton about? I went to the opening but not the closing.

Ms Arabena: I was doing the Mexican wave at the first one, at the opening ceremony, and at the closing one there was a rather large milk carton, representing Canberra Milk's sponsorship of the volunteer component of the masters games program.

Ms Moskwa: With Healthpact's involvement in the group, we were able to negotiate that the volunteers were sponsored by Canberra Milk, not Vili's pies. That made a big difference to the food that was supplied to the volunteers for the whole games, and we were really pleased with that.

MS PORTER: Page 26 mentions that the staff are encouraged to undertake opportunities to enhance skills and knowledge through various training courses and other such opportunities, and several of the courses are listed. Given the number of volunteers that deliver Healthpact programs and initiatives, has Healthpact ever offered staff courses in understanding the dynamics and value of the volunteer work force?

Ms Moskwa: No, we have not had specific training. The previous work of a number of the current staff was in NGO areas, including mine. I ran a volunteer program for a year. It is a great idea and we could do more in that area, but a number of staff with NGO experience have had training in the volunteer area.

MRS BURKE: I refer to the reference to Aboriginal and Torres Strait Islander reporting on page 31 of the report. I note the opening statement in this section that Healthpact is committed to implementation of the recommendations of the Royal Commission into Aboriginal Deaths in Custody. I particularly want to look at the third paragraph, continually building capacity within the community. It looks like there is a good activity happening there with the funding of a multi-year health strategy project at Winnunga. Could you elaborate on that a little and tell me how it has gone in the past year, given that we are doing 2003-04?

Ms Moskwa: The Winnunga project has been an excellent partnership between Healthpact and Winnunga. I think it has grown in strength. The person doing the job, Jodie Fisher, has taken on a health promotion development officer role. It is putting health promotion and community development together, a first officially in Australia, which is very important to the Aboriginal community in working alongside communities. There are very important health promotion issues to work through but the mechanisms of the community development strategies are just excellent. The work at Winnunga is

terrific.

MRS BURKE: Thank you for that. I have a quick supplementary question. I have noticed that you are not funded for recurrent projects, but it would seem that in this case you are making an exception. I appreciate and value that you are doing that, given some of the difficulties within that section of our community. Is it a funding issue? It must be, otherwise you would be recurrently funding other people. Are there some other primary things for which you consider recurrent funding to be necessary? Did you notice in 2003-04 how you could have added your message to a further section of the community? If so, what would that have been?

Ms Arabena: Unfortunately for us, our funds are finite and the number of applications that come through is seemingly infinite, but there are a number of areas in which we do affirmative action and the board has made a very determined effort to give mental health projects and those that relate specifically to Aboriginal and Torres Strait Islander priority and we will try to multifund where possible. Healthpact's funding arrangements are usually a fairly small seeding grant for innovation and then help create pathways. Sometimes the pathways are more difficult for other community groups to access and we have nominated for those, too, at this point in time.

MRS BURKE: During 2003-04, what needs were becoming more evident? If the world were your oyster and you had huge buckets of money, which projects would you consider, other than mental health and Aboriginal and Torres Strait Islander issues?

Ms Arabena: It is pretty hard to answer that kind of question in the context of the annual report that we have before us. What we are doing with the research and evaluation centre is that, instead of us saying that something looks to be a really important area that we need to put our minds to because of the number of applications we have received, we are really establishing an evidence base that I think will become very clear and apparent in the next annual reporting period. If I can take that one on notice until next year, that would be great.

MRS BURKE: We are crunching right up to that now. You have identified some things. I think that has answered the question.

Ms Arabena: Watch this space and come to the awards night, if you can. I am sure that you will see lots of people there.

MRS BURKE: That is a good plug for the awards night.

THE CHAIR: I have a question on community engagement, which you talk about on page 30 of the report. How successful do you think Healthpact is in engaging the community? I know that you put out a notice in the last couple of days on community grants funding. Obviously, there is always more that you could do, but how do you envisage letting the people in the community know that Healthpact exists and getting them involved so that, if there is a health promotion activity that they are doing or are interested in doing, they know that you are there to assist in getting them going?

Ms Arabena: I think that we respond very well to community requests through our community engagement process. I think that you will see in the annual reports from at

least 2001 and continuing for the rest of the decade gradual improvements in the way in which we engage with, inform and ignite passion within the community on health promotion activities. I think that in this part here we have a very good synopsis of where we are at now. I think that what we can spend some more time doing once we have the research and evaluation centre and we have a more concise evidence base to work from is on projecting where and how we are going to engage with the community in the future

I think that we have a very well run, slick, smooth machine to administer the grant funding and I think that it is something for which other organisation can look to us to see how we do that. The health development officers, the small grants round that has come about as a result of community requests for funding, our mentor program, the networking capacity that we have taken on board and now the evidence base are really important forms that will help guide us in doing that.

We have taken notice of the equity reports. We have a dedicated position now that is just about community engagement and fulfilling that. We have strengthened our marketing capacity in the community sector and we have taken on a lot of the points that came through from the last inquiry into our health report and really built on those. I am not going to say that where we have got to now is absolutely excellent, but it is a continual relationship and a conversation with the community sector that we have made a real investment in continuing.

Ms Moskwa: In the board's new strategic plan, 10 per cent has been identified for funding new applicants, so it is not the same group every year coming through and being successful. We have been working on that informally, but now we will actually have a key progress outcome identified of 10 per cent.

THE CHAIR: It was not intended to be criticism, because I think that you do a very good job at engaging the community, but it is often the case with things like this that you do get the same lot of people coming forward and it is always difficult to try to let the people who are not aware of the organisation's presence know that you are there.

Ms Arabena: In terms of some of the criticism, whether it is real or perceived, Healthpact has received that we have become more of a welfare organisation, helping disadvantaged people access the programs more than an elite sporting group, I am quite happy about that. I think that the annual reports reflect some of the changing synopsis about equality and access to community funding, rounds and grants, which is healthy.

THE CHAIR: At last year's estimates we had quite a discussion about that.

Ms Arabena: Yes, we did.

THE CHAIR: That was because somebody else had a great interest in the former role of Healthpact.

MRS BURKE: I have a question on page 30 and community engagement. I noticed from the third paragraph that you have had a good working relationship with the ACT Council of Social Service and you did some research into the social determinants of health and the way social and economic experiences relate to people's health. I am wondering whether the outcomes of that have been published. Was it a good experience? Was it

a worthwhile way of doing research, et cetera? Could you give me some more information on that?

Ms Moskwa: ACT Health also asked for research at the same time. I am not sure if it has been published, but we have seen the results. The board considered it and initiated a project with ACTCOSS to identify an action model. They identified three main areas and we are waiting on the results of that. That was a major investment with ACTCOSS, working with the Canberra community, on social determinants of health and a specific action model of what works.

MRS BURKE: What was the cost of that?

Ms Moskwa: It was $120,000 over two years. It was a significant investment, so they could afford a project officer.

MRS BURKE: Do you believe that, whilst it is not public at this time, it may well be, or are you not sure?

Ms Moskwa: I think it is due to be finalised in October 2005.You have to read the health inequalities assessment report that the board did.

MRS BURKE: Yes, they have come up with the action model.

Ms Moskwa: That was an international project and the board put its hand up to say, "Are community funding rounds equitable?" There is a lot of interest round the world in the outcomes of that.

THE CHAIR: There being no further questions, I thank you for your attendance today and wish you the best of luck for the awards night this year.

Mr Corbell: Madam Chair, I wish to place on record my appreciation of the Healthpact board and their officers for the work they do during the year. They administer quite a large program on behalf of the territory and do so, as you have heard, by managing lots of competing priorities. I thank them for their ongoing work.

THE CHAIR: Commissioner, did you wish to make an opening statement at all, or do you wish to move straight to questions?

Mr Moss: We will go straight to questions.

MS PORTER: I note that page 7 of the report refers to a reduction in the number of new complaints lodged, as well as improvements in practices which have taken place, and there is the comment that this is due in part to efforts on the part of health service providers to respond. This is not a question; I wish to place on record my endorsement of those efforts and congratulate you.

Mr Moss: Thank you. I'd like to receive more congratulations. I must point out initially that I was appointed to this position on 1 October and this, of course, is a report dated 30 June 2004. So it is, in fact, the report of my predecessor, Ken Patterson. He was community and health services complaints commissioner for 10 years. This is his 10th

and final annual report in his appointment as commissioner. I am very pleased to receive any credit coming from you, but it is in fact due to Ken Patterson. I will pass it onto him.

THE CHAIR: Congratulations on taking up the role. I know that Ken did a great job in his role as commissioner. I express the appreciation of the committee for this Assembly. Having been on the committee for the Fifth Assembly, I appreciate the work done by Ken Patterson.

MS PORTER: On page 43 reference is made to the cessation of funds for two positions that had previously been funded by home and community care as part of the home and community care program. It appears that that was deemed to be an inappropriate source of funding. Why were these positions previously funded in this way? Are you aware?

Mr Moss: No, I am not aware. I have Roxane Shaw here from my office. Can I ask her to come forward to address that question?

Ms Shaw: My understanding is that they were funded for the disability functions within the office. It predates my joining the office as well so I don't have the details. It was separate HAAC funding and it had a separate accounting mechanism compared with the functions of the commissioner. At the end of last financial year that funding came to an end and the funding was rolled into the budget.

MS PORTER: I know you don't have the history, but is that the reason it was deemed to be inappropriate—because you were handling two different sources of funding and it could be funded in another way?

Ms Shaw: That's right.

MS PORTER: On page 49 of the report, at subsection 7.1.5, a note is made referring to physical access to the commissioner's office. It doesn't appear to mention other access measures. Could you tell the committee what processes are in place to facilitate access for people from culturally and linguistically diverse backgrounds, and also for those who have sensory disabilities in accessing the commission?

Mr Moss: As indicated in the report, we certainly have access for disabled people. In fact, disabled people have used the office in recent times and there has been no problem from that point of view. In respect of other forms of disability, it is a public building and doesn't contain any special measures for such people. However, if we had knowledge that a person who needed special help or assistance was going to visit the office, we would make sure that was provided.

THE CHAIR: On page 9 of the report you have talked about better utilisation of conciliation as a method for dealing with complaints. It is good to see that such a process is being utilised. Could you outline for the benefit of the committee how that is being taken up and how it is put into effect?

Mr Moss: We had the benefit of a staff member joining our office the year before last. That person is a most capable conciliator. As reflected in this report, the work of that person has started to come through already.

There is no question that conciliation offers a great deal in the area of health complaints. The commissioner's method of dealing with complaints is by assessment, by conciliation and by investigation. Of those three I would certainly place conciliation up there as the most important.

It's a way of dealing with matters in a timely way for parties to participate in the outcome. The involvement of parties in conciliation is most valuable. With the encouragement of my predecessor—I have a background in conciliation—I am trying to make sure that the conciliation available through my office is as extensive as possible.

With the particular staff member I mentioned and a staff member who has been taken on casually in more recent times—and hopefully will have a longer term prospect in the new commission, although that can't at this stage be anticipated—I think we are in a good position to offer a high standard of conciliation.

THE CHAIR: Could you make comment on how well you think the community is aware of the role and function of the commissioner?

Mr Moss: I wouldn't say that at this stage we enjoy great community awareness of our office. I think it is true to say that, in the financial year being discussed now in this report and the present one, our outreach hasn't been very great. But we have, in recent months, started to turn that around, particularly in terms of our present work and our future work in the proposed new human rights commission.

The answer is that I don't think so at a high level, but these things go in cycles and are in direct proportion to publicity and active outreach conducted by staff of the office. I think the emphasis in any outreach we are doing at present is to establish and refresh links in terms of my appointment, and also to alert people to the new arrangements that are coming in the new financial year.

MRS BURKE: How are you intending to do that? I may be pre-empting again. It is difficult to ask anything, quite frankly, on this because we are crunching right up to the 2004-05 report. What lessons learnt from 2003-04 have set you on track to try and better promote yourselves, to let people know you are there and that you are available to the community?

Mr Corbell: It is worth making the point that the government has legislation in the Assembly at the moment for a new human rights commission. That will incorporate the functions of the health services complaints commissioner as well as a range of other commissioners.

The anticipated establishment of that commission is obviously a renewed opportunity to highlight statutory oversight of a whole range of human service delivery, including health service delivery. I am sure the new commission, once established, will want to promote its role as the single point of contact for dealing with complaints, and oversight of issues in the relevant areas. So there certainly will be a significant opportunity with the passage of that legislation. I will ask Mr Moss if he wants to elaborate on that.

MRS BURKE: Thank you for that, minister. I would like Mr Moss to elaborate. The very point where you finished is the crux of this. How are you going to do it? Is that

going to impact on your resources and the way you do it, given that the proposed legislation the minister has talked about is obviously going to cause a whole new layer of stuff, if I can put it that way, for people to have to do out there?

Mr Moss: Are you talking about outreach or information being put out by the commissioner for the remaining period of the present arrangement, or what is going to be done in terms of the new commission being established?

MRS BURKE: We can't talk about the future. This is where it becomes difficult, I guess. In light of what's to come, in light of your past experiences and realising that you perhaps aren't as well out there as you could be, have you identified a course of action that will ensure that people know who you are and the role you play?

Mr Moss: Yes, we have a course of action and we are working through that course of action. It is a course of action which was developed in about November last year to take us through until 30 June this year. It involves such measures as my staff talking at the monthly induction courses run for, for instance, new staff in the health system.

It involves us identifying key associations and agencies with which we work in the health field and me and my staff going to meet them and giving presentations on appropriate occasions by our initiation, and sometimes by invitation.

It is a question of not trying to do too much in the limited time available to us, yet making sure we are putting the message out that, one, there is a new commissioner; and, two, we are there—to make sure that, through those agencies, the community more broadly can be reminded of our existence, our purpose and the help we can give.

Mr Corbell: It is worth highlighting too that awareness of avenues for complaint or review of care is also a responsibility of those agencies that provide that care. A client may be dissatisfied—and obviously in ACT Health that is our public hospitals, community health services, mental health services and so on.

Only in the last few months I have launched a new consumer feedback mechanism for the Canberra Hospital. At this stage it's certainly occurring in Canberra Hospital—I am not sure about Calvary. That listening and learning program acts, first of all, as a feedback mechanism from health care consumers to the hospital and to the staff of the hospital.

Through that mechanism we would certainly draw to people's attention, if they are dissatisfied with the results of a review of care which has occurred as a result of their complaint at the Canberra Hospital, the role of the commissioner and his office. There is a responsibility on health care providers, in the first instance, to make people aware of where they can seek a review of care if they are dissatisfied.

MR SMYTH: On page 30 of the report, in case study 10, the third last sentence says that this most recent case showed that these efforts had not been successful. It was commenting on assurances given to the commissioner in 2001 and 2002 on transfers between clinical teams—that procedures would be made more effective. Is there a serious problem in that, or has it been addressed since the writing of this report?

Ms Shaw: It is an issue that we understand is being addressed by ACT Health. In fact, I think ACT Health, through its clinical improvement processes, has a particular priority area addressed to care coordination, which is what this case study goes to. Through the regular meetings between the commissioner's office and ACT Health we receive updates on progress in that area.

MR SMYTH: Minister, can you guarantee that those transfers have been looked at and that it is working much better than apparently in 2001, 2002 and 2003?

Mr Corbell: Clinical safety and the coordination of care between different clinical areas of the hospital is a very high priority. As an example of some of the work we are doing to address this area, we are now putting care into clinical streams, wherever possible, so that clinical streams are established to ensure that there is continuity of care for the health care consumer.

The obvious example of this is cancer care. We now have a cancer stream which involves both acute and non-acute settings. The care is coordinated through that single stream. We consider it a high priority and we are taking significant steps to address these issues.

MS PORTER: On page 52 at subsection 8.1 the report announces the introduction of an advisory group and lists its terms of reference. How were the members of this advisory group determined?

Mr Moss: Let me give you some preliminary information before that. The advisory group has not met since 2002. In the period of my appointment—nine months—I have decided not to reactive that advisory group. Your question relates to how they are appointed. They are appointed by the minister under the Community and Health Services Complaints Act.

MS PORTER: I am a bit confused. The report says:

> In June 2004, the Commissioner endorsed Terms of Reference for the establishment of an Advisory Group that will provide a forum for those who are interested in working with the Commissioner to improve our services, by…

It then lists the terms of reference. Is this part of the community engagement area? Maybe we are talking at cross-purposes about two different advisory groups.

Mr Moss: I think we might be.

Mr Corbell: There is an advisory body established under the legislation and the advisory council. The operation of that council has proved problematic ever since the legislation was first established in the early 1990s. The ability of the council to provide useful advice to the commissioner has, I understand, been difficult for a range of reasons, a number of which I must admit I am not particularly familiar with. However, I will ask the commissioner to see if he can address your question.

Mr Moss: I will have to ask Roxane to address that one.

Ms Shaw: As I understand it the advisory council, which was appointed by the minister under the complaints act, came to an end after the chair resigned from that position. As a result of the review of statutory oversight agencies the review body—the Foundation for Effective Markets and Governance—recommended that that council not be re-established but that the commissioner look at setting up reference groups. To replace the council, an advisory group was established. Does that answer the background to that?

MS PORTER: Yes. How were those members chosen? Given the problems of the past, I am sure they were very carefully chosen.

Ms Shaw: Rather than setting up a representative group the commissioner went to people who would be interested in the work of the office such as health care consumers, quality and safety officers—those sorts of people.

DR FOSKEY: It is nice to meet you for the first time. I know the report we are discussing was written by a different commissioner so I am not sure how you are dealing with questions.

Mr Moss: The best I can!

MRS BURKE: It has been a seamless transition!

DR FOSKEY: Let me test that. The annual report of the community and health complaints commissioner raised a number of concerns the commissioner had about the proposed amalgamation of the commission with the Human Rights Office—this is on page 10 of the report.

The draft legislation for the creation of the human rights commission, which would amalgamate these agencies, is now before us. I am interested in hearing how these risks will be addressed by the office of the health complaints commissioner. Although I could read them out, I am sure you all have them in front of you in the report. Is that adequate? Do you have them there?

Mr Moss: This is an interesting exercise because I am picking up the concerns of my predecessor and then, in light of my own output into the preparation of the Human Rights Commission Bill, which was presented to the Assembly a few weeks ago, making comment on where we have come.

The first of the dot points on page 10 picks up one of the issues which is that, at the moment, the commissioner—as I am presently established—can assess matters, investigate and conciliate them. Under the proposed commission the responsibility for conciliation will be vested in the president. The proposed health services commissioner won't have the responsibility for conciliating matters.

One of the discussions that took place on that very point in the preparation of the present bill was to ensure that the health services commissioner would have some visibility of matters being conciliated. For instance, suppose the minister should ask the health services commissioner, "What's going on in health complaints?" The health services commissioner would have to say, "I'll bring the president along too, so he or she can tell you about what's being conciliated." The health services commissioner would have no

visibility of that side of the work of the commission.

However, what has now been put into the bill to deal with that is that the president will report to the health services commissioner and the other commissioners on progress and issues relating to matters under conciliation by him or her. That is one of the issues that has been raised and that is the outcome that has been achieved to deal with that.

The question follows in the next dot point that anyone will be able to make a complaint. That will be the case in the new bill, except for those making complaints about unlawful discrimination. It does broaden the field to say that complaints can be made by any person about the delivery of a health service in the ACT.

As to the commissioner's concern, as expressed and articulated in this report of 2003-04, that was thoroughly looked at and it was decided that, at the end of the day, it wouldn't be a problem to expand the basis of a person making a complaint.

The process of public shaming is a question of judgment; it is a question of how that will be used by the president and the commission, as represented by the president and the individual commissioners. That provision, as I recall, is there but it is a question of how it will be used. The commission will be answerable for its use or misuse of that power, but it certainly is available should it be deemed necessary.

The location of the new body, being within justice and community safety, presents a challenge for the health services commissioner and the disability services commissioner to make sure that, despite the location of the commission in the Attorney-General's portfolio, the links are maintained with those other agencies. Dr Sherbon and I are determined, should I be in the position of having to act or be the health services commissioner, that despite that relocation we will maintain and establish the links we presently have.

There is no bar to the respective commissioner going to the respective minister on issues relating to the minister's responsibilities, although the new agency will be based in the agency's portfolio. I don't think the other two are particularly important.

I think an interesting situation will develop as to the last point, when staff movements begin to occur after the establishment of the proposed commission, because each of the commissioners sitting around the table and forming the commission will, of course, want to have someone who will have expertise or strength in their particular area of responsibility, but that will be sorted out by discussion.

At the moment it is a question of two staffs coming together and they will bring their expertise with that amalgamation. So from day one it should go well but, down the track with staff changes, the question of maintaining the balance of skill and background in the new commission will be an important one.

DR FOSKEY: On page 12 of the annual report under this year's issues, the following issues are identified—forgive me if these questions have already been asked; please tell me. There are calls from people who are having difficulty gaining access to general practitioners, with many GPs not accepting new patients; and finding a GP who will bulk bill is almost impossible. It continues:

> Consumers have more frequently expressed concern about nursing standards, mostly about the attitudes of nurses towards patients rather than unsafe practices.

Does the commission intend to undertake any further investigation of these issues and/or research possible projects to address them, given that they come up so often?

Mr Moss: In the life of the present office, at this stage projected to be until the end of June with the proposed commission at this stage being thought of as commencing on 1 July, I don't intend to address those two issues in particular. I have other priorities at this point.

One is to make sure that my office moves into the new commission in good shape; two is that our list of older cases is reduced as far as possible; and three is that the staff are fully aware of the new opportunities available to them in the new commission. Those are my priorities, rather than these sorts of issues. If my office were to have an ongoing existence, I would certainly address these in turn and make sure I have them fully under control, in the event that they become an issue for the new commission after 1 July.

DR FOSKEY: Why does the commission not currently report on indicators of accessibility for specific target groups, including indigenous people and people from culturally and linguistically diverse backgrounds?

Mr Moss: I think it should and, if possible, I will do what I can to reflect that in my first and last report ending 30 June this year.

DR FOSKEY: Thank you.

THE CHAIR: There are no further questions for the commissioner. Thank you very much for making yourself available today.

Meeting adjourned from 3.00 to 3.15 pm.

THE CHAIR: Welcome back. I will do the preliminaries for the people who weren't here before. The committee is inquiring into the 2003-04 annual reports. I would like to welcome those people who weren't here before. We have already taken evidence from Healthpact and the Community and Health Complaints Commissioner and, of course, now it is the turn of ACT Health.

Before the committee starts taking evidence, for the benefit of those present, I would like to note that this is a public hearing and a *Hansard* transcript of the proceedings is being made. There has just been a short break.

Answers to questions taken on notice and additional information should be received by the committee no later than next Friday, 29 April 2005. Witnesses should also understand that these hearings are legal proceedings of the Legislative Assembly, protected by parliamentary privilege. That give you certain protections but also certain responsibilities.

It means that you are protected from certain legal action, such as being sued for

defamation, for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

I welcome back Mr Simon Corbell, the Minister for Health. I see that Mr Corbell is accompanied by Dr Tony Sherbon, chief executive, and Mr Mark Cormack. Mark, are you a doctor? Have I insulted you?

Mr Cormack: No, I am not a doctor. You wouldn't insult me at all!

THE CHAIR: Welcome. We haven't met before. When officers are called to answer a question for the first time, I request that they state their full name and the capacity in which they appear. Please speak clearly and directly into the microphones to assist the Hansard staff recording the proceedings. Minister, would you like to make an opening statement for this part of health?

Mr Corbell: Once again, I don't wish to make an opening statement. I and officials of the department are happy to try and answer your questions.

THE CHAIR: I will kick off with one question which came up at an earlier annual reports hearing. I understand the North Building is being vacated for the multicultural centre, but that this has been delayed. Can you tell us why that is the case?

Mr Corbell: I will ask Dr Sherbon to give you the detail on that, but I can advise that, just in the past week, ACT Health have relocated from the North Building and are now located in Moore Street on the other side of the city. They are all getting a little bit more exercise when coming to my office for meetings, which is welcome. I will ask Dr Sherbon to outline the reason for the delay.

Dr Sherbon: You are quite correct, chair; there was a delay. The delay was on account of the need to secure alternate premises. There was an opportunity with the construction of a new building at 11 Moore Street, which I think is built on the old Silverton centre. Not being a native Canberran, I'm not familiar with that but I understand it is well known.

We have had an opportunity to move into those premises, as will the Office for Children, Youth, and Family Support and the Auditor-General. We have been able to consolidate a number of government functions in one building, and it was timely to await that opportunity.

THE CHAIR: How are the new premises?

Dr Sherbon: The new premises are satisfactory. The staff are working hard in the new premises.

MS PORTER: I have a question relating to page 14 of the report. There is a reference to the development of antenatal shared care guidelines having been developed in conjunction with Calvary Hospital and the division of general practice. I presume that's between the Canberra Hospital and Calvary Hospital. I was wondering if you could you detail the benefits that have resulted from the hospitals engaging in this arrangement with

the GPs, and if it's been of benefit to everybody including, of course, the GPs and the expectant mothers.

Mr Corbell: I will preface this one, if I may. I launched the shared care guidelines a little while ago—I think it was last year. Those guidelines bring together for the first time common forms for the recording of care to expectant mothers, which is a very basic thing but something which hadn't previously been done across the system.

Each hospital and the GPs all did it a little bit differently. Essentially now not only do we have a uniform record-keeping mechanism for occasions of care for expectant mothers but also a consistency of approach in how that care is provided, so that there are agreed approaches in a range of areas in respect of that care.

That really means—and I guess this picks up on the point Mr Smyth was raising before the break—that, as people transfer, as they can from time to time, between their GP and the hospital or between hospitals, there is a consistency of format in terms of how their occasions of care are recorded, and there is also a greater consistency of approach. That's valuable in terms of continuity of care which we are trying to achieve.

Dr Sherbon: The benefits to women and their as yet unborn, or soon to be born, children are those described by the minister—better coordination of care and more options for women in terms of the ability to feel supported by the community midwifery program, in conjunction with their family doctor and obstetrician, if required. As you know, many pregnancies progress without the need for a formal obstetric consultation, apart from perhaps an assessment early on.

I think it is fair to say that they are new guidelines, and they are already in the process of updating as we receive feedback from GPs and community midwives. The process has been extremely productive in helping GPs and community midwives work together and, as a result, women will get a better service.

MS PORTER: I have another point, in the same sort of area on the same page. Page 14 outlines the support for the Beyond Blue project. How is that project assisting with women suffering post-natal depression?

Mr Corbell: The information is that we have received funding from Beyond Blue to participate in their post-natal depression initiative. I am not familiar with the details of that. I might ask someone who is familiar with it to answer that.

Dr Sherbon: With your permission, I will ask Mr Jacobs to assist on that question.

Mr Jacobs: As the minister has indicated, the project has now been underway for some time. There is a report due soon, I understand, in terms of how it is rolled out. I don't have that to hand at this stage, but I can try and get some more detail on that.

Mr Corbell: We will take it on notice and provide that information.

MRS BURKE: I am probably going to go a bit deeper into the report at this stage. I refer to some of the health programs listed on page 45. Minister, have you submitted the 2003-04 business report to the federal minister? Have you submitted an annual plan to

the federal minister for 2004-05? Have you submitted the funding package for 2004-05?

Mr Corbell: Which business plan?

MRS BURKE: The business plan relating to HAAC funding.

Mr Corbell: Yes, I have.

MRS BURKE: A full submission has been provided?

Mr Corbell: Yes. I signed that off earlier this week. It has been sent to the federal minister.

MRS BURKE: No funding has yet been released to the community, although I understand they put in their submissions in November 2004. Is that correct?

Mr Corbell: I am not familiar with when they put in their submissions, but we have provided all the documentation the commonwealth requires quite recently.

MRS BURKE: I am wondering why there was a delay.

Mr Corbell: As I understand it, the issue was that the commonwealth normally requires that both the report and the business plan be dealt with separately. One is submitted and then the following business plan is submitted.

In conjunction and in consultation with the ACT office of the federal department, we submitted them all at the same time, the reason being that it would enable us to move more quickly on utilising that funding, rather than doing it in the staggered way the commonwealth normally requires. We did that in consultation with the federal department and with the agreement of the officers in the federal department.

MRS BURKE: Again, why has there been such a delay in the ACT government forwarding the submission to the federal government? This is obviously holding up essential auxiliary services within the ACT home and community care sector.

Mr Corbell: No, it has not held up that funding. In fact, by taking a little more time to do the business plan at the same time as doing the report on the previous year's activity, we have been able to provide the commonwealth with everything they need to make a decision on the provision of funding. Previously, as I understand it, the process was that you reported on the last year of activity, you waited to hear back from the commonwealth and you then started preparation of your business plan. We have done the report and the business plan at the same time and submitted them in tandem so that the commonwealth have everything they need to make a decision on the release of that money. I am very pleased to advise that that documentation has been provided. My department has been working very closely with the ACT office of the federal Department of Health and Ageing to deliver that.

MRS BURKE: How much longer is the sector going to have to wait? I understand they are under extreme pressure at the moment taking inquiries but are unable to provide essential auxiliary services.

Mr Corbell: I am advised by Dr Sherbon that the growth funds have already been distributed to the non-government sector. In relation to money for new initiatives, that is now a decision for the federal minister.

MRS BURKE: Is that growth fund or base fund? My understanding is that it is the growth funding that the HAAC services are waiting for.

Mr Corbell: I will ask Mr Thompson to give us some more advice on that.

Mr Thompson: Each year there are two components of the overall growth funding provided under the HAAC. One is indexation for the agencies currently receiving HAAC funding, and indexation funding has already gone out. At the same time we call for submissions for new initiatives. That is what is in the package that has gone to the commonwealth.

MRS BURKE: That is the very thing I am talking about. I am not talking about the ongoing, recurring funding, I am talking about a community sector that is being severely hampered and held up because of not being able to deliver services. I am just wondering if the minister can tell me why there has been a delay this year. It seems that nobody is advising the community sector.

THE CHAIR: We are inquiring into the 2003-04 annual report.

MRS BURKE: This is appropriate to that.

THE CHAIR: Mrs Burke, while there has been a bit of latitude given, I would say that this is an inquiry into the 2003-04 annual report. I believe the minister has answered your question, but he may want to add some more.

Mr Corbell: All I wanted to reiterate to you, Mrs Burke, is that I've explained why the documentation has been submitted in the way it has been submitted and I do not believe there has been any significant delay in that. The commonwealth minister has received the documentation she needs to make a decision, and we now await her decision.

THE CHAIR: Reference is made on page 7 to the very new ANU medical school. I understand that it is very new—it is only a small reference towards the bottom of the page. I am interested in whether there is any anticipation of how many of the graduates are expected to remain in Canberra, and the sorts of enticements—"enticements" is probably not the word I would use.

MRS BURKE: Encourage!

THE CHAIR: Encourage—thank you. How are we going to encourage people to remain in Canberra once they graduate?

Mr Corbell: I am advised that the first intake of interns will be in 2008. Those are people who have completed the course and become interns in the hospital. The government's philosophy is based, first and foremost, on the premise that where people train they are more likely to stay or return to at some point. That is certainly the evidence

right around the country. You are more likely to work close to where you train.

We have the advantage in the investment the government has made in the medical school—in the same way the government is making the investment in allied health at the University of Canberra and in the same way the government is making the investment in nursing activity at the University of Canberra—of growing our own health work force, and that is very important. It is a long-term strategy but one which we believe will deliver significant improvements in terms of work force availability for us.

We don't have any specific measures proposed to attract or retain those graduates once they leave, except that we will obviously be exposing them to our system; they will be learning in our system and they will certainly be being advised of the opportunities for continuing professional development in our system.

The government is targeting its expenditure, particularly in acute care, for example, to improving the quality of health infrastructure in terms of equipment and in terms of the quality and safety program, to make it an attractive place to continue to learn and develop professionally as doctors.

That can be in relation to surgical interns—which is a bit further down the track—or someone graduating, having completed the course at the university. We can nevertheless, hopefully, be in a position to demonstrate to people that we will invest in the equipment through our new robotic and laparoscopic theatres which the government committed to during the last election.

We can say, "This is a place where you can come and learn on state-of-the-art equipment in a well-resourced hospital where the government provides funding to support its development and therefore your development as a health care professional." That's the broad approach the government takes and one that I think in the medium to long term, thanks to the investment this government has made, can move ahead.

If you go out to Canberra Hospital now you will see, just behind the tower block, an increasingly large hole in the ground next to the library, which is the site for the new building for the medical school on the hospital campus. That work is well under way now, and that is an initiative of the government.

MS PORTER: Returning to page 14, can you outline, minister, how the patient mobility status chart assists in the prevention of staff injuries?

Dr Sherbon: The minister has asked me to answer that. The patient mobility status chart assists nurses in evaluating the risk involved in manual handling of patients. It advises staff as to the ability of the patients to move themselves. It is one component of our extensive manual handling program. In 2003-04 the minister secured from the government funds which have flowed through into 2004-05 for manual handling equipment. I am pleased to report that as of last month, March 2005, we had the lowest number of claims for workers compensation in ACT Health for four or five years. The manual handling claims are reducing and this component is part of that. We did suffer in 2002-03, flowing into 2003-04, a significant increase in manual handling claims, which are now coming under control. This was one element of that program, along with equipment and staff training.

MRS BURKE: I have a question about page 138 of the report and the contingent liabilities. I note the statement there. I am wondering whether somebody could shed some light on that situation.

Mr Corbell: I will ask an officer of the department to answer that. Can you do that, Dr Sherbon?

Dr Sherbon: Yes, I can address the issue. All health services internationally incur liability claims, and we are not exempt from that process. The question perhaps, if I can be so presumptuous, is directed at the 137 claims. I can report that in 2003-04 we devised a new incident monitoring policy by which I and other senior executives were notified of incidents that, in turn, are notified to ACTIA as potential claims. That system did not exist prior to 2003-04.

There was no system for notifying senior managers of incidents in the organisation. There was a system used to notify middle level managers of incidents at the local level but it did not feed into senior managers. On ACTIA's advice, we formalised our process for incident reporting and those incidents were reported in 2003-04 and the actions that you can see, the 137 actions, were largely in relation to incidents of previous years that became claims. Some of them would be for that year, being 2003-04. As you can see, it has decreased from 210 to 137.

MRS BURKE: But the actual liability has risen.

Dr Sherbon: That would probably relate to two major baby claims, one of which we won. The other one, the Galea claim, is not private; it is a public case. As you are aware, the award was against us and that was for an incident that occurred in the 1990s. I will have to specify which year on notice.

MRS BURKE: You are saying that it has not been provided for in the accounts here. A couple of things come to mind. How would that affect insurance and where is it provided for?

Mr Corbell: Provision is made through the government's insurance arrangements and you would need to ask the Treasurer and the insurance authority as to the detail of that. I am not privy to those arrangements. These matters are fundamentally managed by ACTIA, which is the responsibility of the Treasurer.

Dr Sherbon: As the minister said, that is exactly how the system works. These are contingent liabilities; they are not actual claims. As the claims are made and settled or the claims are made and won or lost by us in the contested court arena, ACTIA, us and Treasury works to meet the cost of those claims through our various insurance arrangements. As you have heard from ACTIA in previous hearings, there is a reinsurance arrangement for major claims.

MR SMYTH: I refer to page 1 and Dr Sherbon's transmission letter to you, minister. It notes that the emergency department had seen a 22 per cent growth in high urgency cases in 2003-04. What is the definition of "high urgent"? Is "high urgent" category 1 and category 2 or does it include category 3?

THE CHAIR: Mr Smyth, are you referring to the chief executive's review or the transmittal certificate?

MR SMYTH: The chief executive's review on page 1.

Mr Corbell: I am advised that Dr Sherbon is referring to categories 1 and 2.

MR SMYTH: If you go to the chart on page 11 and add up categories 1 and 2 and compare that to the previous year, it is probably more like 77 per cent. Category 1 remains fairly close at 1,021 and 1,073, but category 2 doubles, going from 3,830 to 6,802. If you add categories 1 and 2, the increase is about 77 per cent, not 22 per cent. Why did you have such an increase in high urgent cases?

Mr Corbell: I will ask Dr Sherbon to provide some more information there, but the issue we have, and it is not unique to the ACT system, is that we are seeing an increase in high acuity cases. People are waiting longer before they seek care and part of the reason that this is occurring is that people are finding it more difficult to access general practice, where perhaps the intervention can occur when the situation is less acute or not acute at all. As a result, they are presenting to the emergency department with higher acuities.

That is not unique to us. It is regrettable that the commonwealth government's funding arrangements around general practice have seen the ACT with one of the lowest levels of bulk-billing in the country and there seems to be little in commonwealth government policy at the moment that is going to turn that around. That means that the burden is coming back to our emergency departments and we are seeing that increased acuity in the emergency departments as a result.

MR SMYTH: Category 1 is resuscitation and category 2 is emergency, which is organ threatening and limb threatening. Is that really because people cannot see a GP? Surely it is fractures, accidents and things that are not normally GP-type injuries anyway.

Mr Corbell: We are seeing older people presenting more often with symptoms or conditions which have got out of hand because they have not been able to be monitored as closely and as consistently by their GP as perhaps they were previously because of problems with access to a GP and the cost of seeing a GP has gone up. That really is preventing people from being prepared to go and see their GP, if they have one, if they are able to get in and see one, as often as they would have liked. The cost of that is significant. Dr Sherbon points out to me that the sorts of conditions you are looking at are, for example, heart attacks and issues around high blood pressure. Those sorts of matters are in the category 1 and category 2 cases and the increase in the elderly people presenting is a factor in that overall increase.

MR SMYTH: What have we done to get more GPs into the ACT?

Mr Corbell: As you would understand, Mr Smyth, the funding of GPs for primary care is fundamentally the responsibility of the commonwealth government through the Medicare arrangements. We all pay the Medicare levy in our taxes so that we get access to decent primary care. The ACT government has been successful in getting the commonwealth government to extend some of its provisions around areas of work force

shortage to apply incentives to attract GPs from metropolitan areas to other areas that are not metropolitan. We have been successful in getting Tuggeranong, Woden-Weston Creek, Belconnen and Gungahlin designated as outer metropolitan for the purposes of commonwealth policy. That means that we are able to take advantage of subsidies that the commonwealth government provides for doctors to relocate from inner metropolitan to outer metropolitan areas.

That was a significant win for us and that certainly assists us in getting doctors to relocate. It is still difficult to convince doctors to relocate from one city to another, but we have had limited success in that area. Also, as I indicated in my answer to Ms MacDonald earlier, the government is taking a long-term strategy of investing in the training of our own doctors in Canberra, because fundamentally that will be one way that we can help ourselves in terms of the availability of trained doctors into the future. By investing money in the institutions that will train them here, we will have more success in keeping them here once they graduate and are able to practise.

MR SMYTH: At a public meeting of the Tuggeranong Community Council last year you committed to working to see a GP practice established at Lanyon. That has not happened at this stage. I think that most of us came away from that meeting with the impression that the doctor who had put his hand up was going to deal directly with the government for a grant of land. Why has that fallen through?

Mr Corbell: The government released an additional site in Lanyon which had as part of its use conditions the opportunity to be used as a medical centre. We put that land out through a competitive process and that land was purchased. I understand that there are two sites in the Lanyon Valley—one under construction, I think, and the other sold but development has not yet commenced, the one that we sold most recently through auction. I understand that the site released by the previous government—I think when you were minister, Mr Smyth—is being developed for a range of uses, including the provision of commercial office space or commercial suites. I may be wrong about that, but that is my latest understanding of the situation. That obviously gives the capacity for office space for doctors if they wish to locate in the Lanyon Valley.

Equally, the land release which the government made recently and which has been successfully sold at auction also has the ability for office space to be made available for doctors to locate in the Lanyon Valley. The government believes that that is an appropriate approach. Most doctors in the ACT do not own their premises—they rent their premises from building owners—and we do not see why the situation in the Lanyon Valley is any different in that regard. Indeed, when you look at the availability of doctors across the city, the Lanyon Valley is not in the same situation as many areas in, say, west or north-west Belconnen, which is in fact the area where we do have a greater level of need and demand compared with some of those areas in Tuggeranong.

DR FOSKEY: I seek clarification. Currently, are we just talking about hospital and acute health issues?

THE CHAIR: We are talking about all issues within the annual report.

DR FOSKEY: Okay. I was just wondering whether you had established an order for questions.

THE CHAIR: It seems to be fairly higgledy-piggledy.

DR FOSKEY: That is hard for me, as you can imagine. On page 13 of the annual report, under future directions, you refer to increased demand for cancer services and plans to establish a networked cancer care service. Can you put a figure on the increase in demand and say how a networked service will address this increase? I have heard that some people are travelling interstate for treatment and just want your comments as to whether that is true and your plans to address the issue.

Mr Corbell: I can advise you that we do now have a networked cancer care service for the ACT. We have a cancer care stream; I think it is called the capital region cancer stream. It provides a range of services and, importantly, provides for a continuum of care for cancer patients across the ACT and southern New South Wales. We have developed clinical and financial key performance indicators to demonstrate the effectiveness of the clinical stream and we are, obviously, incorporating cancer services provided by Calvary Hospital as well as the Canberra Hospital and cancer services provided in the surrounding region as part of this stream. I will ask either Dr Sherbon or Mr Cormack to give you further advice on some of the more practical detail around the operation of the stream.

Dr Sherbon: The stream was established late in 2003; so, at the time of the publication of this annual report, it was foreshadowed. The stream incorporates the medical oncology service, the radiation oncology service, elements of surgical oncology at Canberra Hospital, the breast screening service and the cervical screening service, which, as you know, operate in the community, and, in a matrix fashion, has strategic oversight of the medical oncology service at Calvary Hospital. As the minister outlined, that service is coordinated as part of the stream. Although operationally it is managed by Calvary Hospital, managed by the Little Company of Mary, strategically it is overseen by the director of cancer services for the region. It was a significant moment for the territory in that this is a regional service, not just a territory-wide service; so southern New South Wales is incorporated. As you know, we provide the vast bulk of cancer services for southern New South Wales. The issue that you mention in relation to patients going out of the territory is an issue in radiation therapy services and the minister has overseen a process by which we have improved those services.

Mr Corbell: A couple of initiatives are worth highlighting. The first is that we have undertaken a program to recruit additional radiation oncologists and radiation therapists to the ACT. We have also recruited a number of radiation therapy professional development students, people who will go on, hopefully, to work here upon completion of their studies. A radiation therapy proceptor position has been established to improve the support to radiation therapists. Three new graduate radiation therapists have been attracted from interstate to commence work in radiation oncology this year and we are also exploring options to upgrade the linear accelerator capacity at the Canberra Hospital. So there is a range of measures that we are undertaking to address work force shortages.

There is a national shortage of radiation therapists and radiation oncologists and we need to address that. As you can see, we are not being backward in addressing this issue. It is very important and we are undertaking significant work. I would say, however, that

radiation therapy is a key health care service if you are diagnosed with a cancer and the important thing is that you get treatment within the appropriate time. Patients are classified according to their clinical urgency. Just to give you an example, patients classified as non-urgent normally would receive treatment within six weeks and we are working hard to try to meet that.

We do not always meet the six weeks. Because of that, we are working to ensure that people get that treatment, even if it means that we have to make arrangements for them to be seen elsewhere in New South Wales, because the bottom line is that the treatment must be provided as soon as possible. I have to stress that we treat all urgent patients. All our urgent patients are treated here and only semi-urgent and non-urgent patients are offered treatment, if necessary, outside the ACT. We work with those patients and their families to coordinate that and make arrangement for them to receive that care elsewhere if we are unable to do it within the clinically appropriate times.

DR FOSKEY: On page 15 it is stated that the Canberra Hospital is looking at innovative changes to medical rostering to improve patient care. Could you expand on?

Mr Corbell: I will ask Dr Sherbon to answer that question.

Dr Sherbon: Canberra Hospital has spent a significant amount of management time and resources on reducing the amount of extended hours worked that medical staff do and thus improve safety for patients. You would be aware that it has traditionally been an element of health system hubris that medical staff work impossible shift lengths and hours. Over the last five years all health systems, the ACT in particular, have worked to reduce the excessive length of hours. I was asked recently about that by a committee and, on notice, we supplied an answer that indicated that most of our junior medical staff are working between 45 and 50 hours a week, which is a lot less than has been the case in the past. The rostering is about reducing the risk to patients from unsafe hours.

MS PORTER: Page 16 of the report refers to a pilot undertaken at Calvary about caring for older Australians as part of the national demonstration hospital project. Could you please report on the progress of this pilot in terms of throughput and the reasons for people being referred or needing access to that unit?

Mr Corbell: Are you referring to the clinical decision unit or the Calvary aged and acute bridging service?

MS PORTER: The second one.

Mr Corbell: I will get some advice for you on that, Ms Porter.

Ms Williams: The Calvary aged and acute bridging service was a project that was funded through the national demonstrations hospital to try to reduce the length of stay for older Australians within the group by bringing them into an area of rapid assessment to know what their issues were and to bring them forward. It was originally incorporated in a ward within the hospital and had some quite successful outcomes in reducing their length of stay, the statistics for which I do not have with me at this time. The plan was then to move that into the clinical decision unit as an offshoot of the emergency department. At this point in time, that has not occurred due to the funding not being

there, but it is still occurring as part of the clinical decision unit but not as a specific Calvary aged and acute bridging service.

MRS BURKE: I turn to the reference to output class 1—principal measures for health and community care—on page 152. Nearly every measure is significantly down. Could somebody elaborate on that? I have taken the notes on board. I am just wondering whether there are some other underlying issues impacting upon this item.

Mr Corbell: If you would like to highlight the particular matters that you have an interest in, we would be more than happy to try to answer those.

MRS BURKE: I guess the ones in particular I would look at would be those concerning alcohol and drug services, the registered clients on pharmacotherapy, the number of residential rehabilitation clients and the impact, obviously, on Karralika of the high retention rate in December, the units of dental services for adults, breast screening, and service providers complying with agreed time frames for service delivery.

Mr Corbell: As you can see, Mrs Burke, I have had some fairly detailed advice on each of these. On the first one that you asked about—I will not do these in any particular order—concerning community health services and the number of bed nights of respite care, what we have seen here is that there has been some difficulty in terms of providing the number of bed nights that we expected. The variation in terms of Burrangiri being below target, a five per cent variation under target, is due to the flow-on effects of industrial action taken by the ANF against the Salvation Army, which runs Burrangiri on behalf of the territory, and due also to a gastroenteritis outbreak which caused Burrangiri to close and cease operation from 10 November to 23 November 2003. The industrial action that I referred to took place in July and August 2003.

MRS BURKE: Is that all settled now?

Mr Corbell: That is settled now, but it did result in Burrangiri not accepting any new referrals during that time, so resident numbers did decrease during that time. In relation to the alcohol and drug program, there was a target of 800. This represents the number of registered clients on pharmacotherapy treatment programs, methadone essentially. The total of 800 represents the maximum number of places available under the program and the underachievement was due to demand which was lower than expected. The target is basically our capacity, the capacity we have in the program, and we had fewer people accessing the program than we expected, but it was not due to any lack of capacity. There was less demand than we made provision for.

In terms of the number of residential rehabilitation clients being 16 per cent below the target of 300, there were a couple of reasons. First of all, the number of client admissions tends to be lower when the length of stay increases. Most rehab services aim to have people stay for between six and nine months, but they can and do have high dropout rates. What we are seeing, actually, is more people tending to stay longer. That is, in our view, a good sign, because it means that people are staying in the programs and going through the rehabilitation process.

Finally, in relation to dental services, the variance is 15 per cent. This was due to a shortage of available dental officers during the year, due to dental officers taking leave

during that financial year. That is the key issue. There was also a change in the methodology for calculating the target. However, that is a separate matter that I am sure Dr Sherbon or others could go into in a bit more detail if you wished, but the key issue has been the shortage of dental officers during that time. It is worth stressing again, as Dr Sherbon points out to me, that there was an additional $500,000 allocated for dental services during 2003-04 by the government and dental waiting times for restorative services decreased from 22 months as at 1 July 2003 to only nine months as at 30 June 2004.

Again, I need to make the point that the reason we had a 22-month wait was that the commonwealth government completely removed funding from the dental programs. A longstanding commitment on the part of the commonwealth to provide funding for public dental programs was basically pulled and there was no funding for the dental program. Since that time, the ACT government has committed significant additional funds. Whilst, as you can see, those waiting times are significantly better than they were before they are, nevertheless, still too long and we will continue to focus our efforts on doing something that the commonwealth government does not appear to be interested in, that is, providing basic dental health care for those who cannot afford to go to a dentist.

MRS BURKE: The last one for which I did seek information was about service providers complying with agreed time frames for service delivery.

Mr Corbell: This issue relates to the providers reporting on their performance on a regular basis. I think that we achieved over 90 per cent within one further week. It just means that the NGOs were not as prompt in reporting.

MRS BURKE: Was a reason specified to you for that?

Mr Corbell: No, just that they were not as prompt. Without approaching the individual NGOs, I could not tell you. I must admit that this is one of those measures that I do not think necessarily tell us very much. It is not as though they did not report. Indeed, most of them reported within one week of the deadline for reporting. As a measure, I must admit that it does not add very much and it is the sort of measure that we will be looking at, but steps were taken to remind NGOs of their reporting responsibilities. Indeed, letters and advice were provided to those NGOs about the need to report in a timely manner, consistent with their agreements.

THE CHAIR: My question relates to the ACT mental health strategy and action plan 2003-08. It has been going for a while now. How is it running? How has it affected Mental Health ACT overall? There has been a huge number of changes to mental health in the few years since I first came into the Assembly. It is a general question, but I am happy for you to confine it to the 2003-04 annual report.

Mr Corbell: I will ask Mr Jacobs in a moment to give you some more specific detail, but I would like to make the point up front that the strategy and action plan set some basic principles about the way in which mental health services should be delivered in the ACT. That really does inform in many respects a cultural change in terms of the operation of mental health services, reinforcing the importance of working with clients directly in the provision of their care, respect for their needs and the conditions that they tackle, and making sure that, wherever possible, the provision of mental health services is done in

a way which tries to see mental illness as just that, as an illness, and as something which can be accommodated not only in an acute setting but also, importantly, in a community setting.

The government services have focused very strongly on increasing our capacity to deal with mental health in the community in community settings through outreach services to parts of our city that previously had not received that care—for example, Gungahlin. The government has already committed funding, and the service is now provided, to outreach support for people in their own homes in the Gungahlin area, the fastest growing area in the ACT but previously not serviced by that sort of support in any comprehensive way.

We are undertaking a range of other measures to provide better support for clients. For example, discharge planning is now a fundamental part of support for people leaving following an acute episode at, say, the psychiatric services unit and going into a community setting. People are not simply discharged without any direction or guidance and assistance in terms of support back in the community. Measures like that are encompassed in the principles and the philosophy that underpin the strategy.

In terms of some of the more detailed work that is going on, there is a range of projects occurring. I might ask Mr Jacobs to elaborate on a number of the key ones just to give you a feel for how the action plan is influencing how we deliver services.

Mr Jacobs: With the strategy and action plan, there were over 50 actions identified that were meant to be achieved through the life of the strategy and action plan, which goes through to 2008. In pursuing those actions, we have a number that actually have a range external to Mental Health ACT and we have a cross-agency implementation group involved in driving that part of it. That includes education, promotion, prevention and early intervention and the members of the group include people from JACS and ACT Housing, with consumer consultants and carers being included in that overarching implementation group. We are also pursuing a number of actions specific to Mental Health ACT.

I will just run through a few of the things that we are making significant progress on to date. Work is in progress on revising the corporate and clinical governance structures within Mental Health ACT to enable the service to provide a more integrated responsive service and reflect the increased focus on rehabilitation and older persons' mental health, which are going to be particular targets for us in future years—not that all areas won't be, but they are two that are high on our radar. A clinical services review committee has been established to review current services and develop more consistent models of care across the public mental health system.

An audit of the mental health promotion activities has been completed. The Mental Health ACT promotion, prevention and early intervention plan is out for consultation now and we are expecting it to be finalised within the year. A project to improve the physical health of people with severe mental illness has commenced. That involves the recruitment of a primary care nurse to facilitate support and the access of mental health consumers to the regular GP services. A feasibility study regarding the high secure needs of consumers with forensic issues was undertaken in 2004-05 following the recommendations of an interdepartmental committee for forensic mental health. Further action and intervention in this regard will proceed once we finalise the approvals on that.

A collaborative therapy project in partnership with the Mental Health Research Institute of Victoria has been implemented and is presently progressing. The advanced agreements project, which is client driven, has also commenced in partnership with the ANU. The project will trial the use of advanced agreements and monitor the outcomes and effectiveness of this planning tool. When clients are well, they identify how they want their care managed when they become unwell.

A working group is progressing the development of an information and education program to facilitate increased skills for a range of agencies in working with people with mental illness. We already do a good deal in regard to community awareness and education and we are continuing to build on that. A mental health services planning project is in progress to project mental health service needs, models of care and infrastructure requirements through to 2014. Policy and planning and our HIM manager are helping to drive that.

MS PORTER: Page 16 of the report states that Calvary public's mental health services were integrated with those of Mental Health ACT. What has been the effect of the integration? Has it resulted in better outcomes for those who are using the service? Is there any data that indicates the effect of the integration?

Mr Jacobs: Over 12 months after the operation of the Mental Health ACT stream we had a review of the benefits that rolled out of the integration of 2N. That was done with the team leader, a clinical consultant from Calvary, plus a number of the staff. They identified a range of different benefits that they perceived with the integration from a staff perspective and a consumer perspective. I can make that summary report available. From memory, among the things that they perceived as benefits was better integration in terms of client transfers between the units. We now have better integration of the medical cover for that area. We also have improved access to education for the people who are working in the 2N unit.

MR SMYTH: On page 151, relating to outputs, the number of raw separations dropped by 13 per cent. The notes claim that that was due to a shortage of qualified staff. That would indicate that you are losing a significant number of staff. How many staff have left Mental Health ACT?

Mr Jacobs: Have left Mental Health ACT?

MR SMYTH: Yes. The explanation is that the reduced number of beds was due to a shortage of qualified staff. Given that you had expected 1,400 separations and there were only 1,216 delivered—

Mr Jacobs: Staffing continues to be an issue for us and we have a number of strategies in place to continue our supply of staff to back up those that are leaving. People leave for a number of reasons including age retirement and that type of thing.

MR SMYTH: But how many had left was the question.

Mr Jacobs: I do not have that specific number here.

Mr Corbell: I do have that figure, Mr Smyth. The advice I have is that 44 staff separated from that area of ACT Health during that time period, 2003-04.

MR SMYTH: Out of a total of how many staff for that area?

Mr Corbell: I am advised that it was 15.6 per cent of the total number of staff, but I cannot tell you now the total number of staff in Mental Health ACT at that time.

Mr Jacobs: To June 2004, at that point in time, we had 303.7 EFT, effective full-time positions. As of March, according to the report I have here from Mr Hickey, we were using 301 EFT. So we had been able to keep the number up, despite the difficulties in terms of mental health recruitment nationally.

MR SMYTH: Does that apply to the number of community-based services? It was down four per cent. Was that for the same reason?

Mr Jacobs: Basically, each year we have a number of staff movements into and out of Mental Health ACT in terms of them pursuing promotion, retirement, et cetera. During this period, we had difficulty in maintaining staff against the bed-based services, because people do seek promotion into the community, and we had to use a combination of agency ENs as well as registered mental health services and RNs to maintain the work force, particularly against bed based.

THE CHAIR: When using acronyms, I ask that you say what they stand for. What does EN stand for?

Mr Jacobs: Enrolled nurse.

THE CHAIR: I know what "RN" stands for.

Mr Corbell: My apologies. It happens to me, too.

DR FOSKEY: The feedback to me from mental health consumers and carers is that there are a number of issues in areas that I will outline in a second, none of which have been identified in the report as current or future issues. I am just wondering whether anything could be done or is being done. These are identified as the operation of the crisis assessment team, communication between carers and health professionals, particularly around issues of confidentiality, operation of the memorandum of understanding between Mental Health ACT and ACT Housing, and the continuing one of long-term care for consumers whose parents and carers are ageing.

Mr Corbell: That is a fairly broad-ranging area of issues you have raised, Dr Foskey. Perhaps the best way of trying to understand that and do some justice to the questions you have raised, all of which are very valid, is to offer you a more detailed briefing with Mental Health ACT so that you can have that discussion, rather than trying to do it here, because it would be a fairly broad-ranging discussion.

DR FOSKEY: Thank you. I would appreciate that. I think we have an answer to my second one, which someone else asked. The Mental Health ACT official visitor's report for 1 January to 30 June 2004, which is an annexure to the ACT Health annual report,

identifies on page 297 concern regarding the number of deaths of mental health consumers not long after discharge from an inpatient unit. I know that this was identified just recently as a concern in New South Wales as well, so we are not unique. I am interested in knowing how many deaths have occurred and whether anything is being done to address that.

Mr Corbell: Obviously, any death of a person with a mental illness is a tragic occurrence. I think that the point often needs to be made, and perhaps is not made enough, that all too often our mental health services do intervene in a timely way to prevent someone from harming themselves. It is those instances where they are unable to predict or take action to prevent someone causing harm to themselves that attract our attention, but all too often there are many, many, many more occasions in which intervention is successful and the person is able to be provided with care so as to prevent harm.

I meet regularly with the official visitor. She raises with me her concerns on a regular basis. I have to stress, though, that the most recent discussion I had with the official visitor, which was only last week, indicated to me that she is seeing significant improvement in a range of areas across mental health, but that problems still remain, and I certainly accept that that is the case. I was pleased, however, to hear from her only last week that the number of compliments that she is receiving from patients or clients of mental health in her and her other official visitors' contact with them has indicated that they are seeing improvements in the approach of staff of mental health. That is pleasing.

In relation to the number of death, I think that has previously been answered in answers to questions on notice that I have provided to, I think, Mr Smyth. So it is already on the public record. Deaths which involve the care of Mental Health ACT are usually referred to the coroner and I think that there are a number of coronial inquiries ongoing at this point in time and we are familiar with those over the last little while.

In relation to some of the systemic issues that have been identified, particularly in the psychiatric services unit, the government has allocated funding for the provision of a new psychiatric services unit and planning work on that has commenced, because the existing psychiatric services unit does not meet our needs. It certainly does not meet client needs, in my view. It has some very serious deficiencies that cannot be addressed by redesign of the existing facility.

We have spent a significant amount of money on upgrading as best we can safety in both the psychiatric services unit and ward 2N at Calvary Hospital and about $200,000 has been allocated—I am not quite sure of the time frame; presumably within the time frame of this report—for a safety upgrade of ward 2N. There has also been a larger amount of money allocated for safety upgrades at the psychiatric services unit at the Canberra Hospital.

So the government does treat the issue of deaths of mental health clients very seriously. We take whatever steps we can to improve the safety of our physical facilities, both in the short and the long term, and we do strive to ensure that there is sufficient supervision of clients once they leave the psychiatric services unit. However, it is an unfortunate fact of life that some people will commit suicide, and that is the main cause of death of mental health clients that attracts public attention. The rates of suicide in the ACT are

below the national average and we want to continue to keep them that way and to reduce them further, but suicide is, regrettably, part of the human condition and I think it is unrealistic to expect that we will never see clients of mental health services harming themselves. Unfortunately, it does occur, even with the best will and clinical management in the world.

Dr Sherbon: We now monitor the percentage of clients that are discharged from the PSU or ward 2N at Calvary that are seen by a community mental health team within seven days. I am happy to report that that figure is now over the 75 per cent target which we set ourselves for both groups. The 2N group is complicated by the fact that some patients prefer to see a private psychiatrist or a GP on discharge, but for those who our patients the community mental health teams are monitoring the percentage seen within seven days post-discharge in light of the official visitor's observation. It is something that we specifically focus on as a management team.

MRS BURKE: I acknowledge on the public record the excellent work done by the mental health crisis team. My question relates to pages 95 and 96, 'justice, options and prevention policy framework', under the heading 'options for women'. At dot point 3, it notes:

> ACT Health will provide safe options for women affected by violence to stay in their home, through Karinya House for Mothers and Babies' outreach support, and supported accommodation services.

Minister, does this then indicate your ongoing support for Karinya?

Mr Corbell: The government provides support to Karinya. I am not quite sure at which point the government's funding arrangements with Karinya are up for review. I will get some advice on that for you. Karinya provides an important service and we will obviously continue to assess the opportunities to continue that.

MRS BURKE: Do you know how many clients accessed the service in 2003-04?

Mr Corbell: I would have to take that on notice.

MRS BURKE: Do you want to take the whole question on notice?

Mr Corbell: The number of clients, yes; I can't answer that today.

MRS BURKE: Yes, okay, but your commitment to the service?

Mr Corbell: I am advised by Dr Sherbon that there is recurrent funding in the budget for Karinya—in the existing budget that is, so they are programmed in outyears to continue to receive funding. They have a level of base funding which we expect to continue.

MS PORTER: Minister, on pages 180 and 182, there is mention of the introduction of syringe vending machines in certain locations on a trial basis. Is there any evaluation data available on that?

Mr Corbell: I am getting some further advice on that. Whilst that is coming, syringe

vending machines have been installed at our key community health centres—that is, the city, Belconnen, Woden and Tuggeranong. They have been operating now for a number of months. It is probably fair to say, and I will get this clarified, that it is too soon for an evaluation of that. But certainly I am pleased that it has happened with a minimum of fuss, because there can be some emotive issues around the provision of this equipment. We have worked to keep immediate neighbours of the health centres informed that this is happening and I am pleased to say that to date—as far as I am aware—I have not received any adverse comment from shopkeepers or other operators close by to our health clinics about the provision of the vending machines. If that continues, it is vindication of all the evidence we cited in the decision to install these machines—that they remain low profile, that they do not cause major problems for the broader community, but they do provide an important option for people who need clean injecting equipment, and to stop the spread of blood-borne diseases.

Dr Sherbon: There is an evaluation process incorporated in the program. It is in its early stages but it is too early to report on. But we can report that all four machines are being used and we understand from reports back from the community that they are proving useful for those who require such equipment and, as the minister reported, there seems to be some neighbourhood accommodation to those machines.

MS PORTER: Still on page 182, it says that the government is considering the feasibility of providing a needle exchange program for the territory's correctional facility. Has any decision been made about that or are we still awaiting the decision on that?

Mr Corbell: That work is ongoing and it is very much tied up with the development of the Maconochie Centre. This is a difficult and complex issue. Obviously the safety of prison officers and other staff who will work in the correctional facility is paramount but equally the opportunity to prevent the spread of disease within the prison population is an extremely important public health issue. So work is ongoing and health remains in discussion with the justice department and the prison team on that.

MRS BURKE: Just by way of a supplementary—the decision to install vending machines throughout Canberra came under the previous health committee in the Fifth Assembly, and I was a member of that committee. My understanding of that was that the chair of that committee was to hold discussions with you and to then make public to the committee at that time the type of machines that would be installed. Did that discussion ever take place before those machines were installed? I did not hear anything about it and I was told I would be consulted on what machines were going out there.

Mr Corbell: No, I did not meet with Ms Tucker, the chair, on that issue. The government looked at the specific recommendations in the committee report and responded to them accordingly. This was recommendation 7 of that committee report. It recommended the installation of these machines and that the location of the vending machines be trialled in consultation with key stakeholders. We agreed to that recommendation. We made the funding available to implement that recommendation and we undertook careful consideration of where they should be located. I am not aware of any committee decision to have discussions with me on that. The government simply looked at the report's recommendation, agreed with it, and, I am pleased to say, implemented it.

MRS BURKE: I appreciate that but there was a discussion with the then committee about the needle equipment packs being accessed by money and that was posed as a concern of the committee. Obviously the previous chair is no longer in the Assembly but it was posed as a concern. I put it on the public record that I was concerned because of the fact that money was involved. We were shown several machines. I do not know where the break down in communication came.

Mr Corbell: Perhaps next time you see Ms Tucker you can give her hard time about that. But on the substantive issue that you raise, which is the matter of the requirement for payment to access the injecting equipment, the view the government took was that a small charge was appropriate to prevent opportunistic access and use of the syringes from the machines. We did not want people coming out, pressing the buttons, thinking it was great and then using them for inappropriate purposes outside of the context for which they are meant to be used. A small charge does prevent that opportunistic abuse of the machines but still makes it very accessible, affordable and available.

MRS BURKE: I do not want to labour the point but, with the range we saw, it was fit pack for fit pack—so it was more like a needle exchange. Anyway, I was quite concerned not to have had any word back about what machines were being installed and I did not remember hearing anything publicly about those machines being installed. I saw it in a magazine. That is how I found out.

Mr Corbell: I certainly issued media statements that they were occurring.

MRS BURKE: I looked on your web site and I could not find it; maybe it is there now. Thank you.

DR FOSKEY: On page 202, there is a brief report on the supervised drug injection trial advisory committee, which says it had met once after 18 months. Has it met again or what is the situation?

Mr Corbell: The advisory committee has been disbanded, following the government's decision not to proceed with a supervised injecting place at this time.

DR FOSKEY: How will the government be responding to the findings of the three reviews into the alcohol and drug program, which, as is mentioned in the annual report, were triggered by Ms Tucker writing to John Stanhope raising the serious concerns of former employees from 2001 to 2002.

Mr Corbell: As you have rightly indicated, there have been three separate investigations into the matters that were raised in Ms Tucker's representations to the Chief Minister. I have tabled two of those reviews in the Assembly and I have also outlined in the tabling the government's response to those issues. The third review, which is the clinical governance review, has been completed and is with the department and the department will be providing advice to me on that matter shortly. If at all possible, I intend to make public that review and the government's response to it.

MS PORTER: I did have a series of questions on mental health but I will leave those and see if we have time later, given that Mr Jacobs has sat back down again.

I congratulate Calvary Hospital for receiving an exemplary rating in its formal review by Professor George Rubin and Linda Justin, also for being a finalist in the National Baxter Innovations in Healthcare Award and for having six projects in the finals for the Quality First Award 2003, with the falls minimisation project being the overall winner. As a resident of Belconnen, I have had direct family involvement with the services provided by Calvary on a number of occasions. My youngest son gave me many opportunities to visit the accident and emergency due to his frequent accidents in our swimming pool—not drowning accidents, I might add. He was meant to lift his head before he careered into the wall when swimming down to the other end! I thought we were going to have a private suite in accident and emergency there at one stage. I have also been there for the birth of two of my step-granddaughters. So I commend the staff of Calvary. I notice on page 17, the report mentions the development of a new MOU between Calvary and the ACT government. Can you report on that?

Mr Corbell: That work is ongoing. The issue the government is seeking to resolve at the moment is that the understandings and the arrangements that drive the governance of the ACT government's relationship with Calvary are quite complicated and old. They date back 25 to 30 years, since Calvary was first established really. Calvary has raised issues with us around that and the government has issues around that and we are in discussions with them about that.

MRS BURKE: I would like to talk about a training issue. Ostensibly, it starts on page 286—it is in connection with a rather unfortunate radiation incident where it would seem a nuclear medicine technology student appears to have misunderstood the direction from the supervising technologist as to where to dispose of waste and placed the material in an ordinary waste bin instead of the radioactive decay waste bin. On page 284, I note that a review was done very quickly and I commend that. However, it does not say anything in that review on page 284 about processes that might be in train in terms of having future students in the workplace and how you intend to coordinate that review and the procedures. How are you working with students to make sure that it does not happen again?

Mr Corbell: I would imagine that all staff in nuclear medicine areas would be properly informed of their responsibilities and I will ask Dr Dugdale to elaborate.

Dr Dugdale: We have a radiation safety officer and staff, and licence all radiation emitting equipment in the ACT and provide detailed guidance to any people who are using radiation-emitting equipment, including nuclear medicine. I am not sure if there is a specific induction program for new staff but I can certainly say that there are detailed programs and protocols for handling the material and that that is a very important part of the training for nuclear medicine staff, as they go through their training.

MRS BURKE: Where are the students drawn from? It does not make it very clear here whether it was someone who had come straight from university into the workplace. Is there an induction for such people or is this an ongoing member of staff who is being retrained or what?

Dr Dugdale: I cannot comment on the staff member.

Mr Corbell: We will take that on notice.

MRS BURKE: Yes, you can see what I am getting at—I am just trying to offer a solution to what may be a gap here that we have not identified.

Mr Corbell: It is a highly specialised area and obviously anyone working in nuclear medicine needs to be aware of the issues around that use. This would appear to be a single incident. The syringe was placed in an incorrect container. I would imagine appropriate steps were taken to advise and counsel the person involved, and ensure it did not occur again. This was some period of time ago and I am not aware of any other incidents. I will undertake to provide you with a little more information on that but safety procedures are paramount in these areas and I think I can quite safely assure you that appropriate action has been taken.

MRS BURKE: I don't doubt that. It was just identifying that there may be an issue in regard to training or some sort of lack of induction.

Mr Corbell: I understand your point. We can provide further information.

MRS BURKE: Thank you.

MR SMYTH: Page 56 points out the ongoing capital works projects for the department. I note that for the year 2003-04 no money was spent on the sub/non-acute inpatient services building. Are there plans available for that? Has a DA been prepared and submitted and what is the expected opening date of that facility?

Mr Corbell: The subacute facility is in its planning stage at this time. Just by way of background, it is a 60-bed facility. The project control group accepted the final design for the new facility earlier this month and a development application will be lodged in June. That is the advice I have and we anticipate, all being well, that construction should commence in the last couple of months of this year.

MR SMYTH: Which means that the June 2006 expected completion date is now impossible, if it is only starting in the last couple of months of this year? Is there a revised expected completion date?

Mr Corbell: I am advised, December 2006.

Dr Sherbon: The minister has approved the utilisation of vacant capacity at Calvary and TCH to bring some of those subacute services online in an advanced manner. There is an allocation 05-06 and 04-05 in the project in terms of recurrent funds. Some of those recurrent funds will be utilised in advance of the definitive facility being completed at Calvary. The service enhancement will commence in the coming months and be significantly enhanced when the definitive facility is completed at the end of December next year.

MR SMYTH: And that will be basically for the nursing home type patients?

Dr Sherbon: No, these are rehabilitation patients. These patients are not nursing home patients, almost by definition, because nursing home type patients tend not to be candidates for rehabilitation. These are generally the people with general frailty who

need return to strength, nutrition and retention of activity as daily living skills, as well as a group of post-amputation and stroke victims who require return to daily living functions. The nursing home type patients are addressed through the intermittent care service that the minister recently announced with federal Minister for Ageing, Ms Bishop.

MR SMYTH: I thought the positions the minister announced previously with Ms Bishop were 12-week placements. Wasn't this project at one stage up to 80 beds and it was a mixture of nursing home type patient accommodation and disability and rehabilitation places?

Dr Sherbon: No, not in my time here. I am not sure what the original concept was but—

Mr Corbell: The intention has always been subacute and pyschogeriatric. The facility has always been planned on that basis. It was never the intention to accommodate nursing home type patients in the facility. In relation to the intermittent care program, those packages are for a set period of time. It is a rolling program so those packages continue to be made available to people as needed—as and when they are discharged from hospital or to assist them in preventing readmission to hospital following operations or other incidents of care.

MR SMYTH: Minister, being the 21st of the month, I know you would be disappointed if I didn't ask if you have the waiting list numbers available and if you would share them with the members here at the committee?

Mr Corbell: I have a very large pile of briefs on my desk and I have not looked through them all yet.

MR SMYTH: So you have not seen the waiting list numbers for last month?

Mr Corbell: I have not seen them.

DR FOSKEY: I have a couple of questions regarding inquiries and reports. I am wondering why the ACT Health annual report does not acknowledge a report of the standing committee on health in the last Assembly entitled *Pregnant pause*: *the future for maternity services*?

THE CHAIR: It is because this is the 2003-04 report.

DR FOSKEY: Yes, but it was dated to April 2004.

Mr Corbell: I can answer that. The reason is that the government has not yet responded and so there are no responses to recommendations to be reported on yet.

DR FOSKEY: Okay, so it doesn't have to acknowledge it, fine. I understand the department established a maternity services advisory group within that reporting period. There is probably some very confusing reason why there is no report from this group in section 8.10, which details advisory and consultative boards and committees.

Mr Corbell: Which page are you referring to?

DR FOSKEY: I do not seem to have the page number.

MRS BURKE: I think it is page 195—advisory and consultative boards and committees. Is that it?

DR FOSKEY: Yes, that is where they start. There is a list of them. It does not include that particular committee. The question is about the omission.

Mr Corbell: The advisory bodies listed in the annual report tend to be those established either as a result of government policy or they are statutory advisory bodies. It does not include all of the less formal advisory bodies that are established to develop policy within the department and between departments. Obviously there are working groups and a range of committees is put together all the time to assist the department in its policy work and, clearly, they are not all listed here. These tend to be the higher order statutory bodies or other ministerial advisory bodies—bodies established as a specific policy direction of government or statutory bodies.

DR FOSKEY: Is it in order to tell me whether that group continues to meet?

Mr Corbell: I need to take the question on notice.

MS PORTER: I have a series of questions about how the Gungahlin outreach service is going and the step up, step down short and medium to long-term supportive accommodation initiative, the support for carers initiative. Because these are quite long questions, I am happy to put them on notice and find out later how those projects are going. I also wanted to know numbers of clients who were assisted through the post-bushfire counselling service. Can I put those on notice?

Mr Corbell: Yes.

MR SMYTH: Ms Yen would be disappointed if I did not ask the question about the cervical cancer register, which I cannot see in this report. Am I looking in the wrong report?

Mr Corbell: That can be dealt with through the arrangements under the new cancer stream now.

MR SMYTH: Do we maintain a register of cervical cancer?

Dr Sherbon: Yes.

MR SMYTH: Is the register still functioning? Are the numbers being recorded?

Dr Sherbon: We could get that for you on notice. It is still functioning and we can get you numbers.

MR SMYTH: It has been reported in previous years in annual reports. Maybe I have just missed it. I just cannot see it in this year's report.

Dr Sherbon: We report so much, I am surprised to see that we do not report everything. It is something we can note for future and supply to you in coming days.

THE CHAIR: I have a comment in relation to acronyms and how they can be quite confusing. Yesterday we had the minister along with the Department for Disability, Housing and Community Services. They are the newest department and I thought their annual report was well done. The front of their report had their list of acronyms. I would recommend this to the department of health as a possible way to go in the future. I cannot find in this report a list of acronyms.

MS PORTER: There is one at the back. But it is very short.

Mr Corbell: Madam Chair, in so far as acronyms are always confusing, especially if you are not familiar with them, this annual report is very much focused on ease of understanding. And, from my reading of it, there is not a very large usage of acronyms. However, we will take that on board for the publication of future reports.

DR FOSKEY: I have comment about the format. I find the inclusion of an index very good. They are probably time consuming in report preparation but I think it could be more detailed than it is so that we would know by looking at the index that the cervical cancer register is or is not there.

THE CHAIR: Can I just add, that my suggestion was not a criticism rather that I found it useful yesterday and I also think the index at the back is very useful.

Dr Sherbon: I will transmit the view of the committee to our communications staff who compile the annul report. We did employ a writer this year and we have paid specific attention to comments raised by the committee in previous years so that the report is structured to the committee's wishes. But, in terms of editorial changes, we can certainly bring those acronyms forward. There is no problem with that.

THE CHAIR: I ask now that all further questions are placed on notice and that they be transmitted to the secretary of the committee electronically, if at all possible, as well as hard copy. Thank you to everyone for your attendance today.

The committee adjourned at 4.59 pm.