LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL SERVICES

(Reference: Annual and financial reports 2008-09)

Members:

MR S DOSZPOT (The Chair)
MS A BRESNAN (The Deputy Chair)
MS M PORTER

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 2 DECEMBER 2009

Secretary to the committee:
Ms G Concannon (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 that have been authorised for publication by the committee may be obtained from the Committee Office of the Legislative Assembly (Ph: 6205 0127).

APPEARANCES

ACT Health.....**1**
Department of Disability, Housing and Community Services.....**34**

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Amended 21 January 2009

The committee met at 9.02 am.

Appearances:

Gallagher, Ms Katy, Deputy Chief Minister, Treasurer, Minister for Health and Minister for Industrial Relations

ACT Health
- Cormack, Mr Mark, Chief Executive
- Thompson, Mr Ian, Deputy Chief Executive, Clinical Operations
- Brown, Dr Peggy, Director and Chief Psychiatrist, Mental Health ACT
- Cahill, Ms Megan, Executive Director, Government Relations, Planning and Development
- Childs, Ms Judi, Executive Director, Human Resource Management Branch
- Guest, Dr Charles, Chief Health Officer and Executive Director, Population Health Division
- O'Donoughue, Mr Ross, Executive Director, Policy Division
- O'Brien, Dr Eddie, Senior Specialist, Public Health, Population Health Division
- Woollard, Mr John, Director, Health Protection Service, Population Health Division
- Foster, Mr Ron, Chief Finance Officer, Financial Management Branch
- Bracher, Ms Tina, Acting General Manager, Community Health
- Smalley, Mr Owen, Chief Information Officer, Information Services Branch
- Thornton, Ms Anna, Acting General Manager, the Canberra Hospital
- Carey-Ide, Mr Grant, Executive Director, Aged Care and Rehabilitation Services
- Croome, Ms Veronica, Chief Nurse
- Austin, Ms Heather, Deputy Chief Nurse
- Murphy, Ms Karen, Allied Health Adviser
- Kennedy, Ms Rosemary, Executive Director, Business and Infrastructure
- McGlynn, Ms Lisa, Executive Director, Capital Region Cancer Service

THE ACTING CHAIR (Ms Bresnan): I am filling in for Mr Doszpot this morning. He will be about half an hour late. I would like to welcome you all to this annual reports hearing. Thank you, Minister Gallagher, for taking the time to be with us today. I draw people's attention to the privilege statement which is on the desk in front of you. Before we go to questions, minister, would you like to make an opening statement?

Ms Gallagher: I do not have an opening statement prepared. I am happy to use the majority of the time this morning for questions. The issues, including the overview and highlights and the agenda for this current financial year, are clearly outlined in the report. It has been another busy year for the health system. The report goes to that, and shows the considerable growth in activity right across the portfolio. It also outlines all the initiatives that we have put in place to try and manage demand and expenditure. But it remains a challenge. The report refers to the very significant capital program that ACT Health are managing for the government as well. I know there is a lot in there, and I know people have a lot of questions. Officers remain ready, willing and able to assist the committee in your deliberations this morning.

THE ACTING CHAIR: Thank you, minister. I will go to my first question. I refer to page 4, the overview and highlights, and the question is in relation to access block at emergency departments. The report notes there has been an improvement in that figure. It says that access block at emergency departments has improved and is down from 29.4 per cent to 26.9 per cent. Obviously, that continues to be an issue within the hospital system, and it has been identified as an area for further improvement. Can you provide a bit more detail on some of the strategies which are being implemented to improve the access block issue?

Ms Gallagher: With respect to the major initiative, I think our target is 25 per cent in this financial year. We have never reached 25 per cent; that was a target that was implemented when our access block was over 40 per cent. ACT Health initiated a target and we are nearing that target. In fact, this is the closest we have been to that target. That is despite, as you can see from the annual report, considerable growth in presentations.

The most significant area which improves this is beds—more beds. If you get people through the emergency department faster, you reduce bed block, essentially, in the emergency department. If you have beds available in the hospital that people can move seamlessly through, if they require admission to the hospital, that will be the single biggest area to improve access block.

The different methods we have used in that respect include not only additional beds—I think we are up to an additional 205 beds since we came to government; there has been essentially a 30 per cent increase in the number of beds in the hospital system—but also the type of beds that we have introduced. I refer, for example, to the MAPU—the medical assessment and planning unit. That was designed specifically as a relatively short-stay ward. The length of stay, from memory, is about 72 hours. That really was targeted at our older patients presenting to the emergency department, who often have very complex needs. They would traditionally spend a lot of time in the emergency department while they had consultations from different areas of the hospital.

MAPUs are emerging right across Australia as one of the key ways to drive improvements in access block. The MAPU-type patient, the complex patient, the one whose issues are not going to be solved easily, is pretty much pulled out of the emergency department as quickly as possible and admitted to MAPU. The consultations and the decisions about their future care requirements are made on the ward. Because of the MAPU's success, there will be the SAPU, which is the surgical assessment and planning unit. MAPU is really for medical-type patients. The SAPU will come online next year. There will be 16 beds in the SAPU, which is being constructed at the moment in the old records area of Canberra Hospital. That is because the surgical patients have been the next patients identified as a significant cause of their block in the emergency department.

THE ACTING CHAIR: In addition to that, what about investment in what are not necessarily preventive but convalescent-type facilities as well? It might prevent people from ending up in the hospital system in some instances, which also obviously contributes to bed blockage to some extent. Is that something which is going hand-in-hand with those other types of programs?

Ms Gallagher: Yes. In the emergency department there is a range of initiatives which are designed to get people through the emergency department quickly, if they present. Access block really occurs for patients who require admission to the hospital. It is the patients who have spent more than eight hours waiting for their hospital bed.

THE ACTING CHAIR: If people were able to be assisted in the community, that contributes to—

Ms Gallagher: That is right. We have the RADAR project, which really goes to what you are saying. I think it has avoided presentations in a very high number of cases. Seventy-odd per cent of people that they have seen have avoided the emergency department presentation. So there is RADAR. That has been really well received. I know, from feedback I get from general practice, that they are very positive about the RADAR project. It has won a couple of awards—quality in healthcare awards.

The other area that we are looking at implementing—it will go to tender shortly—is the in-hours locum service for aged care. That is, again, in response to concerns of GPs but also of the emergency department, about people not getting access to care and then becoming sicker and then requiring the emergency department's involvement. GPs, it would be fair to say, struggle to see their patients that are in nursing homes, for a variety of reasons, often because they require long consultations and GPs are booked up with sessions in their surgeries. That will provide an in-hours service. I do not think we are calling it a locum service anymore—an in-hours GP service to residential aged care. I think that will complement RADAR as well.

THE ACTING CHAIR: Ms Porter.

MS PORTER: My question, just leading on from that, is about the Aged Care and Rehabilitation Service. On page 125, midway down the page, it mentions the waiting times for placement in a residential aged-care facility decreasing from 24 weeks in 2007-08 to four weeks now, and waiting times for rehabilitation medicine outpatient appointments decreasing from four weeks to one week. I was wondering if we could have a bit of information about how we have achieved those particularly good results.

Ms Gallagher: I will ask Mr Grant Carey-Ide to answer that as the executive director of aged care and rehabilitation services. I think it is fair to say that all streams in Health and all units in Health are very much focused on improving access to care and timely access to care. A lot of the reform and access improvement programs that have been run across the hospital are designed to improve our performance in access to assessments and access to treatment and access to appointments. That has been a big focus of the Aged Care and Rehabilitation Service.

MS PORTER: So if there is quicker access, patients are more likely to be going home earlier, I guess, so that frees up more beds for more people.

Ms Gallagher: Yes. Do you want to add to that?

Mr Carey-Ide: Thank you for raising that point. It has been a real achievement for our service throughout the past year. The assessment time reduction has been the

result of really significant work that has been undertaken by our ACAT service. It has essentially looked at the processes that they had in place. With respect to the examination of those processes, it was realised for that service that they could do things more effectively, more efficiently. They put in place a team leader position out of their established staffing, and that immediate liaison point for referrals to the service meant that the referrals could be immediately prioritised. That meant that we were also able to redirect inappropriate referrals to more appropriate services, so there was an immediate response to the needs of those clients. That, essentially, is what brought about a very significant reduction in wait times.

Further to that, there has been a real focus on in-hospital assessment for people waiting for nursing home placement that has been consistently achieved throughout the past year at a level lower than two working days. We have seen a real decrease in the waiting time for people from time of assessment in hospital to placement in residential care in the ACT, which is another very good achievement.

THE ACTING CHAIR: Mr Hanson.

MR HANSON: Calvary: could you update me on where we are at in terms of the appropriation bill and the peer review that you discussed at the Treasury annual report hearing?

Ms Gallagher: I have not received the peer review yet. In fact, I inquired yesterday about when that might be likely. I understand Treasury has seen a draft copy of it, but the final copy has not been received. As soon as I get it, I will be making that available. The appropriation bill will not be introduced this year. In fact, cabinet is still currently considering the overall consultation process. It has not finalised our position on that.

MR HANSON: Just following up from some media yesterday, you were quoted by Wayne Berry as saying, "We'll just build another hospital and let Calvary die a slow death." He is a previous health minister and opposition health spokesperson for the Labor Party. That statement from someone who has had such a prominent role in development policy, as a minister in particular, is one of great concern to me—that that would be the attitude coming from him, which may be reflecting the broader opinion. Can you extrapolate on that?

Ms Gallagher: Yes, I did imagine you would have enjoyed that quote. Well, it is what it says. I have had discussions with Mr Berry. His view was that we should not pay for the hospital, that that was not the right thing to do and that we would be better off building the third hospital. I explained to him that that would result in Calvary dying a slow death, and it was not a view that I shared.

MR HANSON: Thank you.

THE ACTING CHAIR: My question is in relation to an indicator on page 88 of the annual report, going back to the Aged Care and Rehabilitation Service. I note that two of the indicators there relating to aged care and rehabilitation are below target. It notes for subacute services that a number of beds were closed over two weeks in the fourth quarter, which I notice was at Calvary hospital. So, for occupied beds days there was

a closure of a unit of some beds at Calvary for two weeks. It notes also that the target for occupied bed days is 95 per cent and that the June result is 11 per cent under target and that a 90 per cent rate is now deemed to be a more appropriate level. I am just wondering if that has been impacted by that two-week closure and if it can be explained as to why for two weeks those beds were closed at Calvary hospital.

Mr Cormack: All of our clinical units across ACT Health, including Calvary, have scheduled wind-down periods throughout the year. Any wind-down period is negotiated between the particular clinical unit—in this case, Calvary and ACT Health. Provisions are made for service continuity throughout those periods of time, but, clearly, any period of closure will reduce the number of occupied bed days. So I think that partly explains that. But it is also the case that, from time to time—this happens not only with the subacute beds at the aged-care unit at Calvary but also with the older persons mental health unit—you have staffing issues where we were unable to fully staff the beds. Certainly, our practice and policy in ACT Health is that if we do not have sufficient staff to staff all the beds on any particular shift, we make other arrangements. Sometimes that means having those beds closed. That can also have an impact.

In relation to the occupancy rate of 95 per cent, that was really a target that was set when the unit first opened. Certainly, what we find from time to time—you can look at our overall occupancy rate targets for beds—is that 95 per cent means there is very little room to move. A 90 per cent target, which would be reflected in future statements, is probably considered to be more appropriate for an aged-care unit. A lower occupancy rate may be more appropriate for an acute unit. It just enables us to have the flexibility to be able to move people from other parts of the hospital system. It is very difficult to do that when virtually all your beds are full all the time, and 95 per cent means there is very little room to move. That is the justification for a more realistic target.

THE ACTING CHAIR: Can you just explain about moving people from other hospital beds? How does that impact on that aged-care rehab unit or on those types of specific units that are providing very specific services?

Mr Cormack: Let us just take the example of a not uncommon patient journey. An elderly person may present to one of our emergency departments with a fractured neck of femur—a broken hip. They go through the emergency department and have their surgery. Then they go through these days a fairly short period of acute support and acute rehabilitation—that is, getting them up and mobilising them. But when their clinical condition is stable then they are moved into an environment that encourages a return to normal activity—the activities of daily living—and they are more rehab focused.

Certainly, the subacute unit at Calvary is set up specifically to do that. So it is a less acute unit. The length of stay is longer and it just recognises that that is a better rehabilitative environment for patients than an acute hospital ward with a short stay at Canberra Hospital. But to be able to move patients from the emergency department into an acute bed, then into a subacute environment and into the home, you need to create capacity at each of those points. That is where the lower occupancy rate at the aged-care unit at Calvary comes into play.

THE ACTING CHAIR: Do periods of closure have an impact on the type of occupancy rates you are trying to achieve and on targets?

Mr Cormack: The formula that is used to calculate occupancy rates is the available bed days—that is, is a bed open?—and the numerator is the number of days that bed is occupied. So when the bed is not available then it does not actually have an impact on the occupancy rate of that particular bed. You stop counting that bed because it ceases to be open.

THE ACTING CHAIR: Obviously, that particular quarter is a Christmas period. So that is obviously why they choose that period. People are wanting to leave.

Mr Cormack: Yes, that is right. Also, around the Christmas and holiday periods we tend to wind back elective surgery for short periods of time. That enables us to regulate the flow of activity in our hospitals. So it is a planned process. But clearly it does impact on occupied bed days.

MR HANSON: Would you be able to table the number of days that particular wards are operating without a room open? Is that feasible?

Ms Gallagher: I would be able to provide that on notice.

MR HANSON: Certainly, that would be great.

Ms Gallagher: The Liberal Party's position is that it is 365 days a year, 24 hours a day, seven days a week, I notice. We are costing that for one of your first election commitments.

MR HANSON: We will give people an hour off for Christmas lunch, minister.

Ms Gallagher: Very kind of you.

MR HANSON: On a more serious note, the explanation that Mr Cormack gave is one of staff shortages and staff problems, I guess—problems with rostering people on. I note that there are problems in terms of staff across the board—with nurses, GPs, allied health and I am not sure about the administrative officers. In the staff profile I find it difficult to distinguish between what we actually need compared to what we have got. It seems to be a profile of what ACT Health has, broken down by category—

Ms Gallagher: That is what they are required to report on in the annual report.

MR HANSON: Indeed, but what I am trying to get across is what is actually the requirement versus what we have by category.

Ms Gallagher: We know all that.

MR HANSON: Would you be able to provide that to me or give me a snapshot? That tells us where the vacancies are. As an example, I went around the Phillip Health

Centre the other day, and thank you very much for the visit; I was very impressed with what I saw and I thank the staff very much. I saw the dental chairs. I can't remember how many there were; there were about a dozen. But there were two dentists. We then went and looked at where they are making the dentures and so on. Again, there were about a dozen stations and there were two guys working. As I talked to the staff, it seems that across the board in just about every category you look at there are vacancies. I am just trying to get across those vacancies.

That then leads to the broad concern that I have, which is that as we look to expand our health system, we are already in a position where we cannot staff the current system. How do we get to where we want to be in the future, in 10 years time? It is a bit of a long question, but if we start with what are the current vacancies and then, I guess, the question of how that staff profile grows in terms of what we require in the future and how we fill the delta of where we are at now and how we get to that future position.

Ms Gallagher: I am sure we can provide you with across-the-board figures. We have probably got the nursing ones. I do not know about the figures for right across the health department. We have certainly got all that information. We know how many vacancies there are. I would say we have been growing the health workforce every year. You will notice that when reflecting on previous annual reports.

It remains a challenge. As governments, we have agreed to set up a whole new agency to deal with the health workforce because, across the country, this is a major issue. The states, the commonwealth and the territories are doing that work together, to make sure that we are ready to produce the workforce we need to produce.

It remains a challenge. We are growing it every year. The fact that we are actually serious about redeveloping our health system is helping us recruit staff to the ACT. I think we had more graduate nurses start this year than we have ever had. Certainly, on the medical side, with the ANU Medical School, there is a commitment to growing our services and seeing a lot more interest by medical staff to come and work in the ACT as well.

It is a pity it is complicated. There is not one simple solution to it. It is something that we have worked very hard on in the health system. We could take that on notice.

MR HANSON: Does the $63 million, I think it is, in the budget for scoping of the CADP and the planning for that include workforce modelling?

Ms Gallagher: Workforce modelling has been done as part of the CADP, yes. I would be surprised if you do not have all that data in your FOI.

MR HANSON: I am still trying to get across it. You talk in broad terms about programs. If we are in a position now where we cannot staff wards—

Ms Gallagher: We are not in that position. We have had a 30 per cent increase in bed numbers and we are staffing those beds. Six or seven years ago, we were staffing 670-odd beds. We are now staffing nearly 900. So we are not anywhere near a position where we cannot staff wards. In any health system there will be times when

you close beds. That will be for different reasons.

We are growing our workforce every year. In some areas I think we are surprised at how well we are doing in actually recruiting staff to the health system. But it is not something that we focus on more. It is a big part of the work that the capital asset development plan team have been doing on workforce. It is nationally something that all governments have recognised as one of the biggest risks in terms of the future of our health system; hence the establishment of an agency.

We are not in denial over it at all. There is a lot of work that goes on. We are happy to provide you with vacancy rates. We can give the nursing one now and then follow up shortly on the other.

MR HANSON: Just on the broad categories.

Mr Cormack: Nursing, as it stands now, is running at a 6.46 per cent vacancy rate, which is a bit better than it was this time last year. That needs to be considered against a backdrop of increasing staff overall. By national standards, that is an exceptionally low vacancy rate. Our turnover rates are less than 10 per cent, which certainly in health profession land is a good turnover rate. It is not good if you have limited turnover in health professionals. An industry benchmark of 10 per cent is pretty good.

We have made and continue to make significant gains in our medical recruitment. In the 12 months to June, we appointed and granted clinical privileges to 68 new senior medical and dental officers across the ACT. That is comprised of 30 staff specialists, nine visiting medical officers, 25 grouped medical officers, two visiting dental officers and a career medical officer. By any stretch of the imagination, that is an outstanding performance.

In terms of your earlier question about how we determine the staffing requirements, these are worked on a range of different methods. I guess the one we are refining at present is nursing hours per patient day. There are industry standards available to do that whereby according to the complexity of the clinical environment there may be greater or lesser numbers of nursing hours per patient day. That is a process that we work through with our colleagues in the ANF and in fact we have a workload monitoring committee that looks at all of those things.

I guess the summary point is that our vacancies are low and continue to be low by national standards, against a backdrop of very significant growth in activity. When we talk about periods of closure or activity wind-downs, they are done to manage the requirements that we have. We have requirements under the Occupational Health and Safety Act to ensure that our staff achieve appropriate periods of leave. This is a seasonal pattern right throughout the health sector across Australia and indeed around the world. We try to manage that by having periods of reduced activity. We are not crisis driven. There are certainly peaks at various times of the year, but activity wind-downs are a normal way of managing activity and ensuring that our staff get the necessary rest.

MS PORTER: As a follow-on from that about the nurses, and also going back to the rehabilitation area, page 128, under "Future Directions" talks about establishment of a

rehabilitation nurse practitioner position to enhance the multidisciplinary service. Could you tell me a little bit about that position and also how many people we are going to need or what the plans are with regard to nurses for the walk-in clinics? As a supplementary to the walk-in clinics, how are we going with the federal government legislation around prescribing for nurses? That is a sort of double-barrelled question, first of all around the nurse practitioner role in rehab—

Ms Gallagher: Sure. The development of the nurse practitioner role I think is a very exciting part of the workforce and the workforce diversification that we are going to have to see in years to come if we are to manage the workforce requirements. This is happening both in terms of advanced practice and at the other end in terms of assistants in nursing, which we currently have a trial in the hospital of—they sit below the enrolled nurse—to see whether that can assist our enrolled and registered nurses in their day-to-day workload. There are some pretty strong arguments as to why registered nurses do not need to be making sure people are having their lunch and things like that. There are other skilled areas of the workforce that could perhaps do that kind of work and relieve them of some pressure. So it is happening at all ends of the nursing profession, I would say.

The nurse practitioner role is increasing. We have had one in sexual health for a long time and we have got aged care, emergency, palliative care, and obviously the development of one in aged care and rehab or indeed across the streams in health will occur. The nurse practitioner's role will be significant in the walk-in centres as well. There are positions for, I think, four nurse practitioners and the idea is to run that service for extended hours. They will have very significant autonomy really, within a controlled governance framework so as not to frighten the doctors; they will run that centre for us.

In terms of some of the changes we are seeing from the commonwealth, I think we are well positioned here to make sure that we can use that. Nurse practitioners will say that they do feel constrained outside of the hospital environment in terms of their ability to prescribe, and the federal government has recognised that in some of the changes that it has announced. I am very supportive of the reforms that the commonwealth is taking in this area. It is step by step so as not to frighten the established arrangements that exist in the health area, but it is very exciting and the opportunities it will open up for nurses are very significant and have been hard fought for. The nurses will tell you that this should have happened 30 years ago. Do you want to add to that, Ronnie?

Ms Croome: I am happy to answer any questions further to those that the minister has been able to answer. I can talk about nurse vacancies. I can talk about the role of the nurse practitioner. I can talk about the walk-in centres.

Ms Gallagher: Only the good stuff, Ronnie!

Ms Croome: Yes. There is no bad stuff in nursing!

MR HANSON: Are we recruiting enough? Are we going to have enough of them?

Ms Croome: We are doing very well with nurse recruitment, particularly so. Our new

graduate nurse program is very well regarded across Australia and we have applications for our new graduate program from nurses as far away as Western Australia and the Northern Territory. The retention rate from the new graduate program is as high as 95 per cent and the numbers of new graduate nurses who applied for positions in 2010 is unprecedented—so much so that we have introduced a third intake for new graduate nurses next year, to be able to take as many as we possibly can. The vacancy rates across ACT Health in nursing are at an all-time low. We are very pleased with that.

MR HANSON: And the nurse practitioner? How is that going?

Ms Croome: Nurse practitioners are going really well. The process for appointing nurse practitioners is a lot more complicated than it is for employing a new graduate nurse. As you have raised the issue, we have just appointed into a nurse practitioner position in rehabilitation medicine and that is the first one of its kind in Australia. We are working business cases at the moment around two nurse practitioners in palliative care. We have an excellent nurse practitioner in wound care; she has been involved in the development of international guidelines for wound management. We have nurse practitioners in aged care and of course we have approved four nurse practitioners for the walk-in centres.

THE ACTING CHAIR: It was interesting that some of the witnesses to the primary healthcare inquiry that this committee has been doing said that they thought that having the nurse practitioner roles as part of the health system and more recognised will have an impact on keeping nurses in the system, giving them that opportunity to further their skills and not quite a career path but some form of progression. Are you getting that sort of feedback? I know it is fairly early on in the process but do you think that will flow on as part of this?

Ms Croome: I do. We have an advanced practice nurse who particularly works out of the emergency department and they have a scope of practice that allows them to do more, with adequate training, than a registered nurse would do in the emergency department. A lot of the advanced practice nurses view that as an opportunity to pursue nurse practitioner status, either through additional university training or through ongoing development of their skills. So I think it is a career path for nurses. It has been a slow process, but now a lot of the hurdles have been overcome. This time next year I would not be surprised if we had doubled the number of nurse practitioners that we currently have in the ACT.

THE ACTING CHAIR: Are you getting any consumer or patient feedback as yet about the role? It is interesting because of the experience in the UK, which is a different sort of system but one that has been very positive, from what we have heard.

Ms Croome: We have positive feedback from patients in the emergency department who were seen by the nurse practitioner. She is a particularly skilled nurse practitioner and has a lot of experience in pain management. The other nurse practitioner particularly about whom we get excellent feedback is the wound care nurse practitioner who runs clinics. We get feedback from the patients there about the wonderful care of and attention to their wounds by that particular person. This is not in any way to compare in a negative way nurses with medical staff, but nurses do have

the ability to communicate and liaise with patients on a one-to-one basis and spend time with them, which from the feedback we have received is particularly appreciated.

THE ACTING CHAIR: So patients are making that sort of adjustment to the role fairly easily.

Ms Croome: Absolutely.

MR HANSON: You said you may double the number?

Ms Croome: I think we will.

MR HANSON: What is the current number?

Ms Croome: With respect to the current number of nurse practitioners in position, we have nurse practitioners in position and we have nurse practitioners who are in transition. The thing about nurse practitioners is that they must have a position to be able to go into, to practise as a nurse practitioner; otherwise we keep them in transition. We have 17 nurse practitioners either in transition or in position.

MR HANSON: And that is the figure that you think—

Ms Croome: I think so.

MS PORTER: You also mention the pleasing retention of nurses, once they graduate, and that they remain in the system in the ACT to a much higher rate. Is that what you are indicating?

Ms Croome: I was referring to the retention rate from the new graduate program. The nurses that we take into the new graduate program do a 12-month planned program where they rotate through various clinical areas and are supported with mentorship and educational programs. At the completion of that 12 months, 95 per cent of those nurses are successful in gaining registered nurse placements within the ACT.

MR HANSON: With respect to the comment you made about the feedback you are getting, I note in the annual report there is detailed consumer feedback—

Ms Gallagher: What page are you on?

MR HANSON: Pages 161 to 165. It talks about the feedback and the feedback statistics. It breaks it down for Calvary but then it has it for ACT Health. So it does not compare the two hospitals, and I think in previous years it has. For example, page 164 gives the breakdown for Calvary. This shows the complaints and compliments that the hospital gets. But it is difficult to contrast TCH and Calvary in that sense, so it is difficult to see what you are comparing. Do we have that data collected? It has been presented in a slightly different format from previous years.

Ms Gallagher: It is because they have slightly different governance arrangements.

MR HANSON: Indeed. I do not know who does the collection of data in terms of—

Ms Gallagher: Calvary does theirs and ACT Health does ours.

MR HANSON: Is it done by a separate contractor or separate process?

Mr Thompson: As the minister explained, each hospital has a separate consumer feedback process that is run within the separate organisation. So within ACT Health, we have a consumer engagement team which coordinates feedback, both positive and negative, and follows up on complaints. Calvary have a similar structure within their hospital. They are quite separate but they are not outsourced functions; they are core functions to the way that health services operate.

MR HANSON: Could you provide me with the TCH data? We have got the Calvary data; can you provide me with the TCH breakdown for that as well, on notice?

Mr Thompson: Yes, we can provide that data. I do not have in front of me the time series that you see for Calvary, but we can provide it in that format.

Ms Gallagher: I would say, though, that it is not a competition between hospitals. I think this is where you will be heading with that, because I know you so well, Jeremy. I understand why you are after the information, and separate information for TCH—so that we can have a Hanson analysis of comparing the hospitals, with the ultimate hope that Calvary comes out ahead of TCH; therefore it will be another reason not to purchase the hospital. But I would caution against that. They are different hospitals; they deal with a different complexity of patients and different levels of activity. It is very difficult to compare and contrast with respect to data that is collected in different ways.

I would say that I share your concern around perhaps not having both of the hospitals being able to report in a standard format, so that we can report across the public hospital system, as opposed to hospital versus hospital. That is precisely one of the reasons why we are seeking to purchase the hospital, so that we can deliver that. I am just putting on the record, before I see the press release, my caution about taking that kind of action. The fact is that, by taking that course of action, it can significantly offend a number of people who work in the health system if it becomes a competition between who provides a better level of service. I think it is unfair, and it is a path that the opposition have taken in the past.

MR HANSON: You are making some assumptions about what I am going to do with the data.

Ms Gallagher: I am just getting on the record first.

MR HANSON: As you wish. The issue, I guess, is one of trying to compare data, see where we are at and dig into the detail. The purchase of Calvary is a big issue. It was an issue that was raised at the consultation on Calvary. I am not going to get into the clinical arguments; I note that there are differences in the outcomes of the hospitals. I do understand the comparison between oranges and apples and that it is very difficult to distinguish exactly what we are comparing. But in terms of customer satisfaction, I think that is a comparative issue. You might not be able to compare infection rates

because you might be doing different operating procedures and so on, but if you have something that says people are generally satisfied with one hospital or dissatisfied with another, there is quality of care, and there is a culture that was referred to by you in terms of that sort of culture. That is something that I would be very interested in having a look at.

Ms Gallagher: I agree, as long as that data is presented in the same way, so that you can make those comparisons. At the moment it is not. We are happy to provide you with the data from the Canberra Hospital, but patient satisfaction between the two hospitals is measured differently. I do not even know; TCH might come out ahead of Calvary on this one. I never see it as a race between the two hospitals. I actually genuinely do not know, if you compared the feedback statistics, hospital by hospital, what that would mean. But I would say that there should be an element of caution.

MR HANSON: Sure, and I appreciate that. Can we move from there to some of the comparative data. There is a series in terms of the different indicators between the hospitals in terms of re-infection rates and so on. I think it is on page 91. It does seem that we have a significant difference between the two hospitals in terms of those targets.

Ms Gallagher: What are you saying, Jeremy? Come on, come out and say it.

MR HANSON: I am not. I just want to make sure that we understand what those differences are.

Ms Gallagher: I think we do understand them. It is a matter of what you extrapolate from that. We understand them. They are different hospitals, the targets between them are different and they are set differently because of the difference in the hospitals and the difference in the caseload that they handle. That is why the targets are different and that is why the results are different.

MR HANSON: Nothing further to add?

Mr Cormack: If I can add, when you are talking about figures such as unplanned returns to the operating theatre, where there is a difference between the two hospitals, the difference between the two hospitals is because they are different hospitals, as the minister has indicated. These are linked to national peer groups. The difference between the target and the actual is not statistically significant. You cannot really draw anything from that. When we publish these particular results, we do generally comment that they are not statistically significant.

We continue to provide this information. We provide it on a quarterly basis, as you are aware, on the internet. We release those reports. The minister releases those reports every quarter. We keep an eye on those trends. They will go up and down over time. Generally speaking, we have done pretty well. Our rates, certainly in 2008-09, are not significantly different to those experienced by peer hospitals that participate in the Australian Council on Healthcare Standards clinical indicator program. We monitor them. We think they are doing well.

Ms Gallagher: To add to that, the way we report—these are our two public

hospitals—is not to compare the two hospitals but to compare with peer hospitals across the country. That is what we watch. I know that what the experts watch is whether they see any increase or any continued increase that causes concern. I know that these statistics are watched very closely but they are not watched Canberra hospital versus Calvary hospital. They are watched Canberra hospital versus tertiary referral hospitals in New South Wales. When you compare, a fair comparison will be—

MR HANSON: The targets are different.

Ms Gallagher: That is right.

MR HANSON: Let us look at the ability to meet targets. If you look at post-operative pulmonary embolisms, you have targets that are the same. Canberra hospital did not achieve its target, whereas Calvary did. You have different targets in the rates of unplanned returns to operating theatres, but in the case of Canberra hospital it did not meet its target. There are different targets. I just want to make the point that you can interpret the data that way.

THE ACTING CHAIR: I do not have a page reference for this but I have a question in relation to Calvary. We know the Auditor-General did put out a report noting that an issue was possible in relation to cross-subsidisation of the private and the public hospitals. I am wondering whether or not Calvary may have at some stage administered payments to the public hospital incorrectly. Has that happened at any stage? It was raised as an issue by the Auditor-General.

Mr Cormack: I guess my response to that is encompassed in our response to the Auditor-General's report. There are a number of recommendations and we are in the process of implementing those. We have no new information.

Ms Gallagher: There was a payment made, from what the auditor found, a small payment.

Mr Cormack: If your question is "since that time", we do not have any evidence of any inappropriate payments. Certainly the degree of vigilance since that report has escalated somewhat. Plus, Calvary, in response to the Auditor-General's report, have undertaken a much more formal separation of their public and private activities, in particular in the operating theatres. That was really where the major risk was known. They have put in place arrangements to formally separate that and make the transactions simpler. We do not have any evidence.

THE ACTING CHAIR: Since the report has come noting that, they have actually made some changes; there is more vigilance?

Mr Cormack: Yes.

Ms Gallagher: In the past, when this has come up, the only way we have been made aware, I guess, is through complaints that have been made by various stakeholders if they do have concerns. From time to time over the years, we have had concerns raised us with us and they have been appropriately forwarded on to the relevant investigatory

authorities. The Auditor-General commissioned that report. In a way, as we do not run the hospital, we are having to respond where issues are raised with us.

THE ACTING CHAIR: It is only through the complaints process that this—

Ms Gallagher: That is not fair. There is the contract management side—what we pay for and what they deliver and whether they are over budget and require further assistance. That is a very tightly controlled and tightly analysed process to make sure that the ACT is getting value for funding. If they deliver more, we pay for that. There is that process. Where concerns have arisen on further cross-subsidisation, they have come through some complaint.

MS PORTER: I have a question on a new subject, H1N1. I notice on page 6 going through to page 89 reference is made to the rollout of the vaccine. How is the rollout to general practice going? Do you have an update on that? What are the plans for 2010? Will there be two separate vaccines available in 2010, the ordinary flu vaccine and the H1N1? What will be the situation in 2010?

Ms Gallagher: I will start. We have always expected that this vaccination program would be a long program to roll out. It is the largest vaccination program ever delivered—21 million doses. The ACT has an allocation, roughly, of over 300,000 for our community. We have distributed almost 70,000 doses of that vaccine to general practice. Some has been delivered through ACT Health clinics. We are measuring administered doses but there is some lag in that information. It is not a mandated requirement, is it, to let us know how much has been administered? That is happening voluntarily from general practice. What we have measured as administered doses and what has actually been delivered will be different.

I think the biggest, next step for us, if we keep going with this, once the under-10s are approved for the vaccine, is to push forward again with the public information campaign on the importance of getting everybody to the clinic or the surgery to have their shots.

Dr Guest: The minister has told you about the delivery of some of the vaccine. We have delivered some 60,000 doses in theory. There is a dose available for everybody in Australia. There will be no problem with supply. Then, as the minister said, we lag a little with the figures on actual administration into people's arms. It is going as well as it can. There is a balance to be struck between causing panic and causing undue concern in the context of a pandemic that is mild in most people but severe in some. We believe it is very important for everyone to have this vaccine, however. It is safer to have this vaccine than not to. The side effects of the vaccine are all worse in the event of actually getting influenza. It is a very easy bed to make.

You asked about the plans for 2010. There will a seasonal influenza immunisation campaign, beginning in the autumn. That will contain, as currently planned, the H1N1 antigen. That is one of the three types of influenza that will go into the vial of vaccine. There will be another two, as there are every year. There are three antigens, three types of influenza, in the seasonal vaccine. It is the case that some people have speculated that they should hold off on this pan vac and wait for the seasonal but that is not policy and certainly has not been our recommendation.

There will be movement of people around the world over our summer. We know there is a lot of panic and concern in the Northern Hemisphere now, with states of emergency in the United States. This is a serious pandemic, causing worldwide concern. The result of transmission around the world is actually not predictable now. We remain with the advice that everyone should have this vaccine. Before Christmas, I expect there will be announcements about vaccine for people aged less than 10 years. That will be an important priority for the new year.

MS PORTER: Just to clarify about the two different vaccines, if a person has the vaccine or has just had the vaccine in the recent past, come autumn will they line up again for the one that contains all three antigens or what will happen for those particular people?

Dr Guest: There will be a communication strategy around this that will be signed off really by the Australian Health Protection Committee early in the new year. You are quite right in identifying this as a potential cause of confusion for some people. I expect, though, that we will be encouraging people to have the seasonal vaccine as usual. That is what I would do. It will have two extra antigens in it. There is concern now about a different flu strain that is circulating, an H3N2. That will be in next year's seasonal vaccine. So I think the advice will be, yes, you should have Panvax now and, yes, you should have seasonal flu when it becomes available. They are complementary.

MR HANSON: I would just make the point that I have offered the minister bipartisan support on this approach. I think she has welcomed that.

Ms Gallagher: I have.

MR HANSON: If you are sending a message out there, you can say very clearly that the approach you are taking has got bipartisan support.

THE ACTING CHAIR: Tripartisan.

MR HANSON: Tripartisan as well; up the ante. So we are all behind you on this one and wish you well.

Dr Guest: Thanks very much.

Ms Gallagher: It is just getting a little too friendly in here. You had better go back to normal now, Jeremy.

MR HANSON: Let us talk about GPs then, minister.

Ms Gallagher: No worries, I'm ready.

THE ACTING CHAIR: Do you want to talk about GPs?

MR HANSON: Why not? The task force has reported?

Ms Gallagher: Yes.

MR HANSON: They provided 30 recommendations. Can you confirm that you will be responding in December?

Ms Gallagher: Yes.

MR HANSON: You will be?

Ms Gallagher: Yes.

MR HANSON: Are you able to discuss any of the issues in that response at this stage?

Ms Gallagher: No, I am not able to do that, because it has not gone through our own processes yet. But the expectation is that I would table that response in the next sitting week. There would also be the legislation to accompany that.

MS PORTER: Sorry, what was the last thing you said?

Ms Gallagher: There is legislation to accompany that. It is just a week too early.

MR HANSON: No, that is all right. I understand that. I will wait until next week for the response.

THE ACTING CHAIR: I have a question in relation to the national health registration accreditation scheme, which is mentioned on page 7. I just note that there have been, as I have raised previously, some points and issues raised by local health professional bodies in the ACT with regard to the scheme. Obviously, we have had the various stages. It started in Queensland and then we have had the state-based legislation.

Ms Gallagher: Yes.

THE ACTING CHAIR: Just in relation to that, I note also that the ACT Health Commissioner had some concerns. I am just wondering whether the concerns that have been raised by the commissioner have been addressed and met. Also, have we got assurances that the ACT will have a seat on the executive board of the scheme? Has that been finalised yet?

Ms Gallagher: On the executive?

THE ACTING CHAIR: Yes.

Ms Gallagher: We have got representation on six of the eight major boards. Originally we had a spot on the nursing and medical board and then the smaller states were going to get one spot on the others. So it is six of the 10. That was reviewed, and the small jurisdictions—Tasmania, Northern Territory and the ACT—were given additional spots. That was in recognition of some concerns. So that was a very good outcome. For small states at national forums, it is always difficult to get external

support for your position.

THE ACTING CHAIR: Sorry, did you say it was six out of 10 or six out of eight?

Ms Gallagher: Six out of 10, yes. So, we are at the stage now—in fact, I asked my office to provide both you and Mr Hanson with a copy of bill C. I think, Mr Hanson, you are getting a briefing on Friday on bill C. We have got a draft bill C.

MR HANSON: I am very happy if Ms Bresnan wanted to do that at the same time to save time with various staff.

THE ACTING CHAIR: I would like to. What was in your coffee this morning?

MR HANSON: What was in the water? What did you put in that water?

THE ACTING CHAIR: I told you I put something in there.

Ms Gallagher: Someone will be down to speak to you in a minute, Jeremy.

MR HANSON: They will. A staff member will walk in with a note.

Ms Gallagher: Yes, harden up.

MR HANSON: I can't win either way.

Ms Gallagher: Exactly. With bill C, a draft is ready. There is a bit of interest from the stakeholders. The Pharmacy Guild and a number of the local boards have asked for it as well. In relation to the Health Complaints Commissioner, I cannot speak on her behalf, but I have asked Health to work closely with her to address the concerns that she has had.

The feedback I have had from her through my office is that bill C as it is currently drafted is a significant improvement on where it was and has addressed a number of her concerns. Did you want to add to that? I cannot speak on behalf of her. I do not know whether she is going to give it the complete thumbs up, but I know Health have worked hard to address the concerns within the framework of the national model. We have chosen not to be New South Wales, I think that is fair to say.

Mr Cormack: That is right.

Ms Gallagher: They have sought to keep themselves outside of the national model. That is really history for them; it is about their own established channels for management of health complaints. We think there is capacity to keep our system and keep the very important role of the Health Complaints Commissioner within the national system. That is what our bill tries to deliver. Do you want to add to that?

Mr Cormack: Yes. Again, I certainly would not speak on behalf of the Health Complaints Commissioner. However, the principal concern that was put was that the ACT currently has a system of joint consideration by the board and the complaints commissioner. Certainly, Ms Durkin was very keen to ensure that that is retained.

Indeed, the bill that we will brief you on directly maintains that. In fact, it strengthens it. It is actually a stronger provision than under the current arrangements. That is the principal concern that Ms Durkin has raised. No doubt she will make her own views known to you at some point in time.

THE ACTING CHAIR: Just to clarify, what are the professions where there will not be ACT representation?

Mr Cormack: I will need to take that on notice. That is probably the best way to do it.

THE ACTING CHAIR: Sure.

Mr Cormack: I think we should be able to get that to you by the end of the hearing.

MS PORTER: On that same page, page 7, up the top there, the second dot point, it talks about an integrated cancer centre, which is also mentioned on page 123, where it talks about the commonwealth's budget initiative granting moneys in order for us to establish that integrated cancer centre. I was wondering if we could have an update on that.

Ms Gallagher: Certainly. We are in the planning stages for this project. I am trying to recall—I think it was $28 million—it could have been $26.7 million; anyway, it was a significant amount of money from the commonwealth for our—

MS PORTER: $27.9 million, it says in here.

Ms Gallagher: Exactly, that is the right figure for the integrated cancer centre. That is certainly a help for us in terms of our infrastructure spend. That was for the centre, of course. We have to deliver and pay for all the services to come out of it, but it is in the planning stage. It will occur up near the bunkers, if you can get a picture of where that will go on the campus. We have built the bunkers; so that has guided the decision about where the integrated cancer centre should go. So we are building it around the bunkers, basically, because they cost a lot of money and took a long time to build, and we are not moving them.

Ms McGlynn: Following on from what the minister said, what we are looking at in the integrated cancer centre is really a much more patient-centred focus on cancer. As you would appreciate, we have people who need sometimes multiple contacts with different sorts of specialists for different sorts of treatments right across their journey. The aim is to get integration of those various services for patients who may have to travel some distance: to see if we can coordinate appointments on the same day, where that is appropriate; make sure that they have had all their tests done before they get there—again, so that they do not have to come back and forth and do all that at a time that is already very stressful for them.

We are really looking at a number of focuses in the first stage. The whole integrated cancer centre is looking at multidisciplinary cancer care facilities; bringing research to the centre of our clinical care so that it informs better clinical care and people get access to better clinical trials and things like that with new drugs; that we get a clearer partnership with our south-east New South Wales community in terms of those people

who seek services in the ACT and also with general practitioners; that there is a lot more co-location of the things that are required for patients—things like information services, prevention. We have had early discussions with some of our non-government organisations about how they can partner us in the cancer centre and they will obviously be a big part of our stakeholder engagement in the planning phase.

MS PORTER: So there is quite a lot of service to people who come in from the region as well as those from the ACT?

Ms McGlynn: Yes. We see a lot of patients that come to the ACT for services, but we also do some outreach clinics. It is a matter of how we then, through our cancer planning, continue to develop that relationship.

MS PORTER: Minister, while we have Ms McGlynn here, could I just ask—

Ms Gallagher: Any cancer questions now, yes.

MS PORTER: I have another one regarding breast screening. On page 87 of the report it mentions that demand has increased, resulting in longer waiting times. What steps are being taken to address this trend?

Ms McGlynn: I am happy to answer that. There certainly has been an increase in demand and I think there are a number of factors at play here. We have an increase in demand as more people come into the eligibility age group and also again as people from New South Wales seek our services here. But we are also dealing with another issue at the other side of that, which is how we visit the worldwide shortage of radiographers. That creates a different problem while demand is increasing. We are also looking at particularly people who are trained in mammography, which is slightly different; not everybody is trained in those skills. We have had some success in recruiting in recent times. We have done a major recruitment drive and we have been using some locums, so we have been able to resolve some of those issues.

We have also looked at our business processes within breast screening that allow us to say: are we using our resources as effectively as we could? We have looked at some scheduling issues, how we organise our admin and our scheduling, and the best use of our clinical resources so that we are being more efficient. That is what we are doing to address that increase in demand, but also the other side of that coin, which is making sure that we have the skilled workforce being used in the most efficient way.

MS PORTER: Is this to do with not only the conduct of the examination, the mammography itself, but also reading the results?

Ms McGlynn: That is right, yes. It is about how we set up the reading rooms, who is available and how many staff we have on so that we can get economies of scale, and what the skills mix of those people is. Also, looking into the future, we are looking at digital mammography, which will give us some other kinds of efficiencies and also better quality of images. There are some things we need to do in implementation. Initially when we implement something new, it is important that we have anticipated the kind of hiccups we might get in implementation. So there will be quite a significant job of work to look at implementation issues with the clinicians who will

be using that new equipment and also people like Bosom Buddies, NGOs—those who are on our committees and steering groups, and stakeholders we consult—about how we talk to women about the new technology and how we involve them in those changes so that they are very clear about that too and they help us also to disseminate that message.

MS PORTER: Thank you very much.

MR HANSON: Could I ask some questions around e-health, please?

Ms Gallagher: Yes.

MR HANSON: I am trying to get across specifically what is going to be delivered in terms of a personal health record. The statements that I have seen initially were that people would get a personal health record or a health card that stored the information. I am now seeing that there is going to be a health portal. I am trying to get across how that works and whether that is going to achieve what we need in terms of a holistic health system so that it is not just ACT Health-centric but will talk to—

Ms Gallagher: It is the national system.

MR HANSON: If it is a national system, it can talk to people from New South Wales, GPs can use it and it is patient-centric rather than ACT Health-centric.

Ms Gallagher: It is a complicated series of projects particularly within the $90 million that has been funded, even linking in some of the work that had been funded prior to the $90 million. You are right; there is the patient health record or the shared electronic health record, but there is a whole range of other projects that fit within. The digital hospital as well is part of this, and things that help GPs, for example e-referrals and some of the discharge reports. That piece of work has already started. It all needs to fit together in the ACT and then it all needs to fit within the national system, and that is something that we are very conscious of.

I think it is fair to say, and I am told, that our allocation of $90 million is the envy of health systems across the country. Obviously, we are a small jurisdiction for that kind of allocation to do the amount of projects that we are doing. If you look around the country, that has not been replicated by other governments. We are doing some work on the potential savings of having all of these systems implemented, in terms of the recurrent budget—what that means for the efficiencies that implementing these projects will deliver. That work is being finalised but it is already clearly indicating that there will be significant cost savings to the health budget, which certainly has been driving a lot of my thinking around moving forward with this and moving forward faster than other jurisdictions.

MR HANSON: Are there other examples you can cite internationally where savings have been realised through e-health implementation?

Ms Gallagher: Yes. Owen or Mark can certainly talk through all the projects that are part of the $90 million.

Mr Cormack: I will just make some introductory comments about the savings and then our chief information officer, Owen Smalley, can talk through the projects. I think in particular, Mr Hanson, you would be interested in how it links in with general practice and how it links into the private sector; so we will get to that.

In summary, as the minister said, we are completing some work on the savings that would accrue to the system, not just one-off but on an ongoing basis, through e-health. They really centre around a few issues. The first one is around access to information by busy health professionals when they need it in a timely manner. There have been some studies undertaken which have indicated that over 20 per cent of the time of health professionals is taken up with seeking information. If you have got that all on your desktop, an iPhone or something like that, there are very significant savings in time. I think that is one point.

The second point is around the electronic medication management system, and Owen will be able to tell you about that. One of the most complicated and risky parts of any health system is the way it handles medications. They are a very significant cause of preventable admissions or complications. In part, that is due to the knowledge of the practitioners involved. In the administration of medication you have a chain. You have a chain which starts with the medical practitioner. Medical practitioners are very bright, very well trained but, of course, they need to have access to decision-support tools which guide them instantaneously around which medication or mix of medications is right for this particular client. The e-health system that the government has funded will deliver that functionality.

The second component is the transmission of that information from the doctor via prescription to the pharmacy. That is another potential source of error, both in terms of timeliness and in terms of accuracy. I think it is stuff of legend that the handwriting of doctors can be an issue for people. So if you can automate that in the same way you see people at restaurants going around with those little palm pilots to automate your ordering, it is that sort of principle.

Then within the pharmacy itself where the medications are compiled and dispensed, there are ways of automating that, including the introduction of robotics. Then it has to get from the pharmacy to the patient. There are aspects of just the logistics of doing that. The plan here addresses logistics, but it is also important that you identify the right patient. By having a unique identifier, coupled with a health card—smart technology by the bedside—you are able to deliver the right dose to the right patient at the right time. If those things do not go well then you have cost money.

MR HANSON: The delivery into pharmacies and places like that, who would fund that? It sounds like a pretty expensive system.

Ms Gallagher: That is our hospital pharmacy.

Mr Cormack: This is the hospital pharmacy.

MR HANSON: Just the hospital pharmacies. But if we wanted to see that same sort of system working in the community—I would have thought that would be the aspiration—would it be fit for that? Would it mean that the pharmacy would need to

go and log into the system or purchase some hardware and some software? How does that work?

Mr Cormack: Private pharmacies are funded by the federal government by the pharmaceutical benefits scheme. There are already e-prescribing applications available. The national scheme is about linking up the work that we will do in the ACT with the national work on e-prescribing; so you will have an interoperable exchange, a systematic exchange of information so that, irrespective of whether a patient receives their medication in the hospital or from a pharmacy, there is the same set of rules around identification and prescription in place. That is where the ACT plays a national role in this as well. We have to be part of a national solution. We can fix up what we need to do within our system but, you are quite right, it needs to talk to the systems outside. That is really where the national approach—

MR HANSON: Have we done the consultation with people like the Pharmacy Guild and the AMA to make sure that the people external to ACT Health are comfortable with what is being delivered and see it as the right fit? Have we done that level of engagement?

Mr Cormack: I will get Owen to talk about what we have done with our system, but at a national level, the ACT has a seat on the board of NEHTA, which is the National E-Health Transition Authority. It is a company that is owned by the commonwealth and state and territory governments. It is set up to develop those national standards, those national interoperability and communication frameworks. They are leading the consultation on the national parts of the system with the national peaks, such as the AMA, the Pharmacy Guild and the various professional bodies. It might be best if Owen was able to talk about—

MR HANSON: Keep it simple for us, please.

Ms Gallagher: I will just add something before Owen starts. When I meet the Pharmacy Guild or the Division of General Practice, we are having all the discussions about e-health as well. My sense from them is they cannot wait, in a way. The health system is lagging a bit behind in some of our capacity compared with other businesses and things.

MR HANSON: Absolutely. It is a wonderful opportunity. I just want to make sure that as it is being rolled out we do not then miss an opportunity and that it does satisfy everybody in the health system—

Ms Gallagher: We are very conscious of that.

MR HANSON: Not just the centre.

Ms Gallagher: Yes, and the e-referrals would be a good example of that. I am sure Owen will explain that when we stop talking.

Mr Smalley: Where do I start? Governance is probably a good place to start here. At the top, Mark referred to NEHTA. Above NEHTA is NEHIPC. Effectively, NEHTA is a group that is tasked with developing the standards to allow interconnectivity—in

other words, to get systems to communicate amongst themselves. That is critical to us to allow us to communicate with GPs and specialists and allied health providers. How NEHTA goes about doing that is through the establishment of what they call jurisdictional reference groups.

These jurisdictional reference groups have stakeholders from medical communities; so you have got basically doctors, specialists, medical experts. You have the technologists as well and consumers et cetera. Below that you have then a group of programs they focus on, such as diagnostic reference groups, a medicines reference group, an architectural reference group. On those reference groups you have experts. They are not jurisdictional representations; they are expert representations around the country. They are chaired by a CIO as well as a medico on those reference groups. The intent here is that we use those groups to develop the standards and the requirements to enable that capability. So in terms of, for example, meds, which is a very complex one, the lead for that one is the Northern Territory. There are two parts to meds. There is a thing called—

MR HANSON: What is "meds" sorry?

Mr Smalley: Medications.

MR HANSON: I thought it was an acronym for something.

Mr Smalley: Yes, pick me up on my acronyms. We have a thing called ETP, which is electronic transfer of prescriptions. In other words, it is how a GP writes a script to a community pharmacist. The idea is to make that electronic. That is one aspect of medications.

The other part of medications is knowing what has actually been administered. In other words, in a nursing home or a hospital, knowing what drugs a patient has actually taken. So prescribing is one aspect. The patient may collect the script from the pharmacy; so we need to pick up that information, and then if we have got control to know what they have actually taken or injected. That is part of the whole medicines management.

That group is set up to design the specifications to allow that information to be shared so that everybody can gain access to that information with appropriate security and consent to know what is going on.

There is another group that is part of the governance. It is a CIO forum; so you have got these expert groups working. Then they come together through the co-chairs groups and the CIO groups where we all share our knowledge. That is how the whole thing is being built up across Australia. ACT has a very active representation in that forum. I chair a diagnostic reference group. I sit on the identifier reference group. I sit on the jurisdictional reference group. I sit on the CIO forum and the co-chairs forum. Mark sits on the NEHTA forum. So you can see there is a really strong national approach and the ACT is right in the thick of it all.

In respect of what we are doing back home—I will bring it closer to home—the $90 million program has a number of components, as I articulated previously, that are

really focused around building up this thing called the shared electronic health record, which is what we call shared electronic health records and at the national level it is referred to as the individual electronic health record.

So to give you some idea of what this means, I will start at the bottom. We have medical records, which we refer to as EMR, electronic medical records. We have electronic health records, which is a summation of medical records. That is like discharge summaries between the wards. Above that we have what we call the shared electronic health records. This is the information that is typically shared outside the hospital; so that is information that might be shared with the GPs—the discharge summary, that sort of information.

On the national side, they are developing what we call an individual electronic health record which binds all the jurisdictional electronic health records together. In other words, each jurisdiction has its own electronic health record system and, nationally, there is a model that connects them together.

The thing called the clinical portal is how you actually get to see this information. You log in through a portal and it will then name where to find your piece of information. It is all place-centric, based on national identifiers. It will go through and pull information from respective jurisdictions. If you have a visit in the Northern Territory, say the Darwin hospital, if you have a visit in Victoria and if you have another visit in the ACT, the portal will be able to pull those three visits together and present it as one, on one page. That is the plan.

To make all that work, we have to have standards on interoperability, making sure we all talk the same language and information comes together. That is NEHTA's role. Our role locally is to make sure the systems that we build can present the information to that standard so that it can then be provided. That is how it all fits together.

MR HANSON: Who can log in, the individual or the GP? Who gets to log in?

Mr Smalley: That is a very good question. The plan for us is that there will be access by clinicians and access by the individuals. Individuals will have access to look at the information-shared electronic health record. The clinicians will have access to look at the information they have consent to have access to in the electronic health record. The whole consenting regime has not yet been developed but the plan will be that a clinician will be able to log in and see the information they need to treat the patient should the patient consent.

There is another one I have not mentioned yet. That is a thing called the personal electronic health record or PEHR. The personal electronic health record is a facility by which patients or clients can actually enter their own information. For example, if you have done an overseas trip and you have an injury or whatever or you want to record you have had a vaccination for malaria or some other event, there is the opportunity for you to actually record your own information.

Jurisdictions like ours will be providing that facility for individuals to record their own information. It is basically information that is entered by a patient as opposed to a share or the AHR, which is information entered by clinicians. The personal

electronic health record is not available unless the patient consents. In other words, you, as an individual, make your entries in your personal electronic health record. It does not mean that just because I am hosting it all of my clinicians will have access to it. There is still a consent regime around that.

The intention here is that, instead of having to repeat your story every time you visit a different clinician, you can go to the PEHR and they can look up your information. Plus, the information will tend to be more accurate than your memory. After a while, your memory starts to fade. That is the intention with the PEHR. We will find jurisdictions will be creating it. We will be creating it to support our chronic disease management program as well as a lot of other programs. It will do more than just the basics; it will have a lot more and richer functionality.

The clinical portal is a method by which people can gain access to this information. The clinical portal also provides a channel to get into active systems. For example, you might use a clinical portal to see a radiology result and you may want to order a pathology result. The portal will allow you to go into the order entry system and actually place an order. You do not have to log into another system. There is this thing called context switching, which means it carries the name of the person you are dealing with and who you are into the next system. You can go straight across into the order system. The person's details are already entered. All you do then is record the tests you want to do.

MR HANSON: In terms of where we are at with that, are we in the design phase, are we contracting or where are we?

Mr Smalley: What we have done so far is around electronic medical records, health records. We are bringing in a consultant to do the development of our requirements on the electronic medical records.

MR HANSON: Who is the consultant?

Mr Smalley: We have not chosen the consultant yet. As I said, that is what we are about to do. We are about to go out to the market to get a consultant to do the medical records requirements gathering for us. In terms of the electronic health record, we have engaged Orion to do some early work on the information they had from the Canadian experience and the Spanish experience. We will be using that input in developing our own requirements for a shared electronic health record. That will be going out to an open tender. The shared electronic health record, the electronic health record and the personal electronic health record will be done as one package.

MS PORTER: I want some clarification on PEHR, where a person is actually inputting their own information. How do we avoid people inputting inaccurate information?

Mr Smalley: We do not. It is no different from when you visit a GP and you give them inaccurate information. "When did you last have a tetanus needle?" "That was in 2007, or 2006 or 2005." It is the same scenario. The intention is that there is a better chance of getting the information right. From a clinician's perspective, they will treat it with the same level of—

MS PORTER: Suspicion?

Mr Smalley: Suspicion, yes, or respect is a better word—as they do when you verbalise it. One might imagine that, as we get this online, people will keep it more up to date, PEHR will also allow electronic connection to devices. If you have got a personal device, say, capturing your blood pressure, you will be able to get those results electronically fed with a time stamp. You can see where this is going to move to. It is going to be part of your own medical record for keeping information.

Ms Gallagher: It is for our children. They will be really well versed in it. Many people who are living with a chronic disease and are happy to benefit from having a personal electronic health record are very good at monitoring their own health. That is something they do. In a way, the personal electronic health record will be more useful for people who are managing an ongoing condition. It will be a useful record for otherwise healthy people who want to create their history from their own point of view. I certainly know, from my experience of dealing with people with a chronic disease, many of them are much better at recording their own health data than some of the professionals they deal with.

MS BRESNAN: I am asking this set of questions on behalf of the chair. The first is in relation to e-referrals by GPs on page 185. It is identified as a major project completed and a major project commenced in 2008-09. Can you advise the committee about the status of e-referrals from GPs? Is this now available to all GPs referring to ACT Health facilities?

Ms Gallagher: From the briefing I had earlier this week, my understanding is that phase 1, the pilot element, has been completed. I understand that involved seven practices with 41 GPs. It has been universally welcomed, as I understand it. The second phase is to move it out more broadly. I think there are some issues with software. Is that right?

Mr Smalley: At the moment, as the minister said, it has been rolled out to seven practices with 41 GPs. Those practices were chosen because they have the same software product and because we had to make a lot of software changes to make this work. The game plan now is to start dealing with the other major GP vendor software products, such as medical director, to now set up the interface between their products and the e-referral interface system. The limiting factor is the GP practice software. From our end, it primarily goes into the ambulatory care system at this stage. The game plan is to roll it out to all our outpatient clinic services. It will go across to community health as well as to cancer and other services so that it is a full electronic, end-to-end service. That is the plan.

MS BRESNAN: Do you have a time frame for that or will it be limited by, as you said, what sort of packages other GP practices have?

Mr Smalley: We are at the mercy of the GP practice vendors. We are also using NEHTA to help leverage this as well. This is part of the NEHTA program. We are using NEHTA standards. We are actually leading the nation on this particular program. We are setting the standards nationally. From that perspective, we use the

national leverage of NEHTA against the practice vendors to assist to make changes to their products. It will probably also result in some of the GPs having to upgrade their products to be compatible. That really is the great limiting factor from our perspective.

MS BRESNAN: Again, I am asking this on behalf of the chair. On page 188, the ACT primary healthcare strategy is referred to. It was due to expire in 2009, I believe. Has the strategy been evaluated? If so, has it achieved its goals? Will the strategy be replaced by a new one? How will this link to the draft national primary healthcare strategy?

Mr O'Donoughue: Thanks for that question. It is very timely because the primary healthcare and chronic disease strategy group which oversees the implementation of those two strategies, the chronic disease strategy and the primary healthcare strategy, met yesterday morning and discussed that particular issue. The primary healthcare strategy was for 2006-09. It had a series of priority actions and performance indicators built into it, especially for the first 12 months of its life. In a sense, there has been a prospective evaluation of which of those things have been achieved. The strategy has been reporting to the portfolio executive on a six-monthly basis, as does the chronic disease strategy.

The group has been reviewing over a period of time what the future of the strategy should be. One of the dilemmas has been that, with the national reform agenda playing out, we have been waiting to see what would progress in terms of the national primary healthcare strategy. In fact, we have only just seen released in the last couple of months the draft national primary healthcare strategy. We still anticipate, at this year's December COAG meeting and in the early COAG meetings next year, further developments in terms of primary healthcare reform. To some extent we have been trying to bide our time in renewing our strategy until we could see what the future direction of the health reform agenda would be.

The group in its meeting yesterday really felt that, given that the ACT is almost in a leading position in the sense that we were one of the first jurisdictions to have a signed and sealed primary healthcare strategy, we really do need to progress the development of a new strategy. We have set ourselves the goal of producing the initial draft new strategy for the first meeting of that group in February next year, with the aim of having draft consultation by the April meeting of that group. The plan is that by mid next year—there will be a slight lag, obviously, before the new strategy comes into place, given that the old one finishes at the end of this calendar year—we will have a new primary healthcare strategy in place.

MS BRESNAN: So is it going ahead with the work? You are obviously waiting for the work happening nationally, but going ahead with your own—

Mr O'Donoughue: We believe that the framework of the current strategy is sound and, really, we are in a position where we think we can refresh it, begin that work and try still to factor in what emerges out of the COAG agenda, but we just cannot afford to wait any longer. We still think—

MS BRESNAN: COAG can take some time.

Mr O'Donoughue: Yes, that is right. So we have been waiting. The federal draft primary healthcare strategy is a fairly broad palate. It is pretty permissive. It is not terribly prescriptive; so we think we can work within that and produce a new strategy. As I said, we are prospectively evaluating which of the KPIs—key indicators—have already been achieved in the current strategy.

MS BRESNAN: Thank you.

MS PORTER: My question relates to a totally different area. On page 111, there is reference to the sleep studies laboratory, which may be already open. I was wondering how work was going and if patients are being scheduled to go through that lab or have already been through that lab.

Mr Thompson: We are still a couple of weeks away from the construction being completed on the lab. Unfortunately, it was a more complicated construction project than we had initially anticipated due to the removal and some of the internal works that were required. Following the construction, we also have a process where we need to put in place the various technologies and get them interfaced; so it will take a little bit longer as well. We are expecting commencement of the service itself to be in about February next year, given we are now coming into the Christmas-new year period.

What the proposal involves is the establishment of a two-bed sleep lab operating four nights a week. Essentially, what that does is enable patients to be monitored while they are sleeping, checking respiratory rates, sleep apnoea and other concerns that might be affecting their sleep. At the conclusion—basically, the end of the night—there will be a comprehensive diagnostic assessment of what is going on with their sleep and, consequently, a management plan to follow from that.

MR HANSON: My recollection from the budget is that there is $57 million in rollovers for capital works?

Ms Gallagher: There would have been more than $57 million.

MR HANSON: I think that is where we were in the budget. Where are we at with our major infrastructure projects? I notice the hospital car park has started.

Ms Gallagher: Yes.

MR HANSON: Have you got anything that we can red flag as falling behind?

Ms Gallagher: We can go through all the projects. There are many of them.

MR HANSON: Really, it is just ones you are having problems with that might not be delivered on schedule, you anticipate slipping or are having budgetary problems with.

Ms Gallagher: There are no budget problems. There are lots of processes. To give everybody everything they wanted, there would be budget problems.

MR HANSON: You only have a certain amount—

Ms Gallagher: Yes, exactly.

MR HANSON: For example, the car park was budgeted at $29 million.

Ms Gallagher: That was a different car park.

MR HANSON: But whatever it was scoped as—

Ms Gallagher: It was in a different place, a different size, which led to that change. But that was not through poor scoping. That was a completely different project in the end.

MR HANSON: Okay. So what you are saying, then, is that with all the projects that we have got listed, none are looking like they are going to exceed budget?

Ms Gallagher: No.

MR HANSON: But in terms of timeliness, we have had a number of rollovers. Are we on track—

Ms Gallagher: Look, in timeliness there are no major delays, but with some of the ones that are going to be completed very soon, there are a couple where it is going to take six weeks longer to finalise them; so nothing major. If I look at what is being done through the reporting period, it is not just the construction running alongside of these projects. It is doing all the design work, the models of care work, the decanting work—for example, the demountable office block that is being built at Canberra Hospital to allow 160 staff to move out of where they are now so that other parts of the hospital can be redeveloped. There is a lot of preparatory work that has been going on. That is being managed through the clinical services phase.

We have had the operating theatres, we have new beds opened, we have got the demountable in place. We have built some car parks. The new car park has started. The preparatory work for—

MR HANSON: In summary, there is nothing on the radar where we are saying that we are looking at delays?

Ms Gallagher: No. If we go through the ones that are going to be finished—the secure unit, perhaps. Yes, the secure unit, perhaps, is the one project where we are finalising the site selection for that. That has delayed that project. It may result in increasing costs, because the budget was originally budgeted for it to be co-located with the adult in-patient unit and, therefore, to share a certain amount of facilities. That will not occur now that the decision has been taken to move it elsewhere. So those costs have not been finalised. Really, it is about finalising the site, and then the costs would be finalised after that.

MR HANSON: Where are we at with finalising the site?

Ms Gallagher: The community consultation process is finished. It needs to go to cabinet as a wrap-up of that. Touch wood, the community consultation process went

very well, from my reading of it. It was not a huge issue of concern to the community. We did a number of community meetings, leaflets, media releases about it. There were three sites looked at: two in Gungahlin, essentially near Bimberi and another greenfield site; the other was the former Quamby site. So the outcomes of those consultations will feed into the cabinet submission that has not gone to cabinet yet. So that is the one project that is significantly delayed.

MR HANSON: All right.

Ms Gallagher: In the next 12 months there will be completed—well, there have been the operating theatres. There are an additional 24 beds for Canberra Hospital. The mental health assessment unit should be finished later this calendar year or perhaps early next year. That is in the emergency department. That is a six-bed unit. There are the temporary car parks, the walk-in centre will be at practical completion in March, I am told. That is linked to the Village Creek refurbishment, because that is where, for example, the equipment loan service is going. That is moving people out of the hospital to allow the walk-in centre the room. The PET scanner purchase and insulation will occur. So the car park is started. The SAPU has started. The neurosuite is due for completion late next year. The Tuggeranong community health centre will start. The Gungahlin community health centre will start. The women's and children's hospital will start in earnest. There has been some preparatory work done. Calvary intensive care unit is the new building on the site with all the scaffolding on the side of Calvary Public Hospital. And there is the commencement of the adult mental health unit, which is due for completion in 2011.

Then there is a lot of design work that is being done as well. That is on top of all the actual general work that Health do. So I think they are travelling pretty well for a big project like that. For a politician, you would like to see everything open tomorrow, but it is all on track. I am very pleased with how it is rolling out. I think over the next three years you will see just a constant stream of new infrastructure opening across the territory.

MS BRESNAN: A question on behalf of the chair, Mr Doszpot: it is in relation to page 158, consultation, briefing and reporting. It refers to eight reviews and one audit conducted by Walter Turnbull. The committee notes that these are not reported in section C14, government contracting, which is pages 222 to 228. Can you outline the process for engaging Walter Turnbull and why this contract is not reported in C14, noting that, obviously, contracts of less than $20,000 have a different process?

Mr Cormack: I will make some comments on that, but also, just seek to confirm those. Walter Turnbull is part of an ACT government-wide panel of internal audit service providers. I think that is where we have sourced them. In relation to whether they do or do not appear on our list of contractors, I will take that on notice and provide you with some more accurate information.

MS BRESNAN: The process in terms of engaging them is the general part of—

Mr Cormack: Yes, the ACT government has a panel. In years gone by, each agency went out to tender for its own individual audit provider. Now we pick from a range, which is very good for us, because most of them are small engagements, and we are

able to get different expertise in different areas brought to bear on the particular audit that is in place.

MS BRESNAN: How many are on the panel?

Mr Cormack: I would have to take that on notice, I am sorry.

Ms Gallagher: We had a couple of questions about the national registration authority. We have ACT jurisdictional reps for medical, dental, nursing, midwifery, pharmacists, physios and psychologists. They are the six. In addition, we have a practitioner rep, who I understand is from the ACT but it is not an ACT designated position, for osteopaths, and we have two community reps, one on podiatry and one on chiropractors. So the ACT is represented on nine out of 10, but six are official ACT designated spots. It is a sort of happy convenience for us, those other three. There is no representative on the optometrists board.

Mr Cormack: Can I also clarify an answer given before about nurse practitioners. We have nine in position and 10 in transition, giving a total of 19 at November 2009.

MR HANSON: Pretty close.

Mr Cormack: It was pretty close but we have got to be accurate.

MS BRESNAN: I have not got a reference for this question but, if possible, can you provide any information on what progress has been made in terms of the workplace conditions for junior doctors, in particular representation for them in workplace negotiations?

Ms Gallagher: This is an ongoing dispute between two professional organisations, the AMA and the ASMOF. Previously to Fair Work Australia—I think that is what it is called; I must get on to this, being the IR minister—the ACT government committed to bargaining with registered employee associations, unions, through their conditions of employment, which meant that we negotiated for our doctors through ASMOF as their representative organisation. The AMA in the last couple of years—I guess what we are seeing here is a local dispute that is not replicated across the country—has had a desire to represent junior doctors in particular and have a spot at the bargaining table. In the future that will occur because under Fair Work Australia employees can nominate their bargaining representative, so we would be breaking the law if we just continued to negotiate with ASMOF. So it is not a problem in the future. But the issue is that under the current agreement we are bound to deal with ASMOF.

I meet with the AMA and I meet with the junior doctors and I am very happy to have them at the table, but I think it is fair to say that ASMOF is not as happy as I am. I guess what is easy for me to see as a resolution, and easy for the AMA, is not easy for others. I do not want to start off a fight with ASMOF to solve one with the AMA. I would like the parties to come together at some point and I think they will in the future.

MS BRESNAN: With the junior doctors themselves there has been a desire for them to have representation there from the AMA as well.

Ms Gallagher: Yes, and we did, in response to that, set up a consultative committee for junior doctors. The major issue they put to me at the time when I met with them was that the issues for junior doctors are quite different from those of senior doctors. There is probably a feeling amongst junior doctors that the senior doctors sell them out. So we set up a consultative process for the JMOs. The difficulty for the JMOs in forming some sort of organised group, though, is that they are only in a hospital for a very short period of time.

MS BRESNAN: You would hope they would stay.

Ms Gallagher: But they have to go off and do their training elsewhere; they cannot stay. So in a way it is probably—

MS BRESNAN: Or come back, I should have said.

Ms Gallagher: Yes. We want them to come back. But then they come back as more senior doctors and all of a sudden they do not care about the junior doctors' issues. It is a moving feast dealing with them and their issues. I have worked pretty closely with the AMA on this one. I think they do strongly represent the interests of JMOs. We will just keep muddling through it, but, under the new arrangements when the new agreement comes in, they will be at the table.

MS BRESNAN: We are out of time, so thank you very much, minister, Mr Cormack and Mr Thompson.

Meeting adjourned from 10.59 to 11.16 am.

Appearances:

Burch, Ms Joy, Minister for Disability, Housing and Community Services, Minister for Ageing, Minister for Multicultural Affairs and Minister for Women

Department of Disability, Housing and Community Services
Hehir, Mr Martin, Chief Executive
Sheehan, Ms Maureen, Executive Director, Housing and Community Services
Collett, Mr David, Director, Nation Building, Asset Management Branch

MS BRESNAN: I am just filling in for Mr Doszpot at the moment. Even though he is here, I am speaking on his behalf because of some dental work.

Ms Burch: Yes, I have memories of that not so long ago.

THE CHAIR: I can talk, but there is a chance of biting my tongue off and giving you guys a lot of blood.

MS BRESNAN: So, in the interests of safety, I am filling in. Thank you, Minister Burch, for joining us here today for the annual reports hearing. I draw the attention of everyone to the privilege statement, which will be on the table in front of you. Before we go to questions, I invite you, minister, to make an opening statement, if you would like to.

Ms Burch: Thank you. I am pleased to have an opportunity to appear before the committee as minister for housing to discuss the Department of Disability, Housing and Community Services and the services it provides to the residents of the ACT. Housing ACT is responsible for the management of more than 11,500 public housing properties, and it provides advice and support to tenants on a range of complex needs. The commitment to supporting our public housing tenants is backed up by 10,439 annual client service visits conducted by housing managers in 2008-09. Tenancy management officers work closely with our community partners to help tenants to access services and supports that they may require to sustain their tenancies and participate in the community and economy.

Success is reflected in a significant reduction in the level of tenant debt through rent owing, which is down from $1,138,963 in 2007-08 to $953,642 in 2008-09. Housing ACT has instituted a range of processes and programs to target particular groups of people who are dealing with complex issues. These include people escaping domestic violence, people with disabilities and vulnerable families. The focus on those most in need is evidenced in housing data for 2008-09, where 96 per cent of the 632 new tenancies created were for priority and high-needs clients.

The ability to focus resources on such people is assisted greatly by the work of the multidisciplinary panel, and the panel representing government and the community has wide-ranging expertise and meets to review all cases for priority housing. In 2008-09, the panel met on 45 occasions and reviewed 485 cases. Of these, 86 per cent were approved for priority housing. In September 2008, Housing ACT implemented a specific youth housing program to increase young people's access and engagement with Housing ACT. It focuses on young people who are exiting care and protection,

juvenile justice or homelessness services. The program works to support these people from their initial application for a tenancy through to providing connections with education, training and employment services.

My department has also worked to increase support and housing options for Aboriginal and Torres Strait Islander people in the ACT with new tenancies allocated to Aboriginal and Torres Strait Islander families increasing by 22 per cent in 2008-09. In 2008-09, five properties were identified for priority upgrading to assist Indigenous families experiencing overcrowding and, in addition, in 2009-10, the final two properties were allocated for the Aboriginal and Torres Strait Islander boarding house program, taking the total to six dwellings that are providing short to medium-term accommodation needs.

A needs analysis of children in public housing has also been conducted, and this needs analysis will provide Housing ACT with clear directions on how to improve service delivery in, for example, the assessment and allocation of homes to better meet the needs of children in public housing.

The department also has a strong commitment to engaging with its tenants. A record number of public housing tenants have joined the Joint Champions Group to assist the planning and management of public housing in the ACT. The Joint Champions Group comprises public housing tenants, Housing ACT staff and regional community services and meets regularly to discuss broad-ranging housing issues. There are 90 regular and active tenant members. The input from the Joint Champions Group is highly valued. Its work is vital in fostering a housing system that is aware of and that can respond to the issues and concerns of tenants.

The maintenance of our public housing properties remains a major area of focus, with some $40 million expended in repairs, maintenance and capital works in the 2008-09 year. More than 1,200 homes received planned maintenance work ranging from kitchen and bathroom upgrades to new carpets and painting. Importantly, the department also assists clients to remain in their homes when age or disability may have otherwise forced them to move.

In this regard, 406 homes were modified during the financial year, allowing clients to age in place, and 43 homes had significant disabled modifications undertaken. The department has also spent $3.5 million to improve energy and water efficiency. Not only will these modifications assist the environment, but they also assist the tenants to save energy bills.

Housing ACT capital programs saw the purchase of 70 properties, including seven five-bedroom properties, a response from the need to accommodate some of our larger families. We saw the sale of 12 properties to tenants, and 17 three-bedroom properties were constructed at Uriarra settlement to replace the properties burnt in the 2003 fires.

In June 2008, the ACT government tabled a final evaluation of the ACT homelessness strategy, and that evaluation highlighted the significant achievements from the strategy across its four years of operation. The strategy assisted the ACT government and its community partners to reform the homelessness sector from a series of discrete services to a coordinated service system that includes homelessness services and

public and community housing. These reforms have created a service continuum for people experiencing homelessness or at risk of homelessness.

Public and community housing is now positioned as a post-crisis response with a specialist homelessness sector providing the crisis response. Other achievements from the strategy include the finalisation of the ACT homelessness charter and a service guarantee for homelessness service providers. We also saw the finalisation of research into the children experiencing homelessness and the development of an implementation plan to incorporate key findings of research into the homelessness sector. The road home and the new national affordable housing agreement and associated partnerships payments focus on achieving a closer alignment between housing and homelessness. They also prescribe a range of reforms to achieve better integration between the two, with their ambition of halving homelessness in Australia by the year 2020.

In May 2009, the government announced a range of new initiatives to address homelessness in line with directions of the white paper funded by the Australian government. These initiatives focus on vulnerable target populations and hard-to-reach client groups. The ACT is ahead of the national target in its work to achieve a common waiting list for public and community housing and a new centralised intake service to streamline access to all ACT homelessness services and social housing providers.

Over recent years, the ACT has experienced a steady influx of refugees escaping from oppression in other countries. The refugee transitional housing program is a tripartite program between Catholic Care, Companion House and Housing ACT, and it began in 2007. This is an important program that provides stable accommodation and support bases for newly arrived refugees.

Domestic violence is a serious social matter in our community. Housing ACT is currently finalising a domestic violence policy manual, and the manual outlines the principles guiding our practice as well as providing a practical guide for the day-to-day application of policy and procedure. That manual will be available to all Housing ACT staff and to our community partners. A new program will commence shortly to build on existing work to support women and children to stay in their public housing tenancies following domestic violence. This program is a joint program between the Domestic Violence Crisis Service and Housing ACT.

Finally, the commonwealth's nation building and jobs package has provided a much welcomed boost to public and community housing. We have been able to provide additional housing assistance under the maintenance component to the value of $3.2 million with this work completed by June 2009, as required by the commonwealth. This was a significant achievement in the time frame and allowed 143 properties to be brought up to current accommodation standards and consequently retained as public housing stock.

The social housing construction program has provided significant housing to allow a range of building works to be undertaken in 2009-10. This will include the development of an unprecedented 351 properties, which is 15 per cent more than the commonwealth requirement of 307.

I thank the committee for providing the opportunity to discuss the programs and achievements and look forward to talking around those and other matters pertaining to the work at this human service department.

MS BRESNAN: Thank you, minister. I will start with the first question from Mr Doszpot.

Ms Burch: A proxy question.

MS BRESNAN: It is in relation to page 78 on the number of evictions. It states that the number of evictions for breach of tenancy fell from 27 to 18. Why is this number falling, given the level of complaints that have been received from neighbours of public housing tenants?

Ms Burch: So it is around—

MS BRESNAN: It is around the fact that we have seen a fall in the number of breaches of tenancy but, according to Mr Doszpot, they have received a number of complaints.

Ms Burch: I will ask Mr Hehir to respond to that.

Mr Hehir: The breach of tenancy that is normally utilised for an application for an eviction is non-payment of rent. What we are seeing throughout the year is a significant improvement in our processes for collecting rent. You will see a 16 per cent reduction in our debt relating to public housing tenancies. So we actually see that reduction as quite a positive.

During the 2008-09 year, in terms of the question around behaviours of our tenancies, you will recall that the Residential Tenancies Act was amended to allow Housing ACT to seek conditional orders for matters other than rent. As you would be aware, the then Residential Tenancies Tribunal had previously allowed conditional orders for matters other than rent, but that was appealed. From my recollection, the Supreme Court said no, conditional orders were only allowed in relation to payment of rent. The Assembly varied the Residential Tenancies Act to allow Housing ACT to seek conditional orders relating to other matters.

We have over 50 conditional orders being sought at the moment, and I think of the order of about 40 have been granted by the tribunal to date. The process for an eviction is a lengthy process, there is no doubt about that. But it is a process that we have to follow, because it is set out within the act. The tribunal itself requires a high level of evidence for granting an eviction. While it is easy for us to identify that evidence in the matters of unpaid rent exist, in relation to disruptive behaviours, it is a much more difficult task. However, the tribunal has been very happy to date to provide those conditional orders. That is the process that we will utilise to try and manage the behaviours of our disruptive tenants and, where appropriate, we will seek evictions under those orders. Where they breach the conditional order, we will go back into the tribunal and say: "The order has been breached. We'd now like to have an eviction."

So, in summary, we actually think the reduction in evictions is a very positive thing, because, primarily, it relates to fewer people being evicted for non-payment of rent. You can see within the figures a very positive step forward in terms of our rent collection, with 100 per cent of our rent being collected and rental debt for public housing tenants actually reducing. But, in terms of managing the disruptive behaviours, the legislation was passed during 2008-09. The practice has now been put into place of seeking the conditional orders and, where appropriate, we will go back to the tribunal to do that and, in fact, we have done so.

THE CHAIR: I will attempt to ask a supplementary question. We agree that it is a positive if the number of evictions falls, so long as the number of complaints does not increase, and our anecdotal evidence is that there is a great number of complaints that we are receiving. That is the point that we are trying to get across—that is, attention should be paid to this. We are aware that you are doing that, but certainly the evidence that we are getting is that the number of complaints is on the increase.

Ms Burch: Can I just make the comment that there are two aspects of this: one is evictions for management of rent arrears. We will not step back from supporting tenants to keep their properties and sustain them in that.

THE CHAIR: We are not getting complaints about that.

Ms Burch: The other is around disruptive behaviour. I think what Martin Hehir has just outlined is that we recognise that everyone has the right to an amenity and quiet in their home, whether they are a public tenant or a private tenant. We take that quite seriously. We have got structures in place to look at that and to manage that.

Mr Hehir: It is also important to note that those structures are relatively new. The Residential Tenancies Act had needed to be amended, and we actually had to work with ACAT to actually make sure that our processes were working with them, and we also have to build the evidence case. It is not a case of us going in, asserting something and the tribunal accepting it. They certainly will not accept our assertions. We actually need to take the time to build the case to go forward. I think the other thing that is always important to say in this is: with 10,500 tenancies, the number of people we are talking about is a really small component of our tenancy.

There are also often circumstances that we will not talk about to other tenants and to private landlords because of privacy issues around what might be causing some of the behaviours that people are concerned about. So, for example, if the tenant has some mental health issues, our process will be to try and bring supports in to reduce the impact of their behaviours rather than going around and telling everybody that our tenant has mental health issues. There are sometimes complaints and multiple complaints about individual tenants where we will keep working with the tenant to try and address that rather than moving forward to an eviction, because the basis for the behaviour is actually a significant concern for us.

My personal experience is that there are very few completely bad people, and that applies within our public housing tenants. The majority of them are fantastic and they want to do the right thing. There are some people who need support and skills, and we

certainly work to do that. There are, however, other people where the only option we have is the conditional order. At times, that is followed by a request for an eviction to the tribunal.

MS BRESNAN: My question is in relation to page 77 in reference to the national affordable housing agreement—the NAHA. I note that there has been some confusion about how much funding the ACT is receiving under NAHA and how this affects issues, and that is in relation to the changeover of agreements and all that has gone on there. If you had taken the new issues which had been included under the move through these agreements, including land release and supply issues, does funding for homelessness actually increase or is it going down? I know it is fairly complicated, because there are a whole lot of different pools of money. Also, just in relation to that issue of ongoing funding, I understand that the stimulus package is going to put significant money in, but then there is not necessarily going to be ongoing funding associated with that. Then there are going to be costs with maintaining properties. Sorry for the long preamble, but I am just wondering if we can have a bit more discussion on that.

Mr Hehir: You are right; it is a difficult question to answer. The premise of the NAHA is to adopt a distinction between what was public housing funding and what was homelessness funding. I can answer your question in terms of where the adjustments were applied and then how we are dealing with them, which might give you a little bit of clarity.

When we went to the national affordable housing agreement meeting, the Australian government said, "We are going to apply per capita payments." That had always been the case for housing agreements, so there was no significant change there, apart from the usual fluctuations that go with differences in population growth. It had not been the case for SAAP funding. The ACT had a significant portion compared to its population size of the total SAAP pool. I am going to say 3.6 per cent of the total SAAP pool was available for the ACT. We were required to match that. The ACT did match that, in fact, it overmatched it. So, when a per capita payment of the total funding pool was applied to that, our payment was reduced to 1.61 per cent. Now, the Australian government said that they could not do that to us straightaway, so that actually tails in over a period of six years, I think. So we lose a little bit of money there each year.

Yes, there is a reduction in the overall level of funding when you combine the previous CSHA and SAAP payments from the Australian government with what the Australian government pays us in SAAP. The ACT government contributions have not dropped at all. The ACT government's contributions in relation to the previous SAAP and public housing have remained exactly the same. That is a good thing.

However, given that the Australian government has tried to release some of the specific controls they had around the funding, they said, "It's up to you where you apply that funding." With the previous minister, we had a conversation about where we thought the NAHA funding for the next three years should be applied. We made a decision that we would maintain all the homelessness services funding and, in fact, it would be indexed. So we have said the homelessness side of it is where we are going to keep our funding concentrated for the next three-year contracts. Those contracts are

either all in place now or close to being in place. That is built into their contracts. We have not reduced the funding there. Accordingly, we have, in previous terms, slightly less funding available for CSHA than we had previously.

We were conscious of a significant capital boost coming through from the Australian government under a number of agreements—the homelessness, nation building and social housing—contributing in the order of $120 million to $130 million worth of capital. We felt that was the best way of managing that situation. We do have to look in the long term about how we fund and how we change what we are doing. That is a conversation that we are engaged in with the homelessness sector right now in terms of thinking about what model to run. The white paper sets a number of challenges for us in terms of our service delivery.

They are conversations we are having. They are conversations that the sector is willingly engaged in and is very keen to progress. Does that clarify the situation for you?

MS BRESNAN: Yes, we did receive a briefing on it, so it was just seeking further clarification. Just one further question on that—again, it might be too simplistic a way to look at it, but when you talk about the provision of dollars per client, has that stayed the same or has that been affected at all? That is in terms of the sorts of services that are being provided to clients.

Mr Hehir: I do not know that I have done the figures on a per client basis. We would have been, and have been over a number of years, seeking to improve the number of clients per dollar, if that makes sense. If you look at some of the ROGS data, we were very high in terms of our per client costs. While we had some positive outcomes as a result of that, the cost difference was quite substantial compared to the Australian average, so we do believe we have to improve the overall efficiency. I think the sector has done that. We are also looking at and talking about different ways of service delivery. You will be aware that the white paper talks about the need for prevention, outreach support, both post crisis and at the first point of crisis, to try and sustain a tenancy rather than let it go into the crisis and into the system. That will change and that will mean a different dollar spend per person because it is a different way of working. I suppose it is difficult for us to answer that. In principle, yes, we have been seeking efficiencies and we believe the sector has delivered those efficiencies, and that has been over a three or four-year process.

MS BRESNAN: I guess my question was not just about the efficiencies but about the fact that we are still maintaining the level of support that is needed for the clients that are in housing. Has that been affected by the change in funding arrangements?

Mr Hehir: No. I think our overall homelessness levels have not changed significantly from the previous reporting, from the national census. I do not think there has been an exceptional increase in load there. We are certainly sometimes asking services to do things differently and see where they can do it. In fact, we had a service approach us recently and say: "We've got internal capacity to do another two properties for crisis accommodation. If you've got the properties for us, we'll be able to do that." And we have been very happy to do that. They were not asking for any extra money. They said they have their operation operating the way they want it and that means that they

have the capacity to do two more properties for us, which is a fantastic thing. I think everyone is talking about how we can improve and get better service out there.

MS PORTER: My question is going back to something you mentioned, minister, in your introductory remarks, about the joint champions group. I am sorry if I missed it but by the time you got to the end I was not quite sure whether you had already answered this question, so I apologise if you have. How many people are on the joint champions group, how do people get to be on it and how often do they meet? After you have answered that question, I would like some update on the other matter that you mentioned, the youth housing pilot.

Ms Burch: The joint champions demonstrate that we see this as a strong community social service to address the cycle of homelessness and sustained tenancies. We do that in partnership with not only the community sector providers but also the tenants themselves; hence the creation of the joint champions group that assists in the planning and management of public housing across the ACT. The group comprises public housing tenants, Housing ACT staff and regional community services and meets regularly. I understand that there are 90 regular and active tenant members within that group. Whilst there are 25,000 tenants or thereabouts, to have an active representation group of 90 is quite satisfying to us and shows the interest of the sector to be involved.

The work the group is doing is around fostering response systems within ACT housing and making sure that we are on top of our programs. Housing ACT is one aspect, but it is the raft of programs that come under the banner of homelessness. I think Ms Bresnan was referring to our maintenance of support structures and programs, which we have maintained. As to how people get into this think-tank of joint champions, I will have to ask Maureen Sheehan.

Ms Sheehan: The group was formed simply by asking all public housing tenants if they would like to express an interest in participation. We did not have any limit on the number of people who could express an interest because, obviously, participation was the name of the game. We decided to structure how people could be actively participating once we had the total number of people to participate. In the previous joint champions group, we had 25 participants. That was a small enough group so that the whole group could meet on a quarterly basis. Once we had 90 people participating, I think everyone would understand that 90 people can have certain sorts of interactions but you cannot have a working group with 90 people on it.

The way that things are structured and that tenants are very happy with is that the 90 people meet twice a year and the 90 people set an agenda which is to have three working groups focusing on the issues that the minister outlined. Each member can express an interest in one working group, because if you expressed an interest in all working groups you might have 90 people on each working group. So we have three working groups. They meet quarterly and they feed information back to the joint champions group that meets on a twice-yearly basis. The idea is that it is not just a talkfest; people can identify very concrete actions that can be taken by Housing ACT to improve services.

I will give you one example: the joint champions group that was focused on

maintenance issues was able to look at a revised tenant handbook that we were going to provide to all tenants, not only as they took on their new tenancies to outline their rights and their obligations but could be distributed to all existing tenants. The joint champions group made a fantastic contribution to what that handbook should look like. Of course, there are no better people to tell you what is useful information than the people who require the information.

THE CHAIR: Thank you, Ms Sheehan.

MS PORTER: I would like to know also about the youth housing pilot.

Ms Sheehan: Yes. The youth housing program was conceived by Housing ACT at the time of the homelessness strategy when an addition to the homelessness strategy was going to be a specific youth homelessness strategy and there was an action plan arising from that. All parts of the service system, including Housing ACT, were asked to have a look at: what are the issues for young people and what are you going to do to address homelessness? In Housing ACT we had identified that a number of applications were coming forward for independent tenancies from really quite young people, as young as 16. While it is possible for us to provide a tenancy for a very young person, the question is: how is that young person going to be able to sustain their tenancy and what supports do they have in the community? Many children have the support of their parents and family but it is quite common for young people who have experienced homelessness to not have those supports.

So the question for Housing ACT became: what supports can we provide, in combination with our community partners, to make sure that young people can sustain their tenancies in public housing? That is where we devised the idea of a youth housing program where we would employ youth housing managers whose job it would be to not just manage the tenancies of young people coming through, particularly young people at risk either because they were coming out of homelessness or out of the out-of-home care system, but also to work with them from the time of their application, through to their allocation into a property and then help them sustain their tenancies. So we are delighted with the way that program is going.

I am afraid that the word "pilot" is a bit of an unfortunate term because it makes it sound as if we might decide at the end of the pilot not to do it. In fact, we were piloting the model, and we are very happy with the way the model is operating and we have some ideas about the way in which we might expand the program. As I have just described, at the moment the youth housing managers work with the young person from the time of application through to their tenancy and sustaining their tenancy.

That model still is very much for people in stand-alone properties, but one extension that we are really excited about exploring is to help young people who are on very low incomes to be able to share tenancies in the way other young people do in the community. There is no reason why because you are a young person on a low income who needs to be in public housing you cannot share a house the way someone else might be able to who is a student or whose parents are giving them some help to rent in the private sector. That is just one example of the way we are looking forward to extending that program to assist young people.

THE CHAIR: Minister, on page 79 of the annual report there is a table indicating quite a substantial increase in the number of applications for housing, from under 2,000 to over 2,500. Can you tell us how Housing ACT will address these issues?

Ms Burch: The increase in—

THE CHAIR: The very sharp increase in—

Ms Burch: In waiting lists. Mr Hehir.

Mr Hehir: The Housing ACT waiting list, as shown on that graph, is actually a combination of a transfer list and our applicants list. So it overstates the number of people seeking public housing.

THE CHAIR: Has that changed from previous years?

Mr Hehir: No, the growth is still there, but I wanted to make sure you were aware—

THE CHAIR: Has the combination of what you just said been there in previous years as well?

Mr Hehir: I would need to check the previous annual reports. We tend to make a distinction between the housing applicant list, which is those people who are not in public housing, and the housing transfer list. I would need to check the previous annual report.

THE CHAIR: I understand your statement on it, but was it the same for 2006-07 and 2007-08?

Mr Hehir: There is a substantial increase. That is from a number of factors, including people being concerned about their finances, people having trouble accessing the private tenancy market and also the impact of some people losing their employment through the global financial crisis outcomes. In terms of how we manage it, we manage it as we have in all other years. We have criteria that we apply. We have quite tight criteria in terms of eligibility, and we seek to apply the classification process to identify those who are priority, those who are high needs and then those who are standard, to make sure that we work with those priority clients to get them houses urgently, if we can.

There will be many people on this list who will be in private rental. There will be some people on this list who are living in their friends' or their families' homes. We will try and make the priorities right so that those in the highest need get housed, or those with priority needs get housed, as quickly as possible.

In a sense, we do not control those people who apply, and with a finite resource we ensure that we work as quickly as we can to place people appropriately. We anticipate that the significant increase through the stimulus package will allow us to address this growing component, at least for a one-off point. It will be important for us to keep an eye on the number of people who meet our criteria, to see where they are going, but at this point we apply our normal rules and we are seeking to build the stimulus

properties as quickly as we possibly can.

Ms Burch: Can I add that in 2008-09, 96 per cent of the 632 new tenancies that were created were for priority and high needs. So we are working within our resources and allocating to the very pointy end of what is, indeed, a substantial list. With respect to the stimulus package, 350-plus units will be coming on by the end of next year, and there will be stronger partnerships across the community housing sector. We are not going to eradicate the list totally, but we are certainly moving the right way.

Mr Hehir: The other point is not to look at the ACT in isolation. At 1,600 applications on our waiting list at the moment, that would be about 15 per cent of our total housing stock. Most other jurisdictions are operating with housing lists of between 50 and 80 per cent of total housing stock.

THE CHAIR: You said 1,600; isn't it 2,500?

Mr Hehir: That is the number of applications that came through the year and also includes the transfers. So it bulks up. There are roughly 1,600 people on our applicant list at the moment. That was from a month ago; I have not checked the figure since then. In comparison to other jurisdictions, it is actually a relatively low number of applicants per property compared to other jurisdictions.

THE CHAIR: Can you give us an indication of what the average waiting period is for applicants? Also, what is the longest period that you are aware of for an applicant currently on your books?

Mr Hehir: I might just correct something. I was right; it was about 1,600 a month ago. As we have advised this committee before, we do an annual review, just to see who is still eligible. The waiting list has dropped down to about 1,460 at the moment. So that is actually a substantial—

THE CHAIR: As at?

Mr Hehir: 24 November. Something that we always need to do is go back and check to see who is still eligible, because people's circumstances change, obviously. I do not have the figures off the top of my head but I can happily get them for the committee.

THE CHAIR: If you would, for the record—the average waiting period and also what is the longest waiting period currently on your books.

Ms Burch: That would be across the priority, high needs and standard.

THE CHAIR: Sure.

Ms Burch: We can provide it across the three categories.

Mr Hehir: And the standard waiting time will be quite long.

MS BRESNAN: My question relates to what we have just been talking about in terms of Housing ACT properties. Page 80 states that the number of clients with rental

rebates has increased. Obviously, we want people with the highest needs to be going into properties. Does Housing ACT have as a policy maintaining a certain level of market renters to assist in maintaining some of the viability of Housing ACT properties?

Mr Hehir: The policy we have is to house those people most in need. Quite clearly, we work with our priority clients first, and our high needs clients, with a really high proportion of those tenancies being met. Some of those tenancies will translate over time into market rents; there is no doubt about that. When public housing does its job and people are stabilised and are able to get into employment or education, we see that as us having succeeded in our job, in many ways—providing stability for somebody.

We do not have a target in terms of market renters. We have a policy which looks to work with people who have sustained incomes in the order of $80,000 per year over two years, in terms of looking at their options. There is a significant number of people earning below that figure who will still be paying market rent. So there is no requirement for them to leave. Someone on $50,000 a year could quite easily be paying, and it could be a couple working and getting paid between $30,000 and $20,000 each—relatively low wages. They would be entitled to stay in their property and continue paying market rent for as long as they choose to. We would regard that as a positive outcome for them and for the housing system.

Do we have a target that we will not drop below? No, we do not. That will be how the market works, in a sense. But it is something that we are very interested in, in terms of how we work with our tenants around their prospects in terms of employment et cetera. We think that is something we need to pay attention to. It is something that we do both for our own purposes and because it is a good outcome for tenants.

We are looking at some programs that have been run interstate about encouraging tenants to get into employment. Certainly, that is the fastest way to get someone to pay market rent. That is part of the reason why we will be doing it. The other part is that we think we get far fewer social problems if people are not sitting at home all day and doing nothing. We think that employment, paid or otherwise, is a good thing. The other program that we have is shared equity, which the minister announced—

Ms Burch: Just last week.

Mr Hehir: We will lose some of our market renters to that program. We will keep an eye on that and see how it is going.

Ms Burch: I think it is a good thing if people are then in a position to actually own their property—

MS BRESNAN: Absolutely, and then they can stay in their property as well.

Ms Burch: That is a very positive outcome.

MS BRESNAN: And stay in their community as well.

Ms Burch: That is right. We will maintain; as someone may buy a unit, we will then replace that unit. So our stocks may—

THE CHAIR: Just a supplementary on the shared equity scheme: for the record, what was your announcement?

Ms Burch: The shared equity scheme that I announced last week, or the week before—it is all a bit of a daze, this last month and a bit—we have got a financier, IMB, to be able to come in with people in the first instance to share equity up to 70 per cent of the value of the property with an ultimate aim, if they can, of acquiring 100 per cent ownership. It does, for the first time, give people a real opportunity to actually start to have equity in their own home. So that is available now.

THE CHAIR: In the annual report the department mentions that negotiations were expected to be completed by August. So when were negotiations completed?

Ms Burch: Not that long ago. I do not know the time we got IMB, but certainly they have just recently come on board.

Mr Hehir: The preferred proponent was identified some time ago. I certainly think the preferred proponent was identified by August. I would need to check that with Mr Collett, but the detailed negotiations around the form of the financial contracts, the form of our security, all need to be negotiated, and that dictates the time in terms of getting the documentation right.

THE CHAIR: There is a signed contract with IMB?

Mr Hehir: No, the contract is not yet signed, but IMB have been prepared to say that it is just sorting out the minor details at this points. They are happy with that.

Ms Burch: They were on national television, Steve, signing up to the program.

THE CHAIR: No, no, the question I am asking is: if there is no contract signed, I presume that there cannot be any negotiations between them and any customers?

Mr Collett: The shared equity program adds on to a program that we already had for a number of years, which has been very successful—that is, our sales to tenants program. There are a number of steps that are necessary in order to determine whether in the first instance is tenant is able and eligible to purchase their property, and then there are a number of steps that we go through to determine that the property is available for sale.

In terms of the tenant, we need to establish that they have been in place for five years, that we have not spent significant money on disability modifications, for instance, to the property, that they will remain on the title after the property has been transferred and that we have a level of confidence in their ability to service the loans or enter into a financial arrangements. Now, we will step back from that in the sales to tenants program.

From the department side, there are a number of steps that we go through in terms of

looking at our maintenance spend on the property in its history, what the further maintenance requirements would be, whether the property is in an area that we are underrepresented or overrepresented in terms of the percentage of stock that we hold or whether it has redevelopment potential to help us to make a decision about whether the unit would be available for sale. So those steps that we will go through will be the same for the sales to tenants program and for the shared equity scheme. So there are a number of steps that need to be walked through. IMB also have a process of doing a forward approval of assessing the details. So we have been taking applications since the announcement of IMB as our partner. We have been sending out the kits for the sales to tenants program. We have been starting that assessment process.

There are a number of agreements both between ourselves and IMB, between the tenant and ourselves and between the tenant and IMB. There are a number of requirements around consumer credit and around financial regulations for borrowers, as you would understand. The final documentation of that has been the result of daily exchanges of letters between the lawyers for both parties. Our expectation is that that will be completed by the end of this week or very early next week.

THE CHAIR: I guess the community is a little bit gun-shy of announcements, as we found out with a recent activity back before the election which cost the territory $3.5 million, so we understand announcements being made, but we are also very much concerned about when the spend is going to be implemented. That is what I am just trying to get a handle on. I understand the announcement has been made. When will this be implemented to its full capacity?

Mr Collett: When will the final—

THE CHAIR: When will the ink be dry so people can actually have shared equity?

Mr Collett: As I explained to the committee, that has already happened in that sense that we are now taking applications and we are doing our assessments, as are IMB doing their assessments. Both of us are confident that this will be achieved at the end of this week or early next week. That was the reason for the announcement. There were a number of people on our sales to tenants waiting list who were putting off making a decision about the purchase in anticipation of the sales to tenants program being introduced. There were a number of other tenants who are indicating an interest. So we took the decision that once we had resolved the major issues and received advice from IMB's independent legal advisers and our own legal advisers that we were at the point of reaching agreement on the substantive issues to make the announcement, that enabled us to process those applications that we are receiving. If the question is when will the first mortgages be written, I would hope that we are able to do that before Christmas.

THE CHAIR: Thank you.

MS PORTER: I do not think that cost has been attributed yet. The cost that you mentioned with regard to the delay, I do not think that cost has been attributed yet.

THE CHAIR: No, that is correct.

MS PORTER: It is not necessarily the fact that the territory is going to wear that. I think we have to make that point.

THE CHAIR: I was using that as an example.

MS PORTER: Yes, but we cannot use that as an example because it has not been attributed yet.

THE CHAIR: I understand. Thank you, that is what I was after. Ms Porter.

MS PORTER: I am the chair of the Standing Committee on Planning, Public Works and TAMS, and the committee has reported on the variation to the territory plan in relation to the Lyons site, which is mentioned on page 82. I was wondering where that is all up to now, given that we have reported and there has been a change to the territory plan.

Ms Burch: David Collett can speak far more eloquently than I, I suspect.

Mr Collett: The committee might be aware that the territory plan variation to allow the increase in the density on the residential component of the former Burnie Court site was very important to us, because, along with our joint venture partner, Hindmarsh, we had taken the decision to divide the site into a residential component and a retirement component. The retirement component is well underway, but it was necessary to increase the density on the residential component of the site in order to give us the flexibility to provide that very important additional form of accommodation for residents in the immediate vicinity.

I can report to the committee that the majority of the sales of the first stage of the retirement complex have been taken up by residents in Lyons, Chifley and in the surrounding areas, allowing them to age in place and to stay in their own locations. In fact, at this very moment, Hindmarsh are with the Chief Minister formally opening the first stage. The works have been completed for the retirement component. The majority of the units are occupied now. The community facilities are in operation.

As a result of that, a DA has been prepared for the second stage of the retirement complex, and our expectation is that that will be lodged either late this year or early in the new year. Plans are proceeding against the controls that we introduced with the territory plan variation for the residential component on the northern end of the site. So getting back to the answer to your question, Ms Porter, the architects have prepared sketches, prepared materials and finishes. Those sketches have been shown to the residents of the retirement housing so that they can see what to expect. Their comments have been taken on board by the architects, and we are finalising a development application for lodgement to build the residential component.

THE CHAIR: Mrs Dunne.

MRS DUNNE: If I could turn members to page 83, there is a reference at the bottom to the right sizing program. It says that 11 applicants and 11 tenants were transferred under the initiative so that it was a 100 per cent service delivery there. What are the principal reasons for right sizing? This is not necessarily people who are downsizing;

they might be people who are moving the other way as well. What are the estimations of the unmet demand or whatever? How many other people are not appropriately housed? For example, they are in a big, rambling house when they could do with something smaller et cetera?

Ms Burch: Before I defer to either Mr Hehir or Mr Collett, can I share a number of conversations we had at the cabinet in community at Tuggeranong over the weekend. Right sizing was the predominant theme for that group of people in need with the supported aged care accommodation that is coming across a number of sites, particularly in Brindabella. There is a strong interest in here for older people, as you say, rambling around in the larger homes, to come down to smaller units but in their local areas where they are comfortable, where their friends are, their networks, their doctor services and things like that.

The detail I am happy to go to the department for but, given that it was just last weekend, it is worth pointing out that a very strong component of that conversation was about this, and I wanted to share that with the committee.

Mr Hehir: I will get David to talk about the detail of the numbers but the answer is: we believe that there are substantial numbers of older people, in particular, who are living in three and four-bedroom homes who no longer require all of those bedrooms, and a number of them are keen to look at what their options are, particularly if they can stay within their area. It was one of the reasons that we pushed very hard for two-bedroom properties under the stimulus package for stage 2.

One of the things we do know from older tenants is that they still want two bedrooms. Notwithstanding that they may be a couple and only using one of them, they still want an extra bedroom for their grandchildren to visit them or, at times, people have to separate their bedding and sleep in separate rooms. So they want that option. It is also a more useful asset for us.

We certainly have anecdotal information from our tenants that they were very keen for that, particularly if it could be located close to their existing communities. We have done the analysis in terms of our total numbers of tenants, particularly older tenants in those areas, in three and four-bedroom accommodation, who could well move to the two-bedroom accommodation.

The majority of our 300 properties that we have for stage 2, I think, are nearly all two-bedroom properties, with this particularly in mind. We do want to try to encourage people to move out of three and four-bedroom stock into two-bedroom stock. One of the things we actually have to make sure of is that we have that stock available and that it is attractive for people.

THE CHAIR: As a supplementary on that, can you give us an indication of what is the stock of two, three and four-bedroom houses?

Mr Hehir: We can get those figures for you; I do not have them off the top of my head.

THE CHAIR: Thank you.

Mr Hehir: I might pass to David or Maureen for the actual number of tenants we identified in the process.

Ms Sheehan: In the downsizing program, when it began, when the government announced reforms to public housing in 2007, there were two tranches of the reforms. One was encouraging people to downsize, and the question was whether the stock was available. That is why, as you will see on page 83 of the annual report, only 11 people were able to downsize because we did not have the stock available. As Mr Hehir has explained, at that stage we could not just suddenly produce enough two-bedroom adaptable properties for older people. This is where the stimulus package came in. So the world changed for us dramatically when we had access to the nation building and jobs program money.

The first thing that we did was an analysis of the age of public housing tenants on our books and then looked at what was the size of the properties they were living in and looking at that and looking at people's ages and looking at who is over 95, who is over 90, who is over 80, who is over 70. We then looked at what land the ACT government had access to which was, under the territory plan, classified community facilities land, because that does allow for the construction of supportive accommodation, which is aged persons accommodation.

Once again, we mapped where the greatest number of older people were at the different levels and were in properties bigger than they had said that they wanted to be in. Government was then able to grant at no charge to Housing ACT, as part of its contribution to the properties to be developed under nation building and jobs, that community facilities land.

As Mr Collett will talk about in a minute, what we have been able to do is then identify land in the same community that people are currently living in so that they can downsize not only into a beautiful, new two-bedroom, six-star energy rated home with minimum class C adaptability but in the same community that they have been in.

THE CHAIR: Can I ask you a question there. Sorry to interrupt you but it is relevant. You spoke about shared tenancies for young people.

Ms Sheehan: Yes.

THE CHAIR: Has any thought been given to shared tenancies in this category you are talking about? Rather than downsizing in areas where people lose a spouse or whatever, is there an option for older people, perhaps, to share accommodation?

Ms Sheehan: I think the short answer is that many of our tenants decide to invite another person to come and live in their property, and they simply have to notify us that there is an additional tenant. Building on that theme of what are the needs of older people—Mr Collett can outline this further—in that older persons accommodation, we have taken feedback from our own staff and from the community, but sometimes people need to have a full-time carer living with them. So we have deliberately ensured that there are a number of three-bedroom properties so that there is space for a carer as well as an extra space for older people and their grandchildren to come.

Mr Collett: In terms of those numbers, I can inform the committee that if you look at our housing population as a whole, our tenant population as a whole, almost 30 per cent of them are over the age of 50. More than 20 per cent of them are over the age of 60, and about 15 per cent of them are over the age of 70. So it represents a fairly significant group. In raw terms, that is over 2,300 of our tenants who are over the age of 60.

The work that we are doing at the moment is to narrow that down and find out for which of those tenants the accommodation that they are in at the moment is unsuitable and for which of those tenants the new housing that we are building under the stimulus package would be suitable in terms of its location and in terms of its design.

Some of the key characteristics of the housing we are building under the stimulus package initiatives are that we have got improved similar access, lower heating costs, improved energy ratings moving up to six star, secure rear yards, individual front yards, secure car accommodation, fully adaptable and accessible units under the Australian code. They are designed to allow the tenants to continue to live in place. That has made them significantly more attractive than our stock of existing aged persons units, which, typically, do not have secure accommodation. They are often bedsits and, at best, single-bedroom units and do not really suit older persons in the current social climate who are exiting a larger house with the furniture, with the connections, with the pet, with the gardening interests, with a motor vehicle.

We are seeing a very significant level of interest. In fact, we are coordinating our work with the tenants with our construction work. Earlier this week Maureen signed off on a flyer and a letter of invitation to a targeted group of 400 residents who are in the immediate vicinities of sites that we have identified under the stimulus package which, in turn, range from Florey down to Bonython.

MRS DUNNE: What are the sites and what is proposed for those sites? You can take it on notice.

Mr Collett: I will answer the question and give you a representation of them. I might not get all eight of them off the top of my head. They are a number of community facilities sites for which the territory plan allows supportive accommodation—that is, accommodation in which a level of support is given to the people who live there. That restricts the housing to either housing for elderly or housing for people with disability.

MRS DUNNE: We have changed the territory plan arrangements for supportive accommodation, have we not? At one stage it was very difficult—

Mr Collett: That is right.

Mr Hehir: That change enables this.

MRS DUNNE: Yes.

Mr Collett: So we are building on that change. Under this initiative we will not be targeting people with a disability who are not elderly. There is separate housing being

developed for that cohort. So it is community facilities land. It is a range of sites; some of them are large and some of them are small. They are Florey and Macquarie in the Belconnen area. There are two surplus school sites at Kambah and Rivett and a range of other sites in south Canberra, including Bonython and Condor. Chapman and Curtin are the last two. So that gives you the full eight. They are being developed, as I say, under the stimulus package.

MRS DUNNE: Could you, on notice, give us the block and section numbers and the number of dwellings that you are proposing?

Mr Collett: We can give you the block and section number and I would be happy to do so. The number of units that have been developed on site is still subject to some adjustment, given the conditions that are being imposed through the development assessments—the protection of trees, ingress and egress. On one of the other sites there are heritage issues. There are a number of planning issues still being resolved so I can give you an indicative number but it will not be the final number.

THE CHAIR: Could I ask a supplementary on the back of Mrs Dunne's? When we were talking about waiting lists before, one of the questions I meant to ask but did not was: what is the number of disability-related people on waiting lists? Can that be answered?

Ms Sheehan: We do not have a separate waiting list for people with a disability but we do record in the application any need that someone identifies, so if someone identified that they had a disability—

THE CHAIR: Is that high needs?

Ms Sheehan: Having a disability could certainly get you into the high-needs category, but we do have a special classification in the priority group for people with a disability whose natural supports are breaking down. That was necessary because we had seen quite a number of people with a disability whose parents were ageing, who were fine at the moment with their parents but there would come a point in time when their parents would not be able to look after them any more. Under our old categories, the person would have had to become homeless to get a priority allocation. So we have made that provision in the current list so that you can have a smooth transition of those people.

MRS DUNNE: On the subject of smooth transitions—I am probably going back to you, minister—you said this was a hot topic in Tuggeranong over the weekend. What demand is there from people who may be in the private rental market and who are facing retirement to move into, say, government aged persons accommodation?

Ms Burch: If they are eligible for Housing ACT then they are eligible for Housing ACT. If they are eligible for this particular market then they are eligible for this particular market. So they would go on the list, as with others.

MRS DUNNE: So are people who might be retiring on modest superannuation or pension supplementation recorded on your waiting list?

Mr Hehir: If they are applicants, they will be on our waiting list. Would I be able to pull those particular circumstances out? I may not. If their current income is higher, they probably would not be eligible, so they would not be on our waiting list.

MRS DUNNE: So you would have to wait for their income to fall?

Ms Burch: You would have to wait for them to apply.

Mr Hehir: In a sense we would have to see what their income was going to be, but they would not be on our waiting list as approved applicants while their income was higher; that would be right. The process around housing people who are older is a little bit faster than the normal waiting list, if that makes sense, because if they have made an application for an APF or an APU—the aged-persons flats, which are for 55-plus, or the APUs which are for 65-plus, broadly—in actual fact, depending on their age and their income, they are likely to be housed quite quickly.

One of the individuals that Minister Burch was talking to on the weekend had had to withdraw her application because we had provided her with a property too quickly for her needs. Her son is leaving but has not left yet and we had offered her a property. She had said, "Hang on, I'm not ready to go yet," so she withdrew her application. That part of our waiting list moves a little bit faster than other parts. Certainly, at the moment I do not believe we take pre-applications. In that sense the income has not changed yet.

MRS DUNNE: In the case of people who are elderly and are downsizing, who are already housing trust tenants but are downsizing, is there any assistance, minister, with the move?

Ms Burch: I would say, yes, there is support, but the detail Mr Hehir can provide.

Mr Hehir: I might pass that too as I am not around the exact details—

Ms Sheehan: The assistance that we provide is for relocation expenses. We pay for relocation of utilities such as telephone and electricity, then we provide another amount, up to $2,500, to assist with relocation expenses. The other thing I would add is that, as with all of our tenants—because we have engaged quite a large number of community support providers, including all of the regional community services, most of whom are also providers under the HACC program, the home and community care program—when there are additional support needs in that move, we engage those providers to assist with those additional support needs. That is something that we have had a particular eye to with respect to the construction of these new properties.

MRS DUNNE: I suppose the other part of my initial question is that this is about downsizing. What demand is there for upsizing and how has that been addressed?

Mr Hehir: I might start, if that is all right. In the ACT we have one of the lowest levels of overcrowding in the public housing stock in Australia. That is not unexpected. That does not mean that we do not have larger families who are looking for accommodation. In Minister Burch's opening statement, she highlighted that in fact we had to purchase seven five-bedroom properties to house some larger families.

We are also looking at five, I think, properties that have Indigenous tenants that have some overcrowding issues. We are doing work about extending the property or looking for alternatives for them. It is something we are aware of and certainly it is an issue that we see often on our priority housing list—quite large families who struggle dramatically in the private rental sector for housing.

We do not tend to go much larger than five or six bedrooms, on the basis that there are not too many of those properties built, and we recognise that in some of the larger families that requires a level of sharing. I suppose Maureen and I, both coming from quite large families, think that is quite natural, so maybe we have a bit of a bias happening there but—

MRS DUNNE: Sharing is not necessarily overcrowding.

Mr Hehir: No.

Ms Burch: There are modifications in addition to new structures as well.

Mr Hehir: Yes, that is right, so we will do extensions and that sort of stuff. We work with families where it is appropriate for them to remain in the same place. They might have very strong support networks there and, if physically possible, we might do the extension. David or Maureen might have a bit more detail.

Ms Sheehan: With respect to the Aboriginal families, we have a specific allocation of capital funds that we are using not just for extensions to the properties but modifications to external areas to make them culturally appropriate. The feedback that we have had from Aboriginal and Torres Strait Islander tenants is that a lot of their family activity happens in communal areas, both within and outside the house. As Mr Hehir said, that enables people to stay in their own communities. We have visited every Aboriginal or Torres Strait Islander family that have identified to Housing ACT that they were overcrowded, and almost all of the families indicated that they did not want to move into a larger house. They preferred to stay where they were because of their connections, and we were able to make those modifications.

THE CHAIR: We are almost out of time but I must say that I think Ms Burch's opening statement rivalled Mr Hargreaves's opening statements, so do you mind if we have one more question from Ms Porter? She has a very quick question.

Ms Burch: If it is a quick one, because I do have other commitments.

MS PORTER: You may want to take it on notice, minister. It relates somewhat to the larger family issue. Page 83 talks about the needs analysis of children in public housing that was done and says that it "will inform future policy and service development". I was wondering if you could, either on notice or now if it is quick, update us about that.

Ms Burch: I will ask Maureen to give a very quick response and then we will give a detailed response on notice.

MS PORTER: Thank you very much. That would be lovely.

Ms Sheehan: The information that we have identified was through doing a lot of research in the statistics that were available to us in Housing ACT. We looked at: where are children housed and what are issues that might appear as problems inside Housing ACT that we are actively dealing with but where the data indicates there may be children involved? That is, where are there requests for transfers which involve children? Where are those transfer requests coming from? Are they coming from multi-unit properties? If there are multiple complaints about particular disruptive tenants, are their children involved in any way, either in terms of the family that is being complained about or a family that is being impacted? That gave us a very good view about where people were located in public housing and what we should do in terms of reviewing our policies about the allocation of families with children, the timely transfer of families with children. We are having a very close look at whether there should be allocations into multi-unit complexes of families with very small children under five. That will be invaluable to us in terms of good allocation and maintenance of tenancies where children are involved.

MS PORTER: Thank you very much for that.

THE CHAIR: Thank you, minister, for attending this hearing, and we look forward to seeing you at the next one.

Ms Burch: I thank you. It is very interesting sitting here.

THE CHAIR: And thank you to all the departmental representatives for the information provided.

The committee adjourned at 1.32 pm.