LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL SERVICES

(Reference: Annual and financial reports 2009-10)

Members:

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

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 3 NOVEMBER 2010

Secretary to the committee:
Ms G Concannon (Ph: 6205 0129)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 21 January 2009

The committee met at 9.30 am.

Appearances:

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

ACT Health
Brown, Dr Peggy, Chief Executive
Thompson, Mr Ian, Deputy Chief Executive
O'Donoughue, Mr Ross, Executive Director, Policy Division
Woollard, Mr John, Director, Health Protection Service
Pengilley, Dr Andrew, Acting Chief Health Officer
Carey-Ide, Mr Grant, Acting Executive Director, Capital Region Cancer Service
Bracher, Ms Tina, Acting General Manager, Community Health
Ainsworth, Ms Brenda, Executive Director, Health Performance Improvement, Innovation and Redesign
Cahill, Ms Megan, Executive Director, Government Relation Planning and Development

THE CHAIR: Good morning, everyone. Good morning to you, minister. Welcome to the first public hearing of the Standing Committee on Health, Community and Social Services inquiry into annual and financial reports for 2009-10. Today we will be hearing from the Minister for Health and officials from ACT Health. Minister, I presume you and your colleagues at the table are well aware of the issues related to the privilege card information, so I do not have to go through that. Minister, can I ask you to make an opening statement.

Ms Gallagher: Thank you, chair, and thank you for the opportunity to appear before you today. As you can see, ACT Health and I are here, ready and able and willing—some probably more so than others—to provide the committee with all the assistance we can around our annual report.

You can see from reading the annual report that, across all areas of health, this report outlines significant demands on the organisation but also significant achievements. I think you can see that it has been an extremely busy reporting year where ACT Health continue to rise to the challenge of increased demand for services and, at the same time, continuously looking at ways to improve their service and provide new ways of doing things within the reform environment.

Whilst particular areas of ACT Health always get the focus of attention in these hearings, if you drill down into the report, it gives you the magnitude of the variety of the services that ACT Health provide that often do not get the attention publicly that perhaps some areas like elective surgery would. I thought it was important when I was reading through this report to look at some of that. I will briefly go to that. I do not usually do this.

For example, in the patient safety and quality unit—these are little projects but they are very important—the report outlines the hand hygiene program that the patient safety and quality unit has been running, which has seen a 21 per cent improvement in

compliance around hand hygiene in the acute setting. In the access improvement program, the acute coronary syndrome patient journey has won numerous awards for the way that project has been rolled out through ACT Health and the ACT Ambulance Service. It essentially provides a continuum of care around your heart attack, from the moment the phone rings to the moment you get to the hospital.

In the acute services, some of the things to be proud of in this report include the beginning of the sleep lab. For the first time in the ACT we have a public sleep lab where people with sleep disorders can go and be assessed and treatment options provided. With respect to the success of the NICU webcam, if you look at that in the report, it has had 20,000 hits. These are the little webcams that operate in the neonatal intensive care unit. It was the idea of the director of that service, who saw it working overseas. There have been 20,000 hits, including hits coming from the UK, Canada, France, Italy, Hungary and India. That is so that families can show off their newborn premmie babies online.

The diagnostic breast imaging service—again, the first for the ACT. The PET scanner is due to commence operations soon. Again, it is something that we as an Assembly should be proud of.

In mental health, I think the seclusion results are the highlight in this report. We set ourselves a target of seven per cent and it came in at about 2.7 per cent. Also, the significant increase in non-admitted services is something that Mental Health have been working on and it is reflected in this report.

In community health, there are lots of achievements there, but one I am very proud of is the impact program that works with vulnerable families. There are over 90 clients in that program at the moment—again, trying to target support to the most vulnerable of our young babies.

In cancer, the implementation of the productive ward at the hospital, which is something that I got the opportunity to go and visit and speak with staff around, is a very interesting project—as is, I think, the research project around breast cancer, the 10-year report.

In aged care and rehab, I note the ACAT assessment teams, which got the Commissioner for Public Administration award this year for their national benchmark setting of four weeks for assessment, coming down from 28 weeks. In the public health services, I would have to say the Chief Health Officer's report stands on its own. I think it has been a very busy year for that area of ACT Health with some of the issues around overcrowding, with the implementation of some of the smoking laws and also some of the challenges that we are seeing in food inspectorate services.

I just wanted to speak to those briefly because they are in the report. They rarely get the attention that they deserve but they are all part of making ACT Health the organisation it is. I think they are all achievements that we should be very proud of. Certainly, as minister, I am very proud of this report and the achievements of ACT Health through this reporting year.

THE CHAIR: Thank you very much, minister. You mentioned elective surgery, and

that was one of the areas that I wanted to start with before I throw it open to some of my colleagues.

Ms Gallagher: What a surprise!

THE CHAIR: There are references to it in quite a number of places within the report. Can you give us any more information? Perhaps the question of whether this information should be included in the annual report is another matter. If it is there somewhere, I look forward to seeing it. How many people are currently on the elective surgery waiting list by category? Do we have a listing by category? Do we have the median waiting time for each category—information along those lines? Is that currently available?

Ms Gallagher: It would be. It would be provided in our quarterly performance report; where that is provided every quarter. Indeed, we provide an annual snapshot of that. The last figure I saw for the waiting list was around 5,200 across all categories. That has remained fairly static over the last few years. In fact, it has come down in the first six months of this year. Yes, 5,268; it peaked at 5,700 in January, which is, again, not unusual, because there is not a lot of elective surgery done during the December-January period because of doctors' leave.

Certainly, the median waiting time has not significantly changed, and it will not significantly change as we move through some of the increased elective surgery work. In fact, the increased elective surgery work will make the median waiting time go up in the short term. I think that remains at around 74 days. We expect that will go up, as you remove people with long waits from the list.

THE CHAIR: How many patients are currently waiting longer than a year for elective surgery? Do you have any figures on that?

Ms Gallagher: There are about 2,000 that are waiting longer than the standard waiting times. I imagine we could get you the figure around those who are waiting for longer than a year.

THE CHAIR: Okay. It would be interesting, of course, to know a little bit more about what proportion of patients, say, from 25 March 2010 to date have waited longer than the recommended waiting time for each of the categories.

Ms Gallagher: Longer than 25 March?

THE CHAIR: No, from 25 March.

Ms Gallagher: Can you tell me the significance of 25 March?

THE CHAIR: It is a figure that we have picked that goes back about six months.

Ms Gallagher: Okay. We do not necessarily report from 25 March. We report as required under our performance arrangements and the commonwealth reporting requirements, which generally look at things over a quarter. But I am happy to assist in whatever way we can.

THE CHAIR: Obviously, as you say, a lot of this information is available in the quarterly reports. There is already a comprehensive annual report. Is there a way of including some of this information in the annual report as well?

Ms Gallagher: As you said, I do not see why not. I think we do provide quite a lot of information in the annual report, and the quarterly reports come out more frequently than that. We could provide it in the annual report and not provide it in the quarterly reports, or do you want to see duplication across the quarterly reports and—

THE CHAIR: No, a consolidation of the figures, I guess, is what we are talking about.

Ms Gallagher: If the committee comes up with that recommendation, we will certainly work with that, Mr Doszpot.

THE CHAIR: Thank you. Ms Bresnan.

MS BRESNAN: I have a follow-up on the waiting times for elective surgery. Has there been any examination of the percentage of patients that might be impacted by, say, doctors wanting to simply hold on to that patient and not hand them over to another doctor when that becomes available? Has that been examined?

Ms Gallagher: Yes, continuously. There are a number of specialties where there are high volumes and long waits. They are urology, orthopaedics and ENT. Some of that is to do with the number of specialists available to do that work but some of it is also about how the lists are managed by those specialists.

I think we have made significant progress. That is not to say everyone is necessarily happy about that. For instance, in urology, I do not know if the nurse has been appointed yet but there has been agreement, largely, reached with the urologists—as I said, not entirely 100 per cent agreement amongst all of them about how that should be managed—to allow for movement between Canberra and Calvary where Calvary can do some increased work. Indeed, just in those arrangements that we have put in place, the waits for urology have come down considerably.

I think part of the work that we have been trying to do with the surgeons is not just around extra money to increase throughput but around how we manage the lists, how we manage the theatres and how we interact with the private sector.

MS BRESNAN: Has the addition of the urology nurse been—

Ms Gallagher: That was really to manage the urology patients on the list, so a clinical nurse, a senior nurse, is able to look at the list and think, "Well, that person really could be done at Calvary in two Saturdays time where we've got some extra urology lists going," and have that interaction with the doctors. Instead of surgical bookings managed by administrative staff and then having to deal with doctors and the doctors rooms, this is putting another person in there.

MS BRESNAN: So it is a bit of a circuit breaker?

Ms Gallagher: That is right, and someone who is able to look just at the urology lists and make some decisions about how to manage those lists. For example, if you are going to have a patient that takes a longer time, whether they are booked at the end of the list and more people are booked before them, to make the most efficient use of the theatre list, the efficient use of the surgeon's time and the efficient use between Canberra and Calvary. That sounds relatively simple, easy and almost common sense to pursue, but I have to say these are not necessarily easy discussions to have, unless you get a reasonable level of agreement and the ability to implement them.

MS BRESNAN: Are there any thoughts to have that sort of position in other areas? Obviously, there are particular areas where there are waiting lists. Could there be a similar position?

Mr Thompson: Yes, the plan is that we are looking at urology as a pilot, with the potential to expand it to other areas. The particular reason we have focused on urology is that we have had a number of long waits and a number of staged procedures, which involves people who have a procedure with an expected follow-up procedure in a defined period of time, and that adds a dimension to the coordination task that we are trying to address. If it is successful with urology, we would be looking at expanding it to other areas.

THE CHAIR: Ms Porter?

MS PORTER: Thank you, chair.

MR HANSON: I have got a follow-up one on that.

MS PORTER: Well, do your follow-up, because my question is going on to a more general topic.

MR HANSON: I think there are about 200 patients who were transferred to private lists, is that correct?

Ms Gallagher: We are expecting that. We have not let all of those contracts. There have been some contracts let in ENT.

MR HANSON: Could you expand on the process, how that is going to work, where the patients are coming from, where the money is coming from and whether that is going to be an ongoing situation or whether it is a matter of trimming the lists down and then reverting back to public?

Ms Gallagher: It is being paid for out of the increased money that we have got going into elective surgery this year. It was $14.7 million over four years.

MR HANSON: So it is all federal funding then?

Ms Gallagher: No, no, because that had some ACT government funding in there as well. So we have got some extra ACT government funding and some extra commonwealth funding. That is assisting us to do the extra volume. We cannot do all

of that extra volume at Canberra or Calvary. Calvary have agreed to 864 procedures on top of what they normally do, and Canberra have agreed to about 162 on top of what they normally do, but that pretty much has those organisations going full bore. There is not much more that can be done there with their emergency work as well. So, in order to get the extra cases done—we think there are probably around 200—that is going out to the private sector. We have let contracts in ENT, plastics and urology, and we are looking in orthopaedics.

MR HANSON: How do you establish the price for that?

Ms Gallagher: It is negotiated through the department and the specialists.

MR HANSON: Right.

Mr Thompson: It is based on what it would cost to be done in the public sector, so we look to ensure that it is not costing any more when we pool work out to the private sector.

MR HANSON: Is there scope to increase beyond the 200? Do you think that that is about the right level, or do you think that it will just clear the lists and then that will be the end of it? Is this a surge or is this an ongoing thing?

Ms Gallagher: At the moment, it is the money that is available. Of course, these things come to budget cabinet every year about how much more you need to do, so that remains under consideration. I think the private sector would tell you that there is more capacity to do more, if we wanted to.

At the moment, we have got a target of, I think, 10,770-odd for the delivery of procedures for this year. That is what we are basing the negotiations with the private sector on. You could do more, but you need more money. You could do that right across ACT Health. It is a matter of budget as well.

MR HANSON: So you think there is capacity to do more if you wanted to, if you had the money?

Ms Gallagher: Yes, if you had the money.

MR HARGREAVES: Minister, could I ask this: this initiative—

THE CHAIR: Through the chair, please.

MR HARGREAVES: Sorry, I beg your pardon, Mr Doszpot. Off to a good start. Good morning to you. I hope you have a very pleasant day. Or I hope I can improve it for you, since it got off to such a shithouse start.

Minister, this initiative, I take it this is just for this financial year only. Those disciplines you have just indicated, are there any other disciplines which are knocking on the door for wanting to have that kind of approach, or are they under control?

I am aware that, when we talk about the waiting lists and waiting times, quite often

people think of one list. In fact, all of the disciplines have their own peaks and troughs and urgency. We laughingly talk about the difference between brain surgery and ingrown toenails, but is that sort of urgency factor taken into account when you actually decide which disciplines have gone out to the private sector, or has it been more about numbers?

Ms Gallagher: There are obviously some things on the list that cannot be done in the private sector for reasons usually around the complexity and availability of equipment. I think the issue that we have looked at under our agreement with the commonwealth is around long waits. When you look at the long waits, you can really put them into those three categories, because they are the non-urgent work in some of those areas. ENT is one of those; a lot of that work would be children with tonsils and grommets, things like that. There is a level where the capacity is in the private sector. It is not as complex as a lot of the work that is done in the major hospitals, and there is a high volume of it. I think that has been directing our decision making.

MR HARGREAVES: You mentioned plastics as one of the other disciplines. What sort of work is that going to be? Is it cosmetic stuff or is it repair? Can you give a little bit of an idea on that, please?

Ms Gallagher: Not cosmetic.

Mr Thompson: It is very definitely not cosmetic; we do not do cosmetic work on the public waiting list. The majority of the plastic surgery that we are looking at putting out to the private sector is what is colloquially termed lumps and bumps. Although that underplays the importance of some of the work, it is things like mole removals, potential or actual skin cancers and those sorts of procedures which are relatively minor procedures and, therefore, can be comfortably done outside of the hospital setting but which are potentially very significant.

MR HANSON: Could I have a follow-up on plastics while we are at it? I have heard that there is a shortfall of plastic surgeons at the Canberra Hospital. There have been some problems there. Could you extrapolate on where we were at with the problems and explain what the issues are and what we are doing to resolve them?

Ms Gallagher: I do not know about problems. There has been a shortage of plastic surgeons dating back to the year of self-government and probably before that. They are extremely specialised and hard to attract. In the past, we have peaked at three fully credentialed plastic surgeons. One of those left the public system about 18 months ago, so we have been operating with two plastic surgeons, which is a very heavy workload. We have been trying to recruit to the hospital, and I think in the next few months we will see considerable success in that area.

MR HANSON: Why did they leave the public system? Was that voluntary?

Ms Gallagher: It was a disagreement between surgeons.

MR HANSON: A disagreement between surgeons?

Ms Gallagher: Yes.

MR HANSON: Okay.

Ms Gallagher: Within the unit.

MR HANSON: So that left the two?

Ms Gallagher: Yes.

MR HANSON: I have heard that there were periods of time when there were no plastic surgeons available.

Ms Gallagher: In the last two months, one of our plastic surgeons was on leave and the other one was not available for the roster, so locums were brought in. I think there were a couple of occasions, periods of 24 hours, where there was some plastics coverage but not full plastics coverage. I think one person was transferred interstate during that time.

MR HANSON: Do you need full plastics coverage to reach the accreditation standards for a hospital?

Dr Brown: In terms of accreditation with the Australian Council on Healthcare Standards, they do not actually set a specific number or ratio of specialties like plastic surgery, so it is not required for accreditation with them. If you are talking about accreditation as a training program with the Royal Australasian College of Surgeons, there is a specific number of surgeons that are required, and we have had some discussions with the college of surgeons. Part of our desire is to reach that number. We have not had an accredited training position since 2001, so we are certainly aiming for that.

MR HANSON: You are looking to recruit interstate?

Ms Gallagher: There are a couple of options on the table. There are some interested plastic surgeons who are doing short stints here to have a look at how it all operates, and there are also some discussions happening with units interstate around the potential for a rotation for their surgeons to really combine a unit. Our unit is always going to be small; that is going to be the challenge for us. It is going to be hard. For those doctors who want to be part of a bigger unit, Canberra will always be a challenge in that regard. We are also talking with units interstate about whether there is the opportunity to rotate surgeons and particularly for training opportunities to come through. So there is a lot of work being done in plastics.

THE CHAIR: Ms Porter, I think you are next.

MS PORTER: Good morning, minister; good morning, officials. I just wanted to talk more broadly, as I said before. I note considerable work is being done in the development of the new structure for ACT Health. Obviously, as you outlined before, you have had a number of successes and a number of challenges. I am wondering where it is up to and what stakeholder groups have been involved in this major piece of work.

Ms Gallagher: This is Peggy's favourite subject, the restructure.

Dr Brown: I am very happy to provide an update on that. We have been looking at a restructure essentially to position the organisation to meet the challenges. We have, of course, growing demands for service delivery. We have the capital asset development program and all that that entails. We are also facing the national healthcare reform and changes coming as a result of that.

We have undertaken a two-stage consultation process. In stage 1, we went out with a discussion paper around a number of forums. We, in fact, conducted, I think, 39 forums over a four-week period. We sought feedback from staff and from unions, and we had over 250 pieces of feedback and submissions. That was essentially looking at the high level structure, and we followed that up by reviewing our proposed structure and going back out with more detail around the changes that we have made to the structure as a result of the first round of consultation.

We also went out with a discussion paper around governance and what might need to change in relation to the governance. Again, we had a five-week consultation process with staff and relevant unions. I think we had 49 forums over that five weeks, and we received about 270 pieces of feedback and submissions. So we are just in the process now of collating that and finalising a structure. We are almost there, but not quite.

MS PORTER: Through you, minister, Dr Brown mentioned the capital asset development program. Could you give us a bit more information about that particular program? Also, how does all of this work feed into any national reforms that are happening?

Ms Gallagher: It is a big question and involves a few people and a long answer. But, in short, the national health reform runs alongside very well the capital asset development plan. Within the national health reform there is agreement and acceptance that hospitals need infrastructure improvements, but we also need to look at the way we are doing things. That is where we are not just looking at the hospital; we are looking at our enhanced community health centres and some of the opportunities that exist to provide services in the community. That very much runs along the general theme of the national health reform agenda, which is to better identify opportunities for primary care and community health services prior to the demand actually hitting the hospitals. That is very much part of the capital asset development plan work.

I think the Belconnen enhanced community health centre and the Gungahlin community centre should be complete by the second half of 2012. Particularly with the Belconnen one, which will be the larger one—it is about a $50 million project—you will see the opportunity for some of those services to come out of the hospital and to be provided. Things we are looking at include the opportunity for potentially—we were talking about this yesterday—offering some cancer treatment in the right setting. I think renal would be part of that on the north side as well. So, traditionally where you have had to come to an acute setting for health care, we are really trying to be creative in how we can maximise the opportunities where you could receive that care close to home and in the community.

MS PORTER: Thank you.

Ms Gallagher: The capital asset development plan is a bigger piece of work. If you want an update on that, Megan Cahill is probably the best person for that.

THE CHAIR: Thank you, Ms Porter. Ms Bresnan has indicated she has got a supplementary, and then we will come to you—

MS PORTER: I am just waiting for Dr Brown to finish.

THE CHAIR: Sorry.

Dr Brown: I was just going to add to the minister's comments in terms of the restructure. Part of what we have done within the restructure is to align staff who currently are in the community health division. We have transferred them into other divisions and we have aligned community and ambulatory and in-patient care. We have those staff working as a continuum, aiming to enhance the patient journey in a more seamless way. I think that is an important point.

MS PORTER: Thank you very much.

THE CHAIR: Ms Bresnan.

MS BRESNAN: My question is actually in relation to that. On page 5 you talk about some of the achievements that have been made through efficiency savings within Health. It mentions the patient journey being one of them, but it also mentions that ACT costs per admitted patient are now closest to the national average. I think it is about three per cent above the national average. What strategies are actually being used to get those hospital costs down in terms of those efficiencies?

Ms Gallagher: The background is that in, I think, about 2002, as it says in the report, it was about 30 per cent above average. In 2006, as part of the functional review, we set ourselves a target of reaching 110 per cent—so 10 per cent above benchmark. I think we gave ourselves five years to do it. So we have exceeded that and we have hit now 103 per cent above benchmark.

It has been in one way efficiency through our own spending, but also you cannot ignore the fact that it is about what everyone else is spending around Australia. As the national benchmark, I guess, is set from all jurisdictions and what they pay for health, that has some influence in that figure. But there is no doubt that it has been a very significant focus of work within the hospital, which is where the large costs are met. Ian or Peggy might want to add to that answer.

Mr Thompson: I can expand on some of the specific activities we have undertaken. For example, we have had a strong focus on nursing recruitment with the objective of employing nurses directly ourselves rather than relying on more expensive agency or overtime arrangements. We have seen a substantial decline in our costs for agency nursing in particular. That obviously improves the efficiency of those services.

Another thing that we have done when we have expanded services is to look at economies of scale. One of the features that the ACT health system will always face is that being a relatively small system it is hard to achieve economies of scale. But as we develop our services and as we expand them, we are looking for opportunities to achieve economies of scale. By doing that, we have increased the overall efficiency as well of our services.

Just to emphasise one of the points that the minister made, I think one of the features that we have seen in the trends nationally on health and hospital expenditure is that other jurisdictions are catching up to what the ACT was spending. While we have definitely achieved efficiencies, it is not necessarily the case that the ACT has been overspending. Other jurisdictions are reflecting the fact that maybe they need to invest more.

MS BRESNAN: You mentioned the nurses. I know there have been some concerns expressed about the manner in which nurses had to be replaced if there was holiday or sick leave. You mentioned that it was becoming a bit more difficult to get temps to come in. As an example, has the ANF expressed any concerns about some of the efficiencies that have been applied?

Mr Thompson: We have concerns raised by the ANF.

Ms Gallagher: Frequently.

Mr Thompson: But we consult.

MS BRESNAN: Have they raised issues about some of the efficiencies?

Dr Brown: They have not raised any concerns about the substantial number of permanent nurses that we have appointed. It is over 100. I can get you the exact figure, but it is over 100 additional permanent nurses that we have appointed that are replacing agency and casual nurses. The ANF is very supportive of that.

MS BRESNAN: Have there been any other staff concerns in relation to efficiencies?

Dr Brown: I think one of the issues that we have looked at as part of our efficiencies is around our leave management. I think there have been queries around the methodology, not the principle. We have worked through those as they have come up.

MS BRESNAN: So leave management has been the primary concern?

Ms Gallagher: I think the other one that comes to mind from the nurses—they are the substantial costs in the hospital, just because of the numbers of staff alone—is the assistant-in-nursing project. That has had some positives as well. I can see Ronnie is busting to get to the table. That is around a lower level of trained staff. The assistants in nursing sit below the enrolled nurse. We have had a trial of that across a number of wards.

That is two-pronged. It has looked at whether we can have any efficiencies in our workforce, but also at whether there are jobs that RNs just do not need to be doing

and whether they can be supplemented by AINs. I think there are some legitimate issues on both sides around how they work in the hospital. But that is certainly one the ANF have raised with me. It is whether they actually do save RNs any work because of the increased supervision that they have to provide and the very clear role, the limited role, they can have in a ward.

MS BRESNAN: Has that been sorted out through the trial that has been undertaken?

Ms Gallagher: It certainly comes out through the report and the analysis that has been done because the trial has been evaluated. It is not necessarily a clear way forward. There were certainly nurses that spoke about the benefits of having AINs. Again, it is the type of AIN that you have—whether you have a very efficient AIN. It is a small trial.

Obviously, the feedback was very good, but there was also feedback about whether it actually improved patient care. I think there was a lot of good feedback about people having time. It is around serving meals, making beds and doing that sort of thing, which I think patients like a lot. But whether or not from the supervisory structure within the ward it was of huge assistance to RNs, I think if you asked a lot of RNs, they would say, "Just give us some more RNs."

THE CHAIR: Thank you, minister. Mr Hanson.

MR HANSON: As a follow-up to Ms Porter's question about the restructure, I will be very interested to hear more about that. I do not know if we have got time, because there is probably a lot that has been discussed out of these 49 consultations. If we have time, I would like to come back to that and hear about some more detail. More specifically on the capital asset development plan, I think it was in last year's budget that we had $57 million in rollovers. This year it was $50 million.

We have had a number of items go up, notably the car park. I know the women's and children's hospital is increasing in price. There seem to be a lot of changes. I am just trying to get a vision when we are having discussions about the potential of a new hospital—a 400-bed hospital. I know that that is not locked in yet but what is the status of the capital asset development plan? What was the start date, what is the finish date and what is the budget?

Ms Gallagher: For the whole project?

MR HANSON: The plan was that it is a 10-year plan for $1 billion in health infrastructure. But I cannot ever get someone to tell me what the start date was for that 10-year plan, what the end date was for that 10-year plan and whether we are on track and whether it is still $1 billion, whether it is now going to be $2 billion or whether we have pushed it to the right. What was the start date?

Ms Gallagher: The start date will be the first budget that we actually funded the beginning of that work, which, I think, was 2007-08 or 2008-09, would it have been? We did not put any money in in 2007-08. 2008-09; there you go. That would have been the first allocation. Yes, it was 2008-09. That was the first budget that we put allocations in. At the time, I think we were always clear that it was a 10-year

commitment in excess of, we always said, $1 billion. I think if you look through the annual reports, you will see that the work which will bring this all together is the project definition plan for the entire project.

That is outlined, I think, in this annual report and the annual report before that. Health redevelopment is not a static process. So I do not think in 2008—well, I know that in 2008 we had an idea of what we needed to build, but we had not drilled down into that very specific final detail.

In a way, you cannot do that until you provide the resources to do that, which is what we did in 2008-09. A component of that funding was to drive the project definition plan and do all the consultations with staff about how it should look. That work is almost finalised now. I am hoping that it will go to cabinet before the end of this year.

MR HANSON: Right; so that plan will include what we are doing in the north of Canberra, will it? We have had this discussion previously about the five months of working out what we are going to do with Calvary or a new hospital, will that be incorporated in that body of work?

Ms Gallagher: It has not been specifically incorporated, because it has sort of been running alongside. The project definition plan is very specific work around what beds are needed, what the design, particularly at TCH which is where the majority of the work will be done, should look like. But I agree that in a way you cannot separate them either.

MR HANSON: It seems that we are going to have a project definition plan that looks a lot at the detail whilst we have still got to decide what we do with Calvary and are we building a new hospital hanging out there in the mix as well.

Ms Gallagher: That does not necessarily have to be part of the project definition plan. What that has assisted us with is knowing how many beds we need on the north side of Canberra. You do not necessarily say they need to be at Calvary or they need to be in a new hospital. It gives you the framework of what type of services you need and how much of them you need. But I agree, and they are the discussions I have been having with Health around how we pull that together so that the infrastructure plan for Health is across the board. It is north side and south side and the community health centres as well.

MR HANSON: I am just trying to get this into my head. The project definition plan will say we need X number of beds for Canberra, for example—I will just pick a figure of 1,500—and then you need over a period of time, because I assume this is planning—

Ms Gallagher: Did you say 1,500?

MR HANSON: Yes, I am just picking a figure that will be—

Ms Gallagher: No.

MR HANSON: I do understand that it will not be that but if I said anything less you

would say that we are underselling it. So I am far better saying more than less, am I not?

Ms Gallagher: Yes.

MR HANSON: Yes, I will pick a figure of 10,000 beds. Whatever that figure is, you would then say that that plan would say, ideally, that you would have a certain percentage on the north, a certain percentage on the south and then that is the project definition plan. Would the next body of work be to determine how that is delivered? Is that the way it is working?

Ms Gallagher: In a way, the project definition plan will very much set out the precinct plan for Canberra Hospital—this is what we expect it to look like and this is what needs to be in it. It has been heavily consulted. That is the reason why, I guess, in 2008 that detail was not provided. I think Megan Cahill's area has spent the best part of two years working with every clinician and interested person around how this should all be put together.

Calvary has been running alongside. Because we do not own or manage it, we could not do that work. It is really work that they should manage. But we have been talking to them about it. They are certainly involved in the capital asset development plan. There is a senior group that meets. Our thinking around what services we have to provide has been part of that. What I am trying to do now, because we have not reached agreement with Calvary about the way forward, is pull together the project definition plan and what we expect we need on the north side of Canberra so that we can come out with a reasonable picture of what the costs are for doing all of this.

MR HANSON: All right. What is the time frame? I suppose this is needs driven, is it not, based on the demographic work that you have done?

Ms Gallagher: Yes. Look, we expect our health needs to peak about 2018 to 2021-22. So that is the time frame. We are updating for population projections as well.

MR HANSON: Okay, so you are looking at what essentially we will need in place at that point?

Ms Gallagher: Yes.

MR HANSON: And building towards that?

Ms Gallagher: Yes.

MR HANSON: And the project definition plan will give us that view?

Ms Gallagher: Yes.

MR HANSON: Because it is something that we will probably have to discuss in the Calvary inquiry.

Ms Gallagher: Yes.

MR HANSON: It is difficult to get a view of some of the restructures and some of the other stuff that is occurring if you do not have that longer term view about where we are actually heading to.

Ms Gallagher: Yes.

MR HANSON: If you are trying to do an analysis of what is going on in phase 1, does that actually make sense? I am just trying to get an idea of what you are going to do.

Ms Gallagher: For example, we know that Canberra Hospital will be a hospital in the order of 800 beds. At a very high level, it will be the regional tertiary referral hospital, as it has always been. On that site you will see the most highly complex kind of work done. We know that we need around 400-odd beds on the north side of Canberra to complement that; so we believe over the system as a whole we need around 1,200 beds.

The decision about how you allocate those beds or manage those beds on the north side is subject to further discussion. But we know that at a high level. This project definition plan really goes to how you deliver that, how you stage it and in what time, because we have got to keep a hospital functioning at all times on that side. So this goes to how you manage that.

You can see the work coming together where you are developing the two ends of the precinct in order to shift some of the services out of the middle of the precinct. So you will move out women and children, Mental Health will go down there, the car park is there, and that will give you some capacity to redevelop that mid-block, which is really the majority of the work that has got to be done.

MR HANSON: I think my colleagues are getting twitchy. Maybe I can get a briefing separately.

THE CHAIR: We will move on. Mr Hargreaves.

MR HARGREAVES: Minister, you mentioned patient disruption during the redevelopment phase, and we are talking about a 10-year plan. I would be interested to know how you are going to manage that provision of services on site at the same time as turning this into the best hospital in the southern hemisphere. It is, I would imagine, a challenge, particularly when you have the ageing infrastructure of the tower block and building 10, and those sorts of things. The whole hospital is going to look different. So there is going to be an issue around provision of services to patients while you are actually building around them. How is that going to be managed?

Ms Gallagher: A lot of work goes into that. Certainly, the first 18 months of significant construction on that site has given us a good indication of the work, and really we have been developing the periphery of the site. The neurosurgery suite should not be underestimated in terms of the complexity of that job. That was essentially putting a five-tonne magnet inside an operating hospital and building an operating theatre. You do not put the five-tonne magnet in last; they built the

operating theatre. But that happened right inside a very busy part of the hospital—admittedly, in a void—so we have already had experience, I think. The mental health assessment unit was built inside the emergency department while the emergency department was running. The SAPU was built underneath the neurosuite just near the emergency department, again, while the hospital was running.

I think Health have good processes. In the next five to 10 years, though, we will not just be building wards and units within units, which I think Health are very skilled at. Even the diagnostic mammography unit sits inside what was a cupboard, I think. It has been extended a little bit. So they are very skilled at managing these projects whilst continuing services. The thing we are conscious of is the magnitude of that, and that will come at significant cost, because you will have to put in cost mechanisms to manage it. Whether you do that with the work happening at night or out of hours, everything comes with a premium. I think less about patients, because I think the staff work very hard to minimise disruption to patients. The issue is going to be for staff who work in a construction site for 10 years, some of them, from beginning to end. So they are the things that we are working on.

MR HARGREAVES: I do recall being at the hospital when the D&T block was actually built. The difference then, of course, was that it was a facility that was put on to the side of an existing facility, and then those same services transferred from elsewhere in the hospital to that particular facility. So it was a bit like having the car park being built next door. It is not a problem; it is just a pain in the butt when you are trying to drive past it. But when it was completed, it was sweet.

I was concerned about how we can actually manage the patient disruption. And is that minimisation perspective actually driving part of the time line? To minimise the disruption, one of the ways of doing that is to actually spin the time out a little bit. Is that going to be part of the process?

Ms Gallagher: If you wanted to build a greenfields hospital of the size we are looking at—Canberra Hospital—it would take you half the amount of time that we are taking to redevelop a brownfield hospital. I think there is definitely a time, and that is around the staging of the development. That is why any change to the tower block or building 3 has to occur once the women's and children's, the mental health and the cancer centre really are up and running.

Anyone who has been out to the hospital lately will see that where the pool used to be—back in those glory days—that is now all demountables up there for office allocation. We are also taking over the North Curtin primary school from the ESA. We have just leased that with LAPS to be another place where we can put non-essential hospital services close to the hospital so that we can minimise people going to the hospital when they do not need to be at the hospital. So it is certainly a timing issue. Certainly, part of our thinking in terms of the way forward on the north side option is the impact of a brownfield redevelopment.

THE CHAIR: Minister, this comprehensive health report seems to have left out a fairly important part and something that is a lot of concern to Canberrans—that is, autism spectrum disorder. Why isn't autism mentioned within the annual report?

Ms Gallagher: This is an issue that I have discussed at length with people like Bob Buckley—whether autism is a health condition or a disability. I know there is disagreement around that. If you are a person who has autism who has associated medical issues with that—and many people do—those are managed as part of ACT Health. But there is not a specific autism program. People with autism would access every service across ACT Health, whether it be paediatric care, aged care or mental health services. It is an integrated part of it. I know there is disagreement around whether or not autism is a health or a disability matter.

THE CHAIR: Does the ACT health system offer any diagnostic or treatment services for autism spectrum disorder?

Ms Gallagher: I think health professionals would be involved in some of those. For example, a child may be referred from Therapy to see someone in ACT Health as part of forming a diagnosis. So, in that sense, Health will be involved, where appropriate. Staff in Therapy ACT or private sector specialists or general practice professionals are also involved in reaching the conclusion around a particular diagnosis.

THE CHAIR: Minister, did the ACT health department tell the COAG mental health group that autism is a pervasive developmental disorder and not a mental illness and that it should not be considered as a mental health issue?

Ms Gallagher: Did ACT Health say that to a COAG group?

THE CHAIR: Correct.

Ms Gallagher: We would have to check. It does not sound like Dr Brown.

THE CHAIR: Which ACT government agency should be responsible for diagnosis, treatment and rehabilitation of children with autism spectrum disorders?

Ms Gallagher: I do not really want to get into the argument around whether it is a health issue or a disability issue. At the moment, that responsibility rests with Disability, Housing and Community Services. But, as I said, for a number of those individuals who might be being diagnosed, ACT Health may be involved in a lot of their assessments. For example, with hearing, audiology and things like that, it is very likely that ACT Health is involved in some way. Having regard to the thinking around the country, my understanding is that this responsibility usually rests with, say, the department of human services or whatever.

THE CHAIR: Are there any discussions between your department and Disability on this, or should there be more—

Ms Gallagher: About who has responsibility?

THE CHAIR: Yes.

Ms Gallagher: Not that I—

Dr Brown: There are ongoing discussions around this issue and about provision of

services that I am aware of. Paediatrics and mental health, I guess, are the key areas. Certainly, there have been discussions from time to time with those agencies, community paediatricians and Disability, Housing and Community Services.

In relation to your previous question, pervasive developmental disorder is a terminology that is used within the DSM-IV, which is the manual for classification of mental disorders. I think autism is not accepted by all professionals as a pure mental illness. It has a developmental component to it. So we will check that statement in relation to what was said, but I do not think it is incorrect to use the terminology "pervasive developmental disorder".

THE CHAIR: With the questions that I have just directed to the minister—what sort of discussions are in place between Disability and yourselves, and should there be more of a dialogue on determining just who is responsible for this area—I would like a little bit more of an answer.

Dr Brown: We will take that on notice.

THE CHAIR: Thank you.

MR HARGREAVES: Chair, could I ask a supplementary to yours, please?

THE CHAIR: Certainly.

MR HARGREAVES: Would it be fair to say that the determination of the lead agency responsibility in terms of Disability or Health rests with the fundamental issue at stake? If we are talking about a person with a disability, physical or intellectual, it would be the Department of Disability, Housing and Community Services. The secondary agency would be dealing with any either resultant or additional issues, whether they be social or health related. Would I be right in assuming that, in this particular case, it has been hitherto the case that, with autism, its lead agency status has been with DHCS?

Dr Brown: Yes, that is probably a fair comment. It certainly depends on whether you are looking at specific medically focused treatment or whether you are looking at support services—if you are looking for speech therapy or at managing behavioural challenges. So it very much depends on what is the actual requirement and what is the focus as to who is the primary agency.

MR HARGREAVES: Am I also correct in assuming that, in most cases of disability, there is a partnership arrangement so that we actually talk about the person in a holistic sense, with that partnership being slightly skewed, depending on which is the primary condition we are talking about at the moment? If, for example, we are talking about people who are wheelchair bound, again, it will be part Disability, Housing and Community Services and part Health. The weighting depends on the primary condition to be presented?

Dr Brown: That is correct.

MS BRESNAN: My question is in relation to page 95 of the annual report, the

supported accommodation bed occupancy rate. The percentage in 2008-09 was about 96 per cent. It is now 89 per cent in this annual report. I do note the comment there about mental health consumers preferring to wait for single supported accommodation rather than going to group housing. Is that one of the reasons behind the percentage rate going down? It is quite a substantial reduction. Are there other difficulties that have been encountered around that particular issue?

Dr Brown: I might ask Mr O'Donoughue whether he is able to provide that specific information. No. We will have to take on notice whether there is an additional reason for the reduction. It usually runs at around 95 per cent.

MS BRESNAN: But it has gone down to 89 per cent, so I would be interested to know about that. It says that there is supported accommodation, so single supported accommodation would be the preference. I was wondering whether there were other reasons. You might have to take this on notice: what data do you actually use to come up with these sorts of figures—the 96 per cent? Do you look at all the patients that are seen in an in-patient unit and what their needs are?

Dr Brown: This figure represents the actual occupancy of the available beds. We have a regular report on the number of beds at each supported accommodation facility and we have a report back from the operators of those services in relation to the beds that are actually occupied.

MS BRESNAN: So it is the number of patients in the in-patient unit?

Dr Brown: This is community based.

MS BRESNAN: It is community based?

Dr Brown: Yes.

MS BRESNAN: You mention in the information the supported hospital exit program that commenced in 2009-10. Do you have some more information you can provide to the committee about that particular program?

Dr Brown: We will have to give you more information on that. We will take it on notice.

Ms Gallagher: Dr Peter Norrie is away and his replacement is sick today.

Dr Brown: Apologies for that.

MS BRESNAN: That is all right. Will we have to take any mental health-related questions on notice?

Ms Gallagher: We will try to cover what we can but, in that specific instance, I think it would have been useful for Dr Norrie or his replacement to have been here just to provide that detailed program knowledge.

THE CHAIR: Thank you, minister. Ms Porter?

MS PORTER: I did have a supplementary on Ms Bresnan's question, then a substantive question. I think you will be able to answer my supplementary. It is really on how the step-up, step-down facilities are going. I have an interest in those particular facilities. I was wondering how they are going.

Ms Gallagher: Very well. We need more of them.

MS PORTER: In the future plans that we were talking about, what do we envisage?

Ms Gallagher: We are looking at a third step-up, step-down facility for young people between the ages of 18 and 25. The one we opened 12 or 18 months ago is for adults; so 18 to 25s can be and are admitted to that. But I think there has been an identification that it would be good to have a separate service for young adults.

Then there is the young person's one, which is from, I think, 13 to 18. I think we have gone out to a request for tender stage for that third one. There is also the outreach model, which is going out for tender as well.

Dr Brown: It is going out for tender. I do not think we have gone to tender yet for the third.

Ms Gallagher: We have had a pre meeting tender or something. The NGOs have come in and had some discussions. So part of the growth funding in this year's budget will go to that.

MS PORTER: Around readmission or preventing a person being admitted, do you think that is working in that regard?

Dr Brown: In terms of measures of that, we do look at the readmission rate in the mental health facility. Our readmission rate is lower than the national average. Has that changed since the step-up, step-down facilities have come on board? I do not have that data in front of me. My sense is that we have tended to be slightly above and have come down but I would need to double-check that. But certainly anecdotal experience and accounts are that it certainly helps to keep people out of the acute in-patient facilities.

Ms Gallagher: I would say that too. Anecdotally, that is certainly so for the organisations I meet with, particularly the one that I went out to that St Vinnies is running at Oaks Estate just in the last month. They certainly spoke of a number of clients out there whom they are supporting and who have not been to hospital in over a year. These were people that were frequent admissions to the PSU.

Anecdotally, I think there is agreement. I have not met anybody who works in the sector who says that we do not need more of these or these are not a good thing. I think there is agreement that you only want to go to the PSU if you really need to. If there are alternatives to supporting people, we should be looking at expanding those. I think there is furious agreement about that.

Dr Brown: I might add that we are planning a formal evaluation of the adult step-up,

step-down facility. Mental Illness Fellowship Victoria actually operates that, in conjunction with the University of Canberra. It is planning to undertake an evaluation.

MS PORTER: Did you have a supplementary before I get to my substantive question?

MS BRESNAN: Yes.

MS PORTER: I will get back to my substantive question.

THE CHAIR: Ms Bresnan has got one.

Ms Gallagher: I think the occupancy rate for the step-up, step-down is higher.

Dr Brown: About 90 per cent.

Ms Gallagher: Yes, 90 per cent.

THE CHAIR: Ms Bresnan has a supplementary, then Mr Hanson.

MS BRESNAN: This is obviously something I have raised before: people who might be termed homeless or who do not have permanent accommodation and are not necessarily being able to access a step-up, step-down facility. I appreciate, minister, you have said it is determining whether or not that is the appropriate option. Step-up, step-down might be an appropriate option for people. Are there going to be any resolutions to that issue about homeless people being able to access those particular services?

Ms Gallagher: They are not excluded.

MS BRESNAN: They are not excluded?

Dr Brown: No.

MS BRESNAN: When we did ask the question on notice about it, you did say that they generally were not admitted to the step-up, step-down facility. That is not correct?

Dr Brown: No, the information provided for the question on notice was correct. It is not a formal exclusion criterion if you are homeless. But what we aim to do is ensure that we do not get those limited number of beds, in a sense, clogged up by people who are unable to move on. So our preference is to have people have an accommodation option beyond the step-up, step-down before they are actually admitted. But we recognise in some cases that that is not in place. It does not exclude us accepting that individual into the facility.

MS BRESNAN: If that is going to be something which is going to be very beneficial to somebody, regardless of whether they are homeless or not, then the onus should be to actually find somewhere, some stable accommodation for people to move on to, rather than say, "Because you're homeless, we're not going to let you stay."

"Clogging up the beds" is interesting. Whether or not that is a reason for someone not to go there, the onus should be to actually find stable accommodation for people to go to, if that is going to be of benefit to them and stop that kind of crisis keeping on going in their lives.

Dr Brown: I guess what we are trying to do is differentiate. We do not see the step-up, step-down as a housing option.

MS BRESNAN: No, I am not suggesting it is either.

Dr Brown: No. We do not admit people to that to provide them with housing upon discharge. But we do not exclude them being admitted there if they do not have stable housing. We do work to ensure that we achieve that housing so that they do not stay longer than the three months, which is the upper limit of the stay.

MS BRESNAN: If that was going to be a suitable option for them but they did not have stable accommodation to go to—

Dr Brown: They could still be accepted there.

MS BRESNAN: So it is not actually a definite criterion then for the step-up, step-down?

Dr Brown: No. As I said, the strong preference is for people to have an accommodation option beyond their step-up, step-down, but homeless people are not excluded.

MS BRESNAN: There is a very high rate of homelessness amongst people who have mental illness. It is something which is going to be an ongoing issue.

Dr Brown: Sure. But as I say, we do not admit people to that facility just to provide them with housing. They actually need to meet the criteria for the service.

MS BRESNAN: No, that is not what I am suggesting.

THE CHAIR: Thank you, Ms Bresnan. Mr Hanson, you had a supplementary?

MR HANSON: Yes. I want to get an update on in-patient support for adolescents with mental health. It does seem to be a gap in the service and I think there is some work being done around that. Can you update us?

Ms Gallagher: That is right. There are a couple of options for in-patient adolescents with mental health, whether they can be supported in the adolescent ward at Canberra Hospital—and that just depends on the nature, really, of their illness—or whether they can get assistance or support through the PSU. They are provided with additional support, I think, if they are under the age of 18.

At the same time, we have identified a site at the Canberra Hospital for a young persons mental health unit. We were originally thinking of Calvary but the paediatricians, who primarily work at Canberra Hospital, lobbied me very strongly to

rethink that and have it located at Canberra Hospital. We found a strip of land. It is going to be a long, narrow building. We have been doing all that detailed project planning for that. It is really just about funding now. It has not been funded as part of the capital works to date.

MR HANSON: Do we have a view on when that might come online? When are you trying to get it—

Ms Gallagher: It really needs budget cabinet approval now. But that work is being done through this year. It was not ready to be considered by budget cabinet last year. So that work is being finalised for this year and it will be ready for this budget.

MS BRESNAN: There was funding allocated for that. Has that been rolled over?

Dr Brown: For the forward design?

Ms Gallagher: For forward design, yes.

MS BRESNAN: That funding is still there? That has not dropped off?

Dr Brown: No.

Ms Gallagher: That has been used for this.

Dr Brown: We are finalising the model of care, and that informs the design.

MR HANSON: In the interim, people are, in some cases, either lodged with adults—they find themselves with adults—or they are going to Sydney?

Ms Gallagher: If that is appropriate, yes.

MR HANSON: To Campbelltown. That is the closest facility.

Ms Gallagher: Again, it comes to scale. Regardless of who is in government and who is the health minister, this is one of the big challenges when you do not have necessarily the scale. We are just getting to the point now where we have the scale to support a stand-alone unit. I am not just talking about the capital expenditure. It is around the skilled professionals who provide support.

We see it with eating disorders as well. This is partly what the young persons mental health unit will be doing, I imagine—dealing with young people with significant mental health issues but also those who have eating disorders which, I guess you could say, are significant mental health issues as well. But we have not had the numbers to support that level of activity, which is why we rely on interstate services or, in the circumstances where someone is admitted to the PSU, we provide that extra support.

I accept that is not ideal. I accept the PSU is not ideal for anybody, and there is furious agreement around that. The new unit will come on board, and I think that will significantly improve that, including how you support people under the age of 18

within that unit while the young person's unit is constructed.

THE CHAIR: Unless there are any other supplementaries, we are going to take a break in about a minute. Do you have any other questions?

MS PORTER: No, not a supplementary. I have a substantive question.

MS BRESNAN: I have got a supplementary.

THE CHAIR: We will take one more supplementary and we will take a break for 15 minutes after that.

MS BRESNAN: You have said there was not the scale of need for a young persons mental health unit. How does that equate with services like headspace which, once they opened, experienced—

Ms Gallagher: Inundated.

MS BRESNAN: Inundated. They are getting to the situation now where they might have to have a waiting list, because there is that demand, particularly. That is where mental health comes out typically in adolescents.

Dr Brown: We are talking essentially, though, about the difference between in-patient-based treatment and community-based treatment. The strong preference for all clients in the mental health arena but particularly for young people—children and young adults—is for community-based treatment within their natural support structures, wherever possible. In terms of the bed numbers for children and adolescents, essentially we are talking only about six for the ACT and then a slightly larger number for the young adults; whereas if you are talking about community-based treatment needs, then it is quite a different account. Headspace is a community-based service.

THE CHAIR: Thank you very much. This is now the allotted time for our 15-minute break. We will resume the hearing at 11 o'clock. Thank you very much.

Meeting adjourned from 10.43 to 11.04 am.

THE CHAIR: I think we all got caught up in some fairly interesting discussions outside, so my apologies for the slight delay. We will now resume.

Dr Brown: Could I provide some responses to some of the questions that we took on notice?

THE CHAIR: Certainly.

Dr Brown: In relation to the question about supported accommodation, the advice I have is that the reduction is related to mental health consumers who are expressing a preference for their own accommodation as opposed to living in the group houses, which is what the supported accommodation normally is. There are no other contributing factors that we are aware of.

In relation to the supported hospital exit program, this is run by the Mental Health Foundation, and in the six months from 1 January this year to 30 June, we had 22 people supported through that program. It provides outreach step-down support after people have had an in-patient stay. The intention is to review that program in light of the outreach support tender that has been let.

In relation to the question on autism and a statement made to a COAG mental health group, I am advised that there was previously a group meeting that oversaw the implementation of the COAG national action plan for mental health. That was chaired by the Chief Minister's Department but had representatives from ACT Health as well as other ACT government departments and commonwealth departments present. The purpose of that group was to oversee, as I said, the implementation of the COAG national action plan. Autism was not referred to in the COAG national action plan. There was a question raised as to whether or not discussion could occur around some commonwealth-funded initiatives that were outside the national action plan, and in that context there was a statement made that it did not fit within the terms of reference of that particular group. So that is the context, I think, to the statement that you may be referring to.

THE CHAIR: Thank you. Obviously, we did not expect instant answers to those questions, but if anything else comes to your attention, we would certainly like to have any further input on any of these questions.

Dr Brown: I have one other in relation to patients waiting for longer than one year. At the end of the 2009-10 year, there were 830 patients waiting. That has been reduced now to 798. In terms of the breakdown into category 1, 2 and 3, currently we have this for patients who have had their surgery and been removed from the list: seven per cent of category 1s waited longer than the standard time, which is 30 days; 56 per cent of the category 2s, which is 90 days; and 23 per cent of the category 3s, which is 365.

THE CHAIR: Thank you very much. Minister, did you say you had some as well?

Ms Gallagher: No. I just had a document I was going to provide the committee with. It was just released today. It is a discussion paper around implementing a local hospital network for the ACT.

THE CHAIR: Thank you. We will look forward to getting that. I might start the next round of questions. The *Canberra Times* of 29 October reported a number of serious concerns raised by clinicians about diabetes services in the ACT, including allegations that administrative staff were ignoring clinical advice. Minister, have you investigated these concerns? Do you believe they are legitimate concerns, and what actions do you think you will have to take?

Ms Gallagher: I have, and I have had some discussions with one of the doctors involved, one of the endocrinologists. I think the issue has been that we need to get on and recruit the clinical director's position. I think there has been a misunderstanding. Because it was identified in the diabetes plan which was released in 2009, the position was not funded until this year's budget, so it has been funded in the 2010-11 budget. I think a misunderstanding around that has contributed to some people thinking ACT

Health has been delaying the implementation. But that money was appropriated and the position is going to be advertised in November. We have had to consult with unions around the position descriptions. That work has all been done.

I accept that perhaps we could have done this two months earlier. But there has been work underway. There have probably been some communication issues. But once that clinical director is appointed to drive the changes to the service, you will see some of those concerns taken out.

These things are always easy to write up in a newspaper article. The harder things are actually to resolve them. There are some differences of opinion, as usual, about the direction the diabetes service should take, and that really comes down, again, to how much should be done in the community, who should do what in the community and how much has to be managed in the acute setting. Again, I would say there is not furious agreement on that. But I think we need to get a clinical director in to drive that and drive those discussions to try and reach some resolution.

THE CHAIR: In the interim, while such a person is appointed, do you feel that the discussions you have had with the clinical people, the doctors, are sufficient or do you need to have further interaction with them?

Ms Gallagher: I think it is on the right path forward. Again, I do not think it is smooth sailing. I do not think that the appointment of this clinical director is necessarily going to be able to ease all the concerns that exist around the table about the structure of the service and how it is managed. This is part of a national discussion as well. There is uncertainty nationally about how diabetes is going to be managed and the role of organisations such as Diabetes Australia and Diabetes ACT, for example. So there are some changes on foot which, I think, always creates concern. The doctors get frustrated if they do not see things happening immediately or within a reasonable time, and I think there are some legitimate concerns around getting this clinical director's position in place. But that is well underway now.

Dr Brown: Mr Thompson and I are planning to meet with some of the key players as well.

THE CHAIR: Is that both the doctors and the administrative staff?

Dr Brown: The request we have had has come from the doctors.

Ms Gallagher: These are the administrative staff.

THE CHAIR: Yes, I understand that.

Dr Brown: I have an appointment, certainly with one of them, on Friday, but we have flagged that we will meet with a broader group as well.

Ms Gallagher: The only thing I would add to that, though, is that, if you read that newspaper article without knowing what is going on in diabetes day to day, you could be left thinking that children with diabetes were not being cared for appropriately in the ACT. There are 130-odd children with type 1 diabetes in the ACT, and I believe,

and our reports and performance data will indicate, that they are very well cared for. I think that is something that you could have taken from that "officials let down our kids" sort of headline.

THE CHAIR: Thank you for that. Unless there are any more supplementaries on that, we will move on. Ms Bresnan, you are next up with a question.

MS BRESNAN: I have not got a reference in the annual report to this but it is in relation to corrections health and blood-borne virus rates. As I said, it is not mentioned in the annual report, but could you give us a bit more information about the sort of detection programs that have been undertaken in relation to hep C and other blood-borne viruses? Is there some information you can provide about that?

Dr Brown: I might ask Tina Bracher to give you the details. Certainly, there has been a series of quarterly reports in relation to that.

Ms Bracher: We have, over the last 18 months, undertaken six quarterly surveys of the blood-borne virus and sexually transmitted status of people in the AMC. We have reported on those to the minister, to the health minister, to the department of corrective services and to the corrections coalition as a non-government advocacy group. Those data are out there in the public domain. The sixth quarterly report is just being finalised as we speak, so that will come up through the appropriate channels and be reported publicly as well. That is the formal reporting regarding the blood-borne virus survey that we are doing at the AMC.

MS BRESNAN: Obviously, when prisoners come to the AMC they have a blood test. Is that based on that? I understand it is voluntary when they leave to then have that test done.

Ms Bracher: The quarterly reports are a snapshot at a given point in time, so on the 30th of the month at the end of a quarter we do a clinical records audit, and that is the data that we report in those reports. The induction assessments that we do for 100 per cent of the detainees on admission to the AMC also have a process where we assess the blood-borne virus status of prisoners based on a consent process. So we ask in our assessment process whether they know what their status is, whether they are interested in finding out and, if they consent to that process, we facilitate that over the next couple of days of their stay in the AMC.

MS BRESNAN: Is that where most of the data comes from, in terms of the quarterly reports? I appreciate it is at a given time, but is that where that primary data comes from?

Ms Bracher: Yes, that snapshot audit would look back to the induction assessment results. That is right.

MS BRESNAN: Are there any estimates of the number of detainees with a blood-borne virus, or a figure on that?

Ms Bracher: We have reported on that in the quarterly reports.

MS BRESNAN: I cannot recall—

Ms Bracher: I will have a quick scan through here. In the last report for 2009-10, that was at 30 June, there was no HIV identified. There were three cases of recent hepatitis C transmission that were identified.

MR HARGREAVES: Did you say "recent"?

Ms Bracher: Yes, recent, and I was going on to explain that "recent" means in that third quarter there were three people that had hepatitis C confirmed. But in that quarter those people had spent some time in the AMC and some time in the community, so it was very difficult to clarify where that transmission had actually occurred.

MS BRESNAN: So it could potentially have been in the AMC?

Ms Bracher: It could. It could just as likely—

MR HARGREAVES: Or potentially not.

MS BRESNAN: No, but it could potentially be in there, too.

Ms Bracher: It could just as likely have occurred in the community as well.

MS BRESNAN: I understand there is difficulty because of when infections become evident as well. Obviously, there is a confidentiality issue with this as well: are there any estimates of numbers of intravenous drug users in the AMC?

Ms Bracher: I do not have that data with me at the moment. The data from the May 2010 health survey is just being finalised through the epidemiology unit in population health, and there will be some indication in that data as to the rates of intravenous drug use prior to incarceration.

MR HARGREAVES: Mr Chairman, I have a supplementary when Ms Bresnan finishes.

THE CHAIR: Yes, fine.

MR HARGREAVES: I am aware that one of the issues confronting us in terms of the good health of those people detained at the AMC is that predominantly, for those people who already have an infection, a blood-borne disease, it comes from previous exposure to interstate institutions. I am aware that when we look at whether or not our particular regimes are efficacious, we need to be looking at the episodes where they occur in people for whom the AMC is their first visit to a corrections institution.

I know the levels that applied at Goulburn, for example. When those people transferred to the AMC, the numbers went through the roof, and you would expect that. But I am trying to get a handle on the number of people for whom, when they go into the AMC, it is the first time they have been put into a prison, and how they are coping. Are those three people that you have indicated here in that cohort or the

previous one?

Ms Bracher: I cannot answer that. We do not drill down to that level in our quarterly report. We just do a snapshot of whether they have or have not been in contact. The inmate health survey does drill down into great depth in terms of the social background of the inmates that were surveyed in terms of how many times they have been incarcerated and where that incarceration had been prior to the inmate health survey, including the rates of intergenerational incarceration within families.

THE CHAIR: Thank you. Unless there are other supplementaries, we will move on. Ms Porter.

MS PORTER: Thank you, Chair. Minister, we have just been talking about particular blood-borne infections and I am interested to know about our health status in the ACT compared to other states. What are the figures telling us by health indicators for us in the ACT compared to other states?

Ms Gallagher: I think the Chief Health Officer's report is the most up-to-date data on that. Did that come out after estimates? It must have.

MR HANSON: Yes, after estimates.

Ms Gallagher: That shows just how healthy the ACT population is. I think that our high immunisation rates, life expectancy, quality of life—all of those things—are much better than the national average. I think, though, with all those positives, the data in the Chief Health Officer's report indicates areas of concern. It is really around the prevalence of chronic disease in the community. That, I think, would be the standout one to me.

When I asked the Chief Health Officer what area of his report concerned him the most, his reply—and he is not here today—was the level of hospital admissions related to alcohol, which has increased significantly over the last 10 to 15 years. That is why the Chief Health Officer's report is very useful—it gives you sorts of areas to focus on. When we look at the health demands of the future, we are starting to get a picture, I think pretty exactly, of what those are going to be.

MS PORTER: The report also mentions on page 147 the objective of reducing the incidence of cardiovascular disease in the community.

Ms Gallagher: Yes.

MS PORTER: Could you expand a little on how we are going to manage that?

Ms Gallagher: Sure. I do not know if there is someone here who can come and talk to the healthy futures program. In the last couple of years we have put increased funding into this area to focus on maintaining healthy lifestyles. Dr Pengilley is the Acting Chief Health Officer. The question was around the healthy futures and what is being done to address chronic disease management.

Dr Pengilley: Specifically with respect to cardiovascular disease?

MS PORTER: Yes.

Dr Pengilley: I think it is recognised that if you are going to prevent cardiovascular disease you really need to look at the determinants of cardiovascular disease fairly early on. The major ones are things like obesity, inactivity, which then also has an effect on incidence of diabetes, and then risk factors like tobacco smoking. There are programs being run that address all of those. They are run substantially through the health promotion branch—things like programs to promote additional activity amongst school children, programs to try and shift people's eating habits away from junk food towards more healthy food. There is a specific program to try and get people, particularly children, to drink tap water as opposed to soft drinks. That is a long-term strategy that is really aiming to reduce the rate of obesity and increase activity in a way that will prevent cardiovascular disease in the community.

Smoking is obviously another big focus. We have got legislative approaches and health promotion approaches to that in terms of trying to reduce the amount of smoking that people are exposed to in the workplace and in recreational areas. Then moving to the more acute, we have secondary prevention projects. All the ones I have mentioned will be primary prevention, which is trying to prevent people from getting cardiovascular disease in the first place.

You also have secondary prevention, which is, basically, once you have got a disease, how do you prevent it becoming worse? Say you have had your first heart attack. How do you prevent that becoming a chronic heart failure and a disability problem? Through clinical services—although that is not my area—there are a number of programs running, for example, cardiac rehab programs, and better case management to improve that. Does that answer your question?

MS PORTER: Yes, it does, thank you.

MR HANSON: I have got a politics in the pub debate with Michael Moore and I am arguing that you cannot legislate against laziness in the health context. If anyone has got any ideas for me, send them in.

MR HARGREAVES: They are too lazy to answer the question.

THE CHAIR: Thank you, gentlemen. I think Ms Bresnan had a supplementary.

MS BRESNAN: I did. It was actually about the health promotion grants, which are obviously about preventative health. The report notes on page 152 that there has been an external review commissioned of the health promotion grants. I am just wondering whether you can give us any information about the recommendations that came out of the review.

Mr Woollard: The question was around the—

MS BRESNAN: The external review of the health promotion grants. Can you provide us some information about the recommendations that came out of that?

Mr Woollard: A number of recommendations were made. Primarily, they were around the way in which the grants scheme operated, for instance, about introducing an electronic application form, the way in which the panels are set up and managed. There were no findings that there were major problems with the way the grants scheme was run. It was really about strengthening the robustness of, as I said, the application process, the way in which the criteria are linked to priorities of the government et cetera.

MS BRESNAN: There are national standards around how those grants operate. Was that in line with the national standards? As you said, it was mainly about the operational factors and not actually about the actual program.

Mr Woollard: And making sure that the grants programs align with both government priorities and the national priorities around that.

MS BRESNAN: It was found that they do that?

Mr Woollard: Yes. It was found that there was some room for improvement, but no major problems at all. It was about strengthening rather than going back and reinventing them. There were no major problems with it at all.

MS BRESNAN: Thank you.

THE CHAIR: Thank you, Ms Bresnan. Mr Hanson.

MR HANSON: Thanks. Minister, regarding the clinical review into obstetrics—if I could just quote a couple of excerpts from that: "Evidence of systemic reticence to address staff performance issues in the maternity unit at the Canberra Hospital, a total lack of cohesion with the executive staff at the Canberra Hospital where the reporting lines were perceived as blurred between the Canberra Hospital management and ACT Health, staff members stretched to the limit with workloads with a lack of staff, on-call registrars expected to cover multiple areas, creating potential clinical risk for a patient and extensive barriers for medical staff interested in working at the Canberra Hospital. These include the excessive workload and perceived cultural resistance at TCH," and so on. Do you now accept that there was a problem, or there is a problem, and that this was more than simple mudslinging and doctor politics?

Ms Gallagher: Well, I am happy to revisit this, as we have covered it a number of times since that review has been released.

MR HANSON: Well, we have not since the report has been tabled.

Ms Gallagher: I cannot believe that. Are you sure it was not done before estimates?

MR HANSON: I am sure it was not done before estimates.

Ms Gallagher: We certainly have visited it a lot in the Assembly, extensively in question time and in motions before the house, which have allowed a fairly vigorous debate around it. We have just finished a consultation process around that review. It is fair to say that some of the feedback we got was around the accuracy of that report by

staff working at the Canberra Hospital and concern that they were not given the opportunity to correct that before that report was released. That is just a bit of the history, I think, to the dynamics that exist around this service at the moment. I accept—and I think I have said it publicly a number of times—that there are things that should have been done that were not done and I think some of that is reflected in the report.

MR HANSON: But your response when this initially arose in February was to dismiss the concerns. I remember this was across ACT Health. There were statements made by you and by senior staff that complaints had not been made.

Ms Gallagher: That is right.

MR HANSON: It turned out that that was not the case—that complaints had been made and errors made. Are we confident that we have learned from what occurred in obstetrics in the clinical review? Can you let me know where we are at with the other review that is being conducted by Dr Price—is that right?

Ms Gallagher: I will let Dr Brown do that because I know as much as you know about the public interest disclosure review, Mr Hanson. In relation to the advice that I received from my department around whether any complaints had been made, the initial advice from my department to me was that there had not been and, indeed, it was not until a staff meeting was held at my request at Canberra Hospital, I think on one morning, that concerns were raised in that forum. That was after I had made those comments.

The comments I made in the media—I think we have been through this a number of times—were around private obstetricians and whether I had got any complaints from them, and I had not. So I stand by those comments. I also stand by the comments that there was doctor politics involved. But the minute that we were made aware there were concerns within that unit from staff in the unit those were comprehensively acted upon.

I think lessons have been learnt around how to respond to workforce issues that have not progressed to the area of serious complaint or, indeed, formal complaint. I think we have learnt a lot. Peggy has been leading that work, to her credit, as the acting chief executive. I think she was in the job for about 10 days before all that blew up. She has gone in and really put a lot of effort into responding, not just in obstetrics but system processes across the hospital. In relation to the public interest disclosure, Peggy?

Dr Brown: I can provide an update. That process is not yet finalised. I do, however, anticipate that it will be finalised in the near future. I expect that we will seek to provide advice, as much as I can, in relation to that particular investigation once it is finalised, because I am aware of the significant degree of public interest.

MR HANSON: That is right. I was just trying to get a sense of what gets released and what does not. I do understand there are requirements to protect individuals and claims against individuals but, as you say, there is a public interest. How do we balance that, particularly if some of the allegations involve—I do not know—you,

other administrators or people in the Canberra Hospital that would perhaps have a real interest for it not to be released and are the people that are making the decisions about what does get released? Who does make that decision? Is there an independent authority that does? How does that work?

Dr Brown: I make that decision as the delegate in relation to that matter. I do need to be very careful to act within the provisions of the legislation and protect confidentiality, but what I would seek to provide in a statement is some indication of whether it has been finalised and what actions might be taken as a result of the report that has been received, because I think that is what people really want to know.

MR HANSON: All right. Do you have an estimate of when that process will occur?

Dr Brown: Within two weeks.

THE CHAIR: Just a supplementary on that. Is there any potential conflict of interest from your point of view in making that decision?

Dr Brown: I do not see a conflict of interest. Within the provisions of the Public Interest Disclosure Act, I am the relevant delegate, the decision maker, that it comes to. As I say, I am very mindful of the public interest that exists around this particular matter, but I am also mindful of the provisions of the legislation. So I would seek to find a statement that can provide information without disclosing what should be maintained as confidential.

MR HARGREAVES: Mr Chairman, a supplementary?

THE CHAIR: Yes.

MR HARGREAVES: With respect to the public interest disclosure legislation, is it explicit in that legislation that the minister of a particular agency is actually precluded from being involved in that process along the way?

Dr Brown: My advice is yes, it does specifically speak to that.

MR HARGREAVES: So it would be illegal for the minister to be informed along the way about the details?

Dr Brown: Certainly the minister has not been informed along the way.

MR HARGREAVES: I mean any minister. It could be the minister for TAMS, for that matter, because it is an overarching piece of legislation.

Dr Brown: We have respected the provisions within the legislation around the confidentiality.

THE CHAIR: Thank you, Mr Hargreaves and Dr Brown. Minister, in the 2009-10 budget, you allocated $12 million to GP workforce initiatives.

Ms Gallagher: Yes.

THE CHAIR: By now, about $4 million was due to have been allocated. How much has been actually provided by way of support to GPs to date?

Ms Gallagher: We probably need to take that on notice, because there is money that has been allocated that might not have been spent. I can give you an example: the GP scholarships within the ANU Medical School. We worked with the ANU Medical School around criteria for those scholarships. Those criteria are under review, because there has only been one scholarship that has been successfully awarded under the criteria. I have spoken to Professor Glasgow around whether we need to be a bit more innovative around the criteria for those scholarships. The money is there. It has not been removed or anything but it has not been allocated because of the criteria.

In relation to the infrastructure funds, we have had two rounds of infrastructure funds and in the order of $800,000 of that $1 million allocation has gone. The teaching incentive payments are being paid, which is the $300 a day for taking a student on in your practice. That is financial compensation for the fact you have to block out several appointments in order to provide feedback. What was the other component? The PGPPP positions are being filled. The money has certainly been appropriated. It is a question of whether it has been finally allocated.

The aged day care service is the other one. The money for the aged day care service has been rolled over, as we have given an extension to the successful tenderer to get that service up and running. I think we have given them until January, when it was anticipated that it would start in the second half of this year. I think it is the division within CALMS that has won that tender.

THE CHAIR: I have got two supplementaries. One, you just mentioned the aged day care. Can you explain why the GP aged day care service was limited to business hours and whether there are any plans to increase its capacity to deliver services outside of ordinary business hours?

Ms Gallagher: In the first instance, CALMS provides an after-hours service for us under the contract, which is over $1 million a year that we provide, for after-hours GP care. This very much was a targeted day service. You could have made it extended hours. You would have had to expand the program. Whether you could staff it, when we already run an after-hours GP program anyway, would be another question.

But it was around providing in-hours healthcare, which was identified as a deficiency for residents of aged care nursing homes. So it was really the in-hours care, where we were seeing people come to emergency. They were not coming after hours. They were coming in hours to the emergency department or GPs were unable to get out of their surgeries during business hours to visit them. So it was the gap that was identified.

THE CHAIR: What you are saying is that there are no plans to deliver outside of hours.

Ms Gallagher: Let us give it a go. The division within CALMS will have to staff that. I think it is reasonable in the first instance to start it with day care, day hours, and then see how it operates and the demand for the service.

Dr Brown: To add to that, I am advised that CALMS does provide visits to residential aged care facilities out of hours already.

THE CHAIR: Thank you. My second supplementary was with regard to the recipients of the GP scholarships. How many of the recipients of the GP scholarships available to third and fourth year medical students will be remaining in the ACT? Do you have any numbers on that?

Ms Gallagher: Only one has been awarded, and that is to, I believe, a third-year student. They have not finished their university training yet. The idea is that they come back and work once they have finished all their training, but that is much longer term. Obviously what they will do is finish their university. Then they will have to work for several years in a hospital setting completing their training. Then they will go on to specialise in general practice. This will benefit the community in the future. There are models where we have based this on of having, in the contract, someone return and work through that.

THE CHAIR: How many actual people, doctors, are involved in this third and fourth-year category?

Ms Gallagher: Cohort?

THE CHAIR: Cohort.

Ms Gallagher: There are about 90 students per year.

THE CHAIR: Does the fact that only one has taken it up mean there is a problem with the scholarship or is there anything—

Ms Gallagher: That is exactly it. Maybe it is too restrictive in this instance. There are some issues around tax, around other scholarships, around other students on other scholarships and how it interacts with those scholarships. You are excluded if you are already in receipt of some other financial assistance. I think we are targeting one to an Aboriginal or Torres Strait Islander student. That is a designated scholarship which excludes the majority. They are the issues that, I think, the ANU Medical School and the government are trying to work through.

We want people to use the scholarships. That is what the money is there for. But I am also not going to allow it to be such a free-for-all that it goes to people that do not really need the financial support and are not really committed to Canberra either. I am sure, if it got to that point, we would reassess that funding and look at another way we could provide that—to support research and training or something like that for general practice. But it is under review, I would say.

THE CHAIR: Thank you. Dr Rashmi Sharma, president of the Division of GPs, seems to suggest that the government is not doing enough, according to an ABC media report a few weeks ago, in terms of assisting GPs. How do you react to that?

Ms Gallagher: That was from Rashmi?

THE CHAIR: That is my understanding, yes.

Ms Gallagher: I meet with Rashmi all the time. It is certainly not something that she says to me. There is the work that the taskforce did, the work that your committee did, the work that is going on in the department, the $12 million program, the work that we have done across the hospital. The division surveyed their members around perceptions of ACT Health. We have surveyed ACT Health about perceptions around GPs in order to identify the blockages around interaction. There is the work Owen Smalley's group is doing around e-health and improving connections between general practice and ACT Health. Rashmi Sharma and the division are very involved in all of those.

There was a report, I think, on Friday around cutting red tape. Rashmi Sharma rang to explain those comments. I think they were largely in the commonwealth's area of responsibility. My response has been that we have been trying to reduce red tape for general practice but also acknowledging that there needs to be some accountability for the support that we are providing as well. So it is a bit of a balancing act.

But I think relations with the Division of General Practice are very good. There is a designated doctor phone at the hospital now, which is something that they have asked for so that GPs do not have to ring that 44222 number and get put on hold. There is a designated nurse who can answer their concerns, who answers that phone and chases up people if they need to be chased up. There is access to the clinics and the out-patient lists so that GPs can have a look at that in their own time and work out what is the appropriate clinic for somebody to go to. I think all of that is significantly improving interactions between general practice and ACT Health.

THE CHAIR: Thank you very much. Ms Bresnan?

MR HANSON: I have a supplementary on general practice, if that is possible?

MS BRESNAN: Sure.

MR HANSON: The $15 million superclinic that was promised by the federal government at the last election, do you know when that is due to be delivered?

Ms Gallagher: I saw a media release that went out two days ago around the community consultation process. So the guidelines are out. My understanding, from my meeting with the health minister, is that the $15 million is already appropriated. I think it will be up to consortiums now to apply for that money. I know of several consortiums that are interested. That ranges across partnerships with universities to community-based organisations that are interested in it as well.

MR HANSON: Do you have a guarantee that we will not see more closures of small clinics as a result of it? This is what has happened.

Ms Gallagher: I cannot guarantee that. No-one can guarantee that. They are individual business decisions. My discussions with the federal minister have been—

I met with her specifically around this—to encourage her to approve one that would benefit the ACT on a number of levels, whether it be research and training for students, connections particularly with research organisations and not drawing out GPs from existing practices. I said I would be very supportive of a model that sought to do that.

MR HANSON: But are you concerned that that is what is potentially going to occur? That concern, I think, was raised by the AMA and others. If you put a $15 million structure somewhere and there is a consortium, as we have seen with primary health, smaller practices close because it is an attractive option for GPs. They get paid good money and it is, in some circumstances, easier for them to work in that environment.

Ms Gallagher: They do not get paid any money. The $15 million is capital. They get a nice building. They then run their practice inside there.

MR HANSON: Yes, but the consortium itself would be looking for GPs. That is my point. Obviously they offer wages.

Ms Gallagher: I would like to see—

MR HANSON: What we have seen historically is that the small practices, when this occurs, close, to fill up the positions within the superclinics. Are we concerned that that is going to occur? That is not going to be a good result if we are just simply robbing Peter to pay Paul.

Ms Gallagher: Really my discussion with the minister was to get that $15 million used to its best advantage possible and whether that is a partnership with the ACT government. Whether it is possible to build on that $15 million to make it something that could attract services other than GPs is one idea. I understand what you are saying.

I would not necessarily support the allocation of $15 million to a stand-alone service, whether it be isolated, with no research or training capacity. That would not be what I would see as the ideal outcome here. If the commonwealth has got $15 million to put into GP infrastructure through this fund, then let us use it but let us use it in a way that is going to deliver the outcomes we want, which is no fights with general practice around the city about who has got what unfairly and whether it will impact on their business, whether there is a research and training capacity, whether there is a future with the universities and whether there is a future with some of our community health programs. For example, the role of nurse practitioners and allied health practitioners as well is part of it. That, to me, would be the ideal outcome. But I am not the decision maker.

MS BRESNAN: A part of the reason why you have seen the smaller practices closing because of the bigger practices is partly the Medicare numbers. That system is established as well. That has an impact. If they just keep adding numbers, there is more paperwork. That becomes a more attractive option. That is the case, is it not?

THE CHAIR: Good question.

Ms Gallagher: Yes, certainly. The health system of the future has got to be integrated and has got to look at more than just your traditional suburban GP practice. That has a role but, if we are going to spend $15 million for a broader community benefit, then I really believe it needs to have a link through education and a link to other health services as well and be done in a way that enlists the support of the doctors across the ACT, particularly those who are working in general practice.

From my discussions with the professional groups, they are very supportive of something that pulls together all of those things. They are less supportive of the awarding of a contract that sees a GP superclinic open, say, in Tuggeranong, without any other add-ons to it, other than being competition for all the other practices in Tuggeranong. That is certainly less supported.

THE CHAIR: You have a substantive question, Ms Bresnan?

MS BRESNAN: Thank you, chair. This is, again, something which I could not find references to in the annual report but is around the social determinants of Health. That is obviously something which has been discussed in a lot of different forums as a measure to apply to policies and programs. I wonder whether that concept is being applied to the programs and policies within Health now, or are there plans to do that?

Dr Brown: I might ask the Acting Chief Health Officer to speak to that. We do have a new population health strategic framework, which was launched earlier this year, but I think it goes very much around social determinants.

Dr Pengilley: The question is around social determinants in health?

MS BRESNAN: Yes.

Dr Pengilley: As I mentioned when I was addressing cardiovascular disease, there are a number of programs which deal with the determinants of chronic disease prevention. In the Chief Health Officer's report, it is clear that one of the major challenges to be faced in the future is the increase in the chronic disease burden in the ACT population. I can go through them but they are integrated with the national partnership on preventative health, which is a commonwealth funding agreement which allows us to design programs within the jurisdiction that are compatible with the objectives of that, and they go through healthy children, healthy workplaces, healthy communities. So it is a fairly structured approach.

We have a number of programs which are going through the approval process at the commonwealth level to be implemented in those areas. Those will deal with things like obesity, increased physical activity, decreased smoking, improvements in diet. Those are really the determinants of chronic disease.

More broadly, there is a body of literature about income equity, housing and these sorts of things. I think that is a difficult issue to deal with in a single portfolio. But those are undoubtedly also issues that affect health. In terms of chronic disease, I think there is real recognition at a commonwealth level and also in programs that we are able to run that we have to get to grips with the long-term determinants of chronic disease; otherwise we are going to get so many people with things like cardiovascular

disease, diabetes, mobility problems and musculoskeletal problems that we will not be able to deliver the services in a volume that is enough to treat them.

MS BRESNAN: Has there been any work done to target particular groups, in particular, low income groups, who are often more disproportionately impacted by some of those areas you have mentioned, because of various issues? Also, older people would be another group, particularly those on a lower income. Has work been done on targeting those activities you have mentioned?

Dr Pengilley: If you want me to answer whether there are specific targets, I would have to take that question on notice. However, I would generally comment that the strategies that are going to target tobacco use, alcohol use and so forth will inevitably target groups in which that is prevalent. So if you look at the distribution of tobacco use, for example, there is a very strong socioeconomic bias there towards people with lower socioeconomic status—and the same with alcohol and drugs. By their nature, the programs that are going to be targeting those as health issues will also be targeting the social groups that have those problems.

There are also specific Aboriginal and Torres Strait Islander programs, and that is one group who are very vulnerable because of all the other determinants that go with it, which, again, are socioeconomic—smoking, alcohol. I am not sure whether it has been phrased in terms of a social stratification of programs, but certainly the conditions being addressed are known to have particular groups that are vulnerable, which will be addressed.

MS BRESNAN: I was asking this in terms of it being a difficult thing to do but if there are particular activities—whether it is around physical activity to counter obesity or about making sure that the message or information is getting to people who will be within that group.

Dr Pengilley: I think that is definitely the case, because if you look at the people you have got to target, and these programs will be targeted at people who have problems with obesity, low activity and problems with diet, you inevitably find there are certain vulnerable groups that you are going to target. So, yes, that will be incorporated in the design of these programs.

MR HANSON: Did you look at the Productivity Commission's report about childhood obesity that said essentially, as I read it, that all of these programs that have rolled out really have not had any effect and that they have not actually done what we thought they would do? Have you got a view on that?

Dr Pengilley: I have not read the Productivity Commission's report. I know that there is constant contention about whether we should or should not be addressing the obesity epidemic. The medical fact that obesity leads to long-term health consequences is, I think, fairly indisputable, so the question is: is what we are doing actually having an effect? I do not think you can answer that question without a long-term view on the data, and I am not sure we have been doing any of this for long enough.

The other thing you have to realise—and getting to whether you can legislate against

inactivity—is that what we do is balanced against the overall environment in which people live. There are an awful lot of McDonald's ads out there; there are an awful lot of Kentucky Fried ads out there. There is a general move away from physical activity. There are built environments in which people find themselves which do not make it easy to walk to school, and these sorts of things. If we are not having a staggering benefit, it may be that we are also up against a substantial problem and that not having achieved great outcomes in the short term is not necessarily a sign of failure.

THE CHAIR: That was the end of Ms Bresnan's questions. Now it is over to Ms Porter.

MS PORTER: You were talking before about GPs and the so-called superclinic. I want to ask you, minister, about the walk-in clinics. I know it is fairly early days but I was wondering if we could have an update on the walk-in clinics. With regard to the early intervention work that we have been talking about, is some of that happening at the walk-in clinic? Is there early intervention work happening there?

Ms Gallagher: I will let the multiple award-winning Brenda Ainsworth answer—award winning for the walk-in centre as well.

MS PORTER: Yes, I am sure the committee would like to congratulate her.

Ms Gallagher: Some of that education focus is definitely happening at the walk-in centre. I have been there myself and received that education. They definitely see that as part of their role. If they identify an issue, they provide information and advice about what other avenues you could take to respond to that particular problem. Brenda, can you give us an update?

Ms Ainsworth: The walk-in centre has been operational now since 7 am on Tuesday, 18 May. We are seeing an average of about 1,200 patients a month. At the moment, we are going through another marketing campaign to make sure people know where we are located and what sort of conditions we see, just to make sure we are getting the most benefit out of it.

Of the 5,000 people we saw up to the end of September this year, about 66 per cent of those could be fully treated within the walk-in centre. So from the time they come, they go right through the assessment process, we can treat them, we can give them antibiotics or whatever is required, and they can go on their way. We redirect a number of patients back to their GPs, not so much because we cannot provide them with treatment but because something may be of an ongoing nature, so that they need to go back to their GP. We are seeing less than six per cent of people being redirected to the emergency department.

Very fortunately, the type of marketing campaign that we have done for the walk-in centre, which was targeted towards the 18 to 35-year-olds—which is why I was not really convinced that it was nice stuff but my kids tell me it was—is actually attracting the right sort of people. Our statistics that we are getting, the data that we are getting, is saying that we are targeting the 18 to 35-year-olds that are attending. The top conditions that they are attending for are exactly what we have targeted—cuts, lacerations, coughs, colds, flu, sprains, strains and earaches. A lot of earaches come

through.

Ms Gallagher: That is what I was there for.

THE CHAIR: So was I.

Ms Ainsworth: There you go. They are coming through. We are collecting quite a bit of information from the patients in regard to how they see the walk-in centre. The types of comments we are getting are that it is fast, it is very informative, they feel well supported by the nursing staff and feel that they get a lot of information. So it is a little bit like the minister was saying. It is not only the information about what is wrong with you at the moment—you might have an earache—but if the opportunity is there, they will talk about other health conditions. If they happen to say that they are smoking as well, it is a matter of saying: "Did you know we've got these programs? Do you know where else you can go to?" So they use it as an opportunity to inform more about health as well.

THE CHAIR: Will the recent changes to Medicare access and prescribing rights have any impact on the work of nurses in the clinics?

Ms Ainsworth: Yes and no. At the moment, the way that the walk-in centre is set up, it is protocol driven. It is within the acute service. Therefore, no. However, as to how we decide to roll that out in the future, that may be different. Also, with the way that we currently staff the walk-in centre, we staff it with nurse practitioners, transitional nurse practitioners, so those people that are working towards becoming a nurse practitioner, and what we call advanced practice nurses that have actually had a high level of education but are not necessarily a nurse practitioner or training towards that.

There is that difference in those staff but because we use the protocols, it means that no matter who you come in and see, you will always get the same treatment. So we are not using any of the Medicare agreement changes at the moment within that context. That is not to say that in the future we will not.

MS PORTER: You mentioned the flu. What is happening with the H1N1 now?

Ms Ainsworth: That is probably more for the public health people, but we can—

MS PORTER: Do you refer people with regard to that?

Ms Ainsworth: We do not screen for H1N1 at the moment because that series of work is now complete. We just check for flu symptoms as they come through and the criteria that they meet for that. But we do not screen for H1N1 at present.

MS PORTER: I just wondered where we were up to with that. Are we continuing with any kind of program? I missed out both times on my injection because I was not well, and I reckon they would not accept me today, either, if I rocked up for one.

Ms Gallagher: Do you have a walk-in centre question, because we will get the Chief Health Officer back for that one?

THE CHAIR: A supplementary from Mr Hanson.

MR HANSON: One of the intents of the walk-in centre was to reduce the burden on our emergency departments. It may not have had that effect yet, but the annual report indicates that we have had a five per cent increase in presentations in our emergency department. Is it that we just have not seen the positive effect of the walk-in centre or is it actually having an effect of pushing more people to come to the hospital and go to ED? If that was the plan, it does not seem to be working at the moment.

Ms Ainsworth: We have had an increase in presentations with lower categories to the emergency department, but we have to remember that not all category 4s and 5s which are considered non-urgent are appropriate for the walk-in centre or not appropriate for the ED. Some patients, even though they are non-urgent, are still appropriate for an ED. Our redirection to the ED, as I said before, is about six per cent, which is within the limits of what we thought might happen. That is primarily around people presenting for something but then finding that it is more complex than the walk-in centre can manage.

What we have demonstrated since we have started, as I have said, is that we have seen in excess of 5,000 patients. Where would those patients have gone? They may have gone to the ED anyway, and our numbers would be even higher, or they may have tried to get in to a GP. Nonetheless, we have had 5,000 people that have still gone to the walk-in centre, so they had to get care somewhere.

MR HANSON: With all the people you are seeing, are people coming to you for things that they could probably fix up themselves or when they do not actually need to come? Are you seeing people that do not actually need to seek medical treatment?

Ms Ainsworth: There was always the understanding—I know that you were part of the consultation that we did and after we saw the walk-in centres in the UK—that we would address what we considered to be the "walking well", where you were worried about something and if you could actually access health care you would, but if you could not access health care, it may actually be resolved on its own.

There is a component of that. People now know it is available, so where you might have had a bad earache, stayed at home and popped Panadol for a while and hoped it would go away, you actually say: "Well, what are my options? I could go to the GP. I might not get in. I could go to the ED. Gosh, that's going to look a bit silly there with my earache. Where else can I go now? I can go to the walk-in centre, be resolved and actually get back to work tomorrow morning rather than maybe taking a day off." So there is that component to it.

But there is a component that we are seeing where we are putting on plasters, we are stitching up fingers, we are actually treating people with antibiotics. There is a real treatment plan there; so we are meeting a health need.

Ms Gallagher: And this will be evaluated after 12 months as well to, as much as it can, answer some of those questions.

MR HANSON: The concern I have regarding these 5,000 people is that if we are not

actually taking the burden off emergency departments—and it might be difficult to quantify that—then there are 5,000 people coming from somewhere else. That is probably from GPs. If they go to GPs, it is either private money or it is commonwealth money. Are we transferring a liability here, in essence, from the commonwealth and from private through to ACT taxpayers with these 5,000 people?

Ms Gallagher: I do not think so. The commonwealth are funding the first four years of operation of the walk-in centre. We constructed the walk-in centre, and we will take over responsibility after that four years. They provided $10 million, from memory. Whilst taking the pressure off the emergency departments was certainly one of the reasons we started the centre at the Canberra Hospital, it was not the only reason.

This is where it is going to get hard to measure, and there will be people sitting on all sides of the fence around how effective it has been. I would imagine that, for the majority of those 5,000 who have been to the centre, they will be happy that it is there. And there is a role for the government to play in terms of the long-term health needs of this community, as identified in the Chief Health Officer's report, around providing early care, assistance and referral as required.

There is a community responsibility here that we think the ACT government has a role in. I think the evaluation report will inform us on a number of aspects of how efficient and effective the walk-in centre will be. We really need to wait for those 12 months. But I still think that, at the end of it, you are going to have people all over the place about what particular role it has played and whether it has been any good. I am not sure that you are going to get a clear answer either way. There are different vested interests about whether it should operate, I think, and, particularly about the next steps on the walk-in centre—whether it moves outside the clinical governance framework of the Canberra Hospital.

THE CHAIR: Thank you, minister. I believe Ms Porter is still waiting on her question on the flu to be answered.

Ms Gallagher: H1N1?

MS PORTER: Yes.

Ms Gallagher: What did you want to know about that?

MS PORTER: I know that we had the very intensive program for quite a while. With that coming to an end, what is the ongoing work that is happening in that area? Is there still underlying concern and do people still need that special vaccination?

Dr Brown: We had vaccination against the H1N1 last year. This year we have had the trivalent seasonal influenza, which incorporates the vaccine against H1N1 but also two other influenza strains. That is still available. In terms of what we are doing in the ACT, we are currently undertaking an evaluation of our influenza strategy, as we did last year, and that will inform what actions we need to take next year.

MS PORTER: For the next winter?

Dr Brown: Yes. In terms of the H1N1 pandemic, the World Health Organisation has actually declared that we are now in the post-pandemic phase. However, the Australian Chief Medical Officer has determined that Australia should remain in our current phase for the time being, just because we are in a different season to the northern hemisphere and there were some late cases of H1N1 influenza in Australia and New Zealand as late as September.

Ms Gallagher: Overall, though, there are some learnings from the H1N1 which are happening against our national pandemic preparedness plan and our local plan and how they interact. Going through that pandemic, I do not think our planning had foreseen the fact that it would roll out quite differently in jurisdictions. What we saw in Melbourne along tram lines and, in particular, school-aged populations was not necessarily replicated in other jurisdictions. What happened on the cruise liners did not happen in the ACT. That created some issues around what stage you went to. I guess all of our pandemic thinking had been that, as a nation, we would all move very nicely through the stages of the plan, and in reality that did not happen.

The other thing I would say is I think our immunisation levels were about 23 or 24 per cent of the community. We did pretty well. I think we came second to Tasmania in immunisation coverage. But it was still relatively low, I would have thought. The other challenge is that it was a mild pandemic. There is a level, I sense, of cynicism around about all the drama that was associated with it and whether you should have been immunised.

The reality is that we did see high levels of illness in the community. We saw very serious presentations to intensive care for long periods of time in healthy young adults that you do not usually see in flu season. We saw lots of absenteeism from work. So even though for the general community it was mild, I think Charles's line was that it was mild in most, serious in some. There were some very serious health implications and productivity implications of the mild pandemic. That will lead us to do a lot more planning around a more serious pandemic. In a way, it was a good thing to go through.

THE CHAIR: Mr Hanson, your substantive question.

MR HANSON: The national health and hospitals network agreement, the COAG agreement, was signed in April. There were some aspects to that which we were told were going to be worked out in the detail, including the 60 per cent of planned capital that was going to be provided. Can you give an update on where that agreement is? Certainly since we had estimates a couple of aspects of that deal have fallen over, including the national body that was going to look at the pooling of GST. That seems to have fallen over. Where are we at with that agreement?

Ms Gallagher: I am not sure whether it has fallen over, but there is no need to duplicate what was agreed to in terms of states having separate areas for accounting of those funds. I think that is just a sensible response to the agreement that was finally—

MR HANSON: Sure, but we were told an authority that was going to be established, but now it is not.

Ms Gallagher: Yes, and then there were some amendments made to the plan in order to address some concerns of Victoria and New South Wales, and there have been changes made around that.

MR HANSON: In the ACT context, there were outcomes that we have got to provide and there was funding that we were meant to get. I just want to know where we are at in terms of meeting our targets. When is the money flowing, when are we giving up the GST? What does the 60 per cent for planned capital entail? Are we going to get any support for our planned capital or not?

Dr Brown: I can certainly respond to where we are at in terms of meeting our targets. We have formed a national access program steering committee, and we have two significant projects underway at the moment. One is in relation to elective surgery and access to elective surgery, and the second one is what we have called care around the clock, which is actually looking at what we need to have in place to provide services 24/7. We need to ensure that we have services available across all hours if we are actually going to meet the four-hour targets in the emergency department as well as meeting the elective surgery. So we have that work underway.

We have had some expenditure of the funds in relation to elective surgery and some capital expenditure. We have those things underway. We have expenditure which we could provide, if you wanted that.

In terms of the other elements of the national health and hospital program, I think the minister indicated that we have the discussion paper going out today around the establishment of the local hospital network. The commonwealth government has put out a discussion paper around the establishment of the Medicare locals, which is an important component of it.

In relation to the funding, Mr O'Donoghue might be able to provide more detail of the discussions that have been occurring between the ACT and the commonwealth.

Mr O'Donoughue: Since the COAG agreement was signed off in April this year, a federal election was called, and the consequent caretaker period for the federal government obviously did not facilitate a lot of the work to proceed. Since the appointment of ministers, the various subgroups that were tasked with working on all those elements that you described, Mr Hanson, have recommenced their work. They are all striving to meet the deadlines that were set out in the governmental agreement.

There is a deputy treasurer and treasurer's process underway, which is seeking to work on identification and costing of the primary healthcare services to be transferred to commonwealth policy funding responsibility. Another piece of work is around identification and costing of hospitals and hospital services, and they are well progressed on the development of the user cost and capital, which will probably be the way the capital contribution to the states and territories will be dealt with.

From our point of view, the immediate targets before us are to agree the boundaries for the local hospital network by 31 December this year. Hopefully, in consultation with the commonwealth, we will also seek an outcome on the boundary for the Medicare local, the primary healthcare organisation, also by 31 December this year.

The first of those Medicare locals is not expected to come into existence until 1 July next year, and in the first tranche there is only proposed to be 15 around the country. It remains to be seen whether the Medicare local that is modelled for the ACT is one of those first tranches to go forward. They are the main items that you have raised. Have you got any other matters I could help you with?

MR HANSON: The structure of the local hospital network and how that is going to work is in that discussion paper?

Ms Gallagher: Yes, it is really extending on what I have said publicly that we would look at essentially the four in-patient units—Calvary, Canberra Hospital, Clare Holland House and QEII—as forming the network and that, in the first instance, the network should be formed along the ACT's geographic boundaries. There are some other issues in there about how we appoint the council.

MR HANSON: Have you had any negotiations with New South Wales to date about extending that to take in Yass or Cooma or Queanbeyan?

Ms Gallagher: Yes, I have. The New South Wales government are not necessarily opposed to it, but because of the deadline in agreeing to it—31 December—there are some barriers that would stop that from happening, and I think it would just slow us down. They are really industrial barriers. The conditions under which staff are employed differ across the state lines. We just cannot resolve those. There would be a massive industrial dispute that would stop your health system from functioning if we sought to address those. Other than, of course, going to the highest condition that everyone—bringing everyone up to the highest possible level. That would probably be the only way.

MR HANSON: Who gets paid more? ACT or New South Wales?

Ms Gallagher: It depends. Particularly the VMOs, for example, have quite different arrangements here than they do in New South Wales. Seriously, it is too complex to resolve by the time the networks need to be in place. But I have had quite detailed discussions around the role that Queanbeyan could potentially play in allowing us to use that facility which, at the moment, is underutilised while our two hospitals are bursting at the seams. We are proceeding with those discussions, because it is my hope that we can get our network in place, work out a way to manage or to use Queanbeyan and then look in the longer term about how you incorporate the regional hospitals into that model.

I did get agreement from the New South Wales government about some joint regional planning around what services they provide. For example, if they stop providing chemotherapy at Cooma or Bega, that has a serious impact on us. We are not part of the decision making, but we see the patients who come because of that decision. They have agreed to undertake some joint planning work around the clinical services that are offered in the region, and I think that will help the ACT considerably if we can get that piece of work done.

Dr Brown: I might just add that New South Wales has actually finalised their local

hospital networks and are in the process of appointing their chief executives and their councils. They are commencing those from 1 January, That is my understanding.

THE CHAIR: Mr Hargreaves.

MR HARGREAVES: I would like to have a bit of a chat about strategic indicator 13 on page 109 of the annual report. In recent times there has been discussion in the chattering classes around radiotherapy services, not always terribly complimentary. These indicators show an incredible performance over recent times. Globally, you are talking about a nine per cent increase which, in terms of quality of health services, is quite a significant move.

I notice that, with the exception of a slight thing with urgent treatments, all the other ones have got substantial increases in achievements. For example, going from 65 to 75 per cent is phenomenal, as is 65 to 86 per cent for non-urgent category B. The overall statement is that 84 per cent have had their care started on time. You must have done something rather remarkable to achieve those particular numbers. Could you give us a rundown on how you actually did it?

Ms Gallagher: As I am advised, as of today or yesterday, there is no waiting list for radiotherapy services in the ACT.

MR HARGREAVES: Way to go! Are they coming back from Wagga?

Mr Carey-Ide: Thank you for your question, Mr Hargreaves. It is a great opportunity, I think, to highlight the really excellent work that has been undertaken by the radiation oncology department over the past year to address what they saw as a significant problem in meeting waiting time targets. As you have outlined, they have achieved very well and in most instances above the targets that had been set.

Some of the things that they have actually done are to maintain a really constant focus on getting feedback from patients and getting feedback from clinicians and support staff within the department about the ways in which they can continuously improve their services. That proactive approach on the part of the staff in that department has resulted, as you have outlined, in some really excellent scheduling practices for the patients.

The other very significant factor that has assisted the department in achieving those results above target has been the provision of funding from February this year to recruit an additional five radiation therapists. Many of you will recall previous discussions in this place that outlined the challenges around recruitment for radiation therapists and the challenges that we experienced when a predominantly young workforce relocated, often with very little notice, and the impact that that had on the provision of services.

The provision of funding for the five additional radiation therapists has meant that we do not have the problem that we used to have around providing backfill for both planned and unplanned leave. We are able to more proactively schedule our patients into the service in addition to providing that backfill. We are also able to focus within the radiation therapist component of our service on ways that we can keep improving.

It is really important that we enable the time, and this funding has enabled the time, for those therapists to be able to have a think about how we can continue to do things better in the department, as well as to research practices that are happening worldwide.

I think a clear result of that commitment from the government has been that we have been able to achieve well above the targets. We have been able to reduce the stress levels for our staff, of course, as a result of that. It is a very emotive service, as I am sure you would appreciate. That does create a great deal of pressure and stress for our staff. It has been a real joy to come here and not to claim any credit but to celebrate with that department the achievements that they have made in what is a very short period of time.

MR HARGREAVES: Apart from the scheduling, what other things have been done—besides bump up the numbers? You talk about funding for those five positions. They are fully recruited now?

Mr Carey-Ide: We do have two vacancies at the moment, but the funding recognised that at any given time we would likely have vacancies in what is predominantly a quite young workforce and, therefore, a very mobile workforce. Having two vacancies is a really comfortable place. We constantly recruit wherever we have vacancies and we have been successful because of the supports that are in place for our radiation therapists staff now.

MR HARGREAVES: How many radiotherapists have you got?

Mr Carey-Ide: I would have to take that on notice, Mr Hargreaves.

THE CHAIR: A supplementary question from Mr Hanson, and then we will come back to you.

MR HANSON: I refer to the plan for the expansion of the Capital Region Cancer Service's new facility. I think it is four or five storeys. I am just looking at some questions that were asked by Senator Humphries at Senate estimates and some responses there. They seem to indicate that the service really is not going to change. It is going to relocate. I think there was an expectation that with that money, the $27.9 million, there would be a reasonably significant expansion of the service. However, the answers here indicate that it is really a relocation and a consolidation of the service. Can you comment on that?

Ms Gallagher: I do not know who the commonwealth person was who was responding. Was it someone from the Department of Health and Ageing in Senate estimates?

MR HANSON: I would imagine so.

Ms Gallagher: Yes. The $27 million is a capital fund to construct the new cancer centre. The issue of recurrently funding it was always left to the ACT government. I think you will see if you go back through every budget that I have been involved in that there has been growth in cancer services every year. Every year we are expanding cancer services.

It is a co-location in some sense, which we have been up-front about, because the integrated cancer centre actually co-locates a whole range of specialties in the one place. At the moment, we have—help me out here, Grant—haematology in one part of the hospital and oncology in another part. The idea of an integrated cancer centre is that the patient comes to the cancer centre and has their multi-disciplinary team approach. They are provided with care at that centre rather than their having to go down to haematology on Thursday at 4.15. The whole model of the integrated cancer centre is to allow integrated care to the patient, to wrap it around that.

The idea is also to have some non-government presence in that cancer centre as well so that organisations like Bosom Buddies, the wig service and things like that that are essential but not necessarily part of ACT Health can be there to support the cancer patient on their journey.

MR HANSON: The answer to the question at estimates was that two of the floors are just going to be a shell. Is that correct?

Ms Gallagher: Megan can respond to that

MR HANSON: It is designed as a six-storey building and two floors are just going to be completely vacant shells.

Ms Gallagher: To allow for growth, I would imagine.

Ms Cahill: The original plans for the cancer centre were always to be built to five levels. This is stage 1 of what will be a two-stage process to create an integrated cancer care centre. The intention at this point in time is to have two of the levels built but not fitted out, at least in the short term. That will allow us, as we develop the stage 2, to not only create additional capacity in the future but allow us to create a centre that will integrate with the new buildings in the future. For example, we would propose to add an additional sixth floor and that would link into the level 6 of a new acute building where the in-patient beds will be located.

THE CHAIR: I have a supplementary as well, but it relates to a couple of pages back. It relates to page 106 and it is to do with mental health. The strategic indicator on page 106 refers to maintaining consumer and carer participation on relevant mental health committees. How many committees are consumers and carers actually represented on?

Dr Brown: We would actually have to take that on notice to provide you with the full list.

Ms Gallagher: Lots.

Dr Brown: It is a lot.

THE CHAIR: You have got 100 per cent participation. I would just like to know the numbers.

Ms Gallagher: There are 2.6 full-time equivalent consumer carer consultants that work for ACT Health. I think another part-time position assists that.

Dr Brown: They sit on things like the strategic executive and the risk management committee. They are involved in the committees around suicide planning and they co-chair the strategic oversight group around the mental health services plan. It is a very large number.

THE CHAIR: I do not expect an answer now, but if you could provide an answer I would appreciate that.

Dr Brown: One I might just particularly mention is the involvement of consumers and carers in the work we have done around reducing seclusion. We actually have a seclusion meeting in the in-patient unit which is, again, I think, co-chaired by a consumer representative. That has been a very strong contributor to reducing our seclusion rates. I think the minister mentioned at the outset that, despite having a target of seven per cent, we got the result down to about 2.3 per cent. I am advised that for the first quarter of this year, it is now down to 1.3 per cent. The involvement of consumers in that work has been a major driver of that.

THE CHAIR: Thank you very much. It is incredible how quickly three hours goes, but thank you, minister, for your time.

MR HANSON: Could I just pass on the opposition's thanks for all the hard work you are doing. It is our job, and we will continue to ask the hard questions, but thank you very much for everything that you do. We really do appreciate it.

THE CHAIR: Thank you, Mr Hanson. There will be some further questions coming. There are a lot of questions we want to put to you. Thank you very much.

The committee adjourned at 12.30 pm.