LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL SERVICES

(Reference: Annual and financial reports 2010-2011)

Members:

MR S DOSZPOT (The Chair)
MS A BRESNAN (The Deputy Chair)
MR J HARGREAVES

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 23 NOVEMBER 2011

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 9 August 2011

The committee met at 2.03 pm.

Appearances:

Gallagher, Ms Katy, Chief Minister, Minister for Health and Minister for Territory and Municipal Services

Health Directorate
- Brown, Dr Peggy, Director-General
- O'Donoughue, Mr Ross, Executive Director, Policy and Government Relations
- Reid, Ms Barbara, Acting Deputy Director-General, Strategy and Corporate
- Martin, Mr Lee, Deputy Director-General, Canberra Hospital and Health Services
- Foster, Mr Ron, Chief Finance Officer, Financial Management
- Ghirardello, Mr Phil, Acting Executive Director, Performance and Innovation
- Sharpe, Ms Liz, Director of Nursing, Women, Youth and Children
- Lamb, Ms Denise, Executive Director, Capital Region Cancer Service
- Jackson, Ms Kate, Executive Director, Critical Care and Imaging
- Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
- Kohlhagen, Ms Linda, Executive Director, Rehabilitation, Aged and Community Care
- Childs, Ms Judi, Executive Director, Human Resource Management
- Kelly, Dr Paul, Chief Health Officer, Population Health
- Carey-Ide, Mr Grant, Executive Director, Service and Capital Planning
- Woollard, Mr John, Director, Health Protection Service
- Neverauskas, Ms Daina, Acting Director, Women, Youth and Children

THE CHAIR: Good afternoon to everyone. Before we start, can I just ask whether you have all read the privilege statement.

Chief Minister, I welcome you in your capacity as Minister for Health to this public hearing of the Standing Committee on Health, Community and Social Services inquiry into the 2010-11 annual financial report of the Health Directorate. In your absence, I have asked whether everyone is aware of the privilege statement and the issues entailed within. If you are comfortable with that, I would like to continue. If you have any questions on that, please ask.

Chief Minister, would you like to make an opening statement?

Ms Gallagher: I apologise for being a few moments late; I think the clock in my office is slow. I am happy to make a short statement in this opening part of the hearing and keep the majority of the time for questions from the committee.

As you would be aware from reading it, the annual report highlights a significant year for the Health Directorate, both in overall activity and in demands on it. The other work that it does, particularly at the moment in ensuring that services continue to meet demand and also in the capital asset development program that is currently underway, is additional to the normal day-to-day work of the Health Directorate.

The annual report shows significant improvements in the services provided across the Health Directorate. I am very proud to be the minister of a directorate where all of the staff are very focused on continuing to improve services to the community. That is reflected in this annual report before you today. The annual report also shows new services that have started during this financial year; this is over and above the day-to-day stuff that happens all the time. They include having a PET scanner in the ACT for the first time and having a sleep lab here. It is all about building up our capacity to provide as many services as we can to the Canberra community. I could talk for an hour or two but I would bore the socks off you; I am happy to proceed to questions.

THE CHAIR: We appreciate your introduction. I should add that the third member of our committee was Dr Bourke but as of this afternoon he is ineligible to sit with us. So we have the deputy chair, Ms Amanda Bresnan, here with us; Mr Hanson, as shadow minister for health, is with us as well.

Page 115 of the annual report mentions strategic indicator 20, prevalence of diabetes. The prevalence of diabetes in the ACT is increasing. Has the new diabetes plan been implemented?

Dr Brown: We will get Mr O'Donoughue to come up and speak to this. There are several components to the new diabetes plan; some have been implemented and some are in process at the moment. Mr O'Donoughue can give you the details.

Mr O'Donoughue: The diabetes services plan has a term of 2008 to 2012. It was developed immediately prior to a period of significant health reform, principally the COAG processes, and also the onset of the capital asset development program. Those developments have required the initial plan and its directions to be reviewed. That work has been undertaken by a transition team. In particular, the model implicit in the plans that a third-party provider would employ and provide much of the allied health services to take pressure off the acute system has not been able to be delivered, so the intention has been to purchase services from the non-government sector.

To that end, in the 2010-11 budget a million dollars was appropriated to fund those non-government services and also to employ a new clinical director and a new operations manager for the service. An expression of interest process was instituted for the non-government procurement. That procurement is still in the process of completion, partly because there have been substantial delays in recruiting to the clinical director and operations manager positions.

The transition team and the service felt that it was important to have the clinical director on board and part of those decisions. Unfortunately, a process of advertising was unsuccessful and it is only very recently that a clinical director has been appointed to that position. As of this Friday, the tender panel was to meet to review those tenders for the non-government services. Regrettably, I had to postpone that meeting due to an obligation to attend a funeral on Friday morning. But we are now very close to completing that procurement process and putting the non-government services in place.

That will provide two planks of the diabetes plan. It will provide services in the non-government community setting to take pressure off the acute system and a new

leadership team in the clinical director and business manager to drive the coordination of the whole service.

THE CHAIR: In terms of my question, has the new diabetes plan been implemented? Where do we stand at the moment as to full implementation?

Mr O'Donoughue: As I have described, the plan in its original spirit has not been implemented in the sense of a third-party provider. And because of those unfortunate delays with the recruitment of the clinical services director, we have not been able to progress much further, as I have described, in the procurement of the non-government services. There has been another suite of services put in place under the chronic disease program generally—things like the telephone coaching service, the chronic disease management program and the patient care register, all of which impinge on diabetes, among other chronic conditions. Essentially that is the status of it as I have described.

THE CHAIR: You have mentioned the recruitment of the operations manager. Is that the same as the business manager or is that a separate position?

Mr O'Donoughue: Essentially that is the same position. Yes, that is right. That position has just been sized, like the human resources department it will be recruiting to as well.

THE CHAIR: The ACT rate for the prevalence of diabetes is 3.1 per cent. Is there a breakdown between diabetes I and diabetes type II or is that all included as one?

Mr O'Donoughue: I believe that would be all inclusive.

Dr Brown: We would be able to break them down.

Ms Gallagher: Are you interested in having a breakdown?

THE CHAIR: I am asking whether there are any figures.

Ms Gallagher: We would be able to provide them to you if you want them.

Dr Brown: We certainly can provide those but we also know that the figures that we have do not necessarily capture all of it, particularly for type II diabetes, because some of it is undiagnosed.

THE CHAIR: Okay, but there are a lot of diagnosed diabetes cases.

Dr Brown: Yes, absolutely, and we can provide that data.

THE CHAIR: That is what I am interested in.

Dr Brown: I am just looking at the Chief Health Officer to see whether he has it in his head.

THE CHAIR: Thank you very much. Supplementary?

MR HANSON: I have a supplementary on this. It seems to be an extraordinary delay. Have we learned lessons from what has gone wrong in diabetes to make sure that it does not happen—

Ms Gallagher: Nothing has gone wrong in diabetes.

MR HANSON: In the delivery of the services plan. It clearly has, minister.

Ms Gallagher: What has gone wrong?

MR HANSON: You have been unable to recruit; you have been unable to deliver the plan as initially intended. It is late. And in the interim period I have had numerous constituent inquiries from people with diabetes—you would probably be aware of these—who are quite disgruntled with what is going on. That is both people that receive the services and also staff within the area. We have litigated this before. It is clearly not working.

Ms Gallagher: We cannot force anyone to take on the clinical director's job.

MR HANSON: No, but you have changed the model. What I am asking is this: have you learned lessons from this? Have we recognised that there are areas of learning so that we do not have a similar situation occurring?

Dr Brown: I think the lesson out of this is that diabetes as a chronic disease is a complex service delivery problem or challenge. It involves service delivery within a hospital setting, both inpatient and outpatient, across adults and children. It is absolutely critical, however, that we also integrate with primary care. And there is a very strong role also for the non-government sector.

In articulating a plan for diabetes, we need to ensure that we can bring all of the players together. I have to say that that has probably been the biggest challenge in progressing the plan. I think we are at a point now where we are ready to go forward. And if you want the lessons learned, they are about how you get all of those key sectors working together. That is what the national health reform is all about. It is about bringing together the acute sector and the primary care sector along with the non-government sector—getting integration and collaboration.

MR HANSON: Thanks, Dr Brown. And the date that you said on the plan—did you say that there is a diabetes services plan for 2008-12?

Mr O'Donoughue: That is correct, Mr Hanson.

MR HANSON: It is 2008-12; we are actually heading into 2012 and it is not yet delivered. I imagine that we are now going to be in the process of trying to develop the next plan, are we? Where do we stand? It seems that the plan that was meant to cover this four-year period simply has not been implemented. What is the next step?

Ms Gallagher: It is not true, Mr Hanson. The plan is being implemented. There are further improvements that need to be made. Yes, there will be another plan that covers

the period post-2012, just as there is for the myriad plans that exist across the Health Directorate.

THE CHAIR: I have got a supplementary in the diabetes area, so if you do not mind I will come back to that. I have raised this issue with the minister for disabilities. This falls in between three sectors: health, disability and education.

A constituent required a student at the Woden school to have a full-time nurse in attendance. After much toing and froing, I understand that a nurse has been provided to the Woden school, which is a special needs school. Most other schools of that same category do have nurses or a nurse in attendance. A nurse has been provided for this year, and this year only. The student will be in attendance next year as well. How can we solve the situation so that we do not have people having to fight for what they currently have and having to reclaim that right again next year?

Dr Brown: I am very happy to take that on notice and look at that. I do have a recollection of receiving previous correspondence in relation to this. I cannot recall the immediate details. I am very happy to look at how we progress in meeting the needs of that individual.

THE CHAIR: I would appreciate that, Dr Brown. My concern is that if a child has that need now and is not improving, why would he not have the need next year? I would certainly appreciate an answer on how that can be provided for next year.

Dr Brown: Sure. It will obviously depend on a contemporary assessment of the needs and whether or not there has been any skill transfer. Without knowing any details of the individual, I cannot speak to it. It is foreseeable that there are circumstances where the needs change because either the condition changes or, as I say, there is a skills transfer in terms of the environment.

THE CHAIR: I am sure the needs certainly will be there next year. The other question is: most special needs school have a nurse in attendance, so why is this special needs school any different to the others in Canberra?

Ms Gallagher: It would be based on the clinical needs of the students. The other schools—Cranleigh, Malkara and Black Mountain—have a higher number of children attending with a higher level of complex medical conditions than would normally be the case at Woden school. However, we are always keen to meet the needs. If there is a clinical need for someone to have a nurse, then that needs to be addressed.

THE CHAIR: I fully understand that. The service provided in the other schools is excellent; I have seen it firsthand. I am urging that the same consideration be given to the Woden school.

Ms Gallagher: Yes.

MS BRESNAN: I do not have a specific reference in the annual report, but I have a question about the federal funding for subacute places and beds. I am wondering if we can get an update on what is happening with that. I understand—correct me if I am wrong—there have not been any specifications provided federally about where the

beds should go or what they should go into. One of the things that has come up before is mental health. I am wondering if we are still going to get those places in the ACT?

Dr Brown: We have a requirement to deliver 21 subacute beds, and we have a range of proposals on the table that we are working through. We have delivered four beds currently that are related to aged care. The specifications from the federal government relate to either aged care, palliative care mental health, et cetera.

MS BRESNAN: Yes, it was the four areas.

Dr Brown: We are also looking at proposals relating to a youth step-up, step-down—youth as in young adults. As you are aware we have an adolescent step-up, step-down and an adult step-up, step-down. So we are looking for that young adult range. We have a proposal on the table around a palliative care service. We have a proposal on the table about what we are calling HARI—housing and recovery initiative—which is intensive support to individuals with mental illness. It complements the HASI initiative but is more intensive for a shorter period of time.

I am just looking over at my colleagues because there are a couple of other proposals that are not springing immediately to mind. With psychogeriatrics we are looking at a proposal around older clients with mental health problems.

MS BRESNAN: When is that going to be finalised in terms of what the actual break-up will be of those 21 beds?

Dr Brown: For this current financial year we have a requirement to deliver six beds. As I have indicated, we have already met four of those and we are just looking at the logistics of delivery of some of those. For example, for the young adult program we are looking around for a property that is suitable.

MS BRESNAN: How many beds or places is that likely to be?

Dr Brown: We are thinking probably six.

MS BRESNAN: And that is the youth one?

Dr Brown: Yes. We are looking to establish 20 HARI places in the first instance and taking that up to 40 by the end of the funding.

MS BRESNAN: And they will be community based?

Dr Brown: They are community based, so they do not count on a one-for-one basis in terms of the bed equivalency. We have had some fairly protracted discussions with the commonwealth to try and define what the bed equivalency is, but we have now got that. It is a work in progress, but we certainly have plans to meet the 21 beds that are required by the end of the financial year.

MS BRESNAN: And there is that commitment for mental health places?

Dr Brown: There is funding available to cover those. We have to confirm that we can

actually deliver on those. For the youth it is about finding a suitable property. We have one that we are currently considering, but we are also in discussions with Housing about other options.

MR HANSON: I have been advised that anaesthetists have been sent an email advising of a reduction in the number of surgical lists that will be operating between now and the end of the year and anaesthetists and nursing staff not being made available and the number of theatres operating being reduced. Are you aware of that at all?

Dr Brown: I will ask Barbara Reid to speak to that. Barbara is currently acting as the deputy director-general for strategy and corporate, but her substantive position is executive director for surgery and oral health.

Ms Reid: I am not aware of the letter that has gone out. We have a closure at Christmas time for theatres, but I am not aware of a letter that—

MR HANSON: How many theatres are you currently operating? What is the normal number?

Ms Reid: Eleven a day.

MR HANSON: So you are not aware of any advice to—

Ms Gallagher: Maybe you could show us the letter you have got, Mr Hanson. That might make things a bit easier?

MR HANSON: Sure. I would be happy to read what I have got if you like.

Ms Gallagher: Yes, sure.

MR HANSON: It states:

> The anaesthetic dept has just recently been advised that Monday AM SAPU lists, Tuesday AM SAPU lists, Wednesday AM SAPU lists, Thursday am Williams lists, Thursday PM SAPU lists, Friday week 1 AM Urology, Friday weeks2-4 SAPU lists and Friday weeks34 non elective lists will not be covered by anaesthetic or nursing staff. Theatres have been instructed to run only 11 theatres on these days unfortunately I do not know for how long this will be the case.

I am just trying to understand the implications of that, if that is the case and that is a—

Mr Martin: We have not reduced theatres at all. For the two weeks over Christmas we are reducing down. Our theatre program is to maximise all the capacity for this year because of our long waiting patient lists. I would really be interested in the sessions that have been put to you so we can cross-check that, but my understanding is there is no drop in theatre sessions and we have not authorised any.

MR HANSON: So no drop in theatre sessions at all?

Mr Martin: No.

THE CHAIR: Page 157 of the annual report deals with the sleep laboratory and indicates that a number of sleep studies that were carried out in the last year. What was the demand for sleep studies including the demand for in-patient sleep studies?

Ms Gallagher: Like all new services when you start them, there was a healthy level of demand, and it is growing.

THE CHAIR: Can you elaborate on that a little?

Ms Gallagher: We were not able to offer this service before so it is fantastic that we have actually got one operational. The demand is increasing.

Dr Brown: As at 30 September we had performed 236 ambulatory and 162 hospital-based sleep studies. There is a waiting list for both, so that is an indication of demand. The figure for the waiting list for the home-based sleep study is 148 and for the hospital-based sleep study it is 57.

MR HANSON: That is the number of people that are waiting, is it?

THE CHAIR: We have been led to understand that specialists are finding it almost impossible to get a patient into the facility due to lack of funding and staff shortages. Would that be accurate?

Dr Brown: No, it is not accurate in terms of lack of funding. There is funding available. There have been challenges in retaining the skilled staff. It is a highly specialised area, but I do not think it is reasonable to say that it is impossible to get people in, because the numbers I have just indicated to you clearly indicate that the service is being provided.

Ms Gallagher: And they are triaged.

Dr Brown: That is right.

THE CHAIR: I thought you also indicated there was a waiting list.

Ms Gallagher: Yes there is.

Dr Brown: There is a waiting list, but we have also delivered a substantial number of the services.

Ms Gallagher: There is a private sleep laboratory operational in the ACT, but this is the first public sleep lab. This is its first year of operation.

THE CHAIR: That is commendable. My question is: if there is such a large waiting list, is it possible to have a look at whether we could increase the number that we could get through? Can you look at shortages of staff, if you like, or the inability to keep staff?

Dr Brown: The issue is about being able to recruit the highly skilled staff required. I

do not think this is a problem unique to our service. Additional funding would not necessarily help. It is about actually being able to recruit the personnel to undertake the task.

Ms Gallagher: The sleep studies themselves are not quick processes either. They are time intensive and staff intensive.

THE CHAIR: I am aware of the problems.

MR HANSON: What is the staff profile? Are we talking about one or two staff?

Dr Brown: I cannot give you the precise numbers. It is a small number, so a loss of one staff member has a substantial impact.

MS BRESNAN: Page 13 of the annual report has a comparison to budget and refers to $10.6 million due to some high payments to non-government organisations. It also lists $7 million for other expenses attributed to cost pressures at Calvary Public Hospital. Could we get an outline of what those cost pressures were and if they had any impact on services?

Ms Gallagher: The Calvary money is activity related, and the additional budget at Canberra hospital was activity related as well.

MS BRESNAN: It would be interesting to know what some of those cost pressures were.

Ms Gallagher: Do you mean where was the extra activity?

MS BRESNAN: It would just be interesting to—

Ms Gallagher: Possibly admissions.

Mr Foster: The explanation is a change in expense between what was budgeted and what happened. When we were putting the budget together we did not really know whether we would be spending a lot of commonwealth money on elective surgery, for example. So a considerable amount of that increase there in the NGO sector was to Calvary to deliver elective surgery in 2010-11. The other cost pressure issue we dealt with is the fact that there has been an increased activity in Calvary in the latter half of the year which they were not expecting—high ED admission—which led to high activity across the system predominantly happening in the later part of the financial year, which came as a surprise to us all somewhat.

MS BRESNAN: So it is an increase in presentations?

Mr Foster: Yes.

MS BRESNAN: The elective surgeries, that is due to the federal regulations that are coming through. I know an issue sometimes has been—it is not a disagreement—views about funding reimbursement between Calvary and the government. Are there any areas of disagreement at the moment or is that something which is going fairly

smoothly?

Ms Gallagher: It is an ongoing discussion.

MS BRESNAN: An ongoing discussion.

Ms Gallagher: Yes. I think it is any area that involves finance. I think it happens within the Health directorate too within business units where they are over budget and pulling them back into budget. It is something that is watched every month. It is a process of negotiation. My own view is that if you can demonstrate through your activity that it warrants the extra funding, then we should pay for it. But it needs to be backed up with the data.

MS BRESNAN: One of the things that actually came up in estimates was the staff entitlements issue. The technical insolvency issue came up. Has there been any resolution to that? When I asked that question it seemed that there was some disagreement between what was actually owing and who owed it. Has that been resolved?

Mr Foster: No, the recommendation coming out of the budget hearings was that we would report to the Legislative Assembly in the last sitting period in December if we have not resolved it. So there will be a report going in response to that. The answer will be that, no, it has not been resolved. To this point Calvary Health Care ACT have not provided the data that we require to commence the process. It will be a rather lengthy process when we do receive that data. I imagine there will be a lot of questions and requests for more information once we get the data and start the work.

So Calvary, while they put the claim on the table, were quite aware that they have not provided the data and have progressed working with us to set up the new network agreements without working out this particular issue. It is still on the table to be resolved.

Ms Gallagher: Its sort of importance to resolve has been reduced by the fact that there is no purchase of the hospital, because it was going to come to a head if there was an employee separation situation, which there is not going to be. So in my last meeting with the chair we raised the issue. My understanding is the data is going to be forthcoming that can allow that work to start.

MS BRESNAN: Was there any reason for the delay in providing the data?

Mr Foster: The timing of when they put the claim in, I guess, was around the end of last financial year. Then their resources going forward for the next month or two from that I understand were dedicated to doing their financial statements, for example. I suspect they are having some difficulty finding all the information that I have asked for. It goes back a long way.

MS BRESNAN: I appreciate that it is a considerable amount.

Mr Foster: Yes, it is a lot of information we are requiring and they have had a lot of change of personnel out there over the years. Probably it is about finding records and

that that will enable us to start the work.

MS BRESNAN: Is that something that is likely to have any impact instead of going forward with agreements which are going to be developed? While there is not going to be that separation, there is still a fairly large amount that is outstanding in terms of basic entitlements—

Mr Foster: That claim to be outstanding—

MS BRESNAN: Right.

Mr Foster: in relation to cash or employee entitlements. Look, there is no risk to any employee at Calvary in relation to their accrued entitlements. Anyone that leaves now gets paid their entitlement. It is not—what we buy from Calvary annually now for services fully covers the full cost of running the hospital, including movements, employee entitlements and that; so there are no cash issues around that from us on a year-by-year basis.

The issue at hand is when it was under a cash accounting environment back in the mid-90s through to the end of that decade—what happens to those employee entitlements. We will have that discussion when we see all the information and ask questions about who is still there and that sort of thing.

MR HANSON: Elective surgery: I wonder if we can get an update on how that is progressing. How many people—

Ms Gallagher: Yes, what would you like to know?

MR HANSON: I have a range of questions. How many people have got on the list currently by category? That would be a starting point, I suppose.

Ms Gallagher: The waiting list itself is sitting just above 4,000. I think about 4,200 was the last figure I saw. We are on target to do over 11,000 procedures this year. Several hundred of them would be done in the private sector. I am sure we can provide you with information by category. We are above target in category 1 patients in the first part of this financial year. I think 97 per cent of category 1 patients have been admitted on time.

I think in category 3 we are above target as well. The area is category 2, where I think our target is 55 per cent. It is sitting just below that. The interesting figure in the latest data that I have seen is that as the waiting list comes down, additions to the list grow faster than we had anticipated. So we have seen several hundred more patients added to the list than would be normally accounted for through growth.

I think we have seen this in the past; when there is a concerted effort to reduce the waiting list, there is almost a commensurate increase on the additions to the list. So the elective surgery performance is tracking very well but we are keeping an eye on what seems to be a rather sudden increase in additions to the list.

MR HANSON: The median waiting time is now what?

Dr Brown: It has reduced most recently and I have not got the precise figure in front of me. I am sure Mr Ghiradello knows but it is around 64 days—

MR HANSON: Sixty-four days.

Dr Brown: which is a substantial reduction.

MR HANSON: It is.

Dr Brown: We are, however, I must point out still reducing our long waits and that, of course, tends to push your median waiting time up.

MR HANSON: The private health system—how many surgeries have been conducted under that, do you say?

Ms Gallagher: It was about 300, I think. Yes, about 300.

MR HANSON: Have we got the costs of that, itemised costs for how much that is costing per patient?

Ms Gallagher: It is the same as it costs in the public system essentially. They are not paid any more to be done in the private system.

MR HANSON: So how does the contract work? Do you say that it is a certain amount—if it is a hip or something like that, do you say that it is going to be X number of dollars? Do people bid for that or how does that process work?

Dr Brown: We went out for a panel of providers by tender. Then we issue work orders depending on the nature of the work that we required done. Mr Ghiradello will be able to provide some more details about the contracts.

Mr Ghiradello: We put out a tender for private hospitals who wanted to be a part of the panel to provide elective surgery services. They then provided the specialities that they had the capacity to provide for us. It was quite a good match because none of the hospitals were competing against each other for surgery. So it was quite easy to be able to then provide work orders which listed specific surgery cases.

We have orthopaedics, ear, nose and throat and urology surgery being the main specialities that we have tendered out. We use the national public hospital price, which is a price which we use to buy services from public hospitals as well. Both of our private hospitals have accepted that as the price for these services.

MR HANSON: The Auditor-General's report into elective surgery, the progress with that: is that going well?

Ms Gallagher: Yes.

MR HANSON: That talked about a centralised list.

Ms Gallagher: That has not been able to be achieved at this point in time, the centralised list.

Dr Brown: No, in terms of one list across the whole of the territory.

MR HANSON: The other issue that has been discussed is the fact that people go onto a list—let us say it is for urology—with a particular doctor and there is pooling—

Ms Gallagher: There is no pooling of lists either.

MR HANSON: Have you had further discussions about that?

Ms Gallagher: About pooling of lists?

MR HANSON: Yes.

Ms Gallagher: Yes, there have been. We would like pooling of lists. There are some doctors who would support a move in a pooling direction but there are others that very much would not and it is not necessarily a change or a reform you could push through without their agreement.

MS BRESNAN: Can I ask a question on that? In terms of trying to get that shared waiting list developed, do you have any data on what percentage of patients might have their treatment delayed because a doctor is not available or because too many people have been booked in with that particular doctor?

Ms Gallagher: You can go online and have a look at each individual VMO's waiting list. That information is publicly available. From that, if you were a patient of Dr So-and-So you could see that there is another specialist who has got a shorter waiting time. In a way the elective surgery coordinator provides a facilitation role in that sense. We can try to encourage people to go and visit another doctor or have that doctor take their care on. It just is not happening in a coordinated way. I am not sure how you could measure—

MS BRESNAN: So we do not really know if it is having any sort of impact at all. Presumably, it might.

Ms Gallagher: I think there is an agreement that pooling of lists in a speciality would allow increased efficiency in the delivery of the service. So there is agreement about that.

MS BRESNAN: Has there been agreement from the VMOs that that would actually assist?

Dr Brown: Essentially, the discussion we have had with them, and we continue to have with them, is around how they can manage the waiting lists within the required time. That is a very active process with the executive director and the clinical director. If they are not able to manage the waiting list within the clinical time, then there is a discussion about what might be required to attempt to achieve that either by additional sessions or by changing to someone else's list. That is an ongoing process. It happens

every month; so it is very actively addressed.

THE CHAIR: Is this still a supplementary?

MR HANSON: Yes, it is in relation to the same subject. I read an extract from an email previously. I have a copy of that here. You asked if I could provide it. I seek leave to table that, through the chair. I will provide that. If you can shed any light on that, particularly by the end of today's hearing, that would be good.

Ms Gallagher: Yes. I do not imagine it has got who it came from or signed off by anyone, which will make the matter of tracing it a little bit more difficult but—

MR HANSON: I understand it is from the anaesthetics area. I understand that that is the case.

Ms Gallagher: We will get in touch with—

MR HANSON: I probably will not let you know who gave it to me but—

Ms Gallagher: What a surprise!

MR HANSON: Well, it is open and accountable government, minister.

Ms Gallagher: Yes, open and accountable opposition too. I am loving it.

MR HANSON: Yes, there you go. I provided you with the document.

THE CHAIR: Keep it to the topic.

MR HANSON: You asked for it. She has got it.

THE CHAIR: Mr Hanson, have you got any more supplementary questions on that topic?

Ms Gallagher: Yes, it is the redacted bits I am after Mr Hanson. It might be a surprise to you.

MR HANSON: Is it? That is always the challenge, isn't it?

THE CHAIR: Order, please, both of you! Mr Hanson, do you have any questions?

MR HANSON: Yes, how many of the long wait patients are waiting longer than a year? You say that you have been targeting the long waits.

Ms Gallagher: I think it is down to 200 from 700. I saw it in a brief on the elective surgery report.

MR HANSON: If you do not have that available—

Ms Gallagher: We will be able to get it.

Dr Brown: We certainly can get it to you.

Ms Gallagher: I am just trying to reduce the questions on notice. It is a significant decline from over 750 or so to just over—

MR HANSON: Yes, it was 800 or so, which is 15 per cent.

Ms Gallagher: It's just over—I think it is about 250 now.

MR HANSON: In terms of funding, moving forward, you have got enough to do, you say, with the 11,000? That is in this financial year, is it?

Ms Gallagher: Yes. There is an ongoing issue. Our funding into elective surgery is continuing and every year it increases. The funding under the national partnership payment from the commonwealth will run out and that will reduce the amount going into elective surgery.

MR HANSON: When does that run out, at the end of the financial year?

Ms Gallagher: I cannot recall. We can provide you with that. I think it is the end of this financial year. It is an issue that has been agitated very strongly across all jurisdictions because every single government around Australia is pumping money into elective surgery and, I think, wants to continue that and will continue that. But there is no commitment from the commonwealth to continue their funding at this point in time. So that is very firmly on the agenda for COAG discussions.

MR HANSON: We recently missed out on $900,000 in funding from the commonwealth because we failed to meet targets.

Ms Gallagher: Yes.

MR HANSON: Are we sure that we are on track to meet future targets?

Dr Brown: Yes, we are undertaking some very detailed modelling to achieve the targets. It is a very complex process. It might sound simple but it is complex because we need to meet the targets across the elective surgery categories. There are then targets around reduction in long waits. There are also targets around the time lines of long waits. We then have to do that across Canberra Hospital and Calvary hospital and then factor in the private hospitals if we need to. We are also currently looking at Queanbeyan as well and we need to break that down across the speciality area of the surgery in terms of some of those targets. So it is very complex modelling work that we are undertaking.

MR HANSON: And in terms of Queanbeyan, have we got any progress on that?

Ms Gallagher: We are making progress.

MR HANSON: Do you have a—

Ms Gallagher: Again, it is complex. It really is.

MR HANSON: Is there anything that is not complex? Maybe we could talk about that.

Ms Gallagher: When you are dealing with people's lives, everything is complex. It is not just a matter of hiring—

MR HANSON: That cannot simply be your answer: it is complex. We got that with diabetes; we are getting it with elective surgery.

Ms Gallagher: It is not simply hiring out a community hall and having a bit of a party, in which case that is not very complex, but actually providing surgery and providing it with suitably qualified staff in a setting that is safe, with adequate funding.

MR HANSON: But this relates to missing out on funding, which we did, $900,000, and—

Ms Gallagher: We missed out on funding because it would have required—and this is some of the craziness around performance targets, in a way—

MR HANSON: Which you signed up for.

Ms Gallagher: We would have had to cancel the surgery of about 106 people who had been waiting too long for care and replace them with 100 people who had not been waiting too long for care in order to get that money. I do not know, but for me that looked a little silly.

MR HANSON: Didn't you sign up for those targets?

Ms Gallagher: Yes, we did. We did sign up to the targets and we aimed to reach the targets. But when it became clear that on that particular target that is what we would have to do, that was a question where I think the decision was made, quite rightly, to continue with the long-wait strategy. The $900,000 would have paid for 100 additional surgery procedures. In order to get it, we would have had to cancel 106 people who had been waiting too long for care. And I just did not think that was a reasonable thing to do.

Dr Brown: I can give you the number of people waiting longer than 12 months. It is down to 237.

MR HANSON: Thank you.

THE CHAIR: Thank you, Mr Hanson, you have completed your supplementaries. Moving on to page 123 of the annual report, is the nurse walk-in clinic at the Canberra Hospital able to authorise X-rays on the weekends?

Ms Gallagher: Never has been able to.

THE CHAIR: Why not?

Ms Gallagher: Because I think it was one of the decisions that were taken at the beginning of the setup of the walk-in centre about the scope of practice and what services were able to be provided. So it has operated from that point.

THE CHAIR: Is there any opportunity for that to be looked at again to see whether it is required?

Dr Brown: Yes, we have already given an undertaking that we are looking at that as part of the overall review of the walk-in centre. That is not to say that it will commence. We are just reviewing the issue of whether or not X-rays are able to be ordered on the weekend.

THE CHAIR: Is this something that you have not had a demand for or—

Dr Brown: It is not presented as a significant issue in terms of the operation of the walk-in centre but it has been raised with us and we have already given an undertaking that we will be reviewing that. As I say, that is not to be interpreted as an undertaking to actually change what is there at the moment. But we will look at the demand and whether or not it is actually creating any hazards.

THE CHAIR: But you are categorical about the fact that this has never been able to be accessed through the walk-in clinic? "This service has not been cut," is what you are saying?

Dr Brown: No, it has not been cut. It has not changed. The essence is: if the X-rays are ordered, they need to be done in the hospital and currently the walk-in centre cannot order them. The individual presents to the hospital and is able to access the service. So it is not really a major issue in terms of being denied a service. There is a convenience aspect to it and we are looking at it for that reason.

THE CHAIR: Are CALMS able to authorise X-rays?

Dr Brown: Yes.

THE CHAIR: And are they able to access the hospital database for previous X-rays for clients?

Dr Brown: I cannot answer that.

Ms Gallagher: Not sure.

Dr Brown: We will have to take that on notice, I am sorry.

THE CHAIR: Please. And when an X-rays is authorised by CALMS, is the cost borne by CALMS or by the hospital?

Ms Gallagher: It depends where it is performed, I imagine, the answer to that is. If it is performed in the hospital, the cost will be met by the hospital. If it is a referral to and done at Canberra Imaging, for example, the patient and Medicare would cover the

cost of some of that.

MR HANSON: A follow-up on that.

MS BRESNAN: I have some follow-ups, actually.

THE CHAIR: Ms Bresnan, first off. We have got some supplementary questions. Do you want to add some further information there or not?

Dr Brown: No.

THE CHAIR: Ms Bresnan has some follow-ups on that and so has Mr Hanson.

MS BRESNAN: It is in relation to the walk-in centre. Was the issue with the X-rays something that was related to the scope of practice or was that another issue that was raised by the stakeholders when the centre was established?

Dr Brown: It was an issue that was raised in the discussions with the stakeholders and the resolution was that there were to be none ordered on the weekends.

MS BRESNAN: Some of the issues that have come up with the walk-in centre are about presentations to the emergency department. Is it a locational factor? It is located so close to the ED. Is it related to the fact that the scope of practice of the nurse practitioners is limited, or is it both?

Ms Gallagher: It is probably a little bit of both, I would imagine. I think what we are seeing with the walk-in centre over time—and it has only had a full year of operation and now the first quarter of this financial year—is a flattening out of where people are going. I think people are understanding what the walk-in centre is actually meant for now. I think it was as high as 30 per cent of people were being referred—20 per cent would go to a GP, 10 per cent would go to the ED. That has come down to about 20 per cent now referral to other services. I think that is telling us people are understanding what the walk-in centre is. It is about, I think, a seven per cent referral to emergency department and the rest largely to GPs.

I think it is probably a bit to do with the scope of practice, but we are looking at the evaluation of the walk-in centre. It does raise some interesting issues for us. Is the walk-in centre a nurse practitioner model or is it an advanced-practice nurse model? What is the role of the medical practitioner within that model? And a number of the staff within the walk-in centre believe that there is a role for a medical practitioner, even if it is as a mentor, someone to get some advice from if they see something unusual that they have not seen before, that sort of advisory role. I think the GP community would like more of a hierarchical model within the nurse-led centre.

MS BRESNAN: In terms of stakeholder interest in this, is the scope of practice issue potentially going to be impacted by other general practitioners or is it going to be based on what these nurses can deliver? What weight is going to be placed on it?

Ms Gallagher: The scope of practice is essentially the negotiated outcome of stakeholders, which made it pretty tight for that first year. And what that has led to, I

think, is nurse practitioners not feeling fully able to utilise all of their highly trained skills. So what we are seeing, in a way, is that it is developing into an advanced-practice nurse model rather than a nurse practitioner model. And that is one of the questions. What do we want the nurse-led centre to be? Do we want it to be nurse practitioner or are we going to settle for an advanced-practice nurse within the relatively narrow scope that exists, as agreed with the stakeholders?

MS BRESNAN: Does that potentially mean we could lose some nurse practitioners who would normally work in the public system but who might go elsewhere to practise?

Dr Brown: It is going to depend on the resolution of these issues and we have not reached that resolution yet. So this is all part of what is being considered. We have the evaluation. We have put that out for consultation. We have received a number of submissions and we are currently in the process of weighing all of that up.

Ms Gallagher: Where the nurse practitioners are coming from—and we have got many; they are growing in number—is that they are finding their greatest opportunities in particular specialties like the palliative care nurse practitioners, the sexual health nurse practitioners, wound care nurse practitioners, where they have got a lot of autonomy within that field. And that seems to me where the greatest opportunity is. I do not think nurse practitioners have felt particularly well utilised in the walk-in centre. So either the scope of practice grows and expands—

MS BRESNAN: Or it becomes advanced?

Ms Gallagher: —or we say this is an advanced-practice nurse model.

THE CHAIR: Mr Hanson.

MR HANSON: One of the issues has been the location of the walk-in centre. My understanding was that at the last election you went to the electorate saying that you were going to put them into Tuggeranong and Belconnen. And my understanding is that the upgrades to the Belconnen healthcare centre and the Tuggeranong health centre are going to have the capacity for a nurse-led walk-in centre. Just on that, how does that work? Are you actually building those centres with the facilities available? Are you building them with it in mind that at a later date you could provide that as an addition? What are you actually building?

Ms Gallagher: From my memory, we went to the election saying that based on the success and the outcomes of the one at the hospital, we would look to move them to the community. And I think that is still a worthy aim. Both health centres are built with clinical treating rooms. Whether they are used for walk-in centres or other clinical opportunities remains to be determined. I need to work through the walk-in centre with the stakeholders.

MR HANSON: I appreciate that. I suppose my question is: if we were to say that the preferred option appears to be to relocate it from the TCH campus to Tuggeranong or Belconnen or somewhere else, in doing so, if we were to move it, is the scope of works at Tuggeranong or Belconnen or Gungahlin, whichever centre it went to,

adequate to house the nurse-led walk-in centre or would there be a capital cost of doing that?

Ms Gallagher: Again, it would depend.

MR HANSON: An additional capital cost?

Ms Gallagher: They are being built with capacity for clinical treating rooms, which is what you need for a walk-in centre. It is also what you need for a GP or a podiatrist or a physiotherapist. They are built with the capacity for that to occur should that be the case. Going back to your original point that there seems to be a view it should not be on the hospital, that is not a view supported by the GPs. The GPs think it should be on the hospital.

MR HANSON: I was basically trying to get across there, to be honest, the capital component. The capital component, I think, was $3 million for the Canberra Hospital funded by the commonwealth, wasn't it?

Ms Gallagher: We did the capital—

MR HANSON: The capital, which was—

Ms Gallagher: —and the commonwealth paid for the first four years of operation of the recurrent.

MR HANSON: Okay, and I think it was $3 million, from memory. So I am just wondering if you were to—

Ms Gallagher: That was a refurb of an older space in the hospital, so I am not sure you could take that as a—

MR HANSON: I just want to clarify, when we are talking about the decision as to whether or not it should move to the community, whether that comes with a price tag. What I am getting from you in this hearing is that it does not, because the—

Ms Gallagher: It does not necessarily. If you were wanting to put everything into Belconnen and a walk-in centre, it may—or the same down in Tuggeranong. It is based on decisions about the services you are going to put out of there, it is based on the times at which you will be looking to operate it, whether it would be shared space. None of those decisions have been taken because of the evaluation. We are waiting for the evaluation.

MR HANSON: When will that be completed? You have got the report.

Ms Gallagher: Yes, we have all got the report, so it is currently—

MR HANSON: You are considering it?

Ms Gallagher: It is currently before government, and I am talking to all of the stakeholders about their views.

MR HANSON: Do you have a time line in which you would anticipate a government response to that report?

Ms Gallagher: I think it would be next year, looking at the program for cabinet—early next year.

THE CHAIR: Thank you, minister. These were all questions related to my walk-in question. So the next substantive question is by Ms Bresnan.

MS BRESNAN: My question is in relation to page 120 of the annual report, in relation to caesarean procedures. It says that there have been some measures put in place to reduce the rate, which has been increasing. Can you give us a bit more of an outline of what some of those measures are and whether or not they are starting to show to have an impact?

Dr Brown: I will ask Liz Sharpe to speak about that.

Ms Sharpe: Could you repeat the question for me, please?

MS BRESNAN: It was in relation to caesarean procedures. It lists that there has been an increasing rate and it mentions that there are measures to reduce that rate. Can you outline what those measures actually are and whether or not they have been shown to have an impact?

Ms Sharpe: The actual total rate for the ACT itself is 27 per cent. The rate for Canberra Hospital sits at around 24 to 25 per cent, which is still one of the lowest rates in Australia for caesarean section. However, we are still working on the rollout of the *Towards normal birth* framework. That is to look at such things as continuity of midwifery care, early identification of any risks associated with pregnancy in order to manage them in the antenatal period and having a defined birth plan in place.

MS BRESNAN: You mentioned midwifery. I know there has been a great demand for the midwifery program in the ACT. In terms of demand for that and also for the birthing centre, has that been factored into addressing this issue or addressing some of the strategies you are trying to put in place?

Ms Sharpe: Yes. New South Wales Health has rolled out a document called *Towards normal birth* and there are 10 steps that they recommend organisations would commit to. As we do a lot of work with the perinatal network services of New South Wales, we are trying to adopt the 10 steps of *Towards normal birth*. Some of those things involve having a management plan for women that have had a previous caesarean section. So what is their next birth after caesarean section going to be? That is working with the obstetric team and the midwives to have an early plan for those women. For many of those women, they do not need to go to repeat elective caesarean section for their next baby.

There are other things. Continuity of care with a known midwife is known to reduce intervention. And intervention will often lead to caesarean. There are such things as use of water for pain relief in labour. The new facility, the new women and children's

hospital, has more baths available for women in the first stage of labour, for comfort. All of these are indicators that actually reduce intervention which can reduce your caesarean section rate.

MS BRESNAN: You mentioned the birth centre. Are you able to cope with the high level of demand to access the birth centre? In terms of turnaway rates, is that occurring at all?

Ms Sharpe: We still have a waiting list for the birth centre. The birth centre has a philosophy around women who are keen to have a non-interventionist birth and with using natural forms of pain relief. But there is another cohort of women who may not want that philosophy but are aiming for continuity of care. We have recently rolled out our second continuity program, which is in the mainstream antenatal services. This is enabling another 200 women per annum to access "know your midwife", who may have to have some sort of obstetric intervention purely because of a medical diagnosis in their pregnancy. So they are not excluded from continuity because of a medical complication.

MS BRESNAN: With the two new suites at the birthing centre, will they have any impact on the type of births that you can accept or the numbers?

Ms Sharpe: What the two extra birthing suites in the new birth centre will do is reduce the incidence of turnaway for women in labour who have chosen the birth centre but where the other three rooms have been full, historically. So we are hoping that that will give people more satisfaction and the opportunity to be in a home-like environment.

MS BRESNAN: Of course I have to ask a home birthing question. That was discussed at the most recent health ministers meeting. Could we get an update on whether it was discussed and whether there was any outcome?

Ms Gallagher: It was discussed briefly—not on the formal agenda, from recollection. My understanding is that Dr Hames in WA is doing a piece of work that is coming back to the next meeting. He was not at that meeting, unfortunately, so he was not able to speak to where that work was up to. But that is going to inform discussion at the next health standing council meeting which is, from memory, in March in Canberra.

MS BRESNAN: So there wasn't any resolution on that particular policy statement?

Ms Gallagher: I think the view of ministers is that no, there is no resolution. In a way, this is not going to come to a head until 1 July next year. So the March meeting really is the crunch time. It may be that there is a similar proposal for a further exemption for the insurance—I am not sure—based on that. And there are some issues in South Australia that the South Australian minister is concerned about, where a baby has died in a home birth—actually, on the way to hospital, a twin pregnancy, assisted with a midwife at home. It is going through the coronial process now. Again, that will inform discussions.

MS BRESNAN: Obviously that is a terrible incident but will it look at the positive

data as well?

Ms Gallagher: Yes, absolutely, it will. With respect to some of the discussions I have had here, following a meeting I had with you and with Justine Caines, I undertook to speak with clinical staff in our women's and children's unit about what are the opportunities for collaborative care and to be operational in our own facilities. They have undertaken to have that discussion with staff and then get back to me.

MS BRESNAN: Thank you.

THE CHAIR: Mr Hanson, you have a supplementary, and then you can ask your substantive question.

MR HANSON: Okay. I have a supplementary on maternity issues. The clinical review that was conducted into maternity services at TCH: where are we at with the implementation of the recommendations arising from that?

Dr Brown: Yes, there has been a working group meeting to progress those recommendations. I do not know if Ms Sharpe has the numbers.

Ms Sharpe: Of the recommendations, all of the immediate and short-term recommendations have been met. The majority of the medium have been completed and the long term are rolling into an agreed maternity services network that we would like to commence in 2012. Those long-term ones are things around establishing standards of practice across the territory, so partnering with the three facilities that provide birthing services, to have standardised clinical practice standards for care of maternity women, and also to enable the rollout of the national maternity services plan across the territory in a standardised approach.

MR HANSON: How is staff retention going? In the lead-up to the clinical review we had a spate where I think 11 staff left. Have we been able to stabilise that and have some continuity?

Mr Martin: Yes. I think we have had very good recruitment over the last six months. I think they are sticking to the plan and the group who have been meeting monthly have put in some really good strategies. We have had some very good recruitment in the doctor groups and in the nursing groups. Liz, can you remember your numbers for nursing?

Ms Sharpe: For midwifery, we have just trialled a new recruitment strategy with HR where we have developed a recruitment pattern. We did bulk recruitment on any given day and if people met the criteria with appropriate referee reports we were able to, with HR, offer them a position immediately, which actually closes the deal and gives you the ability, in a competitive market for midwives, to have that job offer there, then to sign off on it and be committed to work in your organisation before they get multiple other job offers. So we have given 18 letters of offer that have been accepted for March 2012.

Dr Brown: And the doctors have included staff specialists and VMOs, so we have made progress in terms of progressing VMO re-entry into the service.

MR HANSON: That is encouraging. With respect to the Public Interest Disclosure Act, we do not know what recommendations arose from that, but I assume that some did. Have they been implemented or are they being implemented? What is the status of that?

Dr Brown: There was an action plan drawn up around those recommendations and that is being progressed appropriately.

MR HANSON: How do we satisfy ourselves of that?

Dr Brown: It is very difficult to provide public reassurance in relation to that because of the confidentiality provisions within the Public Interest Disclosure Act.

MR HANSON: So we take your word for it?

Dr Brown: I would hope so.

Ms Gallagher: I think on all of the other measures that you have just questioned, the information is there. I am also going to have the public interest act amended to allow for greater public information to be provided when public interest disclosures are made and which is not allowable now under law. So it needs legislative change and it needs Assembly support.

MR HANSON: Will that be retrospective to include this review?

Ms Gallagher: I do not believe so, no.

MR HANSON: Minister, you described a 10-year war in obstetrics that had been raging in Canberra. I guess it is the war that you talked about between various obstetricians, private and public. Do you consider that that war is still occurring?

Ms Gallagher: I think there have been some victims of that war in the past little while. I think there were personality conflicts and I think those personality conflicts have been removed.

MR HANSON: So do you think that the war is over?

Ms Gallagher: I think it will still be a delicate process of negotiation to ensure that their requirements and our focus on a teaching hospital are met with VMO involvement.

MR HANSON: So is that a yes or a no? It is a pretty big claim to say that there is a war in obstetrics. I want to clarify whether you think that war is still occurring or not.

Ms Gallagher: As I said—

MR HANSON; If it is, what action are you taking?

Ms Gallagher: I think it was personality driven and I think some of that has been

removed. So the tension that existed and that caused a lot of the conflict has been removed.

MR HANSON: And how has that been removed?

Ms Gallagher: But I would not say that that means there are not going to be disagreements regarding the way that staff specialists operate and VMOs operate. So it is a delicate process and there is—

MR HANSON: Sure, no doubt. But it is different from a war, isn't it? So the personality conflict has gone. How did that arise? Did that arise out of this earlier process we were talking about or is it separate to that?

Dr Brown: There have been a lot of strategies in which that has been taken forward. With respect to the recommendations coming out of the clinical review, we put the working party together and we have sat down around a table with a whole range of stakeholders, both public and private, nursing and medical. We have worked through the issues. There has been work done internally, looking at the culture, the morale and the processes. I think all of those things have actually progressed us to the point today where I think there is good morale within the unit. There is a very positive outlook. As I say, we have VMOs on staff now and it is working well.

MR HANSON: My final question is this: if we knew that there was this 10-year war, why did we have to wait until the point of the whole thing exploding into war casualties before taking action? If we knew that there were these problems, why was it not resolved long before it led to the situation where we had 11 staff resigning, the Public Interest Disclosure Act and, as you describe, the casualties? Why did you not take action earlier to resolve this, minister?

Ms Gallagher: I must say that I think this predates this. The disagreements between certain staff specialists and VMOs go back a very long way. My focus as minister was very much on ensuring that there was an adequate—in fact an excellent—public health service provided through the Canberra Hospital. I think from the clinical reviews that shows that that was the case—and that is the case. I am not sure a politician could resolve some of those issues that had lasted for years—years before I was health minister and years before this government was in office.

MR HANSON: But we went through a process then, through the clinical services review and the public interest disclosure review, that did resolve those issues. You have said that it did. Those were within the remit, surely.

Ms Gallagher: No, those processes of themselves did not resolve it, Mr Hanson. I am happy to speak to you frankly about what resolved it, and I think you already know what resolved it. There has been a lot of work that has gone into actioning recommendations from the clinical review. That is the day-to-day business of the Health Directorate. Clinical reviews happen in every part of the hospital. Recommendations come out and recommendations are implemented. But in terms of the disagreements that have existed between particularly treating doctors in this town, they were not solved by the clinical review or the public interest disclosure.

Dr Brown: Could I give you some feedback on a previous question in relation to CALMS and the ordering of X-rays?

THE CHAIR: Sure.

Dr Brown: I have advice that the CALMS GPs are not able to access the RIS-PACS. They are provided with the results on a CD, with the images on the CD.

THE CHAIR: What sort of time frame is there for that?

Dr Brown: As soon as the X-ray is taken it is burned onto CD and provided back.

THE CHAIR: Thank you. Moving on to page 101 under "Cancer Services', the failure by cancer services to reach the target of the number of breast screens for women aged between 50 and 69 years was blamed on radiographer staff shortages. What is being done to remedy this situation?

Dr Brown: I will ask Denise Lamb to speak to that.

Ms Lamb: The issue of radiographers and recruitment to the ACT breast screen program has been an ongoing issue over many years. It is part of the overall workforce shortage across Australia. What has occurred in the last year for ACT BreastScreen is that we have now fully recruited; we have just got all of our positions filled. We were able to bring in locum services in the last couple of months to try and help as well.

One of the other major reasons why we have been able to fully recruit is that the separation of the New South Wales breast screen service has provided us with radiographers that were in the past having to go out and service south-eastern New South Wales.

THE CHAIR: I think Ms Bresnan has got a supplementary.

MS BRESNAN: Again, it is on the breast screen targets. A recent article raised an interesting point about over-diagnosis being an issue, stating that it occurs in five to 30 per cent of cases or something like that. Is that something which gets built into the targets? Does any research that might come out which states something like that get considered?

Ms Lamb: The breast screen program, which is part of the national breast screen program, has quite a large range of accreditation measures. Part of those accreditation measures are around your effectiveness of screening in rates of detection of cancer, both small and early cancer. If you have over-screened your detection rates will not be within those accreditation measures. Certainly in the ACT we fit very well within those measures.

MS BRESNAN: So is that something which you then factor in, like you said, so it has an impact on your measurements? Is that something you factor into the target, recognising that that could be an issue—or is it something you just keep an eye on, recognising that it occurs?

Ms Lamb: I think you keep an eye on it through meeting the accreditation measurements. The percentage participation rate is based on your population studies around screening programs, probably more so than the accreditation figures.

MS BRESNAN: Thank you.

THE CHAIR: Mr Hanson.

MR HANSON: Emergency departments—the results for category 3 and 4 are not good. Could you give me some explanation of the deteriorating waiting times, please?

Ms Gallagher: Have you got the page number there, Jeremy?

MR HANSON: Yes, it is page 112. You will see there is a table on triage categories, and we have got a target. For category 3 the target is 75 per cent seen within the time frame.

Ms Gallagher: So 1, 2 and 5 are very good; 3 and 4 have been our areas of pressure. In the latest data they are continuing to improve. One of the issues is that performance at the Canberra Hospital is going extraordinarily well. Unfortunately, performance at Calvary hospital is not in categories 3 and 5. They have had some additional presentations. Their activity has been up and greater than at Canberra Hospital. When you put those two together, that is affecting the overall improvement across the board. I think we have got a range of strategies in place to continue to improve. We have focused on the national agreements. We need both EDs to be working really well to achieve it.

MR HANSON: That is a pretty significant dip, though, isn't it? It is the first time I think I have seen, for example, semi-urgent dipping below the 50 per cent mark. The urgent is down to 54 per cent. Is it demand? What is the issue?

Ms Jackson: The reporting period referred to in the annual report does reflect that dip, but we have actually done some significant work around process and flow to the emergency department at the Canberra Hospital and internally since then and have managed to improve those waiting times quite significantly.

Year to date, to the end of October, 69 per cent of all triage category presentations were seen on time. For our category 1s and 2s, both of them either met or exceeded the target, so 100 per cent of category 1s and 86 per cent of category 2s were seen on time. To the end of October we had improved our category 3s to 66 per cent, which is only four per cent below the target and a significant improvement from the year-to-date figure of 41 per cent. We have also managed to improve our category 4s to 61 per cent and exceeded the target for our category 5 patients.

MR HANSON: These figures seem to fluctuate pretty dramatically. They sort of go up and down. We get up to 60 and then it bottoms back down to 50 per cent and comes up. Have you got an explanation for that?

Ms Gallagher: I do not think it moves.

Ms Jackson: We have actually sustained that; that is a year to date figure. Since about February, March, we have managed to continue to improve and sustain that.

Ms Gallagher: One of the issues here is to look at emergency department time lines and compare them to other jurisdictions. We have two busy metropolitan hospitals here. Go and have a look at the Western Australian performance data. Their category 4 was sitting at about 41 per cent, I think, for their metropolitan hospitals. What they have is the benefit of rural hospitals where you have a couple of patients a day and they are seen very quickly, so their overall performance is improved.

I am not just saying that to say that we do not need to improve; we do. What I am saying is that metropolitan hospitals dealing with hundreds of patients every day are always going to struggle in categories 3 and 4 and it is no different in every other major capital city.

MR HANSON: What work are we doing in terms of infrastructure in both Calvary—

Ms Gallagher: Both emergency departments have capital projects underway for expansion.

MR HANSON: Can you give me a bit of an extrapolation on that—what that involves in terms of additional capacity or what that will actually mean and when that will be delivered?

Ms Jackson: From the Canberra Hospital perspective we are looking at both capital infrastructure and process redesign. Over the next 12 months the capital infrastructure will involve the four extra treatment spaces at the front of the hospital, so building out into the ambulance bay, and up to six treatment spaces at the back of the emergency department, so increasing our treatment space options by 10.

We are also doing internal and external process redesign, both of which are aimed at helping us improve our triage category performance timeliness and to achieve against the four-hour target. That includes strategies like putting on extra emergency department doctors—we have increased our FACEM profile by three over the last 12 months and we will be bringing on another two at the beginning of next year—looking at using those senior staff to what we would call a frontloading model where they rapidly see and make a disposition decision which has been demonstrated well to reduce length of stay for emergency care patients, and looking at ways that we can facilitate decision making with our inpatient team colleagues to rapidly move patients that are waiting for admission from inpatient beds to either our admission units such as our MAPU or our SAPU or other inpatient areas.

MR HANSON: And Calvary?

Dr Brown: Similar work is underway at Calvary. They have got some plans for changes to the configuration of the emergency department and they are also doing a lot of process redesign.

MR HANSON: Okay. Have we got targets similar to elective surgery with our

emergency departments that we have signed up to?

Ms Gallagher: Yes.

MR HANSON: And that relates to the four hours and so on?

Ms Gallagher: Yes.

MR HANSON: And do we look like we are on track?

Dr Brown: We are looking pretty good. It is a staged target and it—

MR HANSON: I imagine it is complex.

Dr Brown: I can assure you, Mr Hanson, it is very complex. By the end of December 2012 we need to have met 64 per cent of patients having their disposition—being discharged, admitted or referred elsewhere—within the four hours. Again we are tracking that very closely.

MR HANSON: The other issue is that there are a lot of chairs that people now move to rather than beds. I suppose you can put more people through. Have you had many complaints about that, where people are unable to go on to a hospital bed because they have been treated in a chair? And are those chairs being treated from a reporting point of view as a bed? How do they get reported?

Ms Jackson: We have five chairs within our acute treatment area. They are the chairs you are referring to I understand—

MR HANSON: I guess, yes.

Ms Jackson: the chairs you would use to see and assess patients in?

MR HANSON: Yes.

Ms Jackson: As I am sure you would appreciate, not every patient that presents to the emergency department needs a bed to lie down in. It did allow us to increase our treatment capacity, so we were able to replace three trolleys with five beds in the same space. It is co-located with a treatment room so that patients that might need an examination or a private conversation are able to be seen in that environment. I am sorry; what was the rest of the question?

MR HANSON: Just whether you report—

Ms Jackson: Have we received complaints about—

MR HANSON: There are complaints. I have had a couple of constituents that were not happy being in a chair—they would rather have been in a bed, I guess—and also whether there is any reporting of that and whether they are reported as a bed or as a chair.

Ms Jackson: They are not reported as an inpatient bed. It is a treatment space. We have other areas within the emergency department, such as our fast track, that are also chairs. There are also other places across the hospital, such as hospital in the home and dialysis, that use chairs for treatment spaces. Have we received complaints? We have had some feedback about patients that have not felt comfortable in the chairs and we have responded to that. However, it is a more appropriate space for someone to be seen than to spend a long time in the emergency department. Certainly that has been one of the strategies that have assisted us to see our patients more quickly.

MR HANSON: Okay. With specific regard to emergency department and access block for mental health patients, page 109 shows there has been a worsening, I guess a doubling, in the time taken to deal with mental health patients. That is probably not your area but—

Ms Jackson: I will let the executive director for mental health respond to that.

MR HANSON: I am happy to take a break at this point—

THE CHAIR: We might just take a break as we have got a 15-minute break coming up at 3.30.

Meeting adjourned from 3.28 to 3.47 pm.

THE CHAIR: Mr Hanson.

MR HANSON: I think we were talking about access block for mental health. The target was set at 15 per cent and the achievement rate was 36 per cent. So I was just wondering whether you could explain why that is and what we are doing to improve that.

Ms Bracher: Sure. We have reported a 36 per cent access block rate for mental health consumers. There are a couple of words of caution that I would like to urge with regards to the interpretation of that data. We have had a significant increase in the number of presentations to the emergency department, which has made it difficult for us to achieve our throughput. There has been a 21 per cent increase from one financial year to the next. Having said that, there are a relatively small number of presentations per day. There are about two or three people that present to the department per day. Any change for one person can have a significant change in the proportion that is reported. So I think we have to urge caution with that.

Having said that, we absolutely acknowledge that we are not providing the access and the throughput to the target and that we will need to for the four-hour target that has been set from the commonwealth. And we are doing a lot of work within our department around that.

We have commenced a redesign project in the last three months where we are looking at the whole adult mental health journey from the community into the MHAU, into the inpatient services of the Canberra Hospital, and then back out into the community. We are actually looking at doing the diagnosis phase of that. We are looking at our data in a lot of detail to work out where we can target our strategies to improve the

throughput through the emergency department. That will be a work in progress over the next three or four months.

We have our senor consultants from the community and from the inpatient areas involved in that work. The nursing staff and the consumers and carers impact as well. So we are trying to pull together a broad solution to address this access block for the next financial year.

The other thing that I would like to say about the mental health assessment unit is about the quality of the service that we actually are providing through the mental health assessment unit. We are actually doing very extensive mental health assessments in the assessment unit in the emergency department, which is actually prolonging our length of stay.

With the need to achieve the four-hour target, we are going to have to work differently from that in the future and do the full assessment in different facilities. So the full assessments might occur in a staged way, with some of it occurring in an inpatient unit or some of the assessment being undertaken back in the community when the person is referred back out there.

MR HANSON: Do you think the 21 per cent increase figure is just a statistical anomaly because of the low number of presentations or do you think that is a trend that is going to continue?

Ms Bracher: I do not think it only relates to the statistical anomaly. We are working very hard for it not to continue in an upwards direction. And in fact over the last three months we have been able to stabilise that, with some small changes that we have done with staffing profiles within the mental health assessment unit. We are measuring that data very actively day by day in fact to address that. And we have stabilised that. With the broader redesign project that we are doing, we are actually anticipating that we will bring that back towards target.

MR HANSON: But that is the number of people presenting, isn't it, that 21 per cent?

Ms Bracher: Yes.

MR HANSON: Is not that a bit beyond your control?

Ms Bracher: Sorry, I must have misunderstood your question.

MR HANSON: What I am saying is that you have seen, as I understood from what you have said, a 21 per cent increase in presentations.

Ms Bracher: Yes.

MR HANSON: And I am just asking whether, because you have a small number of presentations, it is just a statistical anomaly or whether, because that is an upward trend, you consider it is going to be sustained in terms of the number of mental health patients presenting to emergency?

Ms Bracher: Sorry, I did misunderstand your question. Obviously, presentations to emergency department are based on clinical need, and if people are unwell they need to go to the emergency department. Having said that, we are working in a number of ways to reduce the number of places where people can actually be assessed. We are doing emergency assessment appointments in the community mental health teams so that they are having an assessment in the community team to see whether they need to be admitted. And if they do need to be admitted, they are being admitted directly to the PSU. Certainly the plan for the new unit is for direct admissions to the new unit so that they will not have to go through the MHAU for that assessment.

MS BRESNAN: Have the ones now primarily been direct admissions or have they been people being admitted through that new process that you have said you have instituted to try to have more thorough assessments by the community mental health team? Has there been any sort of any analysis of why there has been this spike?

Ms Bracher: We are in the process of doing that analysis now. The data that we are looking at as part of the redesign project is drilling down to that level so that we can understand who are the people that need to present to the emergency department under their emergency orders. The work that we are doing with the police is actually keeping a number of people away from the emergency department and being able to manage people in a more appropriate environment rather than under emergency order in the ED. Sorry, does that answer your question?

MS BRESNAN: Yes. Obviously, as you said, you are looking at that analysis. But it would be interesting to know whether primarily they were direct admissions to the hospital, people just coming to the hospital because they were unwell, or whether they were coming through some other means. Like you said, if there has been that increase it would be interesting to know whether that is primarily the reason.

Ms Bracher: Yes, and that is the analysis we are doing. Once we understand where the increase in numbers comes from, that is obviously where we will target our work to see whether there are other ways that we can manage people.

MS BRESNAN: Has that increase had a big impact in terms of the time someone has to wait in the emergency department at all?

Ms Bracher: It can. Yes, it can for some people. It depends on the presentation of the people. Some people we can move directly through into the acute unit very quickly. It is very obvious that they need an admission and we move them through very quickly. For some other people, we would like to do a more detailed assessment and see whether we can work out a community package or a community support mechanism for their care and then transfer them back to the community. But before we do that we want to ensure that we have got the appropriate package in place, and that does take a little longer.

MS BRESNAN: Where people are being discharged, has there been any similar impact? Is there an increase there as well? Does it have a commensurate impact then on where people are being discharged to when they leave?

Ms Gallagher: Are we trying to early discharge other people?

MS BRESNAN: No. Does that then have a commensurate impact on what is available for people in the community when they have to be discharged, the sort of assistance that is available?

Ms Bracher: Yes.

MS BRESNAN: Obviously it is a short-term thing. Has there been any noticeable impact in terms of that respect?

Ms Bracher: In parallel with what we have been doing in the MHAU, there has been an increase in the number of—and we talked earlier in the committee about this—subacute initiatives, the Hassey model, which is around supporting people in the community. We are discharging to those models and using those models very actively in the community to actually prevent the admissions and prevent the presentations to the emergency department.

Dr Brown: And working with the non-government sector. I think an outstanding result that we have achieved in terms of discharges from PSU is the readmission rate, which has actually dropped to five per cent, which is really quite extraordinary.

MR HANSON: That is work well done.

Dr Brown: It is very good work. I think it indicates the thoroughness of the planning for discharge and the working collaboratively in terms of the after care.

MR HANSON: If I can come back to the 21 per cent—and you probably do not have an answer for this—I am just wondering why there has been such an increase in terms of the people that are presenting. Is it a migrant population that is increasing the need? Is it older people? Is it younger people? Have you done any analysis to work out just what that demographic is? It does seem like a big increase.

Ms Bracher: We are doing that analysis now. That is part of the analysis of the redesign project.

Ms Gallagher: And the opening of the adult acute mental health inpatient unit early next year will provide extra capacity for additional inpatients to be treated over and above what can be done at the PSU and will provide much more appropriate treating places and accommodation for people.

I think one of the interesting things for me in watching how the MHAU has operated, the mental health assessment unit, is that excellent mental healthcare can be provided within the emergency department. It might take a length of time in order to do that. But there are six spaces within there in private rooms. It is not like it used to be for people presenting to the emergency department. If I saw this 36 per cent figure before the MHAU was operating, I would be a lot more worried about it than I am. There was one treatment space. It was in the middle of the emergency department. It was very difficult to provide care to people. The MHAU provides a separated place from the emergency department, close to the emergency department, but also provides some privacy and the capacity to treat people respectfully within that.

MR HANSON: I look forward to seeing some of those things. As you would be aware, minister, I have been asking since May for a visit to the hospital. It is becoming embarrassing. And I look forward to the visit so that I can see some of these things for myself.

Ms Gallagher: I think that has all been organised.

Dr Brown: It has, yes.

Ms Gallagher: The thing is that it is not my job to really worry about you meeting staff at the hospital. I am happy to facilitate visits. But from May, as I explained to you—and it still is an incredibly busy time—it is hard to accommodate resources for people to necessarily interrupt people's working lives to have a look. I am happy to do what I can but it is not and was not a priority during the winter months, as it is for me to do visits like that. I have cancelled quite a number of my own ones based on the workload at the hospital.

Dr Brown: Chair, could I read a couple of answers in?

THE CHAIR: Yes.

Dr Brown: In relation to the elective surgery waiting list, this is as of 31 October, in category 1 we had 208 on the waiting list; in category 2, 2,189; and in category 3, 1,749. That is a total of 4,146.

Can I correct the record? When we were speaking before about the subacute beds, I think I indicated six beds was the target required this year. I am informed that I have overstated that. It is in fact five, and we have four of those already operational.

THE CHAIR: Thank you, Dr Brown. Going to page 103 of the annual report, aged care and rehabilitation services, the number of non-admitted occasions of service provided by aged care and rehabilitation services was nine per cent below target. This was put down to extended leave and consultant resignations. The occasions of service have been falling since September 2010. What is being done to address this situation?

Dr Brown: I will ask Linda Kohlhagen, who is the executive director for rehabilitation, aged and community services, to speak to that.

Ms Kohlhagen: This is due to a number of vacancies we have had in our geriatrician positions. We have had staff on extended leave who remain on extended leave, and we have had two permanent vacancies that we have unable to recruit.

THE CHAIR: This has been in place since September 2010?

Ms Kohlhagen: Yes. We have had staff who have been on leave since that period of time and the resignations. One of them was late in 2010 and another was in early 2011. We have tried a number of times to recruit nationally. Unfortunately there are geriatrician shortages across the country. It has made it a bit more difficult. Most recently our ad closed, the most recent one, on 11 November and we were still

unsuccessful.

THE CHAIR: Is it usual for it to be this difficult in filling these positions?

Ms Kohlhagen: Yes. I think it is unfortunately a national challenge as well. The sorts of things that we are looking at are how we actually grow our own geriatricians and making sure that we have a great working environment, that we have really good learning opportunities, and look at the opportunities that might exist at the ANU as well to attract the right calibre of person to come and work with us.

THE CHAIR: It seems a fairly worrying figure, nine per cent, when you consider that there is quite an ageing population. Obviously this is going to get worse not better. Are there any other measures that can be taken to address this situation?

Ms Kohlhagen: We are certainly trying as hard as we can. In the very near future we do not look like we are going to be able to recruit to those positions but in the next year, 2013, we understand that there will be people who will finish their training and be able to come and work with us as well. But it is a concern that, yes, it is an ageing population and we have had difficulties filling those positions to date as well.

THE CHAIR: Have you tried to recruit overseas?

Ms Kohlhagen: We have had some contact with some recruitment agencies but the applicants have not been suitable at this point in time.

MS BRESNAN: You mentioned that it is nation wide. Is it an area that is being identified throughout the national workforce strategies that are being developed about this particular area given, as Mr Doszpot said, we have got the ageing population as well? I know it is difficult but how do you address it? Is that something that is being dealt with?

Ms Kohlhagen: It is long term to try to address. It is looking at the training programs, that you have the registrars. It is looking at making sure that we can recruit them, often from the junior level as well, so that they can see that this is a career path that they would like to work in as well. They are the sorts of things that we are also putting in place. It has to be seen to be an attractive area that people would like to work in as well.

THE CHAIR: Are there any supplementary questions on this?

MS BRESNAN: This is in relation to page 108. In relation to consumer and carer representation, it states that we have got the 100 per cent representation there. It is about Mental Health ACT in communities. We have had some consumer reps say to us that while there is that 100 per cent representation sometimes they feel it might be a deception and that it sometimes becomes a tick a box exercise. Is there anything done to actually talk to participants or consumer and care reps to see what their views are of the actual participation or the consultation that they are involved in and how they are being involved in that?

Dr Brown: I will ask Ms Bracher to speak to that in terms of mental health.

Ms Bracher: Within the operational division that I manage, we have a very active involvement with consumer and carer participants on our committees. That is one of the strategies that we use to get consumer and carer input. They have been very actively involved with the model of care development for the new unit. I am having discussions already around the model of care for the adolescent and young adult unit, so that is another forum. We do our customer satisfaction surveys where consumers and carers are surveyed. There have been focus groups as part of that process as well.

MS BRESNAN: Is there a formal feedback mechanism for the consumer and carer reps themselves, so that they—

Ms Bracher: On the committees?

MS BRESNAN: They may not feel they can give the input directly—not that it can be anonymous but is there something through which they can provide feedback?

Ms Bracher: When I started in this new division I met with all of the consumer and carer representatives that were nominated for the divisional committees that I chair. I met with them in private. I went through the Health Directorate's policy on consumer and carer participation, so there was a bit of pragmatics and housekeeping around that. I also gave them my reassurance on how I valued their input to the committees and reassurance that they could approach me as the chair at any time out of the committee meetings if they had concerns about how things were being progressed. Granted, coming to me as the chair might not be the only mechanism that they might want to use to provide feedback.

Dr Brown: They are supported by the relevant non-government agencies—the Mental Health Consumer Network and Carers ACT. We have had discussions with those agencies in the past—I cannot speak about the very recent past but about the not-too-distant past—in terms of their role in supporting representatives who participate on our committees. We also have a part-time role dedicated to supporting consumer and carer participation, in terms of a participation coordinator. As part of the budget initiative, we have for the first time recruited a part-time carer consultant to complement the consumer consultants that we have employed. So it is a substantial attempt to provide support.

MS BRESNAN: In terms of being able to provide feedback, is it more the informal process that you have spoken about rather than something which is a more formal and ongoing process?

Ms Bracher: There is a very formal process through the Mental Health Consumer Network. The consumers that are on our committees have a coordinator role that is separate from the government agencies. I then meet with the executive officer of the Mental Health Consumer Network and the Health Care Consumers Association every six months seeking feedback. That is my—

MS BRESNAN: So any issues would come back through you through that mechanism?

Ms Bracher: I would hope so and I have certainly been very honest and open with regard to my desire to have that feedback.

Dr Brown: Across the Health Directorate we have recently formalised our process in terms of evaluation of all of our committees in adopting a standardised approach which will allow every member of the committee to provide feedback and consumers and carers will have the same opportunity as any other—

MS BRESNAN: Is that a recent thing?

Dr Brown: Within the last month, we have got a standardised approach that we have endorsed.

MS BRESNAN: Has that been instituted now or is that still in the process of happening?

Dr Brown: No, because we generally do it towards the end of the financial year. It informs the review of the terms of reference that we conduct at the beginning of each new financial year.

MR HANSON: The workforce plan was due this month. Is that imminent?

Dr Brown: I will ask Ms Childs to speak to that. It is another complex piece of work, Mr Hanson.

MR HANSON: No, you are kidding! There has to be some sort of prize when someone says, "This is simple."

Ms Gallagher: Nothing is simple in health—nothing.

Ms Childs: With the workforce plan, originally we had planned to have released the draft workforce plan this month. That is not going to occur.

MR HANSON: The website, just to clarify, says the workforce plan will be released in October 2011. It does not mention that it would be a draft. The original plan, as I understand it, was for the final, but I stand to be corrected.

Ms Childs: I apologise. There have been a number of issues that have complicated it. Certainly resourcing of the unit involved in developing the workforce plan has been an issue because of the competing priorities with the national health workforce agenda. Health Workforce Australia very recently released a national framework for health workforce planning. We have now taken the decision to recast the work that we have done to date on the plan into that framework, which will delay the release of the plan.

MR HANSON: So when do you anticipate—

Ms Childs: We do have a workforce plan actually in place now. We anticipate that, with respect to the final version of the plan, we need to allow for consultation within the broader integrated regional training group, which is one of the big new initiatives in national health workforce terms. We do anticipate the final product being available

in March next year.

MR HANSON: Are you releasing a draft before then that would be publicly released for consultation?

Ms Childs: We have released a discussion document. We are now seeking feedback on the framework itself and the integration of the work and the feedback that we have had to date in our previous consultations into a draft document.

MR HANSON: So there will be a draft. Has the discussion document gone out to a narrow group of people or is it publicly released?

Ms Childs: A group of 89 stakeholder organisations, as I understand it.

Ms Gallagher: Do you want a copy of it?

MR HANSON: I would love a copy of it, if that is available. The draft will be released for comment earlier than March, I assume, or how does that work?

Ms Childs: At this stage we would envisage releasing a draft in late February to the steering committee and then we will finalise the version and release the plan in March. So there will not be a further draft released for consultation.

MR HANSON: Is there anything that you can tell us about the workforce plan as a bit of a highlight or do I have to wait?

Ms Childs: One of the highlights for me is that it is aligned to the national health workforce planning strategy and framework. I think that is important, going forward. Also, I believe we will improve the rigour around the KPIs.

MR HANSON: On workforce, it does seem that when a number of objectives are not met, when we look at the strategic outcomes, workforce shortage is a factor there. We know that we are endeavouring to grow the health system. How confident are you that we are currently meeting our workforce targets and that we will be able to meet them going into the future?

Ms Childs: We have a number of risk management strategies in place to address workforce shortages. We have a large range of options as far as short-term agency supply, recruitment agencies, locums and that sort of thing. Generally across Australia there are shortages in particular areas. Health Workforce Australia was actually put in place to provide a national coordination analysis of health workforce and then targeted strategies around developing more health professionals. So within the risk plans that we have put in place with the strategies we have around short-term labour, I am confident that we can meet our workforce supply going forward.

MR HANSON: In the workforce plan or other work that you have done, the government has a plan to build a subacute hospital and also to upgrade Calvary by a couple of hundred beds. I assume that when they open, you go from it not being open today and then it is open tomorrow and then you have to staff this thing. How do you go about the process of essentially going from an empty hospital to a hospital that is

full of staff? Do you do that incrementally? Do you open up a ward at a time or is that—

Ms Gallagher: That is how it would usually happen.

MR HANSON: So you are looking at a process of doing that incrementally?

Ms Gallagher: You do not go from nothing to 200—

Ms Childs: I think there are a number of issues as to what services you are going to deliver and what you may move from other facilities. Also, as part of the strategy, you look at what are the marketable aspects of that facility. We need to leverage whatever advantages come from building a new facility.

Ms Gallagher: Yes, you would normally implement a staged approach and in a subacute facility there would be some existing staff providing services, perhaps not in the best location, that would move in there as well as additional beds.

MR HANSON: Are you looking at any growth of the staffing profile within existing assets so that when you do transition you have got that surplus ready to move in?

Ms Gallagher: Yes.

MR HANSON: Are you looking at that sort of stuff? Will that be incorporated in the plan?

Ms Gallagher: The best example is the process underway at the new adult mental health inpatient unit where staff are being recruited and are in training now for an opening in February.

MR HANSON: Ready to move across. The scale is quite big, isn't it?

Ms Gallagher: Yes.

THE CHAIR: Minister, I might need to call back one of your officers from aged care and rehabilitation services, Ms Kohlhagen.

Ms Gallagher: Yes, sure.

THE CHAIR: I apologise for calling you back but there is a question I did not ask before.

Ms Kohlhagen: That is fine.

THE CHAIR: Again on rehabilitation, an independent living unit had a prolonged period of closure due to staffing issues in February 2011. The annual report states that recruitment is in progress but it has been almost a year since the closure. I presume this is similar to the previous question but the question is: why is it taking so long to address this issue?

Ms Kohlhagen: It is actually fully recruited to.

THE CHAIR: Is it?

Ms Kohlhagen: Yes, to this point in time, across the nursing, allied health and the medical. It is run by rehab physicians, not geriatricians.

THE CHAIR: So when was this completed?

Ms Kohlhagen: The recruitment for the nursing staff has just been finalised. We have had a turnover of different staff. There has been a range of temporary staff. The CNC was appointed in around March, I believe. A new ADON has been placed to help support the staff in the service to develop as well during that time. There was a period when we did not have enough nursing staff and we originally opened as a Monday to Friday service and then we have gone to the seven-day-a-week service.

THE CHAIR: It does mention here that this was due to geriatrician shortages, not just nursing.

Ms Kohlhagen: Sorry, what page are you looking at?

THE CHAIR: It is on page 104.

Ms Kohlhagen: It is not talking about Calvary—the GEM beds at the Calvary unit?

THE CHAIR: No. It is on page 104, the top paragraph. We are talking about admissions to geriatric evaluation and management beds closed to—

Ms Gallagher: They are at Calvary.

Ms Kohlhagen: Yes, that is the GEM beds. Yes, that is related to the trouble we have had filling geriatric positions. We have not been able to provide that service since February. Those patients in the 28 beds in the ACHRA building were all admitted into the rehab positions. There used to be a split between rehab and geriatricians. Our geriatricians, if needed, will provide a clinical consult, but the patients are all admitted under a rehab physician. I understand that the beds then at Cavalry are filled by general med beds but under Calvary clinicians.

THE CHAIR: Any other supplementaries on that? No? We will move to Ms Bresnan. Thank you very much.

MS BRESNAN: My question is in relation to the dental program. On 98 it has the target waiting times. Obviously this is another one of those difficult areas, but 12 months is quite a long time in terms of people waiting to get treatment. I am wondering why there is that period of 12 months, why it is such a long period. I know that there are probably a lot of people wanting to access the service. If people require emergency treatment, what happens to them? Is it done through that or is it done through another hospital?

Dr Brown: The figure is also provided in relation to the emergency access.

MS BRESNAN: Yes.

Dr Brown: So if people have an urgent need, that is met. In terms of the 12-month time frame, I acknowledge that that is a significant period of time, but I think that is actually the leading figure in Australia in terms of access to public dental services.

MS BRESNAN: I guess it is acknowledged, too, that there are issues around funding for public dental health services. How many people are working in the dental program?

Dr Brown: I would have to refer to the—

Ms Reid: I think we have got 47 dental—

MS BRESNAN: I am happy to take that on notice.

Ms Reid: Yes; I will get the correct figures for you.

MS BRESNAN: It would be interesting to know how many and the break-up of the staff there.

Ms Reid: I will get that for you.

MS BRESNAN: I have another question on that; this is something which has been discussed federally as well. There will be cuts in chronic disease funding. Is that going to have any impact on dental—

Dr Brown: The chronic disease funding?

MS BRESNAN: In terms of chronic disease funding.

Ms Gallagher: For access to private dental?

MS BRESNAN: Yes. Will that have any impact—a flow-on impact—on the public system, the public program?

Dr Brown: I am not sure I am following your question.

MS BRESNAN: I understand that there has been some cut in funding to the chronic disease program, and there was some discussion about it this morning. And it is if that will have any impact. Obviously if people cannot access the public program they are going to access private, but if there is not that funding there to assist them to do that. Is that—

Dr Brown: Will it increase the load on us?

Ms Gallagher: I think we are just going to have to keep an eye on it.

Dr Brown: We are going to have to monitor that, yes.

MS BRESNAN: So you will be monitoring that? That could potentially have—

Dr Brown: We monitor our performance on these monthly. Lee oversees that school card reporting for all the divisions.

MS BRESNAN: It would be interesting. Obviously this is an issue which gets discussed nationally. I know you said that 12 months is the leading figure, and that is the case in terms of others, but this is one of those neglected areas.

Ms Gallagher: It is the non-urgent restorative dental work.

MS BRESNAN: It is.

Ms Gallagher: We did look at this a while ago. We put some extra money into the budget to improve it, and it came down from 18 months to 12 months. We have managed, with that extra funding, to keep it at 12 months. I think there was an issue and we looked at whether there was any capacity to do more. I am pretty sure—it was a while ago now—that the advice back was that, in terms of both workforce and capacity within our current infrastructure, there was very little more that we could do to improve on the 12 months even if we put another load of money into it.

MS BRESNAN: Thank you.

THE CHAIR: Mr Hanson.

MR HANSON: Thank you. Can I go back to the issue of being provided access for visiting the health system. This is a very important issue for me. I can give some context to it. On a number of occasions when I have been out in the community, I have bumped up against health staff, in particular from the nurse-led walk-in centre as an example, who have said, "We have heard you out there talking about it but you never come and visit us." I have said, "I am trying." I have written to you three times and I am happy to table those bits of correspondence where I have asked for a visit, since May.

Ms Gallagher: Yes, and I have replied to you.

MR HANSON: No; you have not provided me with a date for a visit. I am still waiting for a date for a visit.

Ms Gallagher: I understand that that was well in train.

MR HANSON: I raise it here because—

Ms Gallagher: I am very surprised if you have not been given a date.

MR HANSON: I assure you that it is not. I have been asking repeatedly and I have not been given any dates. When I wrote in May, and subsequently wrote twice, I said that I would accept a delay of seven months until 31 December. I still have not had any dates provided to me. It is very frustrating. I notice that you said that you restrict

the number of visits you have. In August I see pictures of you with Andrew Leigh and Gai Brodtmann strolling through the hospital. I see regular visits—

Ms Gallagher: Yes; I am the Minister for Health.

MR HANSON: Sure. But you are happy to invite—

Ms Gallagher: So it is not unusual to sight me at the hospital.

MR HANSON: No, but I am talking about Gai Brodtmann and Andrew Leigh in this context. What I am saying is that I see—

Ms Gallagher: There was some federal money involved in that, and I have no control over that.

MR HANSON: What you could do is provide me with the number of visits—

Ms Gallagher: I am surprised that you do not have dates before you. The last correspondence I saw—

MR HANSON: I am very frustrated that I do not, I have to say.

Ms Gallagher: I can sense that, Mr Hanson. I am saying to you that the last I saw was that there were dates being provided for a very comprehensive visit. I understood that that was being negotiated with your office. If that is not the case, we will sort it out in the next day.

MR HANSON: If you could get back to me with some specific dates, that would be good, because we have been stalled on this.

Ms Gallagher: Yes; I apologise.

MR HANSON: It has been through your staff. We have asked numerous times and we have been told that it will be some time. And it does not happen.

Dr Brown: We certainly have had some dates that have been before me, along with the program.

MR HANSON: Could I also ask, minister, if you could table the number of visits that you have made to individual health facilities over the last 12 months.

Ms Gallagher: I do not see any need. I am out there all the time, Mr Hanson. It is my job.

MR HANSON: You just said that you are not there because you have restricted the number of visits.

Ms Gallagher: I have. Every fortnight on a Wednesday I had pencilled in the whole morning to spend with any health facilities. I have cancelled a number of those in the last few months based on everyone's extreme busyness. That does not mean that I

have not been out and about visiting health facilities. It is my job. I am the Minister for Health.

MR HANSON: Would you be able to provide me with the number of visits that you made to health facilities?

Ms Gallagher: I do not see why I need to disclose my diary to you, Mr Hanson.

MR HANSON: I am asking you to do so.

Ms Gallagher: If you table your diary, I might consider tabling mine.

MR HANSON: I can certainly tell you the number of visits I have paid to health facilities in the last 12 months.

THE CHAIR: Mr Hanson, I think we will need to move on.

Ms Gallagher: I am not tabling my diary, so that is the end of that.

THE CHAIR: Minister, Mr Hanson, thank you. Can I just suggest that you have been given a date when you will be invited—as I understand, tomorrow; is that correct?

Ms Gallagher: I would be surprised. I will get on to my office. My understanding was dates were being negotiated.

THE CHAIR: Can we leave this topic?

Ms Gallagher: Yes.

THE CHAIR: On behalf of the committee we would appreciate it if a date could be provided to Mr Hanson so he can do his job as well. Thank you.

Moving on to pathology, page 155 of the annual report states that the workload in pathology is increasing significantly. Has the use of private providers been considered to meet this increase in work?

Dr Brown: I hesitate to say it is a complex issue. We have actually had a review that has been underway looking at the issues of not only the workload but the skill level. That review is in its final stages and we expect to be in a position to provide that to the minister within a week. That review has looked at the internal services. We have not at this point in time looked at the issue of outsourcing to private providers. But we are currently looking at the business model in relation to pathology, so I think there may well be some changes in the pathology space.

THE CHAIR: How long has the review been in progress?

Dr Brown: The review has actually been in progress for quite some time. The complicating factor there has been the ill health of the reviewer.

THE CHAIR: I was going to ask who the reviewer is. I do not want to get into

privacy issues but can we ask who the reviewer is?

Dr Brown: It is an external consultant. I can provide his company name but I would prefer not to identify the individual.

THE CHAIR: I understand that. If it is a company can they not provide a—

Dr Brown: I think it is a sole trading company, so it is a single individual, as I understand it, who operates his own private business.

THE CHAIR: You were saying that the pathology part of it or outsourcing to private areas was not part of it?

Dr Brown: No.

THE CHAIR: So will that be looked at in another context?

Dr Brown: I think it is fair to say that we are having a very considered look at the business model around pathology and at this point in time we have not excluded that. But there are substantial challenges in outsourcing pathology services within a public hospital setting. Our preference is clearly to maintain a strong pathology service within the hospital. We need to have a pathology presence that is 24/7. They are some of the issues that need to be taken into account when you look at the provision of the services. But we are looking at the business model for pathology. That is separate to the pathology review which was more around the staffing and the workload.

THE CHAIR: Sure. Will that review be made public?

Dr Brown: That particular review is in the very early stages but I have no doubt that once we provide that advice to the minister—and we are a long way off from having an outcome to that I think—I am sure she will consider what the appropriate distribution is.

THE CHAIR: If it could be provided to the committee we would appreciate it.

Ms Gallagher: The review?

THE CHAIR: Yes.

Dr Brown: Sorry, just to clarify: which review are you talking about there?

THE CHAIR: I was talking about the original review that you said is almost completed.

Dr Brown: The original review.

THE CHAIR: Thank you very much. Ms Bresnan.

MS BRESNAN: Page 114 mentions life expectancy and that it is an indication of the general health of the population. Obviously the ACT has high life expectancy. One of

the issues around that is that while people might be living longer we do have an increase in chronic illness; people may be living longer but are suffering from certain chronic illnesses. Is any research being done in the ACT, or is that a bigger national thing that needs to be done, looking at the quality of life of people? While we might have longer life expectancies, what is the quality of life in terms of chronic illness that people might be dealing with? Are there any data or measurements that we can look to on that?

Dr Brown: I am looking to the Chief Health Officer to respond to that. Certainly there is an increase in the prevalence of chronic disease and we have an increasing ageing population, but of course chronic disease is not confined, unfortunately, just to the elderly. We are seeing diabetes, for example, in—

MS BRESNAN: Yes, obviously. I was just interested in that issue because it is something that I have seen a bit more about recently—that while we are living longer what is the quality of life?

Dr Kelly: Thanks, Ms Bresnan, for your question. It is a very important one. As you know, in the ACT we do have the highest life expectancy in Australia and one of the highest in the world actually. At the moment on the latest data available for males it is 80.5 years and for females it is 84.3 years and that compares with the national figures of 79.3 for men and 83.3 for women. Life expectancy at birth of course is a very blunt measure of health.

THE CHAIR: Sorry, can I just interrupt? It is a minor point but according to this it says 83.9. Is that a misprint or is it—

Dr Kelly: That is right: 83.9. You are correct. Sorry. It is still higher in the ACT. It is a very blunt measure and you are quite correct that a whole range of things come into life expectancy. This is the average; for some members of the society it will be less. It is certainly related to the social determinants of health in terms of economic and other disadvantage, for example. So we should not ignore that in certain sections of our community.

I do not have any actual figures about the quality of life, but clearly people just living up to a certain period is not enough. We need to be looking at, firstly, how we can improve the general health of the population as well as their life expectancy; important issues that were mentioned by Dr Brown around chronic diseases and their prevention; indeed management of chronic diseases that people virtually inevitably have later on in their lives.

MS BRESNAN: As you said, there is an increasing prevalence of chronic illness at younger ages. Has any work been done on the fact that we have an ageing population and potentially people are going to have chronic illnesses that they will have to deal with? Is any work being done on that, because in terms of our age profile it is likely that that will become more of an issue?

Dr Kelly: Nothing specific in the ACT, but nationally and internationally there is a large body of work in relation to the burden of disease, for example, and how certain chronic diseases, injury and so forth contribute to that. Increasingly in Australia, as in

many developed countries, it is the chronic disease burden which is the big one we are concerned about. As I say, a range of issues, projects and programs are mentioned in the annual report around prevention of these things, much of the work done in other areas of the directorate around the management of people with chronic disease, for example, to decrease the burden in the future.

MS BRESNAN: Are we looking at the impacts that will have on the health system in particular?

Dr Kelly: Yes. That is a major concern. The more we can do in prevention the more we are going to be able to save those dollars into the future. If you take the example of obesity in children, we know that a high proportion of children who are not exercising enough and are having a diet rich in calories but poor in nutrient value are the ones that are going to go on to develop obesity in adulthood. Many of those will develop type 2 diabetes; we are seeing already in some segments of the population that that is becoming an issue at an earlier age.

If people who have diabetes for a number of years are not well controlled they will go on to develop more serious complications; renal failure, for example, requiring dialysis—a very expensive issue for the health service—amputation of limbs and so on. So the more we can do early in life and in early adulthood to prevent these issues, the better. We certainly have a number of programs related to that.

MS BRESNAN: Thank you.

Ms Gallagher: Mr Doszpot, three dates have come up as potential days for a visit to health facilities—on 27 January, 31 January or 2 February. The plan that has been put together involves an entire day visiting the Civic health centre, Calvary Private Hospital, Belconnen health centre, Mitchell sterilising centre and Canberra Hospital including the emergency department, SAPU, the MAU and the Walk-In Centre. If those dates do not suit you, Mr Hanson, I am happy to look at alternative dates.

Mr Hanson: I will have a look. But I would express my disappointment that since requesting that visit it will take some eight months for me to actually take part in a visit. I would just like to express that.

Ms Gallagher: We are just trying to coordinate it and make sure that all the senior staff that need to be available for that can be available—

THE CHAIR: Could I just suggest—

Ms Gallagher: in the most efficient way.

THE CHAIR: that this is a matter between you and Mr Hanson. Can I leave that to both of you to resolve?

Ms Gallagher: Yes, sure. They are the dates that have come from Health as being suitable for them in a relatively quiet period. They have not been dates determined by me.

MR HANSON: I will make myself available.

Ms Gallagher: So whichever of those dates suits you we will be happy to facilitate.

THE CHAIR: Thank you, minister. We appreciate your prompt action on that. Thank you, Mr Hanson, and good luck.

MR HANSON: A very complex visit.

On the capital asset development plan, I have got a question initially about the funding lines between what is in the CADP and what is in the clinical services redevelopment budget—or is that a subset of the CADP?

Ms Gallagher: It is a subset, yes.

MR HANSON: It is a subset so—

Ms Gallagher: Yes. It forms part of—

MR HANSON: That is great. On the CADP I asked a question—

Ms Gallagher: On notice, yes.

MR HANSON: on notice and I got a response to that and I thank you for that. There are a couple of elements that are not discussed in that but have been discussed in other fora; for example, the upgrade of Calvary. It is—

Ms Gallagher: I think it was in the question. We had some work that had not been costed.

MR HANSON: There is reference to the sub-acute hospital but I just want to explore the CADP to find out where we are at with some of those projects. I have got some of the more detailed response around phase 1. We start at the sub-acute hospital and the Calvary redevelopment. With the sub-acute hospital, my understanding is that you are looking at a possible location—

Ms Gallagher: Yes.

MR HANSON: and, I guess, the scope of works. You would be doing the same in terms of the scope of works for the Calvary redevelopment review, would you, or—

Ms Gallagher: In a way the priority with Calvary is to get the agreements finalised and reached over the work that the board chair and I announced we had reached in principle about how the operations of Calvary were going to continue. Our plans around redevelopment at Calvary changed somewhat. Part of the original intention was to provide a lot of those beds at Calvary. We have taken a decision to have a separate unit so that redevelopment work included in the new north side hospital means that that extensive work will not be required at Calvary. It will still need refurbishment but we are not looking at a refurbishment of the size originally intended.

MR HANSON: So—

Ms Gallagher: So, if I can just tell you, the north side hospital at the moment is site selection. A number of sites have been selected. It is currently going through a ratings exercise of which of those sites ranks higher than the others in terms of a range of criteria. I have not seen that work yet. It has not been finalised, but when it is the intention would be to make that information public.

Running alongside that is some work that we commissioned in the budget around financing models: should this be a PPP or a DCOM, design, construct, operate, manage? What financing model should we use? Treasury are undertaking some analysis of that. That work only started post the passage of the budget, so that will probably take a little bit of time.

MR HANSON: So the north side hospital then is still a sub-acute hospital, is it?

Ms Gallagher: Yes. It may have some other things such as family planning attached to it—services that are not currently provided—

MR HANSON: But non-acute services?

Ms Gallagher: Yes, non-acute; so it is sub-acute and it may have a few little other things with it.

MR HANSON: And that is still in the ballpark of 200 beds?

Ms Gallagher: Yes.

MR HANSON: The upgrade at Calvary then is now how many beds?

Dr Brown: The bed numbers have not been determined. What we are currently in the process of doing is developing a clinical services plan, taking the broader picture across the territory and looking at the range of services and then how we best configure those services across what will be the three hospitals; looking at what should stay at the Canberra Hospital, what should move from the Canberra Hospital, what might move to Calvary, what moves from Calvary to north side. So it is quite a complex piece of work, dare I say.

That clinical services plan is in the draft stage. I am looking at Mr Carey-Ide.

Mr Carey-Ide: It is being developed at the moment, but it is planned that it will be released for consultation early in February 2012.

MR HANSON: Will we be able to get a look at it then?

Mr Carey-Ide: Once it is released.

MR HANSON: Because, if you will recall, we had an inquiry and we have been through quite a long process with the Calvary issue and then we had the various options and then the options changed and then it seemed that we had a solution. Now

it seems that that has again morphed slightly into something—

Ms Gallagher: No.

Dr Brown: No. This is about working out the finer detail of the solution that has been announced.

MR HANSON: Okay.

Ms Gallagher: The solution is that they remain the owner/operator of the acute facilities as part of Calvary public, that we work out a precedent plan for management of the land and upgrades and things like car parking and that we negotiate around resumption of public beds in what is currently a private hospital operated within Calvary. Obviously that will change as we resume private beds. We will not actually need to construct additional wards because we will be resuming space that is currently in a public hospital but not being used for public purposes. There is also discussion on agreement around role delineation between the three hospitals when they are fully operational, so all of that is on track.

MR HANSON: In February or so that will be laid out in terms of what beds will be planned to move where and what services will be moving where in the jigsaw puzzle? Is that the intent?

Mr Carey-Ide: What will be released in the draft clinical services plan—the plan we release for consultation—will be the final draft proposals of what services we would provide at what facility. There will be demographic data that underpins the proposals for the years ahead that indicate what bed numbers we might actually need. We need to be mindful that that sort of planning is complex, but it is also exciting work because it embraces the essence of the capital asset development program, which is thinking differently about the ways that we provide health care in the ACT and surrounding region into the future. It will not necessarily mean we will have additional bed numbers for all services. It might mean that we provide services differently, and that is exciting.

MR HANSON: Sure. I just want to get across the detail because, as you would say, it is complex. I am wanting to get across what actually moves, for example, to the subacute hospital, what moves out of Canberra Hospital, what moves out of Calvary to go there and then what then moves in to fill that.

Ms Gallagher: There are already rehabilitation services at Canberra Hospital. Obviously building a purpose-built rehabilitation hospital, that will go there. The subacute facility at Calvary, it makes sense that that would go there. There is a rough outline of what is going where.

MR HANSON: I think broadly we have had our tete-a-tete on Calvary, and I am looking to provide a broadly bipartisan approach to this, because we need to rebuild our health services. There is no question that we need to do that, but obviously it is difficult to do so without a—

Ms Gallagher: I will hold you to that.

MR HANSON: I what to achieve that. I really do. I think we have got to get on with it, and we cannot afford delay.

Ms Gallagher: Well, we have been getting on with it. I do not need bipartisan support to get on with it, if you see what is happening in health at the moment.

MR HANSON: Sure. I think the Calvary issue was the delay. What I am saying is it is difficult for me to get an understanding of what the situation is at the moment because it is a bit opaque. If we can provide more information on where those services are going, I want to see that plan when it is realised.

Mr Carey-Ide: We will certainly be able to do that in the clinical sense.

MR HANSON: That would be great. On some of the specific projects which are closer to fruition, the women and children's hospital, which I believe you were touring that today.

Ms Gallagher: I went and had a look at the sample rooms, along with several hundred staff.

MR HANSON: What is the anticipated opening date for the hospital for it to become operational?

Ms Gallagher: Stage 1 will be in the first half of next year. Then as people move out of the current facilities, the refurb of stage 2 will occur. That will take about another year.

MR HANSON: What is stage 1 in terms of what that will deliver?

Ms Gallagher: Stage 1 is the new building, which is being built opposite Garran oval. That will be fully operational in the first half of next year, around May, I believe, is the date that I have been given. So things like the NICU will move in there. They will move out of the old building into the new. Paediatrics will move from the tower block into there. There is the birth centre—the labour, birthing and delivery rooms. Then the refurbishment work will start on the shell. We will essentially gut the current maternity building and it will be redeveloped.

MR HANSON: And then that becomes stage 2, does it?

Ms Gallagher: That will be stage 2.

MR HANSON: What is in stage 2 in terms of what it provides?

Ms Sharpe: Stage 2, level 1, is the paediatric outpatients department. On level 2 it has maternity and gynaecology outpatients, foetal medicine unit and the maternity assessment unit. Level 3 has all the birthing services. So birthing services will be in a temporary decant in stage 1 for 12 months until it goes to its final move in stage 2.

MR HANSON: And when do we anticipate stage 2?

Ms Gallagher: It will be about a year after the exit from it. So May 2013.

MR HANSON: So complete in May 2013. And the budget, I think $90 million has now gone to $112 million in the latest budget?

Ms Gallagher: About $111.8 million or something, yes.

MR HANSON: Does that incorporate stages 1 and 2 or is that just stage 1?

Ms Gallagher: It is both; it is the entire project.

MR HANSON: And is that budget still $111.8 million or has that moved?

Ms Gallagher: It is my understanding. These projects are challenging but—

MR HANSON: They are complex.

Ms Gallagher: They are.

MR HANSON: Is there anything else that is imminent?

Ms Gallagher: The adult acute mental health inpatient unit.

MR HANSON: And that comes on line when?

Ms Gallagher: In February.

MR HANSON: And that is how many beds?

Ms Gallagher: That is a 40-bed facility, but there will be a gradual increase. So we are going from about 21 in the PSU—

MR HANSON: So you decamp from the PSU into that?

Ms Gallagher: Yes.

MR HANSON: And then—

Ms Gallagher: We will look at whoever—

MR HANSON: Have you got a plan for the PSU and what happens there?

Ms Gallagher: Yes, we will be, yes. We are using every space on that site and more. We have leased the former ESA headquarters in Curtin to assist with some of the decanting that needs to happen as well.

MR HANSON: So they are sort of two major projects which are imminent?

Ms Gallagher: Yes, and we have got Gungahlin health centre under construction.

MR HANSON: Yes, what is the time line on that?

Ms Gallagher: That is due for September next year, I think. It is about a year from when it started. And the Belconnen health centre will open in 2013. We have got Hindmarsh appointed to do that work. It has been delayed a month to avoid some parking issues in Belconnen, because it is a car park. It is taking one of the surface car parks at the back of the mall. At Christmas time with the amount of increased activity, the decision was taken not to close off that car park for that month. So they will start in January.

MR HANSON: Okay; and Tuggeranong?

Ms Gallagher: Tuggeranong is underway as well. Again, some decanting strategies need to be put in place there—moving services out into the hyperdome, into a leased area, is occurring. It is underway. We have also had the aged day care service there that has needed to be relocated.

MR HANSON: And what is the anticipated completion date for Tuggeranong?

Ms Gallagher: I think that is 2013 at the moment as well. I am not sure—

Mr Carey-Ide: Yes, mid-2013 is our expected completion date.

THE CHAIR: Thank you, Mr Hanson. I have a very minor supplementary regarding this. You mentioned additional services. Are additional services being planned through the University of Canberra and in what way? Is there any connection between the University of Canberra and the plans for Calvary hospital?

Ms Gallagher: There may be. The University of Canberra is pretty keen to work with us around a new subacute centre. They have obviously got a very big health facility. They have got the nursing school there, the allied health professional school there. So they have—I have met with the vice-chancellor of the University of Canberra and discussed his views around some opportunities on their site.

I think to me it makes a lot of sense. It is a university with some nice teaching and workforce links that could assist us with some of the work we do. It is in the mix of the site selection work. It will be rated along with the other sites about what boxes it ticks.

THE CHAIR: Thank you. Is there any connection between that and the proposed merger between the CIT and University of Canberra?

Ms Gallagher: No. These are completely separate discussions. The university has not made any secret that it wants to expand its capacity around health workforce. I think they see this as an opportunity that would provide their students with training opportunities. It provides us with a growing workforce. There are some nice synergies there. But whether it—there are also some moths living there that are currently being assessed for their habitat requirements. That will all form part of what boxes it ticks.

THE CHAIR: Thank you very much; now on to my substantive question. At what stage are negotiations regarding the status of the cross-border negotiations?

Ms Gallagher: Ongoing. I do not think—

THE CHAIR: Complex again?

Ms Gallagher: Well, again, indeed. Health data and health funding, yes.

Dr Brown: There are two aspects to this that I think we should highlight. One is the negotiations around the past data. Of course, then we have under the national health reform the establishment of IHPA, the Independent Hospital Pricing Authority. We have the permanent authority yet to be established but we have an interim IHPA established. They in fact will have a role in dealing with cross-border issues into the future. But I might ask Mr O'Donoughue to speak to where we are at in terms of dealing with the past data.

Mr O'Donoughue: Thank you, Dr Brown. Thanks for the question. After conversations between the New South Wales minister and our minster, a process has begun looking at regional planning issues. It is proposed that an interdepartmental committee be formed. That group has met once and has agreed terms of reference to be recommended for clearance by both ministers. Included in those terms of reference are the negotiation of a new cross-border agreement between New South Wales and the ACT, which is required under the health care agreements. It is also the desire to resolve any outstanding issues in the current cross-border agreement. So that group has begun its work but only just.

Dr Brown: Sorry, I think the other aspect, however, is the audit, the data audit that we have undertaken in relation to—

Mr O'Donoughue: Okay. So in respect of the previous cross-border agreement, New South Wales exercised its right to request an independent audit of the data. That work was undertaken by a consultant. On the basis of those findings, New South Wales has funded part of what the ACT would regard as its obligations. We are still analysing the audit outcomes and we intend to go back to New South Wales with further negotiation.

Ms Gallagher: Ongoing.

THE CHAIR: Is there any historical data on the amount of cross-border provision of service that occurs from Canberra to New South Wales? Is this a growing number of cases, is it static or—

Dr Brown: In terms of the—

THE CHAIR: The number of people being treated in Canberra who are from New South Wales.

Dr Brown: The number increases. The percentage has been relatively static, is my understanding, in terms of both our elective surgery, our emergency department

presentations.

Ms Gallagher: It varies amongst specialities. But as demand is growing—demand is growing everywhere but the percentage stays the same. Overall, it is about 25 per cent but it can be 30 per cent of the elective list. It can be 50 per cent of the cancer services. It is only 10 per cent I think of emergency department presentations, which makes sense. So it varies.

THE CHAIR: How are these negotiations progressing in the context of national health and hospital reforms?

Ms Gallagher: The New South Wales health minister and I met. I think national health reform is happening. What it has given us the opportunity to do is to, I think—this is work that is being progressed now—use the national health reform framework to actually improve regional health service delivery. For example, there are three LHNs that sort of sit around the ACT—or two really, isn't it? Yes, one on the south coast and one that goes out to Wagga. Then there is our local hospital network that sits in the middle.

One of the things I would like to see is that there is joint work done across all of those three so that everybody knows what everybody else is up to. If there is a decision taken by a local hospital network in Wagga about services they are no longer going to provide or, indeed, services they are going to provide, that impacts on our local hospital network. I think we have reached agreement in principle around that and we have reached agreement around doing some joint clinical services planning for the region. I think in that sense health reform has helped facilitate that.

THE CHAIR: Thank you. In relation to NDIS, is there any correlation between these negotiations from a national point of view and NDIS, or is that totally separate?

Ms Gallagher: The national disability insurance scheme?

THE CHAIR: Yes.

Ms Gallagher: Well, only to say that I am sure everyone in the Health Directorate would be very supportive of the establishment of a disability insurance scheme.

THE CHAIR: Sure. I ask in the context of—I understand that Minister Burch and Minister Barr are both on a committee.

Ms Gallagher: Yes. The treasurers and the disability ministers from around the country are on a select council.

THE CHAIR: Have they met at this point?

Ms Gallagher: Yes, they have met. Minister Burch attended a meeting. The Treasurer could not because it was a sitting day. So we could not afford both ministers to be out of the parliament. But they have had an initial meeting. My recollection is that it is due for an early report back to COAG next year about scoping the work that needs to be done.

THE CHAIR: So will the Assembly be briefed on any of those meetings?

Ms Gallagher: If the Assembly wants to, for sure. The job that has been given to the treasurers and the disability ministers—I think the treasurers are there to keep an eye on the disability ministers, because everyone knows what happens in human service delivery: the costs start adding up. So the treasurers are there to keep everybody honest. They will provide a report to COAG. I am very happy to provide an update to the Assembly or for Minister Burch to do that, as she is sitting on the select council, about how that work is progressing.

THE CHAIR: This is probably slightly left field from this committee's point of view, but with my disability hat on—

Ms Gallagher: It impacts in a sense from the health point of view. This will assist us in the long run particularly with long-stay patients who end up in intensive care for longer than they should be because of lack of support services in the community. So it does have an impact on health.

THE CHAIR: I am interested, with my disability hat on, in any information you can give me on that.

Ms Gallagher: Yes, sure.

THE CHAIR: Thank you very much.

MS BRESNAN: I have a couple of questions in relation to page 100 to get some clarity on a couple of things. In that table there, item b, it says that inspection compliance of licensable, registerable and non-licensable activities is at 84 per cent. I want to check if that is 84 per cent of all the licensable activities, as it states, or 84 per cent of scheduled inspections that were completed. Can I get clarity on that?

Dr Brown: We will ask Mr Woollard to speak to that one.

MS BRESNAN: It is page 100.

Mr Woollard: Just let me read the page.

MS BRESNAN: So basically it has got that point there. It is just whether that is 84 per cent of all licensable activities et cetera or if it was actually 84 per cent of the scheduled compliances that were completed, if that makes sense.

Dr Brown: I think it would be the scheduled. It is not saying—

MS BRESNAN: It just seemed like a very high figure. I know there are quite a lot of activities. It was just to clarify that because it was not clear from that table.

Mr Woollard: The original target was 85 per cent of compliance and what we have achieved is 84 per cent compliance in the premises that we have looked at in the inspections we have undertaken.

MS BRESNAN: Yes, so it is actually of the ones that you scheduled to look at?

Mr Woollard: Of the ones we have undertaken, correct.

MS BRESNAN: Right, so not actually across the whole spectrum of activities?

Mr Woollard: No, of the ones that we have inspected.

MS BRESNAN: I just wanted to clarify that. The second one there says there is a 100 per cent response time for environmental hazards, that they are responded to in 24 hours. This might be one to take on notice. It would be interesting to get some information on what environmental hazards were looked at in the year that this report covers.

Mr Woollard: Certainly. The environmental hazards that we report against are sewage spills. Where we have a sewage spill within the community, an overflowing, blocked pipe or whatever, once we get notified we make sure that we get out there to address the issue within 24 hours.

MS BRESNAN: So that is the only one you look at in this category?

Mr Woollard: Yes.

MS BRESNAN: Okay, thank you. I have a question in relation to page 105, the well women's check for culturally and linguistically diverse groups. It is good to see that this indicator is increasing. It would be interesting to see what work is being done to improve this figure. While it is good that it is increasing, it would be interesting to see how you are proposing to get across to more women in those groups.

Ms Neverauskas: We are increasingly providing outreach clinics, working at the child and family centres, and most recently having opened a clinic at west Belconnen. We are also currently exploring starting a clinic at the Alexander Maconochie Centre. So we are gradually moving our services out to provide more outreach clinics. They are the ones at the moment.

MS BRESNAN: In terms of actually achieving an increase, are they the main activities that you are looking at?

Ms Neverauskas: It is, and we are on target. We have increased for the year to date this year; we are looking at about 45 per cent.

MS BRESNAN: Are there particular culturally and linguistically diverse groups that you are aiming to target with having those outreach clinics in the health centres?

Ms Neverauskas: Yes. West Belconnen is Aboriginal and Torres Strait Islander, and we are also looking at starting a clinic at the refugee centre.

MS BRESNAN: At Companion House?

Ms Neverauskas: Yes.

MS BRESNAN: So it is those outreach ones. There are no particular target groups except with west Belconnen?

Ms Neverauskas: Yes.

MR HANSON: Bed occupancy, on page 107, has gone from 85 per cent to 89 per cent. It is an issue that Dr Brown and I discussed at a Deloitte Access Economics breakfast where I said we had a lower than average number of beds and we discussed this. We have got 2.6 beds per 1,000 population, which is about the national average.

Ms Gallagher: It is now, for the first time ever. We replaced all of those beds that you took out.

MR HANSON: If we look at 2.6 as an average, as we discussed this afternoon, about 25 per cent—maybe a bit higher—is actually accessed by overnight admissions from New South Wales. So the reality is that, in terms of beds available to ACT residents, the number of beds per 1,000—because that is the way the statistics are collated, I imagine—would be less than two per 1,000. Would that be correct? The point that I am trying to make is that, although on the surface it looks like we have got an average number of beds, 2.6 per 1,000, we do not, because 25 per cent or more—

Ms Gallagher: We do, under the way it is currently measured, yes.

MR HANSON: The statistics present a picture that says we have got an average number, but when you consider that 25 per cent are basically unavailable to ACT residents, which is the per capita number that is used, which is ACT residents, and does not, as I understand it, incorporate those people that come from New South Wales, the reality is we have got less than two beds per 1,000, which is well below the national average. Would you care to comment on that?

Ms Gallagher: What I would say to that is that if you have come to realise we need more beds, we do need more beds. This is the first reporting period where the AIHW have recognised that we actually have the national average in bed numbers as they measure it. But yes, we need more beds. We need to keep growing the bed base and—

MR HANSON: Sure. But the point—

Ms Gallagher: Well, no—

MR HANSON: The point I am making—

Ms Gallagher: If I can just finish, the beds have grown from 679 beds to 926 beds over the past six years, and they will keep growing at the rate that they have been growing.

MR HANSON: Sure, but I am trying to get across some of the issues that we have with bed occupancy, access block and so on. If you look at that figure of 2.6, it looks average, but would you agree with me that in reality the number of beds available,

based on the statistics and the way that they are collected by the AIHW or others, is less than two beds per 1,000 rather than 2.6?

Dr Brown: The denominator for that is the ACT population and it does not take into account the New South Wales population that access our beds, as I understand it. But I think that we need to recognise that there is a flow across all borders. All jurisdictions would have to take account of some cross-border flow. It may not be to the same extent but in terms of the calculations, all jurisdictions do have some cross-border flow.

MR HANSON: I would accept that, but the point I would make is that in most jurisdictions that flow goes both ways and most jurisdictions are much bigger than the ACT and the net leakage would be well under 25 per cent—a significant amount less.

Ms Gallagher: So is the point that we need more beds? The answer is yes.

MR HANSON: Of course, but the point I am trying to make is that, when we look at these statistics and wonder why bed occupancy or access block might be a problem, we look at the average bed number being 2.6. The reality is that when you actually do use the ACT's population, we have less than two beds per 1,000, which is well under the national average.

Ms Gallagher: But a significant increase—we have never even been near 2.6. When I became minister, we were 2.1. We have added—636 to 926 beds. We are now at 2.6. We need more beds.

MR HANSON: Sure. It is not so much a criticism as an observation. I just want to make sure that I am right when I am saying that the reality is that—

Ms Gallagher: In terms of our own planning and all of the work that is feeding into the CADP and the clinical services plan, we plan for the region. We include the fact that we are a larger population than 340,000 and we do our own planning based on that.

MR HANSON: Are we doing the planning with a view to trying to get that percentage up to 2.6 for the ACT population, given that the reality is that it is below two?

Ms Gallagher: We are not doing our planning based on average numbers of beds per head of population. We are doing our planning based on what we think we need based on the data available to us. What the AIHW reports is a matter entirely for them.

THE CHAIR: How much is actually being provided, minister, by way of support to GPs to date?

Ms Gallagher: The infrastructure funds have been provided, the teaching incentive payments have been provided. The extra training places are underway. The other two components are the scholarships, which we are still trying to manage to make them attractive for students. But that is not directly to GPs. So all of the commitments we made, the $12 million commitments, are underway and in progress.

THE CHAIR: How much of the $12 million has been committed?

Ms Gallagher: All of the $12 million has been committed to different components within that. The infrastructure fund, I think, is about $4 million. I think we have provided to the committee before a breakdown of that fund, but it is all on track.

THE CHAIR: Are there any barriers existing for GPs wishing to access the GP development fund?

Ms Gallagher: No, not that I am aware of. In fact, I think round 3 has just been finalised. Round 4 will go out early next year. They are independently assessed. Whenever I look at who has got what, it seems to be a pretty good range across the GP territory.

THE CHAIR: How many applicants have you had?

Dr Brown: To date, we have—

Ms Gallagher: It is broken down into different components. There is infrastructure, there is training, recruitment and retention. I think it might be 72.

Dr Brown: Seventy-two in total.

THE CHAIR: So that is the total number of applicants and how many were successful?

Ms Gallagher: No, that is successful.

Dr Brown: That is successful.

THE CHAIR: And how many—

Ms Gallagher: Okay, we can provide you with that information. That will take a bit of time just to pull it out. Some of them got partially funded and not entirely funded; others got entirely funded.

MR HANSON: Will you be able to break down what that was provided for?

Ms Gallagher: Yes.

THE CHAIR: I think Ms Bresnan has a question. Do you have a supplementary, Mr Hanson?

MR HANSON: No, I do not. The only question I have remaining is whether we have had any follow-up from the document I submitted. Have you been able to get any information—

Dr Brown: In relation to the anaesthetists?

MR HANSON: Yes, whether anything has come to light or—

Dr Brown: We have some thoughts but we would rather explore the issue and come back to you with a factual response rather than—

Ms Gallagher: But there has been no wind-down of surgery. I think that is the important message. We just need to have a look and make sure that we are providing exact information to the committee.

THE CHAIR: Ms Bresnan, you have the honour of the last question of the day.

MS BRESNAN: With respect to general accountability and strategic indicators, this is something around suicide reporting. This is something that I find is raised as an issue. Obviously it is a very difficult and confronting thing to report. Has there been any consideration of this? I know that nationally it has been discussed about actually reporting on suicide numbers. Obviously it is a topic that has a lot of pros and cons expressed for and against it. But is it something that is being considered in terms of being a bit more up-front about it as an issue?

Dr Brown: It is not one that we have specifically considered as part of our strategic indicators. It is reported in the report on government services. There is a jurisdictional-based breakdown in that. Of course it is being considered as part of the fourth national mental health plan. As you are aware, under the national health reform currently, we have a working group looking at the 10-year road map. There is discussion within that context around reporting and indicators. So there is consideration there. As part of the national health reform, there is also the establishment of the mental health commission, which will further inform those discussions.

MS BRESNAN: Has there been agreement reached on whether or not that would be something that would be reported on as a matter of practice?

Dr Brown: In terms of the road map?

MS BRESNAN: As you said, it has been discussed. There is a strategic indicator part of mental health issues as well, and there is the commission. Has there been agreement reached on that? I know there are different views about whether or not it is a positive thing to do.

Dr Brown: I stand to be corrected. Richard Bromhead is not here but my recollection is that it is an indicator in the fourth national mental health plan. There has been no decision yet in relation to the road map and/or the focus of the national mental health commission.

THE CHAIR: Minister, Dr Brown and the other members of the directorate, we thank you for your contributions and we look forward to seeing you next year.

The committee adjourned at 5.14 pm.