LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON PUBLIC ACCOUNTS

(Reference: Inquiry into Auditor-General's report No 1 of 2011: Waiting lists for elective surgery and medical treatment)

Members:

MS C LE COUTEUR (The Chair)
MR J HARGREAVES (The Deputy Chair)
MR B SMYTH

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 15 MARCH 2012

Secretary to the committee:
Dr A Cullen (Ph: 6205 0142)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 9 August 2011

The committee met at 9.46 am.

GALLAGHER, MS KATY, Chief Minister, Minister for Health and Minister for Territory and Municipal Services
BROWN, DR PEGGY, Director-General, Health Directorate
THOMPSON, MR IAN, Deputy Director-General, Strategy and Corporate, Health Directorate
REID, MS BARBARA, Executive Director, Division of Surgery and Oral Health, Canberra Hospital, Health Directorate

THE CHAIR: Good morning everybody and welcome to this public hearing of the Standing Committee on Public Accounts inquiry into the Auditor-General's report No 1 of 2011, *Waiting lists for elective surgery and medical treatment*. On behalf of the committee, I welcome you, Chief Minister, appearing in your capacity today as Minister for Health. I also welcome officials from the Health Directorate, Canberra Hospital and my committee colleagues.

I remind witnesses of the protections and obligations afforded by parliamentary privilege and I draw your attention to the blue coloured privilege statement before you on the table. Can you please confirm that you understand the privilege implications of the statement?

Ms Gallagher: Thank you, chair.

THE CHAIR: Before we proceed with questions from the committee, minister, would you like to make an opening statement?

Ms Gallagher: Thank you, chair. I will make a couple of comments. Firstly, I offer my apologies for being a bit late this morning. I had to meet with Carers ACT briefly.

A lot of work has been done and we are very pleased to appear before you today to discuss the Auditor-General's report into waiting times for elective surgery and medical treatment. Running alongside the Auditor-General's report, as members would know, there has been a lot of work done around improving access to elective surgery, which is probably something that the Auditor-General's report did not actually address. It was more around how we manage the list and report against our processes.

A significant part of the effort of the Health Directorate has been going into improving access overall to elective surgery for patients getting their operations faster, and that is bearing fruit. We will deliver record amounts of elective surgery this year. We are seeing already in the first five months of this year that we are ahead of where we were this time last year. We are also seeing improvements in the reductions of people waiting too long for care and we are seeing commensurate reductions in the median wait time, even though I have, as you know, a number of concerns about median wait time being an accurate measure of the performance of the elective surgery system.

We are continuing to work with our doctors, nurses and staff at the hospital to implement the recommendations of the Auditor-General's report, including audits

against our process. I think I have reported against that work to the Assembly. That work is being implemented to a very high standard as well.

I think from my point of view the Auditor-General's report was useful. I do not believe that it will necessarily deliver one extra operation—the actual Auditor-General's report. But we are doing that alongside this work with significant extra resources going in. I think the usefulness of the Auditor-General's report was to look at our processes and identify ways that we could improve them. We have been implementing those.

THE CHAIR: What has been the response from surgeons on the ground to the Auditor-General's report?

Dr Brown: We had meetings with the surgeons. I think it is fair to say that the surgeons felt something similar to what the minister indicated, that the report itself is not necessarily going to deliver increased surgery. But I think there were some procedural issues that were highlighted in the audit that we have addressed as a result of the audit. I think the surgeons appreciate anything that improves the streamlining of processes.

THE CHAIR: Have we now got better with the shared surgeons list? That is seen to be one of the tangible ideas for improvements.

Mr Thompson: I will introduce this and Barbara Reid will provide further detail. We do not have a shared list as such. What we have is agreement amongst surgeons and some quite good examples that Barb can run through in a minute—very good examples of surgeons working cooperatively together to balance and share patients between their lists to improve access. In other words, we do not have a single pool of patients that surgeons draw from, but we have cooperative arrangements and a lot of progress that we are achieving with surgeons to enable patients to be moved between their lists.

Ms Reid: We are getting a lot of cooperation with surgeons—and I will list off the specialties—in general surgery, neurosurgery, urology, ENT, plastics. We have had some in orthopaedics. In those particular specialties, we are getting really good cooperation with the surgeons to share the patients around, so that we can get better access and better timeliness for our patients.

THE CHAIR: The fact that you gave a list implies presumably that it has not been going so well in some of the other specialties. Do you have strategies to improve that?

Ms Reid: Probably with the other specialties in particular, their timeliness is in and they do not necessarily need to share. They are actually addressing their lists themselves. But in the bigger specialties like general surgery and ENT, where they have big waiting lists, or they have had, and we are reducing their lists, they actually share the lists to actually provide better timeliness for the patients.

MR HANSON: Is it an informal arrangement? Is it based on goodwill rather than any change in structure?

Mr Thompson: It is explicitly written into our policy. We have a procedure within the policy as to how to address circumstances where it appears unlikely that surgeons will be able to treat their patients within the recommended waiting time. This is one of the steps within our policy. That policy has been agreed to through our surgical services task force and circulated to all surgeons. So we have an official policy and an agreed policy position on this, but operationalising the policy, which is what Barb is talking about, involves the local discussions.

MR HANSON: If you are a surgeon and someone is on your list and you can see that they are not going to be operated on within the time, how does it work? Does that surgeon then speak directly to other surgeons or do they put that patient into a central pool for others to—

Mr Thompson: We have a series of steps that can be undertaken. Generally speaking, what happens is that the first step is a discussion with the management of the surgical services at either hospital about whether or not there is an alternative operating time that can be made available to that surgeon, whether or not it is possible to reorganise their existing time and/or lists to get the patient done on time, and if those steps are not successful in identifying an earlier time for the patient, that is when the discussions happen with the surgical colleagues about sharing.

MR HANSON: We obviously got to a point with elective surgery where the system was, if not broken, in crisis. The waiting times were double the national average. We saw people who were going to be treated within 90 days who were waiting for over a year. What went wrong? Have we now implemented the systems to make sure that we do not go back to the point where people were waiting longer than the rest of the nation and longer than at any time in the ACT's history? How can we assure ourselves that this is not just a temporary measure that has been put in place and that we now have the systems and strategies that are sustainable, that we are not just doing a temporary adjustment by putting money into the private system and so on? Can you go to that point?

Ms Gallagher: Yes, I can. Nothing went wrong. What happened was that the demand for elective surgery grew at a faster rate than it could be provided at. That is not just operations; that is around staff and their availability, and growing our medical and nursing staff. It is around extra operating theatres. It is around extra intensive care beds. It is about extra beds in the hospital. You cannot just open a theatre for eight hours extra a day and not have intensivists, the beds on the ward, to actually deal with the throughput. When you see in a budget line $2½ million for elective surgery, that buys about 200 operations. You then look to the lines below it—extra intensive care beds, extra acute care beds, that have to match that, and you have to grow that. I think you need to look at the adequacy of the hospital system dating back to the late 90s, and it has taken years to catch up. It is not a problem that you can just fix like that.

Dr Brown: Can I add to that? I know the minister has made reference to it but you raised the issue about our median waiting time being the longest in the country. I think the Australian hospital statistics give some insight into the fact that the median wait time very much depends on the wait list practices that are utilised by the jurisdictions. In the latest Australian hospital statistics, there is actually a draft that speaks to the percentage of total removals for category 3 patients who had their

surgery within five days of actually being placed on the waiting list. These are people who are category 3, who should have their surgery within 365 days, but they had it within five days. In New South Wales that accounted for 10 per cent. The ACT was the only jurisdiction that had zero.

What we interpret that to be is that we are absolutely transparent in terms of the data. But other jurisdictions would seem to employ other approaches to their waiting list management that might help their median wait times. That is suggested by the AIHW in this report and by the data. We do not know that to be true but—

MR HANSON: And I accept that the median wait time is not the be-all and end-all. I am not trying to belabour the point, but we did have a situation where people who were category 2, for example, were waiting well over a year. So it was not just the median wait time. I think—

Dr Brown: No, but again, if you want to go to this report, it will also speak to the issue of the variability in assigning urgency categories 1, 2 and 3.

MR HANSON: Sure.

Ms Gallagher: So there is no standard. When you measure category 2 here with category 2 elsewhere, there is no standard. Health ministers have commissioned work on standardising the waiting lists and how we manage them, and I can tell you right now that my prediction is that it will never be agreed to because it will make someone look bad, and it will not be the ACT.

MR HANSON: You said that the reason for some of the problems that we experienced was unanticipated growth. Obviously we are anticipating significant growth with the ageing population over the next 10 years and beyond.

Ms Gallagher: Yes.

MR HANSON: Have we done an analysis to see what that demand is going to be? Have we peaked? Are we going to see more people coming onto the list? Is it less? Have we mapped that so that we do not get that same situation again where we have unanticipated growth in the future?

Dr Brown: I might ask Mr Thompson if he wants to speak to that.

Mr Thompson: We have mapped that, and we have done very detailed demand projections which cover all aspects of our hospital services, including elective surgery. While we have done those demand projections, however, I cannot say that we will never have unanticipated growth in demand. This is a feature of health systems, and one of the issues, of course, is that the public system in the ACT operates in a context both in the private system in the ACT as well as the public and private system in the immediate surrounding area of New South Wales, and the degree to which we control those sorts of factors is limited. But those sorts of factors have a direct impact on demand for our services. So, yes, we have done the demand projections. We have done it using a nationally validated methodology and it has been rigorously done, but we have to put the caveats on it that there are factors outside our control and outside

of our ability to predict that may have an impact.

MR HANSON: Assuming that you have your numbers right, obviously that will mean growth, be it from New South Wales or the ACT. That will require additional specialists and capacity in terms of operating theatres and beds and so on. When we map that, are we confident that we are going to have enough urologists or general surgeons and so on? Where are they coming from?

Ms Gallagher: We can map it, and that is, in a sense, the entire work that has been done in the health structure program and the work that underpins that, which is the workforce planning and how you actually provide the services. All of those policy documents are interlinked.

MR HANSON: The workforce plan was due to be released in October last year.

Dr Brown: There are two separate documents. There is a health workforce plan and then there is the clinical services plan.

MR HANSON: Right.

Dr Brown: The health workforce plan has been a process. We have had consultation with key stakeholders. That was information, a discussion document, which is due to go out for release very soon, and I am aware that we will be providing you with a copy of that, Mr Hanson, once that goes out. That has, as I said, been informed by discussion and consultation with key stakeholders, but it has been going out as a discussion document, and then that will inform the development of the plan. So there is a staged process. But the discussion document should be released very soon.

MS GALLAGHER: And Health Workforce Australia, which all jurisdictions have supported—indeed, Dr Brown sits on the board—are presenting to health ministers their projection planning across a whole range of health professions at the next meeting, including shortages and predictions going forward.

MR HANSON: And when you look at those predictions and the assessments and the plans and so on, are there any specific areas where we have got problems? Do you look at it and say, "Well, okay, orthopaedic surgeons, we are going to have a real problem coming up," or is there any particular area where we see we have an emerging problem?

Dr Brown: If I speak to the national situation first, Health Workforce Australia has not yet completed all of its modelling around all of the medical specialties. They have done nurses and some medical specialties. They are doing some further work on a broader range of medical specialties and then they will move on to the allied health professionals. I think it is fair to say that there are some professions where the shortages look to be more acute than in others. But I think it is also fair to say that the document will highlight that the response to the workforce challenges is not going to lie just in terms of finding more, whether that is training more or recruiting from overseas. It is also looking at ways of working. That will be a key focus for Health into the future.

THE CHAIR: Going back to what I was asking before about the shared waiting lists, recommendation 1 of the Auditor-General's report talked about integrating the two hospital databases so that we actually manage them together. We did not get to that in the answer. Is that working?

Mr Thompson: The key to achieving that is the implementation of the patient administration system that we currently have at the Canberra Hospital at Calvary. Work is progressing very well on that. We have an October completion date for that. We expect, once we have what is called ACTPAS—the ACT patient administration system—in Calvary, that will enable us to establish a consolidated list.

THE CHAIR: So at present they are still being managed as—

Ms Gallagher: As two systems.

Mr Thompson: However, we do have a central coordination unit that monitors across both, and there is the capacity to transfer patients between the waiting lists at Calvary and the Canberra Hospital.

THE CHAIR: Will that database management system also mean that in Calvary they have full access to your history from Canberra Hospital and vice versa?

Mr Thompson: It is a patient administration system. It is not a full electronic health record. Of course we have work underway around an electronic health record for the ACT, but that has a longer time frame.

MR HANSON: I got my letter in the mail yesterday.

Mr Thompson: You did?

THE CHAIR: I don't think I have got a letter.

MR HANSON: If you join up as a Calvary e-health consumer; I got the correspondence yesterday.

MR SMYTH: Minister, on page 6 of your submission to the standing committee on this issue, in paragraph 2.14 I see that you have directed the Health Directorate to develop an action plan to ensure that each of the Auditor-General's recommendations is addressed. Has that action plan been completed?

Dr Brown: Yes.

MR SMYTH: Is it possible for the committee to have a copy of the action plan?

Ms Gallagher: I am sure it is. I see no problem with providing that.

MR SMYTH: Of the actions in your action plan, how many of them have been completed?

Dr Brown: Sorry, the action plan in relation to the recommendations of the Auditor-

General? I think we have completed all bar one.

Ms Gallagher: I thought I tabled it. I did, didn't I? I tabled that in the Assembly.

MR SMYTH: All right. Is there an up-to-date summary of the actions taken to complete the plan?

Ms Gallagher: Yes, I think I have to table another one. I think I am tabling every three months or so, so it will be coming—every six months, sorry. So if it was in October, there must be one during the March or May sittings.

MR SMYTH: You thought there was perhaps one action outstanding?

Dr Brown: There is one particular item that we are still to get progress on. I am looking at them to work out exactly which one it was. Mr Thompson, do you recall?

Mr Thompson: The consolidated waiting list is the primary one, and we have just discussed that. Associated with that there was a recommendation for a single request for admission form across the two hospitals. We have worked to get consistency between the two hospitals, but some of the local management arrangements mean that it is actually quite difficult and it would be disruptive to try to have the same form at both hospitals. It has the same core information with some local adaptations. We believe we have addressed the core issue associated with that recommendation but it has not addressed fully the exact recommendation.

MR HANSON: The sort of sharing of lists at the moment—the patient administration system, the single list or whatever that you have to complete by October of this year, I think is what you said—

Ms Gallagher: Patient administration is different from just elective surgery, though. It is about patient information being standardised across the two hospitals regardless of what you are there for.

MR HANSON: Is that on track?

Ms Gallagher: Yes.

MR HANSON: How is it exactly going to work—just sort of making sure that the information that is recorded is consistent and—

Ms Gallagher: That it is in the same system. We run two patient administration systems at the moment. Calvary has theirs and TCH a few years ago—ACT Health—implemented ACTPAS. But for reasons I cannot recall, they were not implemented at Calvary at the time but it is being done now.

MR HANSON: Good.

THE CHAIR: Why have there been such delays in getting access to Queanbeyan hospital? When is all that going to occur?

Ms Gallagher: Discussions are ongoing with New South Wales around using Queanbeyan hospital. I know that to everybody from the outside it sounds like a very easy thing to do but—

THE CHAIR: It does, yes.

Ms Gallagher: there are issues about working out what kind of procedures could be done, the funding arrangements for those procedures—who pays, what patients might be the right ones to use, a system got up and running, what doctors should be used? If they are ACT doctors, what credentialling process needs to happen to be able to use a New South Wales facility? Then there is the equipment that the doctors use and whether that equipment is available at the hospital.

So there has been considerable work done in this area and I am hopeful that we will have progress soon. You need to make sure that the patient safety issues are completely addressed and the professional issues for the doctors before you can embark on something. It is not like I can just run a little pilot and see how it goes. There is also the post-care of the surgical patients. All of these matters have to be looked at and it takes time. We want to make sure we get it right and have it as a success from the word go.

THE CHAIR: My understanding is that a lot of our patients actually come from interstate—that is, New South Wales. Would they be, from a funding jurisdictional point of view, the logical patients you would be starting with to move to Queanbeyan, which is New South Wales?

Ms Gallagher: Not necessarily because it is really based on what your surgical need is. Your address does not determine where you have your operation done. Indeed, the reason we have anywhere from 25 to 30 per cent of people coming through the ACT is because that is the best place and probably the closest place for them to access that surgery. So it is less about your address and more about what you need and whether that procedure can be done safely at that hospital.

MR SMYTH: What percentage of ACT patients go over the border to New South Wales for surgery?

Ms Gallagher: I did see a figure once.

Dr Brown: It is quite small.

Ms Gallagher: Yes, it is very small. We can get it for you. It is extremely small.

MR SMYTH: And what areas they go for.

Dr Brown: For example, we do not have specialised burns facilities here in the ACT. So that would be an example.

Ms Gallagher: Some paediatrics surgery.

Mr Thompson: And some other specialised paediatrics surgery on the basis of super

specialisation that we do not have the capacity to maintain here.

MR HARGREAVES: Would you necessarily know that somebody has been referred interstate for surgery by a private practitioner?

Ms Gallagher: Usually. Not necessarily by a private practitioner, but we do because of the size of the system. If people are unwell to the point that they are being referred, that the tertiary hospital cannot treat them, they would normally come through the public system. So we do have a good understanding—a reasonable understanding—but there will be people that we do not catch up with.

THE CHAIR: You were talking about what was required to increase elective surgery. You listed a whole heap of things. Are theatres now being used for longer hours than they were? I understand that that was being looked at.

Ms Gallagher: There has been a lot of work done around the operation of the efficient use of our theatres. I do not know whether Barb wants to respond to that.

Dr Brown: We have increased the number of theatres. At Canberra Hospital, for example, there were an additional two theatres plus the neuro theatre. At Calvary there was an additional theatre added about two years ago. So we have increased the number but we are also looking at increasing the efficiency of the utilisation of those theatres. Barbara Reid might speak to that in a little more detail.

Ms Reid: Apart from what Peggy has clarified, we have been able to get better uptake of lists from the doctors. One of the recommendations was about leave for doctors. We have processes in now around leave. So we are offering up extra lists for the doctors. So it is not just about efficiency on a day-to-day basis like the hours of work. It is about the utilisation overall with the doctors taking up extra lists.

MR HANSON: In our discussions over time we have talked about the building of the hospital system in the ACT, and one of the views the government has, which I agree with, is that Calvary becomes more of a hub for elective surgery and the Canberra Hospital focuses on emergency surgery but not to the exclusion of each other. Is that work progressing? Have there been any steps towards that where we are seeing an increase in elective surgery being conducted at Calvary and a decrease at the Canberra Hospital? Or is that not work that has started yet?

Dr Brown: That work is being progressed as part of the development of the clinical services plan. That is actively being progressed at this point in time.

MR HANSON: Okay, so we have not seen it happen? It is more the planning and the preparation?

Ms Gallagher: I am sure Ray can go to this, but Calvary did the bulk of the extra elective work—half or more, I think—last year that was funded.

Dr Brown: But in terms of articulating it—

MR HANSON: Okay. The extra work that has been done, a lot of it has been done by

private providers.

Ms Gallagher: No, most of it is done by the public system. There have been 389 out of 11,000—

MR HANSON: Okay. Is that going to continue? Is it going to expand? Where are we at with the private provision?

Dr Brown: I think it is fair to say that that remains an arm to what we have got to offer in terms of tackling the waiting list. We look at it and do it on a needs basis, and we will continue to do that into the future. We have the capacity at TCH, the capacity at Calvary, we are looking at building the capacity at Queanbeyan, and the capacity in the private sector is a fourth arm. It is hard to say definitively yes or no as to what extent that will need to be utilised into the future.

MR HANSON: Who specifically has been doing that work, and can you provide the cost of each procedure? Can you provide that information to us?

Dr Brown: We can. Essentially the work is being conducted by doctors who are currently VMOs within our system. We flagged that we would offer the work to existing VMOs first. If they were not willing or able to do it then we would look outside that, but we have not had to do that to date. In terms of the cost, it is essentially the same as what it costs in the public system.

MR HANSON: But if you could table that specifically, that would be quite useful.

Dr Brown: We will see what we can provide.

MR HANSON: Who is doing the surgery and at what price? It would be good if that was open, because a number of surgeons have approached me about the process for this and what rates are being paid. There is a suggestion that it is above certain rates. I asked these questions before—

Ms Gallagher: It is actually more expensive to run—the public system has overheads.

MR HANSON: Yes, so if we had this information, that would enable me to provide the response.

Mr Thompson: We use the cost in the ACT public hospital system for that particular procedure and the associated hospital stay—in other words, each elective surgery procedure has a particular cost load. We have an average cost weight price. We multiply the average cost weight price by the cost load, and that is what we offer to the private hospital.

MR HANSON: I think there is an AMA cost. So you are specifically running a scenario of, "This is what it costs at the Canberra Hospital, therefore, that is what we will bill for that"?

Mr Thompson: Exactly. We pay a single price to the private hospitals based on the methodology I just talked about. We do not discuss with the private hospitals how

they manage that with how much they pay the individual doctors. The position that we have taken is that we are going to pay no more than it costs in the public sector. That is what we do. How it is organised within the private hospital regarding what they pay to whom is not something we—

THE CHAIR: So is that a totally fixed cost? Say you expected the patient to be in hospital for two days but they ended up being in hospital for five days for whatever reason, would you still pay the private hospital the same? They cannot come back to you and say no?

Mr Thompson: We pay the cost weight price. There are always ups and downs. That is not to say that, in certain circumstances, there may be something that is completely out of everyone's expectation. We are very happy to have discussions with private hospitals in those circumstances, but it is not an issue that has arisen.

MR HANSON: Will you provide us with the current cost weight price that you use?

Dr Brown: We can certainly provide you with the current cost weight price and we can provide you with the successful tenderers. That will not equate to which doctors have done exactly what procedures.

MR HANSON: No, that is fine. I suppose there is a contractor and subcontractor type arrangement.

Ms Gallagher: There is, yes.

Dr Brown: I want to make the point, though, that the cost weights are modified, for example, if there are certain complications. So if there is a complication that adds to the stay, that may change the cost weight assigned to that particular individual and that will modify the cost. As Ian said, it is the average cost weight price by the cost weight.

THE CHAIR: Another issue that the audit identified was problems with always having patients' full consent documented. Has this been addressed and fixed?

Dr Brown: We have looked at the consent form. The aim is to have a consistent consent form across both hospitals. We are on our way to that. Calvary has had a slightly different form from Canberra Hospital. Their pilot is due to conclude this month and there is agreement that we will be reviewing the forms and working through the surgical services task force to have a single consent form. We have also been undertaking regular audits in relation to completion of the consent form. Overall, the results of those have been very high. There have on occasions been the odd issue identified as part of those audits, in terms of completion of those consent forms. Where that has been identified then it is addressed with the individual doctor. But that is not large in number.

THE CHAIR: Do the patients of urology and gastroenterology still have significant waiting times at Canberra Hospital's outpatients?

Dr Brown: Again, we have done quite a lot of work in relation to that. I can, for

example, give you some information in relation to urology. What we have been doing is looking at the process from the point of referral to the point of appointment. In the eight-month period from July to February of this current financial year compared to two years ago, there has been a 20 per cent increase in the number of urology outpatient appointments. We have implemented some changes so that at the point that a referral is received, it has to be triaged to determine the urgency of the appointment. That is now done by registrars. That speeds up the process. As of 8 March, there were three urology patients awaiting clinical triage. There is then a wait until the allocation of the appointment and then the wait until the actual appointment time.

For current urology patients, on 8 March, the first available urology follow-up appointment was 20 March and the first new appointment available was 4 April. So I think it is fair to say that there has been significant work done and some improvement. I am sorry; I do not have similar data for gastroenterology but it is an area that is receiving quite a bit of attention.

THE CHAIR: Could you take gastroenterology on notice?

Dr Brown: Sure.

MR HANSON: Minister, on 18 August last year, you received a letter from the previous health minister, Nicola Roxon, about elective surgery and meeting performance targets. One of those was the implementation plan, and that $2.2 million of facilitation funding would be made available on receipt and approval of the revised implementation plan. Has that plan been submitted or when is it due to be submitted? Have we got the money?

Dr Brown: We are due to submit the third implementation plan under the improving public hospitals NPA in the very near future. That NPA of course has elective surgery as well as EDs and subacute. The first two plans addressed some of the first parts of the elective surgery and the ED. The third one contains more detail in relation to those plus more detail around subacute.

MR HANSON: In terms of performance targets, we missed out on some funding last year. I think we have litigated that issue. But in terms of future targets that we need to meet, are we comfortable that we are going to meet those targets? Can you explain to me what those targets are and when they come up?

Ms Gallagher: I had a question on notice, or without notice, on the last sitting day. I think it is by 2016 100 per cent of patients receive their surgery on time, so between 2012 and 2016 there is a gradual increase up to 100 per cent. At this point in time we are confident. It is going to be tough. With 100 per cent on time, I do not think you will find any health minister in the country that will say, "Yep, no worries," including the commonwealth minister. But at this point in time I think it is 70 per cent.

Dr Brown: The target for this year, for example, is 95 per cent of category 1s on time, 55 per cent of category 2s, and 82 per cent of category 3s on time.

MR HANSON: And that escalates?

Dr Brown: That is right. At the moment we are tracking well against those targets. We have got some further work to do around the category 2s, but it is early days and we have got some very good work happening. I am looking at my two hospital managers here, but they assure me they are confident that those targets are achievable.

THE CHAIR: Mr Hanson, this will probably be your last question, given the time.

MR HANSON: Okay. The issue of leave and management of leave, there was something about that in the Auditor-General's report. Doctors want to take leave, understandably, as do staff. I know this is an issue where we see operating theatres and hospital wards close down at various stages. Is this an issue we have been able to address so we can get more—

Ms Gallagher: It is better planning of leave.

Dr Brown: Some of that leave is unplanned because doctors occasionally get sick—and actually admit it, and we would prefer that they do. Some of it, of course, can be planned for in terms of time away for holidays or conferences or what have you. We have been working with the doctors to ensure that they give us adequate forewarning so that we can reassign the theatre time and also look at a management plan in relation to the individual patients.

MR HANSON: So they give sufficient notice and you are able to adjust rather than just all of a sudden being surprised?

Dr Brown: Yes. And I think it is fair to say that, on the whole, that is going well. There are still some individual instances where we get some unplanned leave that would have been better planned, but, on the whole, there have been improvements there. We have certainly seen a reduction in the hospital-initiated postponements of theatre lists across both Calvary and particularly Canberra Hospital over the last couple of years.

MR HANSON: Just extrapolating that to the issue of retirement, it was in urology where there was one retirement that probably was anticipated but where action had not been taken to backfill. Have you done any work to look at that issue to make sure that, with an ageing workforce—

Ms Gallagher: There has been a lot of work done in urology.

MR HANSON: people are perhaps—

Ms Gallagher: There have been mixed views about how to manage transitions in urology but then there has been a lot of work done over a number of years.

MR HANSON: It just seems that sometimes people move on for whatever reason and then we get this gap while we are waiting to find someone else to come along. I am sure it is a complex issue but I am just wondering what you—

Dr Brown: It is a challenging issue because I think in the case that you refer to we cannot plan for someone's replacement if they have not actually told us they are going

to be leaving. That is a first thing.

MR HANSON: I understand that. In the way that you are asking people to give advance notice of leave, have we made efforts to say, "If you are thinking about retiring at the end of the year, could you let us know so we can take steps?"

Ms Gallagher: We are a small system. Everybody knows everybody in the hospital. Some individuals are really good and say, "I am retiring in two years," and a good plan can be put in place. Others will say that they are thinking about retiring and continuing to think about retiring. They will let you know. These are managed very closely. It is in no-one's interests to have gaps in the workforce. It is bad for the other members of the team. But I think everyone in large part does a very good job in trying to plan and if unexpected terminations happen, manage that in the short term and in a longer term sense.

Dr Brown: Currently, for example, we have six specialists in urology, which was the area that you referred to, I think. When we had the challenge we had only four, I think, working.

Ms Gallagher: But there are still areas—plastics is one of them, although there have been some positive changes there where someone leaving unexpectedly creates a really difficult situation to manage urgently.

Dr Brown: You can have some speciality areas where you only have a small number of surgeons.

THE CHAIR: Thank you very much. We have run out of time, unfortunately. Mr Hanson, will there be supplementary questions?

MR HANSON: I will go upstairs and review that.

THE CHAIR: There may be some supplementary questions and we will send them to you if they eventuate. On behalf of the committee, I would like to thank you, Chief Minister and officials from the Health Directorate and Calvary hospital, for attending today. When available, a proof transcript will be forwarded to witnesses to make any corrections to factual errors. I now formally declare this public hearing closed.

The committee adjourned at 10.30 am.