LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2013-2014

(Reference: Appropriation Bill 2013-2014 and Appropriation (Office of the Legislative Assembly) Bill 2013-2014)

Members:

MR J HANSON (Chair)
DR C BOURKE (Deputy Chair)
MR M GENTLEMAN
MR B SMYTH

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 20 JUNE 2013

Secretary to the committee:
Ms N Kosseck (Ph 620 50129)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 20 May 2013

The committee met at 9.30 am.

Appearances:

Gallagher, Ms Katy, Chief Minister, Minister for Regional Development, Minister for Health and Minister for Higher Education

Health Directorate
- Brown, Dr Peggy, Director-General
- Goggs, Mr Stephen, Deputy Director- General, Strategy and Corporate
- Thompson, Mr Ian, Deputy Director-General, Canberra Hospital and Health Services
- Ghirardello, Mr Phil, Executive Director, Performance and Innovation
- Bowden, Professor Frank, Acting Executive Director, Medical Services
- Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
- Carey-Ide, Mr Grant, Executive Director, Service and Capital Planning
- Chatham, Ms Elizabeth, Executive Director, Women, Youth and Children
- Foster, Mr Ron, Chief Financial Officer, Financial Management
- Greenfield, Ms Joanne, Director, Health Improvement Branch
- Kelly, Dr Paul, Chief Health Officer, Population Health Division
- Kohlhagen, Ms Linda, Executive Director, Rehabilitation, Aged and Community Care
- O'Donoughue, Mr Ross, Executive Director, Policy and Government Relations
- Redmond, Ms Judy, Chief Information Officer, E-Health and Clinical Records
- Barnes, Mr Jon, Director and Construction Manager, Redevelopment Unit
- Hall, Dr Michael, Clinical Director, Emergency Department, Medical Services

Commerce and Works Directorate
- Mooney, Mr Colm, Director, Health Infrastructure Program, Shared Services Procurement

THE CHAIR: Good morning, minister and officials. Welcome to the estimates committee. We are on to our fifth day, so we are grinding through it. Today's proceedings are being recorded by Hansard and are also being webstreamed. Can I confirm that you have seen the privilege card? Can I get an indication from the assembled thousands in the gallery that that is the case, so that we do not have to go through that process again? That is great. Minister, do you have an opening statement?

Ms Gallagher: Thank you, chair. Yes, I will make a few opening comments. I will keep it brief so that the committee can proceed to questioning. Just to put the health budget in context for the 2013 budget, this budget provides $1.299 billion across both directorates—that is, the Health Directorate and the Local Hospital Network Directorate—in annual and recurrent funding for health services for the people of the ACT and, indeed, for south-east New South Wales as well. It includes new capital funding of $31 million, and $40 million recommitted to design the next stage of the Canberra Hospital redevelopment and expanding emergency department, including a paediatric emergency space.

The new capital allocation takes the health infrastructure program to $765 million. The budget includes growth and new initiative funding of just under $27 million, or $129 million over four years. All election commitments made for health to start in 2013-14 are included in this budget.

The initiatives focus on areas of growth and need across Canberra Hospital, Calvary Public Hospital and, indeed, community health provision. The budget will add another 42 beds across both public hospitals and six hospital-in-the-home places. It will maintain the commitment we have made around elective surgery and provide for 11,000 operations in 2013-14.

A large part of the allocation of recurrent funding will be to employ nurses, doctors and allied health staff to deliver the programs that are funded. These initiatives also see expansion of some of the community health programs, in women, youth and children, and for the new Belconnen health centre that will come online in this fiscal year.

I am happy to leave it there, chair, or I can continue chewing up time that probably is best left for committee members to ask questions. We all stand here ready and happy to assist.

THE CHAIR: Thank you very much, minister. I will make the point before we start that, because we have the local hospital network this afternoon, there is a bit of duplication, and we are going to bounce around a bit.

Ms Gallagher: It is the same people.

THE CHAIR: It is the same people and the same issues, really, so we will get two bites at the cherry as we go. I mention it so that we have some sort of understanding of that. I apologise to officials; they will get a bit of a half-time break but it will be a little bit clunky. Maybe we will look in future years at whether we combine it, for the sake of an easier estimates committee.

Before we move to output class 1.1, acute services, more broadly, can you confirm who is in what staffing arrangement at the moment? With Mr Martin leaving and the Chief Nurse leaving as well, I am not sure whether people are in acting positions.

Ms Gallagher: The Chief Nurse has not left.

THE CHAIR: Was that last year? Who was it that left?

Dr Brown: I am very happy to provide an update.

THE CHAIR: It was not the Chief Nurse; who left last year?

Dr Brown: Susan Aitkenhead. Mr Stephen Goggs, who is sitting to my left, has been appointed permanently to the position of Deputy Director-General, Strategy and Corporate. Mr Ian Thompson is appointed permanently to Deputy Director-General, Canberra Hospital and Health Services. We have had a review of our structure

conducted by an external consultant, and that made a recommendation that we combine the position of Chief Nurse and Executive Director of Nursing and Midwifery Service, the position that was previously held by Susan Aitkenhead. We are in the process of consulting in relation to that recommendation.

It also had a recommendation in relation to combining the positions of Principal Legal Adviser, which is held by Professor Frank Bowden, and the Executive Director of Medical Services at Canberra Hospital and Health Services, previously held by Dr Jo Burnand, who has left the service. Professor Bowden is currently acting in that combined role. That is also subject to a consultation process at the moment.

THE CHAIR: Thanks very much for that, Dr Brown. That clarifies it for me. Minister, I think the Health Directorate had savings that it had to meet last year.

Ms Gallagher: Yes.

THE CHAIR: I am not sure if there are any in the budget. Can you give an outline of what savings you had, what you have been able to meet or not meet and what savings there are in the budget going forward?

Ms Gallagher: Yes, they are shown in the financial statement. I think there was a $3.6 million saving for this financial year and general savings which are included on page 100 of budget paper 4 of $6½ million. So, yes, there have been savings, as has been outlined in previous budgets, and those savings are being delivered upon.

THE CHAIR: Where have you found those savings?

Dr Brown: In terms of the savings for the 2012-13 year, we looked at a range of administrative areas. That included travel and accommodation, printing publications, stationery, contractors, consultants, training, recruitment and development, advertising and marketing. We have also looked at our rostering processes, our leave management and our overtime management.

THE CHAIR: Thanks very much for that. I will move to Dr Bourke.

DR BOURKE: Dealing with acute services, can the minister outline the progress that has been made in reducing elective surgery waiting times, including the funding allocation in the 2013-14 budget?

Ms Gallagher: The budget includes an $8 million a year allocation for provision of elective surgery. This is really to maintain the effort that we have at the moment. Eleven thousand operations a year is the target; for this financial year, we are marginally going to exceed that. That is because some of the commonwealth money that was used for the elective surgery blitz runs out. So our allocation of 8,000 will maintain elective surgery at that level.

We have also seen very good progress. It is a real credit to the staff, and the managers who are sitting in this room, who have seen the ACT become the only jurisdiction that has met all nine of the targets set under the national reform agreement in elective surgery. We have seen very impressive reductions in the numbers of patients waiting

too long for care. We have seen another 21 per cent reduction in this last financial year in those who are waiting too long for care on the elective surgery list.

There is still pressure, and I am not going to pretend it is all rosy. It is very hard work. The more you remove from the list, the more that are added to the list. What we have seen, very interestingly, in the last three or so years is that we have ramped up elective surgery. When we were delivering 9,800 operations, around 9,800 people were added to the list. We are now doing over 11,000 and we are seeing 11,000 added to the list. So it is one of those things: create capacity, drive demand. It is very expensive. In the last 10 years we have put $160 million into the elective surgery program to deliver extra operations. In that same time our elective surgery output has grown by 44 per cent at a time when the population growth has been at about 17 per cent.

You can see we are putting in a huge effort. It is enormously expensive, and we are seeing the waiting list remain at about 4,000. There are just over 4,000 on the waiting list. So people are getting access to their operations faster, but as you are driving that demand, you are never going to get to a point where the waiting list is half of what it is today, I do not think. You are going to see continual additions to the list. It is going to require governments into the future to continue to invest and also to look at other ways, to make sure people are leading healthy lives and not needing elective surgery for some conditions.

MR GENTLEMAN: I have a supplementary to that. Minister, can you tell us what those nine targets are?

Ms Gallagher: They are different.

Dr Brown: The first three relate to the different categories, category 1, category 2, category 3, and the percentage that need to be done within the allocated time or clinically appropriate time. For category 1, that is within 30 days, category 2 is within 90 days and category 3 is within, essentially, 12 months. The second cohort was in relation to the average overdue wait time for each of those three categories. There was a target set that we had to meet for those who did not have their surgery on time, as to how long they did wait over the allocated time. There was a target for each of the three categories in that cohort. The last cohort of the three related to the top 10 per cent of long waits. We were required to ensure that the top 10 per cent of long waits on the waiting list actually had their surgery within the calendar year.

THE CHAIR: I might ask a supplementary as well. Certainly, when I saw your press release, minister, which said that we were topping the nation, the media was very excited by that—that we are doing well on elective surgery. But when you actually look at the report comparative to other jurisdictions—I will give you an example: in the measure that Dr Brown just talked about in terms of wait times, for the semi-urgent category, that is the 30 days—

Ms Gallagher: Sixty days, isn't it?

THE CHAIR: Sorry, 90 days. We are all wrong. For the 90 days, the ACT had a target of 55 per cent of people seen on time, whereas other jurisdictions are up around 90 per cent. So in some cases we were 35 per cent behind other jurisdictions' baseline.

What you see is that we get 57 per cent seen on time, so we meet our time and everybody is applauding and everybody is happy, but other jurisdictions are doing far better. Let us take WA, for example. It had a target of 84 per cent, it just misses it and gets 82 per cent. So it does not achieve its measures. It is worth noting that we are way behind most other jurisdictions on most of the categories.

Ms Gallagher: I would not agree with that.

THE CHAIR: I have done the analysis and we are.

Ms Gallagher: I am sure you have. I would not agree with that. I do accept that everyone started their baseline with where they were at when these targets were implemented. But on this report, we were the only jurisdiction that reached all nine measures, and that is the basis of the report and the—

THE CHAIR: But we have got the lowest targets.

Ms Gallagher: Everyone has a different baseline according to where they started. On other measures—and don't worry, elective surgery is reported against in a whole range of different results—the ACT, depending on how those measures are reported, will fit somewhere differently, based on the report. But on this report, the point was to get for the COAG reform council who has met their nine targets. Yes, those targets are different for different jurisdictions based on where they were when the targets were imposed, but the ACT achieved all nine. I think it is fair and reasonable that the amount of effort that goes into achieving those targets is recognised, and recognised by their minister. That is the basis of my press release.

THE CHAIR: But if you had reported these when you took office in 2001, we were actually achieving the national benchmarks at that stage. So we were performing at a similar rate to WA, New South Wales and so on. But we have slipped right down the list.

Ms Gallagher: I do not think those were being reported.

THE CHAIR: Not in this detail.

Ms Gallagher: In fact, many of them were not reported. I know median wait time was not reported.

THE CHAIR: Median wait time?

Ms Gallagher: That was a measure that came in.

THE CHAIR: The median wait time was 40 days when you took over and it went out to 76 days. It was reported.

Ms Gallagher: In the last figures I saw it was coming down. I think it is between the 40s and 50s at the moment. Even though it is back in a much more reasonable position against national benchmarks, I still do not think median wait time is anywhere near a measure of how efficient your elective surgery performance is.

One of the most significant issues about elective surgery which is yet to be resolved is that everyone measures their list, additions to the list, removals from the list, just that little bit differently. We are seeing some of that pressure—and their categories—in New South Wales at the moment, with all the discussion around the hidden waiting list that occurs in New South Wales. I am not sure that is an issue that is ever going to be resolved because it will impact differently across jurisdictions.

On the measure, I think this is a reasonable report because everyone is being clear about what their benchmarks were, what their targets were and then they have been measured, and we met all nine. And, yes, there is more room for improvement, Mr Hanson.

DR BOURKE: Given your allocation in this budget of extra funding for elective surgery, how many more surgeries do you expect will be performed in 2013-14 and how does it compare with previous years?

Ms Gallagher: This will maintain our effort at 11,000. Under the health reform agreement, we got some funding from the commonwealth for elective surgery, essentially a blitz program which is coming to an end. I think in the last two to three years we have continued to grow our elective surgery program. As I said, back in 2001-02 we were doing 7,600-odd operations. We are now doing 11,000. So you have seen that incremental growth probably every year. I think there were maybe one or two years where we did not have extra funds for elective surgery.

This is a commitment, and it is across the forward estimates; so it provides 11,000 procedures. We will continue to work with the private sector around delivery of some of that. It has worked well over the last 18 months or so and we think there is room to continue that and we are freeing up, essentially, some of the pressure out of Canberra Hospital in particular to deliver those operations elsewhere.

DR BOURKE: What do you mean by "freeing up" by utilising the private sector?

Ms Gallagher: I think one of the issues we have had in Canberra is that Canberra Hospital, whilst it does a lot of elective surgery, does all of the emergency work as well. I think, where it makes sense—and it is the high-volume work which can be safely done in a non-tertiary hospital—they are areas that we would look at. But we are happy to give you more information on that. We have had the private sector delivering some operations. I think there were—just having a look—171 in 2010-11, 353 in 2011-12 and 66 patients so far this financial year.

DR BOURKE: And you had an arrangement with Queanbeyan as well to do some elective surgery?

Ms Gallagher: Yes. With Queanbeyan, interestingly, there is ongoing discussion there. We have had a total of 65 operations done at Queanbeyan hospital. I think it worked well. It took a lot of work to make sure that we had the systems and credentialing in place. And again, credit to staff at both the Southern New South Wales Local Health District and Canberra Hospital for working that through. I think the next step with Queanbeyan is a more permanent arrangement. So we have trialled

it, in a sense. We have done 65 operations. They have worked.

Now, what is the nature of the arrangement that is going to be permanent? And there are different variations on that. There is the opportunity for the New South Wales government to fund Queanbeyan hospital to provide operations. There is the opportunity for us to have a permanent arrangement with them to deliver operations, but they then need, I think, the certainty from us and they need to be able to ramp up and they need some volume of work so that they can employ staff to deliver the care. It is not as easy as it seems, but we are committed to continuing to negotiate with them.

DR BOURKE: So these are discussions you will be having with the New South Wales Health Minister or Premier?

Ms Gallagher: Yes, and southern local hospital network. It goes to things like what equipment they have, for example. If we commit to a certain type of surgery, what does that mean? Do they have the equipment? Do they have the staff? How permanent is that? They do not want to ramp up only if we are going to do 65 operations a year. But we also, I think, need to make sure it works with our program and with the program we are running at Calvary and at Canberra and with some of the private sector opportunities that exist in Canberra.

THE CHAIR: Minister, on the issue of the private providers, what is the bulk of that work? Is it orthopaedics or—

Dr Brown: It is a mixture of ear, nose and throat, urology, plastic surgery and orthopaedics in the private sector here in the ACT. And in Queanbeyan it has been urology and gynaecology.

THE CHAIR: Have you got a cost, say, of a hip being done by the private provider compared to the cost of doing it within the public system? Is it cheaper to contract it out, is it more expensive or is it the same?

Dr Brown: We put a work order out to the hospital, not to individual practitioners. The hospital contracts with the individual practitioners. And we pay to the hospital the same price as we pay to have it done in the public sector. So it is neither cheaper nor more expensive.

THE CHAIR: Anecdotally—and I have not seen any evidence around this but I speak to surgeons who operate across the public system and the private system; and you would be aware of this, no doubt—there are efficiencies within the private system whereby they can do a hip operation or whatever it might be quicker and cheaper than the public system can. There are reasons for that, and I accept those. But when you are negotiating, then, with the hospital providers, if there are those efficiencies that are within the private system, because they do not have perhaps some of the emergency work to do or whatever the situation is, have you considered, I suppose, negotiating a rate that is actually something that would save the public system some money rather than paying a public rate, which has got all those overheads?

Dr Brown: I think it is fair to say that, having done this now in relatively small

volume but over three years, yes, we are at a point where we are actually reviewing how we issue those work orders and how we contract. So we are actually looking at that quite actively.

THE CHAIR: So you would expect that in the next round or so you will start to, I guess, negotiate a price rather than just have that fixed price that is in the public system?

Dr Brown: I am not going to prejudge the outcome, but what I am saying is that we are actively looking at that very issue.

DR BOURKE: So what effect have these steps had on waiting times?

Ms Gallagher: They have helped. If you look at the work that we have been able to put out, it is traditionally those areas that turn into long-wait patients, because many of them are not urgent and they potentially could be cancelled for more urgent work. And I would say that, for the private sector, it is not a benevolent service. Whilst they work with us and they are interested, there is a need. So that factors into the thinking, I think, around the price.

Dr Brown: Can I say, orthopaedics is one of those areas where they actually require, generally speaking, a period of extended stay in hospital, not lengthy, but it is not overnight surgery, by and large. So the capacity to do that in the private sector actually assists us in bringing down the long waits in the orthopaedic area.

THE CHAIR: Because of bed numbers and bed occupancy?

Dr Brown: Yes, and skill base across the hospital.

THE CHAIR: On elective surgery—I might do all our elective surgery stuff and then move on—the Auditor-General tabled a report in January 2011, from memory, and it had 11 recommendations. Can you give me an update on the progress of meeting those recommendations please?

Dr Brown: I can. My advice is that all bar two of those recommendations have been met. I am just waiting for Stephen to find the piece of paper. One was in relation to the establishment of a single wait list, and the second, from memory, was in relation to a single RFA and consent form. Is that correct?

In relation to the single waiting list across the ACT, we held a very positive planning day, a cross-territory surgical services planning day, earlier in the year. There was general agreement across the hospitals to work towards that. There was also agreement that we should establish a position of director of territory-wide surgical services to actually oversee that work. And we have advertised that. It has not yet closed, but I have had some interest expressed. So that is very positive. The rollout of the ACTPAS at Calvary is also assisting us in terms of getting that single waiting list together.

In terms of the work around a single RFA and consent form, that work is actively being progressed and is a subject for discussion at most of the surgical services task

force meetings which occur approximately every six weeks. All the other recommendations are complete.

THE CHAIR: The single wait list, can you give me a bit more detail in terms of how that would work? Let us take a hip patient, again, or a knee patient. They get put on a central list. How does that then get allocated to a surgeon's list? The problem at the moment, is it not, is that you will have a bunch of people on a surgeon's list and the surgeon is not getting through the list whereas another surgeon might have fewer people? How would it work, the mechanics of it, and how are the VMOs responding to that?

Dr Brown: I might ask Mr Thompson to speak to that. It is still a work in progress, and this is what our new director will be overseeing. Part of the discussion on this has been around do we have a single, pooled list or do we have a single list per surgeon to work across both hospitals. But I might get Mr Thompson to speak more to the detail.

Mr Thompson: And leading on from Dr Brown, what we are looking at is a staged implementation of this. In the first instance, the focus of the preliminary work has been on a single waiting list per surgeon across both hospitals. Many of the surgeons work across Canberra Hospital and Calvary hospital. So what we are looking at is combining the lists of those two hospitals and then allocating to each hospital according to the capacity of the hospital. Some of the complex patients are inappropriate for Calvary but, importantly, we want to enable equitable distribution across the two hospitals and for patients to be seen as soon as possible.

That is the first approach we are looking at. We are still in the preliminary stages of that, but it is looking quite promising. Depending on the success of that, we will then look at combining the lists across surgeons but, at this stage, that is not part of the work.

DR BOURKE: How does that compare with other jurisdictions?

Mr Thompson: It varies across jurisdictions, the way they manage the waiting lists. And I think it is important to emphasise that, for a small jurisdiction like the ACT, adopting some of the practices that are applied across other jurisdictions that have a lot of hospitals to choose from and have much more flexibility in terms of how they allocate patients from one hospital to the next will not automatically be feasible for the ACT.

In general terms, we give the ACT community more certainty than other jurisdictions around which particular surgeon they will be on the list of. This is a difficult issue in terms of negotiating with both the community and the surgeons. Members of the community often have the expectation of a particular surgeon. From the surgeons' point of view, knowing the patient and understanding the care that they have received to date and maintaining continuity of care is something that they consider is important for the quality of the service provided. So we need to balance those considerations with the ability to move patients between surgeons to get the most timely access to surgery. And so that is a work in progress as well.

Dr Brown: Sorry, can I just correct the record? I have just found my note. The second

recommendation that is still outstanding is not the single consent form. It is completion of the consent forms at the time of agreement to surgery, which is where the surgeons actually get the patient to do it at the time they recommend the surgery. And that is a work in progress, but we are regularly—

THE CHAIR: I remember that one of the problems was that patients were being downgraded without the clinical authorisation.

Ms Gallagher: And upgraded.

THE CHAIR: And upgraded.

Dr Brown: And upgraded.

THE CHAIR: You are comfortable that has been resolved now, that that is not happening anymore?

Dr Brown: Yes, and we do monitor that.

THE CHAIR: Mr Gentleman.

MR GENTLEMAN: Minister, the budget continues the government's commitment to emergency departments at our two public hospitals with an additional $12 million allocated over four years for the emergency medicine unit at TCH and the establishment of the rapid assessment unit at Calvary. Can you outline exactly what will be delivered with this funding?

Ms Gallagher: I can, Mr Gentleman, and, more broadly, I think I can link a number of the initiatives to improvements we would like to see around timeliness in the emergency department. Specifically in relation to your question—the expansion of emergency medicine and rapid assessment services at Canberra Hospital—it is an additional six beds at Canberra Hospital and, with the rapid assessment and planning unit, eight beds at Calvary. This is designed to get people through. Perhaps decisions are yet to be made about where their admission should be or what their particular clinical treatment requires. There is a need to do further work, but there is not a need to have them sitting in the emergency department taking beds up. This creates some capacity outside the emergency department, but it is linked very closely to them. It certainly will create capacity and, hopefully, move people through quicker. Because you have got that extra capacity people waiting to be seen in the emergency department will be able to be brought forward and be seen.

I would say that, when you look at a whole range of initiatives within this budget, many of them have links to making a patient's journey through the hospital more seamless and hopefully faster, where there have been delays in the past. One example is enhanced cancer outpatient services. One of the components of this program is for diversion from the emergency department. So you are creating more capacity in your outpatient clinics to look at better planning for patients—maybe patients going directly to the cancer service rather than the emergency department—discharge planning and all of those things, to try and stop people having to re-present.

Another initiative is growth in outpatient services. That is linked very much to the increases in elective surgery. Because we are doing more surgery there is more demand for outpatient clinics. Another example is hospital in the home—the opportunity for people with deep vein thrombosis and cellulitis to have direct admission to HITH rather than come through the emergency department. It is, again, trying to relieve pressure on the emergency department and leave it for emergencies.

Even the initiative around paediatric short stay within the initiative around women, youth and children gives the capacity for paediatric patients to be admitted to a short stay area rather than take up beds within the emergency department. The final example I will give you is the public obesity management service, which looks at those issues around chronic disease, chronic care, diabetes and cardiology. Again, if we are better managing people who are going to be using a public obesity management service, the likelihood of them presenting with a whole series of issues that they often have if they are that overweight will reduce the pressure on the emergency department.

So it is not just the one that is clearly articulated as an emergency department support initiative. It really is right across the board in many initiatives. It is all about taking whole-of-hospital responsibility for all patients that present. The debate really cannot be: what are the emergency department going to do to improve performance? They can do what they can within their unit, but if there is no way out of the emergency department or areas of the hospital are not geared up to take patients from the emergency department quicker then the emergency department performance is not going to improve. There is a huge effort underway at the hospital to improve that.

DR BOURKE: So what exactly will this rapid assessment unit for Calvary Hospital mean for people in my electorate of Ginninderra?

Ms Gallagher: It is creating extra bed capacity within the hospital, again designed primarily to get people through the ED. If those decisions have to be taken about what is going to happen next, we have the SAPU and the MAPU at Canberra Hospital. And this is the RAPU now, isn't it—the RAPU at Calvary?

MR SMYTH: There are another 23 letters left in the acronym list now that you can work your way through.

Ms Gallagher: There is a challenge for the Health Directorate, to actually think of more RAPUs.

Dr Brown: I am sure I can find some ways to do it. I might just expand on that. Essentially, at an early point in the patient's presentation a decision is made as to whether or not this person needs admission or does not need admission. If they need admission then the decision is to admit them and the further assessment that is required to actually clarify the diagnosis et cetera is undertaken in that assessment unit. But it is clear from the outset that they need admission and therefore the admission occurs at an early point.

DR BOURKE: Is there a difference in patients' minds as to whether they are being admitted or not admitted as to whether their treatment is progressing or not? In other

words, do they feel that progress is being made even though they may be already receiving treatment in A&E?

Dr Brown: I have to say I have never seen anything in the literature that actually specifically speaks to that issue of what patients think.

DR BOURKE: I am just talking about perception.

THE CHAIR: You are a psychiatrist, aren't you, Dr Brown?

Dr Brown: And I do read minds often, Mr Hanson, but I do not know whether I—

THE CHAIR: You do? What do you think is going on in Dr Bourke's?

Ms Gallagher: You don't want to know what she thinks.

THE CHAIR: I am just wondering what is going on in Dr Bourke's mind at the moment. If you can let us know, tell us.

DR BOURKE: I am not the subject of the inquiry.

Ms Gallagher: Don't start that slippery slope, Mr Hanson.

THE CHAIR: Scary?

Ms Gallagher: Once we have finished with Dr Bourke, we would have to move down the table.

THE CHAIR: That could take all day.

MR SMYTH: Minister, it could brighten your day.

THE CHAIR: We will just stay on ED.

MR GENTLEMAN: Minister, just on my question, you mentioned hospital in the home. Can you provide some more detail for the committee on how that is working, or how it is going to work?

Ms Gallagher: This is an area—

THE CHAIR: This is a supplementary. Can we just finish on emergency departments and then we will move to hospital in the home as a separate issue. There is quite a bit more to cover on emergency departments before we move there. I have certainly got a couple. Minister, we have had SAPU and MAPU and now we have got RAPU. Every time that we come here we talk about emergency department wait times and every time you give this committee the assurance: "Don't worry, we're on the job, we're going to fix it." But when I turn to budget paper 4, page 118, and I look at the actual outcomes under strategic objective 2, the wait time results are appalling. They are the worst in the country. They are the worst in the ACT's history.

Every year you come into this place and say, "We have the plans, we're going to fix it." Every year they get worse. What assurances can you give to this committee that this is not going to be a continual slide? We are at the bottom of the nation. What are you going to give to this committee as an assurance that this is actually going to get addressed and we are not going to come back here next year and there will be another acronym, another budget assurance, and we will see the statistics that Canberrans continue to wait longer than anyone in the nation?

Ms Gallagher: I have never come here and said that there is not more work to do in the emergency departments. It would be reasonable for the committee to have a view not just about timeliness in the emergency department but quality of care too. I think every time we diminish the emergency department just to a series of concerns around category 3 and 4 on timeliness we do not acknowledge the incredible quality that is delivered through Canberra Hospital and Calvary hospital which, when assessed, in fact leads the nation. I think that is an important part of the dialogue around the emergency department and the measure of the quality of the emergency department.

I would also urge members of the committee to go and look at the MyHospitals website and actually have a look at individual hospitals against their peer hospitals. If you are going to measure Canberra Hospital and Calvary hospital against New South Wales as a jurisdiction or against Victoria as a jurisdiction, you are never going to see Canberra or Calvary sitting at the top, and that is because of the nature of the hospitals they are. But measure them against tertiary hospitals, measure them against major metro hospitals, and you get a different picture.

I am not saying that to avoid the fact that we have to improve timeliness in categories 3 and 4. That is where the pressure is; it is categories 3 and 4. We are seeing more presentations in category 3. We are seeing great improvement certainly in category 5. People do seem to be changing behaviour around less urgent presentations coming to the emergency department. But while that change is happening we are seeing increased pressure in categories 2 and 3. I would also say that this notion that there is a quick fix to any of these pressures is naive.

MR SMYTH: Twelve years is hardly a quick fix; 12 years of plans and changes.

Ms Gallagher: I think in that 12 years we have not just been dealing with a large increased consumption for health services across the board. We are actually seeing continued increases in presentations to our emergency department, and we have had to deal with that as well. It is a work in progress and I think it is going to continue to be a work in progress. But in the last two years the work that has gone into a whole-of-hospital approach to dealing with the pressure in the emergency department should not be underestimated.

THE CHAIR: Your work in progress over 12 years has taken us from the best performing jurisdiction in Australia—

Ms Gallagher: Health systems are always works in progress.

THE CHAIR: to the worst performing. It is a progress, but it is a progress downwards.

Ms Gallagher: I reject that.

THE CHAIR: In terms of this strategic indicator, that is the case. This is what we are talking about—the strategic indicator.

Ms Gallagher: I reject the allegation that it is the worst performing hospital in the country.

THE CHAIR: That is not what I am saying. You are trying to twist my words.

Ms Gallagher: No.

THE CHAIR: In terms of this strategic indicator, which is wait times in an emergency department, we have gone from the best performing in the country to the worst—on this strategic indicator. That is the progress after 12 years.

Dr Brown: Can I say that in that time, though, I think you do have to take into account the changes. Not only have we had the growth of the population but also we have seen an increase in the prevalence in chronic diseases requiring more health care. The Canberra population is ageing at a faster rate than other parts of the country. For example, if we look at the trauma coming to our hospital, we are now, I think, the second or third largest trauma centre in the nation. That was not the case 12 years ago. We were a small regional facility then. The nature of the care that the health service is delivering over time has changed, I think, quite substantially in that 12 years. All of those factors need to be taken into account.

DR BOURKE: Minister, you mentioned the quality leading the nation. What sort of measures and evidence are there for that?

Ms Gallagher: You can look at a range of measures of that. One that is reported against is patient satisfaction with the treatment that they received within the emergency department, but you can also look at it in terms of re-presentations to hospital. Those measures are monitored, and we do very well.

Dr Brown: Even if we look at the four-hour stay in the emergency department, which is the other key indicator used nationally, as opposed to the timeliness—we only have two hospitals, and they are both classified as major metropolitan hospitals—Canberra Hospital is on the national average and Calvary hospital is above the national average on the four-hour rule overall. The reason we do not jurisdictionally compare so well is that other jurisdiction have smaller regional and provincial hospitals that always perform better and therefore they pull the jurisdictional average up. If you look at the peer groups and compare hospitals in the peer groups, we are actually at or above the national average.

THE CHAIR: In terms of that NEAT data on the four-hour rule, there was an article published in the *Medical Journal of Australia* by a couple of doctors who said, in relation to that, that the four-hour rule, from an analysis they had done in WA, I think in an annual period, had saved 80 lives. Would you agree that waiting times in the emergency department are important and that waiting times can save lives?

Dr Brown: Yes. We have Dr Mike Hall here as the clinical director for critical care; he is probably in a better position to speak to that. But I think there is no doubt that there is literature that supports the notion that if you have a shorter overall stay in the emergency department, you will get better outcomes. And the converse is true: if you stay for longer periods of time in the emergency department, the outcomes are worse. Dr Hall might wish to speak to that, and he may also wish to tell you about the complexities of working in ED and making the changes that are actually going to deliver the improvements.

Dr Hall: I am the clinical director for emergency and currently I am acting director for clinical care at the Canberra Hospital. Thanks for the question. It is a very complex issue. There is no doubt that protracted time spent in the emergency department is directly related to health outcomes. Longer time spent in total in the emergency department does increase mortality rate, international and national figures would appear to say, and longer time spent in total in the emergency department makes other aspects of care more complex.

There is essentially zero evidence for the time to be seen from initial presentation. I can further elucidate if you would like me to, but there is much less evidence for the time from the time the patient arrives until they get seen as compared to the total time that they spend in the emergency department. Hence the difference between the triage-based national timeliness targets and the overall perception of the four-hour rule. That is why nationally far and away the greater emphasis is moving towards four-hour rule behaviour—because there is clear evidence that that benefits patient care as compared to the dramatically different concept based on that initial triage assessment, where there is much less evidence.

THE CHAIR: I know that WA went pretty hard on this early.

Dr Hall: Absolutely.

THE CHAIR: I think they were the first jurisdiction to say that this is important, and they restructured their systems with a focus on the four-hour rule. Have you engaged with WA? Have you looked at some of their outcomes and their learnings to implement in the ACT?

Dr Hall: Yes, absolutely. I am from WA originally and still have many contacts back there. We are in regular contact with them. And the Western Australians have been very generous in terms of publishing and providing information about the processes that they have done. It is important to note a couple of things. Theirs has been a protracted process; this was not something that happened overnight. And if you looked at their improvement from figures not dissimilar to ours and the rest of the nation to where they are now, that was something that happened over essentially a 48 to 72-month period. It was not something that happened overnight.

Their figures are starting to drop a little now, because those initial initiatives are now starting to struggle and they are looking for their next set of initiatives. The rest of the country is much earlier in that process and is showing variable degrees of success in terms of improvement. One of the problems is the huge growth in presentation in

emergency departments across the country in the last two to three years, which is dramatically higher than was predicted by population modelling.

To a certain extent, the Western Australians got in before that growth peak and are now struggling to keep up as that growth peak is overwhelming them. The rest of us have tried to provide these initiatives while being hit with this overwhelming growth of patients which has made it very hard. Even keeping at a target when patient presentations grow in a department by five per cent or six per cent is a challenge. Meanwhile that integral part of trying to do that with a growing target as well as improving shows you have to improve efficiency by 25 per cent to get a 10 per cent growth if you have had 15 per cent more people turn up in that same time period.

DR BOURKE: Dr Hall, you said that there was no evidence to support a difference in outcome for time between presentation and time seen in the emergency department, and you said there were more reasons for that. Could you tell us about that, please?

Dr Hall: Again, it is an incredibly complex question, but the simple answer is that triage—it is important for everyone to know what triage is. Triage is a two to three-minute assessment based on a nurse who is essentially trained to filter and sort. Triage was designed as a system to help us allocate resources to different severities of patient. It was initially a research tool when it was first developed; then it became a clinical tool; then it became a sort of national data point.

In many ways it is an unfair thing to judge a department based essentially on a two-minute assessment by the nursing staff member out the front. It puts an unreasonable amount of pressure on that nursing staff member, and explains the unbelievable variation around the country in terms of triage practice. One of the interesting things nationally is that there is no consistency in triage. The exact same 1,000 patients presenting to two different emergency departments will show a different mix of triage, and presenting to emergency departments in two different states may well show a completely different mix of triage.

Essentially, there are two basic summaries of how you get things seen. If you want to get patients seen quickly, in terms of as soon as they arrive, you put senior doctors at the front and you see them as quickly as you can on arrival. The problem is then what you do to make sure the next step happens—making sure follow-up to those initial tests happens, follow-up to those initial treatments happens. Hence the national target of the four-hour concept. It is absolutely clear that there is no magic behind four hours, it could be a 3½-hour target or a 4½-hour target, but it is a four-hour target.

The concept is that that integrates that whole thing. It includes being seen, being assessed, being integrated, seeing how they are going, planning discharge and planning admission. That is why most of us support that. The people that are against it just point out that there is nothing magic about four hours. But nobody argues that less time in an emergency department is a valuable thing. And even when we talk about the difficulties of meeting triage targets, none of us argue that patients should not get seen or that patients should wait. All patients should be seen as quickly as humanly possible—all patients.

The important thing is that we get patients in and out in a timely fashion, not so much

that we meet a target which is arbitrarily set to be the recommendation for this patient to be met. When we talk about evidence, there is no evidence that meeting people within that target makes any difference. For example, with the 30-minute target for category 3 that you would all be aware of, there is no evidence that meeting that 30-minute target, as compared to it being 35 minutes or 40 minutes for individual patients, makes any difference at all. It is about the total time in emergency.

DR BOURKE: You must find that incredibly frustrating.

Dr Hall: A bit, but my job is to try and make sure the patients get seen, that the staff learn, that the staff train and that patients get fantastic care. To a certain extent, we have to use the targets as auxiliaries to that. The day that the target itself becomes the primary focus of what we do on the floor is a bad day for medicine. We try to do the best job we can for the patients, and we use the targets as an auxiliary measure to hopefully show that we are continuing to do a good job. And that is as well as the other things which, you will be aware, many of us have suggested for years: that we continue to work on development of qualitative targets—not quantitative, but qualitative targets—for care. That is a very difficult area as well.

DR BOURKE: So for the targets that really matter, you are doing fabulously.

Dr Hall: No, we are not doing fabulously. There is no suggestion that we are. We can do better. We would like to do better. We are the people on the floor that see the frustration of watching people on some days wait for long amounts of time to be seen, and sometimes then wait for long amounts of time to get to a bed. Nobody thinks that is acceptable across the hospital. Activity in emergency, bed management and on the wards is trying to fix that, but it is complicated.

I guess we do get frustrated that, as a jurisdiction, you cannot argue with the number comparing our state to another state. But as a hospital, we are not the worst; we are by no means the worst. We are at least an average performing department. When the minister and the director-general point out where we sit in terms of the average—even amongst that major hospitals group, there are probably only about six to seven hospitals that we can be directly compared to in terms of mixed adults and children's hospitals that have a regional trauma and referral role; and amongst those we sit almost at the top in terms of our ability to meet those timeliness targets, simply showing how difficult it is in a modern teaching hospital within the Australian structure to meet those timeless targets.

THE CHAIR: You have taken over from Kate Jackson, have you?

Dr Hall: No. I am the clinical director of the emergency department; that is my substantive job. I am filling in for Jeanett Maccullagh, who is the acting director for critical care.

THE CHAIR: When is that role going to be filled? She is acting, is she?

Ms Gallagher: It has not been filled.

Dr Brown: It is actively under recruitment at the moment. Mr Thompson can speak to

the specifics.

Mr Thompson: We will be interviewing next week for that position. We are likely to have a subsequent interview the following week, just for scheduling purposes.

THE CHAIR: Sorry, who is acting in that position?

Mr Thompson: Ms Jeanett Maccullagh. The other thing I would mention just to supplement what Mike has been saying is that the other thing about the four-hour target is that all hospitals have significantly different performance around those patients who are admitted into the hospital and those patients who go home from the emergency department. If you look at the MyHospitals website and the peer group for patients who are admitted, which is probably the best proxy we have got for patients who are the sickest that there is, and therefore the priority for the emergency department, the performance of the Canberra Hospital puts the hospital within the top 20 per cent of its peer group around the timeliness of admitted patients being able to get to a bed, particularly if you exclude the Western Australian hospitals, which, as Mike has been explaining, have been working on this for considerably longer. If we exclude the Western Australian hospitals, on my reading of the website—I may have missed something—I could only identify two hospitals in the rest of the country that have a better timeliness or better performance for admitted patients against the four-hour rule.

THE CHAIR: Going back to Kate Jackson, the Auditor-General's review and the recommendations in that—can you give me an update on where we are at with those, particularly the EDIS system and where there has been—

Dr Brown: We had recommendations arising from the Auditor-General's review and also from the PWC review. We developed an action plan. Some of the recommendations were similar, so we developed an action plan that spoke to the recommendations from both reports. We have been working very diligently at progressing those recommendations. I am looking at Mr Ghirardello to see whether he might be in a position to speak to the specifics of that. An awful lot of work has happened.

Mr Ghirardello: We have completed quite a number of the recommendations already from the Auditor-General's report. We have moved the management of the EDIS systems administrators into the strategy and corporate side of the business away from the Canberra Hospital health services. We have maintained our daily validations. We have introduced new reports to focus on any changes to records within the triage timeliness figures so that we can check those and make sure that they meet the audit requirements.

We do spot audits of all records at the moment. We have put in a dedicated officer to manage the move to the new EDIS system, which is in the hospital now. We are undergoing testing of that system so that we can get it in in the next few months. That system has better audit functionality as well. We will be able to stop some of our spot audits because the system will be able to do those for us and provide lists of records which we need to follow up on. We have completed a full audit of all the EDIS users in the hospital and we have removed EDIS from any system outside of the ED unless

it is essential that they have access to EDIS.

We have also recently completed a replication of the new EDIS system within our new data warehouse, which means we can now also in the next few months remove EDIS from anyone outside of the ED because we will be able to provide them with information directly from that system without touching the EDIS system directly. Even if anyone made changes to the EDIS replication system, the source system would always remain the same, it would update every five minutes and we would always get a feed from the source system. So any changes made in the replication system would be overwritten every five minutes.

We have started to formalise the training processes for everybody—nurses, clerical officers and doctors. We are also nearing the completion of a data integrity audit that is looking at all of our data holdings within the directorate, but EDIS is one of the focuses for that as well. That will also come up with a number of recommendations as well to put in new systems, new processes and new audit practices so that we are sure of the integrity of our data.

Dr Brown: I might add that, whilst not a recommendation, we are very close to bringing on board the new director of what we are going to call now information integrity, not data integrity. We had previously referred to it as data integrity. But that person will start in early July. I am very excited about that, because it is someone who has got a wealth of experience and who will actually bring to the whole directorate a real quality improvement approach or information improvement approach to our data and information in the same way that we have done with quality improvement. I think it is a very exciting development that that position is coming on board as well.

THE CHAIR: Great, thanks. I will ask you to comment on the paediatric ED and explain where that is up to. I could not find a line in the budget. Maybe it is not funded this year or maybe I just could not find it. I refer to an article dated 4 April in the *Canberra Weekly* from Ross Solly. You may have read that one, Chief Minister. It is called, "The day the Chief Minister went AWOL." You scooted off to Sydney. Basically, the text of the article makes it pretty clear. You might have some different views.

Essentially, it is saying that the bureaucrats—I assume that is Dr Brown and others—have been saying not to do a paediatric ED. Yet you actually say that this is one of your greatest regrets. The article states that a couple of years ago, "She proposed a similar measure and was talked out of it by the bureaucrats. 'It is one of my biggest regrets as health minister,' Ms Gallagher said." Then the article says, "It speaks volumes for the relationship between the Chief Minister and her bureaucrats that she needed to pull off such a clandestine operation." Maybe you could tell us about the day you went AWOL, decided that you needed to go and see this for yourself and disagreed with the advice from your bureaucrats. I would be interested to know what the difference is, in your opinion, than perhaps the opinion of the experts.

Ms Gallagher: Like most things you read in magazines, it sounds a lot more exciting than it was. I went and visited, with my adviser, North Shore Hospital, which has just built a paediatric knowledge department. I went on my own. I do not think there is anything highly unusual about that. I did not think I needed to bother other officials to

take a day out of what is an extremely busy directorate to go and wander around an emergency department. Many of them would have seen it before. I do not think you can read too much into that.

When I refer back to the advice, I think it actually pre-dates everybody sitting at this table, other than Ian probably, who has been with me as the longest serving health minister in the country, out-surviving even the longest surviving health ministers, which gives—

THE CHAIR: I suppose there is always a difference between quality and quantity, is there not, minister? It is a matter for debate that we could probably have.

Ms Gallagher: I am sure there will be different perspectives on that as well. It actually pre-dated the officials who are sitting with me today. It was probably, I think, about four or five years ago. At the time I accepted the advice of the directorate to me, which was that based on current presentations, and with the mix of presentations, a separate paediatric emergency department was not feasible. Indeed, that is not what we are planning on with this redesign that we are doing.

It was actually in the context of the Women's and Children's Hospital—I wanted a paediatric emergency department as part of the Women's and Children's Hospital. All of the advice to me was not to do that, that it would be unsafe to do that, that the volumes were not high enough, that the expertise around emergency medicine was concentrated in the ED and should remain in the ED, and I took that advice.

I think what I am reflecting on now is that we should have looked at another—instead of just saying, "Okay, I accept that," I think on reflection I should have looked at what we are actually doing now, which is building a paediatric space, a special paediatric space, and hopefully developing a paediatric stream within the existing emergency department, which is actually what Royal North Shore have done.

They have done probably a bigger expansion as part of their whole new emergency department. But I think it will be a good outcome. It is based on feedback I have had from parents who have used the emergency department, the fact that our paediatric presentations now are a quarter of all presentations, the fact that we are expanding our paediatric and NICU services within the hospital. It makes sense to do it now.

THE CHAIR: In terms of you being the longest-standing health minister in the country, I recall last year in committee you said your view was that—

Ms Gallagher: I was almost.

THE CHAIR: you had probably stuck around too long. Is that still your view, that you have stuck around too long or have you changed your mind?

Ms Gallagher: I am still here, aren't I? And I get to choose the portfolios.

THE CHAIR: Be the queen?

DR BOURKE: Minister, Dr Hall previously talked about a significant uplift or

increase in the numbers of people presenting to emergency departments across the country. You have just talked about 25 per cent of presentations to emergency departments being children. Is there some sort of relationship or correlation there? Why is this big increase in numbers presenting to emergency departments occurring across the country?

Ms Gallagher: I might get Dr Hall back, but I think we have sort of touched on it with ageing—a growing population, an ageing population, an increasing number of people presenting with chronic, complex conditions. In terms of the paediatric patients, I do not think there is any suggestion that our kids are sicker than anywhere else, but the population is growing. We are seeing, commensurate with that, an increase in paediatric presentations.

Dr Hall: Yes, to finish that off, I suppose that adult presentations are growing at a faster rate than children. So the percentage of children that we see is actually smaller than it used to be, although the raw numbers are growing, but simply not as fast as the adult population. About 50 per cent of that growth is purely predicted on the ageing model of the population in Canberra with the ageing baby boomer generation. We can predict how often, in population terms, people will present at different age groups.

As we age you will get a higher number of presentations when we have higher numbers of elderly people. The other challenge is the region. To a certain extent, the surrounding region and New South Wales have de-skilled. So we get increased numbers of patients from New South Wales that would previously have been managed in the local region. That creates a second growth line that we get.

The third growth line is the unknown one around the country, that people are presenting to emergency departments more often than they used to. It is not absolutely clear why that is. Over time the rate of presentation across all age groups across the country has increased.

MR GENTLEMAN: Is there any association with bulk-billing in the general practice area to those presentations?

Dr Hall: Lots of presumptions are made. It would appear to make some sense, although in the data when people have tried to look at that, there is not the correlation you might expect. GP numbers and emergency department presentations do not correlate as well as you would think.

Two interesting bits of research came out in the last week, in fact, from the UK. One looked at GP availability. It suggested that better GP availability and out-of-hours GP availability did decrease the number of presentations to emergency. The other one looked at the emergency department presentations themselves, making the assumption that many of those patients were, in fact, suitable for general practice. In fact, they found a very small number of those patients suitable for general practice.

In Australia it appears that less than 10 per cent of patients that present to an emergency department are in fact general practice suitable patients. There is in fact no predictive tool which helps us decide that when they arrive. We can tell after we have seen them that they would have been able to be managed in a general practice, but we

cannot tell that as they walk in the door.

DR BOURKE: You mentioned that there had been some de-skilling in the region?

Dr Hall: Yes.

DR BOURKE: How or why has that happened?

Dr Hall: It is not completely fair for me to comment on someone else's health system and the region. Much of that relates to the ageing of general practitioners in the region. The old school general practitioner in a rural centre that worked 60-hour weeks, that covered the hospital, that was happy to admit children and older people, do minor surgery and do anaesthetics is a less common breed. Many of the regional emergency departments are staffed by younger GPs who may not be willing to do that. Some of them in fact live in Canberra and commute to the region; so they are unable to provide that out-of-hours service. There has been a lessening in the number of people in the region that can do anaesthetics, that can do surgery and other things, hence putting some of that greater pressure back on to us.

THE CHAIR: Members, I note that we were going to move on to mental health, but if we want to continue on this line, I am happy to. We can adjust in the afternoon.

MR SMYTH: I have some general questions that go across the department.

THE CHAIR: Yes, that is fine. If you have general questions that is fine. Mr Gentleman, have you got a question?

MR GENTLEMAN: General questions, yes.

THE CHAIR: We will move to you and then to Mr Smyth.

MR GENTLEMAN: I did ask earlier on about hospital in the home. I wonder if you can just explain for the committee how that is going to work, the benefits that you see and its effect on the hospital system?

Ms Gallagher: The hospital in the home program has been very successful I think. Again, you create capacity and you see demand grow commensurate with it. I think activity in hospital in the home, or HITH as it is affectionately known, has increased by 29 per cent in the last financial year.

I will let the expert health people talk about HITH, but the feedback you get on HITH from patients who use it is extremely positive. Again, it shows I think the continuous reform of a health system to actually match the needs of what patients are after. I do not think it is any surprise to anyone that if you can be cared for in your home or visit the hospital and then return home to manage your condition, that is preferable to an inpatient stay.

If you look at all jurisdictions, they are all increasing their focus on hospital in the home and looking not only at the services that are currently provided as part of HITH, but also looking at other services that could be provided as HITH going forward. It is

very much a patient-friendly and patient-centred model. This is spread across Canberra and Calvary hospitals, and it is essentially the recruitment of staff.

MR GENTLEMAN: What effect do you think it will have on the outpatients area if there is a 29 per cent growth?

Ms Gallagher: I am not sure if there is a number—

Dr Brown: I am not sure what you mean in terms of outpatients. Certainly, our aim is to try and reduce some of the presentations to the emergency department. These are people who generally are unwell and need treatment now. It might be to provide appropriate treatment for their antivirals, their antibiotics, if they have cellulitis or deep vein thrombosis. Otherwise they may well be presenting through the emergency department and they require admission to hospital. The design is to ultimately reduce presentations to the ED and reduce the demand for an inpatient bed.

Hospitals are dangerous places; so if people can be cared for at home it is actually a better outcome for everyone. Over the last four years we have added an additional 46 HITH bed equivalents to the system, which is a substantial number.

Ms Gallagher: And this HITH funding delivers an extra six, I think.

Dr Brown: An extra six in this—

Ms Gallagher: Bed equivalents.

Dr Brown: Yes.

THE CHAIR: Mr Smyth.

MR SMYTH: Minister, you spoke earlier about the whole-of-hospital approach and how getting the hospital working properly together so that patients can get out of ED has an important place. There was recently a tender worth $43 million to improve facilities at the Canberra Hospital that was cancelled. Why was that project cancelled?

Ms Gallagher: You will see it in the budget papers, Mr Smyth. It is in budget paper 4, page 104: cessation—enhancement of Canberra Hospital facilities (design). You will see it appearing again on page 105. The money has remained within the health infrastructure program.

MR SMYTH: But the project has not.

Ms Gallagher: The project has, because it is still going to be progressing the new buildings at Canberra Hospital. We have, I think, based on some of the consideration and learnings of how the health infrastructure program has developed, rethought how we would like to stage and scope that project. This reflects that change.

MR SMYTH: Shouldn't you have done that before you went to tender and put a number of firms to great expense, including the one who was selected as the preferred tenderer?

Ms Gallagher: Ideally, you are right; ideally, yes. This project is evolving. We are learning all the time around how to keep health services going whilst undertaking redevelopment work. I think it is fair enough that governments are able to reconsider that as the project is rolling out and be mindful of the most efficient and effective use of funding and time to deliver the outcome we need. We have rethought that. I do not think it is unusual. I have looked at this issue closely. There are a number of other examples where governments have either cancelled projects completely or changed them. This is the first time we have done it within health infrastructure. It is also the largest part of the redevelopment. I wanted to make sure we got it right and got it right in a way that it allows it to be delivered whilst the hospital continues not only to function but to grow while that redevelopment occurs.

MR SMYTH: By implication, you put out a tender, therefore, that had not got it right and hence necessitated the changes. Why can you not get this process right?

Ms Gallagher: No, that is not what I said.

MR SMYTH: So you do not have to withdraw the tender?

Ms Gallagher: That is not what I said. I said this is the first time it has happened within the health infrastructure program. That tender could have delivered the design we sought. So there was not anything wrong with that. We have also had to look at the most efficient use of the capital available to deal with what we need to deliver as the outcome and the best way to deliver that. For example, how do we build and when do we build a brand new emergency department? These are some of the things that are fluid in this redevelopment program.

MR SMYTH: Did you state that this was fluid in the tender documents and might not proceed?

Ms Gallagher: No. The tender documents would have gone out for the project that was scoped. But we have changed our mind on how to deliver that. We are still going to deliver it, but not within the context of that large $140 million contract.

MR SMYTH: When was the decision taken to cancel the tender?

Dr Brown: Can I come in at this point? I do not actually have the specific date in front of me. We have here today Jon Barnes, a construction expert, who is employed to assist us with the HIP. He may be able to speak to this issue. His advice to us is that this approach does occur within government construction. Governments are constantly looking at what they are planning and whether it remains the most efficient and effective way to do business. Subsequent to that tender being cancelled, we have been in correspondence with the tenderer. They were perfectly agreeable and reasonable in terms of the correspondence that they had back to me in relation to that outcome. So whilst it is not desirable—

MR SMYTH: So they were agreeable that they had spent several hundreds of thousands of dollars and it was not going to proceed?

Dr Brown: They certainly were. It was a very pleasant tone to the letter. They were happy to come and meet. They remain interested in working with ACT Health on future projects should they be a successful tenderer in the future. I think that reflects the fact that this is not necessarily an extraordinary event in terms of construction within government. I might ask Mr Barnes to—

DR BOURKE: It happens in private enterprise, too, doesn't it?

Dr Brown: Yes. I might ask Mr Barnes to speak to that issue.

Mr Barnes: Given my previous experience as a project director, I can say that in other jurisdictions, particularly New South Wales Health, it is quite common for priorities to change and, as a result of that, tenders are either cancelled or reconfigured. The most recent examples of that that I have had experience with would be three major hospitals—Blacktown, Campbelltown and Wagga hospitals. In the case of Blacktown and Campbelltown hospitals, those tenders were actually halted. In terms of the tender negotiation period for those, they went on beyond 12 months.

MR SMYTH: So what is the delay in this project then?

Ms Gallagher: There is not a delay. We have had that tender out. There has been a 12-month period. I think this was the money appropriated in the last budget. We are now moving to a modified design for this money in the next budget. On the timetable, we have the time in order to deliver the beds that we need, which is what is driving this. I guess the question for me was, with the $40 million available, is this the best use of that $40 million at this point in time?

MR SMYTH: But surely you would have asked that question before you put it out to tender?

Ms Gallagher: As I said, this project is developing, Mr Smyth. When I look at areas of pressure within the emergency department, when I look at how Canberra Hospital is operating, when I look at the operational pressures of having major construction occurring, when I look at what the opportunities are at Calvary and when I look at how we are developing the project on the subacute hospital—and we have more understanding of that—then it does require government to always be looking at this. At times that may require us to reconsider the best use of those funds. This is the first time we have done it in this project. I am very confident that we have made the right decisions.

MR SMYTH: On what date was the decision taken to cancel the project?

Ms Gallagher: The tender was cancelled in May this year.

MR SMYTH: Do you know what date?

Ms Gallagher: I do not have the exact date. It was May.

MR SMYTH: On what date was the preferred tenderer informed that they were the preferred tenderer?

Ms Gallagher: We can provide you with all of that. I do not have it before me, but we can provide you with that.

THE CHAIR: You will take that on notice?

Ms Gallagher: Yes.

MR SMYTH: When the preferred tenderer was told that they were the preferred tenderer, were they then asked by the government to do additional work?

Ms Gallagher: I cannot answer that. I am not involved in the tender negotiations at all, as you would know.

MR SMYTH: Mr Barr told us you would be able to answer all of these questions.

Ms Gallagher: I am sure there are officials who can answer some of these, but I do not sit there and negotiate tenders for the government.

Mr Barnes: My understanding is that negotiation meetings were held with the preferred tenderer during that process.

MR SMYTH: So when was the preferred tenderer informed they were the successful tenderer?

Mr Barnes: I believe that they were announced in August.

MR SMYTH: August last year?

Mr Barnes: Correct.

MR SMYTH: What work was done between August 2012 and May 2013 by the preferred tenderer?

Mr Barnes: I do not think there was any work done. From my understanding—and I stand to be corrected—there were tender negotiation meetings to confirm details of their tender.

MR SMYTH: So the tenderer was not asked to firm up their proposal or do additional work?

Mr Barnes: As far as I understand it, they were doing tender negotiations based on their original submission.

MR SMYTH: Is it normal for tender negotiations to go for—it was August to May—about 10 months?

Mr Barnes: Nine months. In my experience in previous positions when I was working for construction contractors, bidding for public health works, yes—complex, large projects can go for up to 12 months.

MR SMYTH: All right. Were the unsuccessful tenderers given feedback as to what was deficient in their proposals or the reasons that they did not get the contract?

Mr Barnes: Yes, I believe so.

MR SMYTH: I have been told that most of the feedback that people were given was simply that they did not get the tender. Was there a round of meetings with unsuccessful tenderers, or was the offer made to unsuccessful tenderers that they could have a debrief on what had occurred?

Mr Barnes: That is the standard process. Whether it happened in this case, I am unable to answer that question. I will have to take that on notice.

Dr Brown: We do have an official here from Procurement. I might ask Colm to come to the table.

MR SMYTH: Mr Mooney, when the successful tenderer was selected, were the unsuccessful tenderers informed of the outcome, and what debriefing were they given?

Mr Mooney: The letters of offers of debrief were sent to all unsuccessful tenderers, and any unsuccessful tenderers who wished to have a debrief were debriefed.

MR SMYTH: How many took up that option?

Mr Mooney: I do not have that information. If I can take that on notice, I will get that for you.

MR SMYTH: All right. Thank you. How is the debrief conducted?

Mr Mooney: Essentially, it is a review of the specific tenderer's proposal. Whilst we do not go into details as to exactly why they were deficient compared to the preferred tenderer, we do give them as much information as we can to guide them for future prospective tenders.

MR SMYTH: How many tenders were received?

Mr Mooney: Again, I do not have that exact information. I will get that for you.

MR SMYTH: Thank you.

Mr Mooney: There was considerable interest, though, in the actual project, as you can appreciate, for a project of that scale.

MR SMYTH: I am sure there was. Are you aware of the date when the tender was cancelled?

Mr Mooney: I believe a letter was sent out on 9 May to the preferred—

MR SMYTH: And when was the decision taken by government to cancel it?

Ms Gallagher: It would have been around that time. I will take that on notice. That was after I had taken advice about what other staging of this development should be examined.

MR SMYTH: Is this money now to be used for the subacute hospital or is it to be used at Calvary?

Ms Gallagher: No, it will be used to design the staging of the clinical services, the new kinds of buildings, the new towers, that we need.

MR SMYTH: This is buildings 2 and 3?

Ms Gallagher: Yes, along with some infrastructure expansion. So it will be partially used for design and partially used to actually deliver infrastructure expansion primarily in the emergency department as part of the redevelopment at Canberra Hospital.

MR SMYTH: What will be the difference between what will now be built and what was proposed to be built in the original tender?

Ms Gallagher: There will be a different configuration to the towers, perhaps, is the best way of explaining it, and services like the emergency department. This is what is planned. We have not got to the final design stage; so I want to leave some flexibility for that to occur. The plan would be to have the theatres and the emergency department remain where they are now which, in the other scope, was going to be within the new tower blocks.

Dr Brown: But expanded.

MR SMYTH: So what led to that decision to leave them where they are?

Dr Brown: We contracted a consultant to come in and have a further look at what the options might be in terms of how we actually meet the demand but minimise the impact on the continuing operations. This is a very complex piece of work. It is a brownfield site, and it is the heart of the hospital. And the advice to us was that it is possible to do it essentially in more chunks than the previous option that had been considered.

MR SMYTH: You talked about a further look. What prompted calling in a consultant to have a further look?

Dr Brown: I think, as we have already indicated, this is a process that we are regularly looking at in terms of the overall health infrastructure program, the cost, the demand projections, and are we delivering for government and for the community the best value for the dollars that are to be expended. We are talking very substantial investment; so we need to be able to—

MR SMYTH: Surely that work would have been done before you started the tender

process? Did somebody have a bright idea and say, "Maybe we'll leave them there"? What prompted you to bring in the further review consultant?

Dr Brown: It is in the context of the continuing work around the University of Canberra public hospital, the master planning around Calvary hospital and looking at everything that is on the Canberra Hospital site and the flow around the Canberra Hospital site, parking requirements. So, again, it is a process of not taking one look at it and then deciding that is it. We continue to look at what is required and what is the most efficient and effective way to deliver that.

MR SMYTH: In terms of the delivery, I understand firms that operated in a trust structure were excluded from the tender. Is that correct?

Mr Mooney: There was a specific prequalification criterion that had to be addressed around trusts not being acceptable for this particular tender.

MR SMYTH: And why were they not acceptable for this particular tender?

Mr Mooney: The risk associated, the financial risk, was deemed too high because of the value of the actual tender and the complexity of the project. So at the time of tender evaluation setup, the criteria setup, that was a mandatory criterion that a trust would not be acceptable.

MR SMYTH: Were any of the firms that submitted tenders excluded on the basis of being a trust?

Mr Mooney: There was an industry briefing where an outline of the actual criteria was advised. I believe there were three companies that did not have the necessary prequalification status and, as a result, would have been excluded from the process.

MR SMYTH: Did representations from those companies outline the concerns, and were those representations responded to?

Mr Mooney: I am not personally aware. I was not working in the Health area at the time. I can take that question on notice and I can get that information for you.

MR SMYTH: Was that decision not to allow trusts to submit held to or did that change?

Mr Mooney: No, that was held to. Any company that did not fit into that category, as I understand, was given the opportunity to prequalify. And, as I said, three companies fell into that category, but they did not elect to take that opportunity or did not elect to fulfil the prequalification requirement.

MR SMYTH: My understanding is that a number of firms that operate as trusts are some of the largest architectural design firms in the country. Were they excluded solely on the basis that they had a trust structure?

Mr Mooney: The advice that I understand was available at the time was in connection with other jurisdictions' prequalification systems, and the advice was that trusts for

this level of the value of the job and the complexity of the job presented a financial risk to the project and, as a result, it was put in as a requirement that no trust was acceptable for the actual project.

MR SMYTH: My understanding is the advice from other jurisdictions is actually on construction companies, not design, and this was, I understand, the first time that a design firm operating in a trust was excluded from any such tender. Can you verify that in other jurisdictions it is in regard to construction firms, not design companies, that that prequalification is applied?

Mr Mooney: I will take that question on notice, if I may, and come back to you.

THE CHAIR: Thank you very much. We will suspend for morning tea. When we resume, what we will do is just go through any further infrastructure questions and take that as a grouping and then we will move to mental health after that. Thank you very much. See you back at 11.15.

Sitting suspended from 10.59 until 11.19 am.

THE CHAIR: As I said before the break, we will have a look at infrastructure and then move to mental health. It would appear, just by the natural flow of things, that we are doing things together rather than trying to separate the Local Hospital Network. I think that works better, and I will be making a recommendation that they be taken together next year. I think that trying to separate them is not a construct that works.

Minister, with the infrastructure program, I note that in budget paper 3, page 241, there are some $100 million of net rollovers from the Health Directorate.

Ms Gallagher: Sorry, what page are we on? Budget paper 3?

THE CHAIR: Budget paper 3, page 241, project rollovers and reprofiling, Health Directorate, net rollover figure $100.7 million. There are a lot of projects being rolled over. Then there is one that is ahead of schedule. There is obviously a lot of work going on within the Health Directorate in terms of projects. This is something that we go through.

Ms Gallagher: Yes.

THE CHAIR: Could you just give me an update on the more significant projects, particularly the ones that appear there in the budget paper, and an explanation of the reason for the rollover and the delay. And then in other projects that are proceeding, could you give me a bit of an update on where they are at? Then, if we have got any further questions, we will go to those.

Ms Gallagher: Sure. Do you want to go through them one by one?

THE CHAIR: If you have got a broad statement to make, that is fine, but then we will probably go through them one by one because they are so unique.

Ms Gallagher: This is really around the staging of the payments. For example, the

Belconnen enhanced community health centre is due for opening in October-November this year, with commissioning in November. So it has remained fairly on time; it is probably a few months behind schedule, but it is largely on time. So I think that issue is really about the timing—what financial year the payment is in.

Mr Carey-Ide: If I could add to that in respect of Belconnen enhanced community health centre, the other explanation for rolling over funds for the Belconnen community health centre relate to the extension of the defect liability period. The project was late to start, but is on program since the commencement of construction. That means that the defect liability period will extend into a different financial year from that initially expected.

THE CHAIR: The enhancement of the Canberra Hospital facilities—

Ms Gallagher: That is the $40 million that we were talking about.

THE CHAIR: From the $43 million?

Ms Gallagher: Yes.

THE CHAIR: Okay. Women's and children's hospital?

Mr Carey-Ide: This related to slight delays that were experienced in the operational commissioning period for stage 1, with the hospital stage 1 opening last year. That, of course, had a roll-on effect on the commencement of stage 2 works. The rollover of funding for that project, which was a whole project encompassing three separate stages, reflects that knock-on effect.

THE CHAIR: So there were three stages to the women's and children's hospital, were there?

Mr Carey-Ide: There always have been three stages.

THE CHAIR: It is a third of a hospital?

Ms Gallagher: No. You can stand down, Mr Hanson.

THE CHAIR: It is not half a hospital at all; it is a third of a hospital.

Ms Gallagher: It has always been there.

THE CHAIR: Has it?

Ms Gallagher: Yes.

THE CHAIR: It was a secret, was it?

Ms Gallagher: No.

THE CHAIR: But you always said there was stage 1 and stage 2.

Ms Gallagher: Let me just explain it. Once stage 3 is explained, you will understand.

THE CHAIR: It will become clear, will it?

Ms Gallagher: Yes.

Mr Carey-Ide: Stage 1 involved the placement of some services in a temporary home within stage 1. Stage 3 reflects the movement of those services into—

THE CHAIR: They are not temporary, are they? I remember we went through this last time. "They are not temporary; they are not permanent," was the language I think we all agreed on. Sorry; we had this in committee last time.

Ms Gallagher: We did.

THE CHAIR: The minister insisted that they were not temporary facilities. I would not want you contradicting the minister by saying they are temporary facilities.

Mr Carey-Ide: I am not at all contradicting.

THE CHAIR: I think that they are not permanent facilities.

Mr Carey-Ide: Some services moved from their old homes into temporary accommodation within stage 1, always with the intention that they would move into their permanent home in stage 2, at which point the spaces from services that had moved out into stage 2 would be refurbished slightly, readjusted to accommodate the services that will have permanent homes into the future in stage 1.

THE CHAIR: So in terms of the entire project being completed and the minister cutting ribbons—what is the planned date for that?

Ms Gallagher: Have you got a date in stage 2?

Dr Brown: It is October or November.

THE CHAIR: What was the original plan for this project to be completed?

Ms Gallagher: I think it was August. Did we open stage 1 in August?

Mr Carey-Ide: It was August.

Ms Gallagher: It was about, I think, the last published—

THE CHAIR: In August last year it was meant to be complete.

Ms Gallagher: We opened stage 1, and at that point it was envisaged to be 12 months for stage 2.

THE CHAIR: So when this project was first put in the budget—

Dr Brown: Could I just clarify the 12 months. It was 12 months for the construction, the work on stage 2. There is always a period between completion of the construction work and then the actual opening, because you have got an operational commissioning period in between.

THE CHAIR: In terms of operational commissioning for stage 1, I know there were some problems with bits falling apart and so on. That has all been rectified?

Dr Brown: There was a problem. Mr Carey-Ide can speak to the detail of that, but yes, it was rectified very promptly.

THE CHAIR: There was only a problem?

Mr Carey-Ide: There was only one incident, where a bed board fell in a child's room. It was a board above the bed. We took immediate action to rectify that and to examine every other bed board in every other room. The solution that was found, to permanently fix those bed boards to further increase the safety of patients in the hospital, was put in place for every bed, not just the bed that had been affected.

THE CHAIR: There were some other problems, though, weren't there? There was only one incident, but I thought there were—

Mr Carey-Ide: As with every project, there are defects. That is why the defects liability period exists—of 12 months for every project.

THE CHAIR: And that has all been resolved now?

Mr Carey-Ide: The work continues to identify defects on a progressive basis throughout that 12-month period. The defects are all being addressed as they are identified. They are addressed by the project manager.

THE CHAIR: There is a bunch of other minor projects there. What I might suggest is this. There are a couple I want to move to, but rather than going into some of the detail of those, I might make a recommendation in the report along the lines of providing information on each of the health projects and a description of what those projects are, what the cost is, what the times are and all the details around that—just to save this committee some time. If members were agreeable, if there are specific projects to go to, we will do that, but we might get a general overview.

Ms Gallagher: You want to see that in the budget papers?

THE CHAIR: No; that you could provide us that information.

Ms Gallagher: As a question on notice.

THE CHAIR: Basically it is a question on notice.

Ms Gallagher: Yes; okay.

THE CHAIR: There are a lot of projects and there is a lot of detail around it, so more broadly, but I will just keep going. Tuggeranong health centre stage 2—

Ms Gallagher: You are asking why the rollover?

THE CHAIR: Yes.

Mr Carey-Ide: This reprofiling was due to delays in ensuring that the scope matched the available budget. I think committee members would recall from previous committees that Tuggeranong was a project that was delayed. This was totally about getting the scope to match the appropriated budget. We were successful in doing that, and therefore there was a delay to commencing the construction of the project.

THE CHAIR: What are we doing with the central sterilising service?

Mr Carey-Ide: Again, we had the issue of scope for the project not matching the available budget. This is a fairly normal circumstance, I think, in that people generally try to make sure that the project is delivered within the budget, and that is sometimes challenging. The work that we do in service and capital planning is in part about making sure that we are getting the best value for money, but also about delivering the best product that we are able to.

Ms Gallagher: So that project is on hold at the moment, pending some other work that has been done about delivering the sterilising capacity that we need. It is inextricably linked now to the hospital design, because of the location. It was originally intended to be located under—what building is that? It is the VMO car park. That is all I know it as, building 12.

THE CHAIR: Be careful with the VMO car park.

Ms Gallagher: Yes. You have to make sure that is in order before you do anything. That may be compromised by looking at the redevelopment that would occur from having the emergency department and the operating theatres remain where they are.

THE CHAIR: On the National Capital Private Hospital, so it is not within your remit but it is on the campus there, they have asked to expand—I think by 55 beds, or is it $55 million? I cannot quite recall which.

Mr Carey-Ide: I am not sure of the figure offhand.

THE CHAIR: Where is that project at? I know that there was some frustration in terms of a car park that was delaying that, and they had been bounced from one directorate to another. Where is that currently at?

Mr Carey-Ide: I am not sure that I would agree that they had been bounced from one directorate to another, but it has entailed several directorates working together in partnership with Healthscope, the national body, as well as the National Capital Private Hospital, to make sure that we have got the plans for extensions right and that we can accommodate the disruptions to car parking on the Canberra Hospital campus at the same time. I understand that Healthscope are currently preparing their DA for

lodgement, and they have been well supported by the Health Directorate, as well as other directorates, in preparing that work.

THE CHAIR: Where is the parking going to go? Is it going to be over the road or is it going to be within the confines—

Mr Carey-Ide: We are able to accommodate the deficit in parking on the current campus. It is a relatively small number of car parks that will be lost to enable the construction works. The challenge for us, as always, is to ensure that our building contractors are actually parking on the opposite side of Yamba Drive, and we continue to undertake that work of encouraging them to do so on a daily basis.

THE CHAIR: With that work, have you had any discussions with Nat Cap in terms of expanding the number of beds that they have got, so that you have some sort of purchase agreement with them for overflow? It strikes me that one of the problems—

Ms Gallagher: We have had agreements with them in the past. We did have a couple of years where we had a set amount of beds that we purchased, but we are not doing that at the moment. But it always remains an option.

THE CHAIR: When I hear we have not got enough beds and that is the reason for bed block, access block and ED delays—

Ms Gallagher: We have got enough beds; we just have to make them work efficiently.

THE CHAIR: Yes. But then I hear about Nat Capital and the potential there.

Dr Brown: In recent times they have been operating essentially at 100 per cent capacity as well. I do not know that there has been a lot of capacity there for us to go and—

THE CHAIR: I suppose it goes to my point: with respect to the discussions you had with them about that, do you think there might be a provision for some beds to be purchased in the future? Are they anticipating that they will all be used by private patients?

Ms Gallagher: Any more beds in the private system is a benefit to the public health system. We have done it in the past. It has worked pretty well. I think we did it when the swine flu may have been upon us—we bought some beds. So it always remains an option. On a day-to-day basis, the two hospitals work very well. They are interconnected with the walkway, as you know, and there are transfers between the hospital as required.

They are certainly involved in all of the operational planning. For example, if something is not working at Canberra Hospital, they are able to respond very quickly to fill the gap, if we need to. There was an issue a couple of weeks ago with the cardiac catheter lab which, in the end, did not result in any patients needing to be moved to Nat Capital. But those relationships are very good, and I think the opportunity is there to look at it, if we need to purchase beds. I would not say it would be on a longstanding arrangement, though, but if we need to, on occasion.

Dr Brown: We meet quarterly with all of the private hospitals. We work closely with Calvary Private and Calvary John James as well as Nat Cap. So those discussions are occurring on a regular basis.

THE CHAIR: Moving, then, to Calvary, the car park: can you tell me what is happening with that?

Ms Gallagher: That has been funded to design in this budget. It was not to the point where the cabinet felt confident about allocating construction funding. Again, you will see this replicated through the budget papers. It has been an issue in the projects in Health, in terms of some of the issues Mr Carey-Ide has just alluded to around Tuggeranong and the sterilising services. You can fund them as a parcel but, during the design stage, scope creep can occur and then your budget is under pressure.

With Calvary hospital car park, it is funded to design. It is for 700—I am trying to work out what the description is—car spaces in the car park. Also this project will seal the dirt car park. On our advice at the moment there is a deficit of about 380 car parks and that they will need a 700-place car park.

THE CHAIR: Where is it actually going?

Ms Gallagher: On the existing sealed car park.

THE CHAIR: Is it up the top?

Mr Carey-Ide: Towards the front entrance of the hospital.

THE CHAIR: Towards the front entrance?

Ms Gallagher: Yes.

MR SMYTH: How many storeys will it be?

Mr Carey-Ide: That will be a matter for design.

DR BOURKE: How will you deal with the issue of people using Calvary car parks as a park and ride?

Ms Gallagher: You hear anecdotal stuff around the car parks all the time.

DR BOURKE: Yes, it was just anecdotal.

Ms Gallagher: I think these issues do have to be managed, and there is a range of options available to the hospitals around how they manage it, keeping an eye on who is using the car parks. At the subacute hospital, for example, by the time that is built, it will be paid car parking. The University of Canberra have already flagged their introduction of paid car parking. We have to look at options about how we manage car parking demand on both hospitals routinely. There are options not just for paid car parking; there are options about how you restrict access to car parks. Also I think we

have to have a better understanding of how much car parking we provide at the hospitals.

DR BOURKE: Of course, there is a massive open-air surface car park at CIT, just on the other side of Calvary.

Ms Gallagher: Yes.

DR BOURKE: Almost every time I go there, at varying times of the day, there is always a large amount of space available.

Ms Gallagher: Yes, that is right.

DR BOURKE: So there is capacity for people who want to use car parks for that kind of thing to use that place as well.

Ms Gallagher: Yes.

THE CHAIR: How is your relationship going with Little Company of Mary Health Care now? Has it improved? It got a bit testy there for a while.

Ms Gallagher: It has always been good. Tom Brennan wanted us to buy the hospital when he was Chair of Little Company of Mary, and so did Little Company of Mary Health Care. They had a change in chair. John Watkins was very firmly of the view that they wanted to remain an acute hospital. I think the government have shown that we have worked with both on that. So I think the relationship is very good.

THE CHAIR: The walk-in centres: what are the plans for those? One in Belconnen?

Ms Gallagher: Yes.

THE CHAIR: One in Tuggeranong. There is some question mark over what happens to the one at TCH. Could you give me a bit of an update on where that process is at? I could not find any operational funding for the Tuggeranong walk-in centre in the budget. Can you give a bit of an update on when those facilities are planned to be open and operational?

Ms Gallagher: The Tuggeranong walk-in centre would not be operational in this financial year, because of the schedule of the construction work that is underway on Tuggeranong. That is why there is nothing in the budget. But, having said that, the Belconnen one will be operational with the commissioning of the new building, or soon after. I think the fit-out of the work happens once the building is complete.

THE CHAIR: It is going in the new health centre?

Ms Gallagher: Yes, the new Belconnen health centre. I do not know if you have seen it in Belconnen. It is alongside the bus interchange.

THE CHAIR: Yes, I know where the site is.

Ms Gallagher: It is a massive building. Every time I drive past, I am not sure how we are going to fill it up, but I am very confident Health will do that.

THE CHAIR: Build it and they will come.

Ms Gallagher: The one at Canberra Hospital will have to move, because it is in the middle of building 2-3. That is where it is currently operational. So it will have to move.

THE CHAIR: Off site?

Ms Gallagher: Yes.

THE CHAIR: I remember a significant criticism when I said that it was likely to move off site. Do you remember that?

Ms Gallagher: I cannot recall exactly, Mr Hanson, what you were saying.

THE CHAIR: Can't you? I certainly recall from your various friends that there was outrage that that might not remain at TCH.

Ms Gallagher: In time—and that is what I am saying—it will need to move from there.

THE CHAIR: The Tuggeranong walk-in centre is at the health centre as well?

Ms Gallagher: Yes, it will be.

THE CHAIR: We will end up with two. So TCH is going to move out to Tuggeranong and Belconnen, is it, in terms of staffing? So we will end up with one in Belconnen and one in Tuggeranong?

Ms Gallagher: We have got a bit of time to work through some of that over the next 12 months, for those decisions. We are getting the one in Belconnen operational; the one in Canberra Hospital will remain operational. So for the next financial year that will be the change. Then we have to look at the staging of work at Canberra Hospital and commissioning of the Tuggeranong one. Indeed I still think we need to have some discussions with local general practice about how these facilities are going to operate. I have not done that at this point in time.

THE CHAIR: Members, we might look at the bush healing farm under rehab and we will look at the forensic or secure mental health facility under mental health. Are there any other issues with regard to infrastructure?

DR BOURKE: Minister, coming back to matters Ginninderra, the budget allocated $8.252 million over two years for the next stage of the University of Canberra public hospital. What will this funding be used for?

Ms Gallagher: This funding will be used to get the design of the new hospital to the final sketch plan stage? I am looking for a nod. Yes.

DR BOURKE: And how is that proceeding with the University of Canberra as to the relevant facilities within that hospital?

Ms Gallagher: Pretty well. With all of these new arrangements, there are negotiations to be had. So we are having those with the University of Canberra. They are not insurmountable, but we have got to, I think, reach a final agreement on the terms of the deed—I am trying to think of the different names—of agreement. There is a lot of effort going into dealing with those and any outstanding issues. And there are a few.

We have got to focus on delivering the hospital, and the university is focused on improving training opportunities and things for students and the university's reputation as a health university. Sometimes those things are not necessarily going to be on the same page. We are working through those details at the moment, but I am very confident we will reach agreement. Both the government and the university are very committed to the project; so it is just making sure we get the balance right.

Dr Brown: Meanwhile, there is a lot of work actually underway in terms of the site investigation studies, in terms of the commercial adviser around best procurement model. We have been doing work on the models of care, and the work on a service plan is also underway. So all of that work is continuing in parallel, while we are doing the negotiations with UC.

THE CHAIR: Have you worked out what is going in there yet in terms of services?

Dr Brown: Yes.

Mr Carey-Ide: We have. The service, most notably, is a subacute facility; so we do need people to understand that it will not be an acute hospital and therefore will not contain services such as operating theatres or an emergency department. Services that will be provided there from a subacute perspective include rehabilitation, aged and mental health services. And some examples of those are post-operative orthopaedic rehabilitation, neurological rehabilitation, physical reconditioning for individuals at risk, as well as some adult mental health services.

The really important thing to note about the University of Canberra public hospital it that it will relieve the pressures that exist in both Canberra and Calvary public hospitals that come about because people who require subacute and non-acute care, and therefore usually longer terms of admission, are actually in beds in those acute facilities. They are not in beds that are the most appropriate environment for those people to recover from their quite major illnesses, and therefore it is exciting that the University of Canberra hospital will both relieve those pressures in the acute facilities but also provide much more appropriate care environments for patients in the new hospital.

DR BOURKE: Given that the government has also announced a sports commons at UC, will there be an emphasis on sports medicine and sports rehabilitation for injured, perhaps, Brumbies at the University of Canberra public hospital?

Mr Carey-Ide: I would have to say I hope not, only because—

Ms Gallagher: They need to go through—

THE CHAIR: They have probably got private health cover.

Ms Gallagher: I think so. They are best suited in the private system.

Mr Carey-Ide: And we would hope that the Brumbies would not have a need for that sort of admission as well.

THE CHAIR: In terms of the mental health aspect there—and we might get onto this; I am happy to discuss it when we talk about mental health in a minute—the secure facility that is planned for Symonston: have you looked at whether that would be a facility that you could put out at UC and, if you are going to have a concentration of health resources there including mental health, whether you could put it out there? It is a greenfields site and it is flat. And I know there are complications with the Symonston site. Has anyone looked at that as a possibility?

Dr Brown: We did have a discussion around that. We do not believe that that is a suitable site. University of Canberra, of course, have their own views around what they perceive is appropriate for a subacute hospital—the agreement that they entered into. They have their own plans in terms of what adjacent development they may be seeking to undertake.

But in particular, we also need to keep in mind what are the requirements to support the secure facility. The site at Symonston is close to the Canberra Hospital in terms of access to the adult mental health unit there and to the emergency department and any supports that might be needed in terms of general health. So we did have the discussion but we do not believe it is appropriate to have taken it any further.

MR GENTLEMAN: Minister, around 30 per cent of the ACT Health, hospital especially, infrastructure is used by people from New South Wales. What negotiations have you had with the New South Wales government on support for our infrastructure for their consumers?

Ms Gallagher: Those discussions are ongoing. It is tricky, because we are moving to a new way of costing health services. In the past, as I understand it, there has been a capital charge component within the New South Wales cross-border agreement that is paid to the ACT government. Moving forward, though, there is this issue of the national efficient price as the measure of what it costs to deliver a particular health service or occasion of service, to use the old language.

THE CHAIR: Can you just correct me. I thought there was not a capital component, because I remember Professor Peter Collignon wrote a piece about this, and there was not a capital component.

Dr Brown: No. My understanding, and I am looking to Mr Foster for confirmation—

THE CHAIR: Thumbs up? There is? Right?

Dr Brown: Thumbs up. There is in the current cross-border agreement, and in historical cross-border agreement there has been a capital contribution.

THE CHAIR: No worries. There has been, okay.

Dr Brown: Within the national efficient price, there is no capital cost built into the national efficient price. That is the discussions we are having.

Ms Gallagher: So we are in a new set of negotiations with New South Wales around that, and they are ongoing, but I think it is fair to say their view is that the national efficient price is the national efficient price and that it might not be their responsibility.

MR GENTLEMAN: Have you done a calculation on how much they would owe the ACT?

Ms Gallagher: Not on infrastructure. We do it on the activity, based on the activity we are seeing, yes.

MR GENTLEMAN: So what would it be on the activity?

Ms Gallagher: What would New South Wales owe?

MR GENTLEMAN: Owe the ACT?

THE CHAIR: It is in the budget.

Ms Gallagher: In terms of what they owe us now. In the budget is what we forecast to expect in receipts. In terms of what they owe us now, again it is in a new world where IHPA, the Independent Health Pricing Authority, is paying us directly from the commonwealth. We have received some of that money. There is, I think, in the order of $40 million, is it? It is $44 million directly.

Dr Brown: It is from the National Health Funding Body.

Ms Gallagher: Sorry, the National Health Funding Body, yes, that is right. IHPA do the pricing. So this is coming through the national health funding pool. They have paid us $44 million, but we are owed in the order of $85 million by New South Wales.

THE CHAIR: There was an amount that was in dispute as well, was there not?

Ms Gallagher: We have reconciled.

THE CHAIR: That has been reconciled or it has been resolved?

Ms Gallagher: We have reconciled the amounts. But there is $85 million that is owed to the ACT government at this point in time for services already provided.

MR GENTLEMAN: And those impacts would grow, I would imagine. We have got Googong development coming up, and Tralee development shortly after. You would calculate those visits, I would imagine.

Ms Gallagher: We can forecast it, and that is forecast as best we can, mindful of all the changes that are happening at the moment in the budget papers. But it does require us to reach agreement with New South Wales. We had a New South Wales cross-border agreement that was in place from 2003 to 2008, I think. And then since that time we have been operating under that agreement, mindful that national health reform has come in over the top. Now we need to negotiate the cross-border agreements within the confines of national health reform, which does change things, for example, the national efficient price.

There is this tricky bit in the middle, which sort of existed under the old contract, and then, as we move to a new contract, for services up to this financial year, for the reconciled amounts from 2009-10, 2010-11. That is the amount that we are awaiting payment from New South Wales for.

THE CHAIR: Are there any other infrastructure issues?

DR BOURKE: Yes. Minister, can you tell us about the progress that has been made to date on the community health centres at Tuggeranong and Belconnen? I think you have already talked a bit about Belconnen there but—

Ms Gallagher: Tuggeranong is underway as well. Belconnen is almost complete. It will be in the second half of this year. That will be the first opportunity we have got for an enhanced community health centre. So that will have new services in there that we have not had in the Belconnen health centre before. That will be excellent. Some of that also includes moving services out from the hospital. So it will be offering renal dialysis, for example, in a community health centre setting, which will be great. Again, we are looking at what we can do outside the hospital.

In terms of Tuggeranong, we have moved out into the Greenway Waters in the last six months or so, and that has allowed us to keep services going in Tuggeranong. And now the building construction work is, what, 12 to 18 months, is it, for the new centre there?

Mr Carey-Ide: Yes.

MR GENTLEMAN: What has the feedback been from consumers in Tuggeranong about that temporary accommodation in Greenway Waters?

Ms Gallagher: I do not recall having anyone complain about it. I do not recall. I take that as a—

Mr Carey-Ide: And I would add to the minister's comment that I am not aware that there have been any complaints about the service. My understanding is that the community are very excited about the expansion of their centre as well as the refurbishment of the older centre and, therefore, incredibly tolerant of the new spaces that are temporary until the service is able to be reoccupied.

Ms Gallagher: And I think—just to add to that quickly—the fact that we have had to stop dental out of there has been a credit to the communication strategy and the

patience of the community for dealing with that.

MR SMYTH: With all of these facilities, refurbs and bits and pieces going on, of course, you need staff. How are we coping with tracking the correct number of doctors, nurses and allied health professionals?

Dr Brown: At this point in time we continue to grow our clinical staff, and we will have additional need going forward. I think there are an additional 131 positions, the majority of which are clinical positions; 83 nurses, six doctors, 26 allied health and some admin staff are provided for in this year's budget. We do, as I have reported previously, have pockets where we sometimes struggle in terms of recruitment in particular specialty areas. One example that I mentioned at the last committee hearing was around haematology. We have had a new haematologist start work in March this year, I believe. In fact two have started work.

We have had some challenges around recruiting to child and adolescent mental health, in terms of some of the nursing and allied health professionals there. That remains an ongoing struggle for us. Geriatrics has been another area where we have had some issues, but we have got an offer in, in terms of that, and we have recruited a new rehab registrar in the last 12 months. Generally speaking, I think recruitment overall is a positive story. We have been doing a lot of work around our workforce planning and in terms of our onboarding for new staff to make sure that it is a very positive experience for them.

MR SMYTH: There is no loss of admin positions to provide additional front-line service positions?

Dr Brown: There are no plans for losing any positions.

MR GENTLEMAN: What is the level of interns in the system now?

Dr Brown: We currently have 96 interns for the 2013 calendar year. We have been, as you are probably aware, in the process of the offers for intern positions for 2014. We had an exceptional response to that. We are very confident of filling all of our positions for next year with people who want to be in the ACT and have a strong connection here.

MR SMYTH: The chart on page 86 of budget paper 4 talks of the extra 131 FTE. It goes from an estimated outcome this year of 5,608 to 5,811 for the coming year. Are those figures accurate?

Dr Brown: Which particular one are you referring to?

MR SMYTH: Is the estimated outcome of 5,811 accurate?

Dr Brown: No, we are probably exceeding that at this point in time. It is always a challenge with workforce figures to get the precise number at any given point in time, as strange as that sounds. Our most recent data is that we have hit the 5,700 mark or above, I believe.

MR SMYTH: If these figures are accurate, the numbers on page 579 are different numbers. What is the correct projection for 2013-14?

Dr Brown: The projection is an additional 131 positions provided for in the new recurrent dollars in this budget. The challenge for us is always in terms of dollars that come in, for example, from the commonwealth under national partnership agreements, dollars coming from Health Workforce Australia. We currently have over $10 million, $10½ million, over four years for projects in association with Health Workforce Australia. So there are additional dollars that come in that require additional staff. That is why the numbers change from what has been predicted to what we then end up with, as well as some internal efficiencies. Where we can drive efficiencies, take on new staff and deliver more services, we do that. We have actually done quite a bit of that, too, in the last 12 months.

MR SMYTH: But on page 86 you say that the budget for 2013-14 is 5,811 staff. On page 579 you say that the budget for 2013-14 is 5,831 staff. Which is correct?

Dr Brown: It is 131 over the 5,680, so that would take you to 5,811. The estimated outcome is what is different. We have 5,700 versus 5,680.

MR SMYTH: So which is correct?

Ms Gallagher: I think Dr Brown has just explained it. They expect the estimated outcome to be 5,700; therefore that number is 5,831.

MR SMYTH: Which figure do you trust? I note you have already—

Dr Brown: They are different by a figure of 20, I believe, and they are estimated, Mr Smyth. That is all I would say.

THE CHAIR: It is a fair point. Whichever figure it is, if you have got a budget paper that has exactly the same indicator or exactly the same number, or saying that it is, and it is different by 20, that looks like a transcription error of some sort. It is misleading. It is an estimate for 2013-14—

MR GENTLEMAN: In the notes on page 86 it gives an explanation for it.

MR SMYTH: No, they go up consistently by 131, but what is the starting point; that is the question? Which one do we believe?

Ms Gallagher: We will see if there is any further information we can provide. But I take the point.

MR SMYTH: Are there any other details or numbers that are incorrect, apart from the one you have already distributed?

Dr Brown: I have to commend you for your eagle eyes, Mr Smyth, in finding that.

MR SMYTH: You know I love the numbers!

Dr Brown: Indeed.

THE CHAIR: I suppose we have had an incident before where Health numbers were not entirely accurate. I do recall that.

MR SMYTH: Yes. Moving to page 108, the operating statement on employee expenses, how are negotiations with the nurses union going?

Ms Gallagher: Ongoing.

MR SMYTH: So when is the resolution likely to be?

Ms Gallagher: I am not sure we can put a timetable on it. At the moment we have got an offer on the table. They have rejected that. Negotiations need to continue until we reach agreement. That is the way we operate. As soon as we can.

MR SMYTH: When does the negotiation period finish?

Ms Gallagher: I do not think the negotiations have a finishing period. The agreement expires on 30 June.

MR SMYTH: You have put four per cent in for this year as the increase in the employee expenses and four per cent for superannuation. In the outyears it goes up six, seven and then eight per cent, but the superannuation only goes up a consistent four per cent.

Dr Brown: We might ask the Chief Finance Officer, Mr Foster, to speak to that.

THE CHAIR: While we are waiting, can I put a question on notice about infrastructure? We seem to be moving to staff now. What I am after is a detailed explanation of each of the Health projects, including their purpose, their scope, any times attached to them in terms of various stages of completion, the budget attached to those projects, and any changes to the budget, scope and cost since they initially appeared in the budget. So any changes that have occurred over time.

Ms Gallagher: For the projects that are on now?

THE CHAIR: Yes, and if you have any that are at the planning stage as well, like the University of Canberra hospital work. There are some that appear in the budget but it is only the scoping works as opposed to the full scope of the project. It would be useful to say, "This is the full intent of it." I accept that for those that are budgeted there is a lot of detail. For others, it is indicative or it is only planning.

Ms Gallagher: Yes, so for planning and those projects underway?

THE CHAIR: Yes, and if you could give as much detail as possible, that would be very helpful.

Ms Gallagher: Yes.

THE CHAIR: Moving back to Mr Smyth's question, you might want to repeat it.

MR SMYTH: Welcome, Mr Foster.

Mr Foster: Sorry, what was the question?

MR SMYTH: On page 108 your employee expenses go up four per cent and your superannuation expenses, oddly enough, go up at four per cent. In the outyears your employee expenses go up six, then seven and then eight per cent but the superannuation expenses are consistently just at four per cent. What is the difference there?

Mr Foster: I might take that one on notice. Certainly, we expect superannuation to be decreasing in the outyears because of the change in the mix of membership. The CSS and PSS memberships will decline in the outyears. It is a declining thing because they are sealed off. So we will see an increase in the lower value of superannuation growth at 9¼ per cent rather than the 20-odd per cent that applies to the others. But with the actual percentage increases, I will take that on notice.

MR SMYTH: Thanks for that.

DR BOURKE: Minister, can you outline for the committee how many beds will be opened at Canberra and Calvary hospitals as a result of this budget?

Ms Gallagher: Yes, I can. It is 42.

Dr Brown: There are 16 general beds at the Canberra Hospital and 15 at Calvary hospital. That includes four stroke beds at Calvary hospital. There will be three additional beds in the Centenary Hospital for Women and Children. There are eight rapid assessment beds at Calvary in addition to that. I think that all adds up to 42.

DR BOURKE: Can you tell me a bit more about the stroke beds at Calvary hospital?

Dr Brown: I might ask Mr Ghirardello to speak to that.

Ms Gallagher: This is something Calvary have been after for a little while. We have got a stroke unit at Canberra Hospital, so it is building up Calvary's capacity to treat people who have had a stroke.

Mr Ghirardello: That about answers it. The idea is to provide Calvary with the capacity to have four stroke beds and for the whole service across the ACT to work as a networked service.

DR BOURKE: I know that beds really means staff, so what sort of staff are we talking about?

Mr Ghirardello: We have got those numbers, but I will take that on notice to give you the exact numbers.

Mr Thompson: One of the things to emphasise is that Calvary does care for stroke

patients now. In general terms, where a stroke unit differs from a general neurology acute bed, which is probably the nearest comparator, is that there is a higher intensity of nursing care available, as well as additional allied health support, looking at physiotherapy, speech pathology, social worker, to address some of the other associated effects of stroke.

DR BOURKE: And allied health support workers, presumably, as well?

Mr Thompson: Yes.

THE CHAIR: We will move to mental health now—mental health, justice health and alcohol and drug services. Minister, the secure mental health facility: could you give me an update on where that is at the moment, particularly in terms of its scope? I think the security has dropped, from memory.

Ms Gallagher: Yes, that is right. We have undertaken some further review of this facility in the last 12 months. The size of the unit has changed to 25 and, instead of having a high secure facility we are proceeding with a medium secure facility. We have increased the size of it from 15 to 25 and reduced it from high security to medium. That is based on three separate pieces of work that were done. One was around the cost of infrastructure; one was best advice around provision of forensic mental health services and learning from some other jurisdictions; and some advice from our own Health Directorate and the expertise, particularly, of Dr Brown in running and managing mental health services.

THE CHAIR: What are the time lines now?

Ms Gallagher: It is now in the design stage. We have got the money for the design stage. That will commence in July. There is the procurement of the principal consultants and the commencement of preliminary sketch plans. There is, obviously, ongoing consultation with the local community and the required planning approvals et cetera to be undertaken. I said at the press conference on budget day that if this project is able to get to having a costing for construction within this financial year, for example in six months time, then I have the agreement of the Treasurer to look at how we deal with that in this financial year—whether it be looked at through the financial updates through the mid-year review—to make sure we continue to deliver this as fast as we can, mindful and very cognisant of the delays of this project.

THE CHAIR: Do you have an estimate for what it will be? I think it was 11.9 in a previous budget and then it blew out close to 30. Have you got a view now? Have you capped it?

Ms Gallagher: I think it was heading up to 40, actually.

Dr Brown: It was in the mid-30s. No, we do not have that just at the moment, because obviously we do the design and then we do the costing.

THE CHAIR: Sure, but there is a big difference between 11 and the mid-30s.

Ms Gallagher: Yes. The 11 figure—and we can go to and fro on this—was the figure

from 2003, if my memory is right.

THE CHAIR: It was in the 2009 budget and it was your election pledge for 2008.

Ms Gallagher: I do not think it would be the $11 million figure. It was part of the decision when the decision was to co-locate the secure unit with the adult mental health unit. We took a decision way before 2009 not to proceed with a co-located facility. The 11 figure is not measuring like with like. I expect that this project will be in the order of $30 million. I will be very surprised if we can deliver this project for less than that.

Dr Brown: But that is with 10 additional beds over the previous 15 that we were talking about.

THE CHAIR: But with less security?

Dr Brown: Yes. It is 15 medium secure and 10 low secure.

Ms Gallagher: But we are not doing that as a cost-cutting measure. I just want to be clear from the beginning that that is based on what we reasonably believe the need is going to be and what level for forensic mental health. The issue for us in delivering this project is the low volume, the low level of demand, and how a jurisdiction our size actually delivers a one-size-fits-all model for every type of forensic patient. That is the challenge. I must say that I became convinced, from arguments put to me, that a high secure unit would benefit—I think we have had two people in the last five years; is that right?

Dr Brown: It is a small number.

Ms Gallagher: It is a very small number who would have required a high-level secure unit. Therefore, are we designing it around them, those very low numbers, or are we going to design it around the majority that would need that type of care? Again, I think experience has shown that it is very difficult to run a small forensic unit with a relatively isolated workplace and very, very difficult patients that you are dealing with. We have been mindful of all of that. The decision around reducing it from high to medium has not been around budget.

THE CHAIR: It has been 10 years. You mentioned 2003 and there may have been work done before that. It has been 10 years and nothing has happened.

Ms Gallagher: We do not have a secure mental health unit. It is the missing piece of the puzzle. But we have been building the mental health assessment unit within the emergency department. We have been building the acute mental health unit. We have been doing step-up, step-down facilities, of which we have a number now. I think that when people discuss this there is not the acceptance that we have a forensic mental health service that runs across the territory. The actual service is being delivered. Is it being delivered in the most appropriate infrastructure? I would say not. That is what we have got to finish.

The service is being provided. Indeed, one of the initiatives in the budget in this

budget year is extra funding for community forensic and public forensic mental health support. We need to get the building done. But, again, it comes to this: do you plough on and build a building that you are not entirely convinced is going to meet the needs of the community for the next 20 years or do you stop, review, change your mind and build something that is actually going to meet the needs of both the staff and the patients who need it? Yes, it has taken longer than it should have; I agree with that.

MR GENTLEMAN: Minister, what are some of the challenges with the infrastructure of the building and the location?

Ms Gallagher: Around the location, on any measure it is the most appropriate location. We took almost a year to look at appropriate sites for this, mindful of the fact that these projects are extremely controversial. Wherever they are constructed anywhere in the world, you will get views around where these units should go. The majority view is they should not go near wherever people are living in close proximity. Whether that is right or wrong, I think that is probably the community response at times.

With Quamby, it was land that was available. It has been used as a juvenile justice facility. It is well located between the AMC and the Canberra Hospital. Again, going back to what Dr Brown says, for acute medical needs it is close to the ED, close to the adult mental health unit—if that is an appropriate place—and close to the jail where many people who are in receipt of forensic mental health are located. So it makes a lot of sense.

There are some sensitivities, the main one being the animal farm that is across the road from this site. We need to work through that with those residents, rather than accept it is the wrong place for this to go, and address any concerns they have through the design stage. If the problem is that it is going there then we are not going to be able to address it. But if it is concerns about how it looks and the likelihood of people leaving—if they need more of an understanding of the type of people who might be spending time there and what the staff are going to be doing—then I think all of those issues can be addressed in the design stage.

DR BOURKE: Isn't it right next to the periodic detention centre?

Ms Gallagher: Yes.

DR BOURKE: Do those objecting to the secure mental health unit have an objection to the periodic detention centre?

Ms Gallagher: Not that they have raised with me. The animal nursery was started after the periodic detention facility. That was there and operational. I guess they would go into that with their eyes open. This is a new service coming in so I guess in their minds—

THE CHAIR: I think the design work or the forward design had in it that it should not be located near facilities where children are. I think through an FOI I have seen something like that as part of the—

Dr Brown: I do not recall that, I have to say.

THE CHAIR: I think that is part of their concern.

Dr Brown: I think it is understandable that people are anxious about what they do not know. Certainly, in my time in Queensland as director of mental health I was involved when we actually opened three new units. One was adjacent to the site of the old one at the Wolston Park Hospital. That was not a contentious issue, but the other two—one was a combined high and medium secure; the second one was a medium secure unit—both opened in residential areas, one in Townsville and one at Chermside, and we had exactly the same response from the community. They were anxious about what they did not know. We worked through that with the community and engaged with them about the purpose and the design. We continued to communicate with them and were successful in opening both of those units. This is understandable. I think it is something we just have to commit to working through with the neighbouring residents.

Ms Gallagher: It would be great if we had a unanimous view. That would make it easier on the secure unit and the location. If there is not a unanimous view about where the secure unit should go—or, if it should not go there, a suggestion about where else it should go—it would have to be put on the table. I think in the interests of getting this project up and operational, it would be fantastic if the Assembly would have a view on that, because it is going to be hard.

DR BOURKE: You have allocated $1 million per year for recurrent growth in community mental health. Could you outline what that additional funding will be used for?

Ms Gallagher: It is a range of different things. I think it is five different projects, or five different components to that initiative. There is forensic community support—as I said, some extra funds going to public forensic services—a program around supporting women in the antenatal period, a suicide research program and some support around return to work, a vocational support program.

DR BOURKE: I understand the Mental Health (Treatment and Care) Act is under review. Could you tell the committee about the progress on that review?

Ms Gallagher: We are up to, I think, the second exposure draft stage on that. I think this beats the Children and Young People Act, which took about five years to develop. This is probably exceeding that now. It has been a very useful process to take this long. It is legislation that deals with our community's most vulnerable at their most vulnerable time. There are a lot of different views around how legislation should manage this time in people's lives.

We have tried to get the balance between the rights of those people covered by the Mental Health (Treatment and Care) Act, including how they can be involved in decision making when they are well and that they can be taken into consideration should elements of the act be required, and looking at best practice right across the country around all of these areas, which are fraught, and where there are very different views, it is probably fair to say, within the clinical area, within the consumer movement and within the carers movement around how you manage your legislation

here.

Based on the advice to me from both the directorate and the Mental Health Advisory Council, which I chair when I meet with them and talk about it—I do not want to do anything that damages it—we are getting the balance about right, I think. But we have got some more work to do. It is out on second exposure draft stage now.

MR SMYTH: Just on the act and the consultation, were the TWU consulted with regard to the paramedics? Were the AFPA consulted with regard to what is happening now? A lot of the time the AFP are providing the service.

Dr Brown: All along we have had a review advisory committee that has a very broad membership. The unions have not been part of that. Certainly, ambulance was a part of that committee and is still a part of that committee.

MR SMYTH: The ambulance service as in the ESA?

Dr Brown: The service, yes.

MR SMYTH: But not the ambulance officers themselves.

Dr Brown: No, but as part—

Ms Gallagher: Through their employer, yes.

MR SMYTH: What about through their union?

Ms Gallagher: Well, it is a public process.

Dr Brown: As part of the consultation process we have had the first exposure and it went out for public consultation. There was a second exposure process. The head of the ambulance service did meet with the TWU, is my advice, and there were no issues raised at that time. I think that subsequently they raised issues around whether or not they felt that was adequate advice to them, but it is a public consultation process.

Certainly, the provision around providing additional powers to paramedics and ambulance officers is a provision that has existed in other jurisdictions for a number of years. It is not one where we are seeking to put ambulance officers at any risk. It is providing them a power to exercise in circumstances which they actually face on a daily basis when confronted with someone with a mental illness but they are unable to take the appropriate action and have to call police or the mental health services; whereas, if this legislation is passed and they have that power, they can smoothly go from dealing with someone and, where necessary, detaining them and taking them for the appropriate assessments.

MR SMYTH: On how many occasions do the police bring people in distress to the hospital?

Ms Gallagher: Frequently.

Dr Brown: It is a regular occurrence, although I have to say that it has reduced since the commencement of the mental health policing initiative. I no longer have those figures in my head, Mr Smyth. They are in the Chief Psychiatrist's report annually, but I am not sure whether Katrina Bracher—we might have to take that one on notice, because I do not think we actually have that figure with us. But it is a regular event.

MR SMYTH: Has any work been done on what is the likely number of additional services the Ambulance Service might have to provide as a consequence of this, and will they get supplementation for their budget?

Dr Brown: As I indicated, we are not specifically seeing this as providing additional work for the ambulance. It is more for their use in a circumstance where they are called to see someone. For example, it may be after an overdose, and they may have formed the view that this person has a mental illness, it warrants an assessment under the act, but they do not have the power to effect the transfer of that person. It is to provide them with the power to act in those circumstances. It is not necessarily envisaged that they would be called specifically to exercise this power.

MR SMYTH: But at this stage they would not take that person to the hospital. That service is provided by the police?

Ms Gallagher: They may well, but they would have to call the police as well to do it. If the patient was unwilling—obviously, if they are unconscious then they are just—

MR SMYTH: There is not an issue.

Ms Gallagher: Yes, but if the patient was unwilling, but they formed the view that they had to, and they had a duty of care to, they would have to call the police. That person may still medically need to be transferred by the ambulance, but that would have to be done under the powers that the police have under the mental health care and treatment act.

MR SMYTH: So do they now travel in the police car, or do they now travel in the ambulance?

Ms Gallagher: I guess it depends on the clinical state. If their clinical need requires an ambulance, they would need the ambulance with police attendance.

MR SMYTH: I just wonder what work has been done to ascertain whether this will put additional pressure on the ambulance service.

Dr Brown: We do not believe that it will be used in such a way that it will add an additional load to the ambulance. That is not the intention behind it. It is—

DR BOURKE: They have already turned out for the incident anyway.

Dr Brown: Sorry?

DR BOURKE: They have already turned out for the incident anyway.

Dr Brown: Essentially that is what we are saying—that it will be utilised in the circumstance where they are already currently being called but they just have no power to act.

Ms Gallagher: And it reflects the rest of the legislation, which is about a dignified, non-stigma-based approach to supporting people with a mental health issue in the community at different points of their life. The TWU contacted me after this was highlighted in the paper; I have urged them to get involved in the next stage and to feed that back through their members and back into the legislation.

THE CHAIR: Before we move to Mr Gentleman for a new question, I just want to clarify. My understanding is that we were talking about the secure mental health facility before, and the budgeted amounts, whether it was ever $11 million. My understanding is that there was $11.6 million in capital in the 2008-09 budget for that facility.

Ms Gallagher: Yes, so rolled over. It sat there for a number of years.

THE CHAIR: And then it went. But—

Ms Gallagher: And then, when we had not made up, I returned that capital to the Treasury, so it disappeared.

Dr Brown: But that was for a co-located facility.

MS GALLAGHER: Now we are doing the next stage. It was never sitting there going, "This is how much it costs." That $11 million was sitting there as money that had not been returned.

Dr Brown: But it was also for a co-located facility.

Ms Gallagher: Yes.

Dr Brown: And that is an important point. It was not a stand-alone; being a stand-alone facility brings additional requirements and hence additional cost.

THE CHAIR: Mr Gentleman.

MR GENTLEMAN: Minister, $1 million per year has been allocated for recurrent growth in community mental health services. Can you outline for the committee what this additional funding will be spent on?

Ms Gallagher: Yes. I think I just answered that. That was those five different programs, yes.

THE CHAIR: Do you have another question?

MR GENTLEMAN: The budget includes an extra 1.4 over four years for the establishment of the outpatient services for alcohol and drug services. What will this fund deliver or fund?

Ms Gallagher: Drug and alcohol services are a good, quiet service that do not get a lot of attention, but they do an amazing job. This will be to fund several positions, including an addiction specialist and some nursing and allied health support. This has very much been driven by the alcohol and other drugs sector. The community, I think in the ATODA election forum, specifically requested an outpatient service like this. It is not an area of much glory or attention—let us just say that—but it is a very important part of our health system and our response to people who have alcohol and drug concerns.

MR GENTLEMAN: Thank you.

MR SMYTH: Just following up on that, what percentage of mental health funding is now given to the community sector?

Ms Gallagher: We can take that on notice.

Dr Brown: Yes.

Ms Gallagher: It is the highest in the country; I know that. It depends what you measure, too.

Dr Brown: It depends on how you define "community". It is about 69 per cent, from memory, and I will confirm that, that goes into the community, but that includes public sector community plus community organisations.

MR SMYTH: Yes, delivered by community service organisations.

Dr Brown: Community service organisations, I believe, is in the order of 13 to 14 per cent.

Ms Gallagher: Yes.

Dr Brown: But again, I would have to confirm those figures.

Ms Gallagher: It would be.

MR SMYTH: Are we still working towards 30 per cent?

Dr Brown: Thirty per cent has always been an aspirational target. Certainly the horizon has changed in relation to the introduction of DisabilityCare Australia, the national disability insurance scheme. Mental health will be included in the NDIS. One of the criteria does incorporate those individuals who have a psychosocial disability that is permanent, or likely to be so, and causes significant functional impairment. Some of the funding that currently goes to the community sector, the non-government sector, to provide for the psychosocial support of people with severe mental illness will now go into that DisabilityCare funding, so in future I think it is going to be well nigh impossible for us to actually tease out those percentages.

MR SMYTH: But you will take it on notice and tell us what it is at this stage?

Ms Gallagher: Yes.

MR SMYTH: Thank you.

THE CHAIR: In terms of corrections health, the needle and syringe program, I do not see any money in the budget for it. I assume that this is ongoing. Could you give me an update, please.

Ms Gallagher: We do not expect it to need budgetary supplementation, so you will not see money in the budget for it. In a general sense, if you are looking for more money for any supplementation to corrections health, it would be done as an initiative to corrections health, because the way the model is being recommended to be implemented is that it is done through an existing consultation with your doctor when you see them, so it is not establishing a stand-alone service or anything like that.

THE CHAIR: Where is the process up to at this stage in terms of negotiations?

Ms Gallagher: The last article written in the *Canberra Times* is probably where it is at, too. Health and JACS have done a presentation to staff during their normal staff consultative processes. That is now open for feedback. I understand it was a good meeting. No surprises: staff are still very concerned around it. They raised some concerns and some ideas around the model that was being presented, and it is now going through that process. I do not know if you want to add anything to that?

Mr Goggs: I can do. I led a consultation session with the staff from the Alexander Maconochie Centre, both custodial and health centre staff. As the minister has indicated, the staff were forthright in their views. I think that was accurately reported in the press. We provided an opportunity for feedback by staff in relation to the model that was presented, but we have clearly indicated that this is not a definitive version at this stage, and we are open to suggestions about ways that a model could be made to be even more effective for both the employees at the centre and detainees.

THE CHAIR: It strikes me that the staff are going to remain in some sense opposed. There might be some nursing or corrections staff who are agreeable, but it seems that certainly the majority of corrections staff—and also, in terms of the models, when I read the reports, and the Moore report, quite a few nursing staff in the ANF—said that they did not support the model, from my memory. What are you going to do, minister? The continual process of consultation and mediation seems to be getting nowhere. Are you going to at some stage bite the bullet and say, "Do it." Or are you going to say, "This is not doable." At what point are you going to stop this process of negotiation that seems to be going nowhere?

Ms Gallagher: I would not agree with that. We have taken this a lot further than the original decision about examining a needle and syringe exchange program in the AMC. If you are asking me whether I am going to give up on making sure we look after people with bloodborne viruses in a correctional setting the best we can, then I can say I am not going to. I am convinced that this is part of the answer. It is not the only part, but it is an important part of responding to the health needs of a very vulnerable population. And if it takes time to get there, I am not going anywhere.

THE CHAIR: So this process will just keep chugging along?

Ms Gallagher: The flipside is "It's hard, so I give up." It is hard on people when they get hepatitis C and their liver packs in, frankly. That is hard on them. Yes, this is hard, and I face resistance. But I would say a number of our public sector employees—in fact, the majority in front-line positions—do not get to pick and choose what aspect of government policy they are going to implement. Our nurses do not; they look after people from AMC on the ward all the time. They have to engage in risky behaviour, through providing health services to vulnerable groups, all the time.

THE CHAIR: That being the case, why aren't you moving ahead with this? You are saying that that is not up to the staff to determine.

Ms Gallagher: That is right. It is not. However, I am taking a very reasonable—more than reasonable and more than patient—view that we need to work with the staff. It is a different environment from the general community, where needle and syringe programs now exist without the slightest bit of concern from the general community, albeit that they existed controversially when they were first implemented. The jail is different from that; it is a closed community. Therefore, I have to listen and respond where reasonable concerns are raised. It is going to take time. I am not going anywhere. Neither are the correctional officers. The only thing that seems to be moving in a way that we do not want is infection rates within correctional settings, and we have to respond to that.

THE CHAIR: In terms of treatment for hep C, there were 10 treatment spaces. Is that right? Are there still 10?

Dr Brown: Yes.

THE CHAIR: How many people are currently awaiting treatment or testing?

Ms Gallagher: Within the AMC?

THE CHAIR: Yes, within the AMC.

Dr Brown: I will have to take that on notice. I am not aware that we have any waiting, but I will have to confirm that.

DR BOURKE: Is that waiting for treatment or waiting for testing?

Dr Brown: Testing is offered to detainees at the time that they enter into the correctional environment and then periodically thereafter. There is also an appointment made for them to have further testing, should they so desire, prior to their departure—generally about 28 days prior to their scheduled release date. The percentage of people who actually have the testing on entry is—again, I am doing this from memory—about 60 to 70 per cent. That is the percentage that actually takes up that offer of testing at the time of reception. Very few take it up at the time of discharge. There are not usually people waiting for testing. But, certainly, we do have a cap on the number that are treated. I will have to confirm whether there is any

waiting—

THE CHAIR: I remember that there were quite a number. It seems intriguing that you are expressing concern for people with words like, "I am concerned about people waiting with their livers packing in," I think was your quote. But then you are not providing the treatment for people who can be treated or basically providing treatments for people right now.

Ms Gallagher: We are.

THE CHAIR: If there are people waiting—

Ms Gallagher: We are. I think we are probably the only jail that is actually providing that kind of care.

THE CHAIR: How many people are waiting? We will see when we see how many people are waiting for treatment.

Dr Brown: We have in place a protocol for monitoring those individuals who may be awaiting treatment. We do that in the correctional setting. We do it in the general hospital setting. There is a capacity to reprioritise as required. There is also some prioritisation undertaken in relation to specific factors around the individual that would make them more favourable or less favourable in terms of treatment outcomes. All of those things are looked at in terms of people—

THE CHAIR: I would like to know of those who are able to be treated, how many are waiting. On another issue, the Burnet Institute did their report in 2009, 2010. I cannot quite recall.

Dr Brown: It was 2010 or 2011.

THE CHAIR: That was on essentially drug policy and other health issues within the jail. They had, I think, 65 recommendations.

Ms Gallagher: Yes, I do not think there were enough.

THE CHAIR: A lot of those were around health, mental health and drug rehabilitation. What has the government's action been in terms of responding to those recommendations and implementing those recommendations?

Dr Brown: Again, we have worked very collaboratively with JACS and Corrections in relation to progressing those recommendations. We have an AMC health policy committee that meets regularly to actually look at the health priorities within that correctional setting. I actually chair that meeting. My recollection—again, I am going to look for some confirmation from my officials—is that we have actually closed all of those recommendations from Burnet. We have written a final report, I think, and closed all the recommendations. I will get Ms Bracher to speak to that.

THE CHAIR: Ms Bracher, before you start, I think I saw your name on a website for the Vinnies sleepout. Is that right?

Ms Bracher: I think I saw your name too.

THE CHAIR: Yes, we might be able to catch up on this in more detail tonight at minus three. I will look forward to that.

Ms Bracher: There were 69 recommendations in the Burnet review. The 69th recommendation was around the needle syringe exchange; so that one is definitely not implemented yet, although that was around consideration of a program. So we are working on that. The other recommendations have all been closed off.

THE CHAIR: Closed off as in actioned or no further action?

Ms Bracher: I do not have the definite numbers in my head, but a number of the recommendations were accepted by government. A number were noted, a number were agreed in principle and a very small number were not accepted, and they have all been closed.

THE CHAIR: I am not sure if that has been tabled in the Assembly. I simply cannot remember.

Dr Brown: No, it is on its way. There is a process between the Minister for Health and the Minister for Corrections.

THE CHAIR: That is going to be tabled in the Assembly in terms of the government's response?

Dr Brown: There is a process to finalise that report.

Ms Gallagher: To report, yes. We have tabled the response. This is to the final report—updating it.

THE CHAIR: I will await that. Thank you.

Ms Gallagher: I think in the response we committed to updating the final.

Dr Brown: Could I read into the record while I have it the number of apprehensions by police? In the 2011-12 year, taken from the Chief Psychiatrist's report, there were 942 emergency actions, of which 677 were undertaken by police, 175 by mental health officers and 90 by medical practitioners.

DR BOURKE: The budget includes $404,000 over the next two years for Aboriginal and Torres Strait Islander smoking cessation. What will that money be used for?

Ms Gallagher: This is to implement a social marketing campaign targeted at the Aboriginal and Torres Strait Islander community around smoking cessation. Work has been done to work with Indigenous communities locally around essentially how to make the smoking cessation message relevant. Whilst we have seen decreases in the general population around the uptake of smoking, the smoking rates, particularly for young women in the Indigenous community, have actually increased in the last eight

years.

In terms of young women or women who are pregnant, 52 per cent of Indigenous women who are pregnant are reporting that they smoke in pregnancy. The last data we had was that 36 per cent of the adult Aboriginal and Torres Strait Islander community in the ACT were smokers. On any way you look at that, those measures are going against what we are seeing in the general population where we are seeing continuing decline in smoking rates, particularly amongst young people.

DR BOURKE: Does this mirror a national effort in respect of Indigenous smoking?

Ms Gallagher: I think there is. It is certainly seen as a priority within Indigenous health, not just because of the impact of smoking but the flow-on effect into other areas like diabetes and other illnesses. Yes, I would say that it ranks highly in terms of Indigenous health. It is a relatively low cost, but a very important initiative.

Dr Brown: It is part of our closing the gap commitments.

DR BOURKE: Which local organisations has the directorate been working with to deliver this program and to get that kind of local community flavour that will be so important in the success?

Ms Gallagher: We can provide you with that. I know that when I was looking at this initiative going through the budget round it did talk of a very significant engagement process with the local community, including input to the types of material that are going to be used, the videos and songs that are going to be used, to progress the message. But Ross O'Donoughue can expand on that.

THE CHAIR: Are you sleeping out tonight, Mr O'Donoughue?

Mr O'Donoughue: Fortunately not, Mr Hanson. Well done, though, on your part. Thanks for the question, Dr Bourke. We have had a long process to come to this point for the social marketing campaign. We actually had a PhD student do a literature research. We had a community consultation process with the Aboriginal community in particular and we have been working very closely with Winnunga Nimmityjah and Gugan Gulwan, both of whom have had funding through the broader Aboriginal and Torres Strait Islander tobacco cessation strategy. We have funded positions both from ourselves and from the commonwealth.

As the minister alluded to, the initiative in this budget builds on previous recurrent funding of $200,000 per annum. This will enable us to really now implement the materials that we have developed under the beyond today campaign. We are very proud. It is a local product. It uses the voices and the images of people who have been identified by the Aboriginal community locally, not necessarily celebrities, interestingly. I thought that perhaps the Patrick Mills of the world might be real candidates, but that was not the way the community thought about it.

They chose people who were famous to them but not necessarily famous in the broad. They have, through a digital story telling process, recorded their own stories and their images are used in the campaign. We will be able to roll this budget initiative out

locally and it will give it a bit more prominence. There is, as you say, a federal Aboriginal and Torres Strait Islander tobacco cessation campaign underway as well. There was a major function in the territory on World No Tobacco Day a couple of weeks ago.

DR BOURKE: Are there any learnings that you have managed to garner from other jurisdictions that have helped you in the development of this program?

Mr O'Donoughue: One of the findings from the literature review and the consultation was that there is not a lot of evidence in the literature about what is effective in these communities, although broadly speaking we have built on other experiences of other jurisdictions. What we have found is that the importance of family is both an enabler and a problem in some respects. There is a strong culture of sharing in Aboriginal communities and family is very important.

That is a great thing in terms of asking people to be protective about their families and perhaps not smoking in enclosed environments like the car or the house, for example. That is a strong enabler. However, the culture of sharing also means that if there is one smoker in the family, it is likely that other people will also be co-opted into smoking as well.

That notions of the importance of family and the idea of asking people to respect protecting children and other family members in closed environments are important learnings. Also, we are trying to build a campaign around culture, around the fact that smoking is not part of traditional Aboriginal culture and way of life. I suppose they are the main things, Dr Bourke.

DR BOURKE: What would be the health effects for the community if we were able to reduce smoking, if your program is successful?

Mr O'Donoughue: Without doubt, it must be one of the strongest avoidable causes of illness in the Aboriginal community. It would make a major contribution to closing the gap in life expectancy in health outcomes if we were able to reduce that rate of smoking. The rate of daily smoking in the ACT generally is about 10 per cent. It is one of the lowest rates in Australia. It is the lowest rate in Australia. It is one of the lowest rates in the developed world.

A rate of 36 per cent, as the minister alluded to, in the Aboriginal community is really unacceptable. As the minister also alluded to, it is as high as 57 per cent in women who are pregnant who report smoking. It also crosses over to other populations, like the population of the AMC, where Aboriginal people are over-represented. There is a very high rate of smoking in that environment.

DR BOURKE: The contrast there is between, say, maybe five people in this room smoking as opposed to 30 people in this room smoking?

Mr O'Donoughue: Yes.

MR GENTLEMAN: Minister, page 94 of budget paper 4 states that the mental health and justice health and alcohol service works with community partners to

provide integrated and responsive care. Can you go through how important it is to work with those community partners and what support government provides for them?

Ms Gallagher: I might ask Tina to come back. I think this area of health—I do not want to offend anyone who works in other areas of health—is one of the most developed areas of health care across different sectors. That is my own unexpert view of looking at mental health justice, health, alcohol and drugs. I think that there is probably an historical basis to the fact that it has had to work that way, that you have seen a relatively high level of non-government services targeted to these very vulnerable populations. A lot of the care and support that is provided is provided outside of the public system. Also, I think they are a very well organised sector in terms of coordination of their peak message and having agreement on what the priorities are. That helps, I think, in working with government. Do you want to add to that, Tina?

Ms Bracher: From an operational perspective, we work very closely with the non-government sector in both the mental health arena and the alcohol and drug sector. The co-morbidities there mean that the two sectors, likewise, work very closely together, both public and community. Many of the newer initiatives are actually partnership arrangements with the community sector.

The step-up, step-down facilities have the care component provided by a non-government agency and the clinical component provided by our public mental health services. The youth and young adult step-up, step-down are a couple of examples of that. They work very successfully together. We have very well-defined flows of people between our acute and tertiary level public mental health services and the community mental health services.

In the alcohol and drug sector, we work very closely with ATODA—the Alcohol, Tobacco and Other Drug Association—which is the peak body for the community sector organisations in that environment, around coordinating the services, the flow between our withdrawal unit where we do the acute inpatient withdrawal and then the rehabilitation services which have very strong connections and referral paths—referral into our withdrawal unit and referral paths out.

When you look at the custodial environments, both Corrective Services and Health work very closely, likewise, with a through-care model between the acute higher end public sector services that we provide and then the ongoing care that people can access through community agencies.

THE CHAIR: On page 97 of budget paper 4, there is an accountability indicator in terms of the health checks at Bimberi.

Ms Gallagher: Yes. You are just wondering why it is 96 and not 100?

THE CHAIR: Yes.

Ms Gallagher: I looked at this too. It relates to small numbers. There were 70 out of 76 young people who were seen within the 24 hours, as I understand it, and the

difference is really about small numbers. Three young people were seen outside the 24-hour window, by 60 to 90 minutes. So it relates to very small numbers, and I think if you extended it to 25 hours, you would have seen a different result.

Ms Bracher: I have been asked the same question clinically. As you are aware, ensuring that the young people are well or, if they are not well, are receiving the appropriate health care in a custodial environment is very important. And for those three young people that missed the 24-hour mark, they were all seen within 25 hours through that year period. Yes, from an accountability indicator, there is a three per cent variance. However, the intent of those young people being seen within that statutory 24-hour period has actually been achieved.

THE CHAIR: What permanent staff from Health do you have at Bimberi?

Ms Gallagher: Nursing staff?

THE CHAIR: You have got the AMC setup, but what have you got at Bimberi?

Ms Bracher: We have permanent staff recruited to our justice health service, which provides services to both AMC and Bimberi. For Bimberi specifically, the clinical nurse consultant is across two sites. She provides an oversight into Bimberi. We have a registered nurse who works out there full time. We have enrolled nurses—that is an initiative this financial year—to support the medication management over a seven-day period. In previous years, the youth workers had done some of that under the legislation.

Within our forensic mental health service, the care of the mental health needs of the young people out there is provided, and I think there are two-point-something mental health workers that are permanently out there. They are also part of our forensic mental health service, in that they do provide some services in Bimberi and some services to the community.

THE CHAIR: We are still on mental health and, given the timing, I would suggest that we start on other matters when we reconvene.

MR SMYTH: Somebody put it to me that when the fit-out of the new facility at Canberra Hospital was done, some very expensive conference tables were purchased for use in the facility and they were quoting very strange numbers like tens of thousands of dollars worth of furniture. Did we purchase any very expensive conference tables for the—

Ms Bracher: For the adult mental health unit?

MR SMYTH: Yes.

Ms Bracher: In the high-dependency area there is a custom-made timber dining table. That has had to be custom made so that it was of a strength and calibre that would be safe in that environment. Yes, it was an expensive table.

MR SMYTH: How much did it cost?

Ms Bracher: I cannot answer that question, off the top of my head.

MR SMYTH: Take it on notice?

Ms Bracher: Yes.

THE CHAIR: Members, minister and officials, I would like to advise you that members of the Victorian Legislative Council's Environment and Planning Legislation Committee have arrived to observe our proceedings. It is almost standing room only. Our committees are very well attended here. This is just a normal day of committee proceedings. We are very popular. This reflects the number of Health officials. It is lovely to have you here. Thank you for attending. You are very welcome. We are close to lunch, but I might ask one more question.

There have been a number of methadone overdoses at the AMC, and I know that some procedures have changed in terms of how the methadone is administered. Can you give me an update in terms of how those changes have perhaps affected the potential for further overdoses?

Ms Bracher: Following the discussion in the Assembly about a year ago, I believe it was, we had a review of our procedures out there, and there were a number of recommendations that came from that, in the order of 15 to 20 recommendations. Some of them were significant recommendations for changing practice. Some of them were tweaks to improve what we were already doing. A third are completed, a third are being worked on. Two were not accepted as operationally viable in that environment.

We have changed our nursing roster. We now have two nursing staff do the methadone distribution in the AMC, not relying on a custodial officer. The custodial officer is still present for the security arrangements and to ensure that the people are observed following the dosing. We have separated methadone dosing from the other medications that people are provided with through the medication round. So we have quite clearly separated those so that the nursing staff can concentrate clearly on the methadone distribution at that point in time.

We are currently working with the general manager of the AMC around some satellite sites for dosing within the AMC. At the moment we move a trolley around through the AMC, and that has not only some workplace safety concerns but also concerns around medication management. So we are looking to set up sites in different places within the AMC, and that obviously has security arrangements associated with that. They are the three biggies, I think.

THE CHAIR: That is good. That gives me an idea. Thank you very much. Members, minister and officials, we will suspend for lunch. We will reconvene at 2 pm when we will move to output 1.3, public health services.

Ms Gallagher: Sorry, chair, does that mean you have finished with mental health, that output class, or are you wanting all the people to stay for the rest of—

THE CHAIR: We have probably finished. I will just check with members if mental health is finished.

Ms Gallagher: We will keep the hospital staff.

THE CHAIR: Yes, keep the hospital staff, because they always interact. We will catch up tonight if we have got any further questions in an out-of-session discussion. Thank you very much.

Sitting suspended from 12.59 until 2.02 pm.

THE CHAIR: Members, minister and officials, we will now recommence the hearing.

Dr Brown: Mr Hanson, do you mind if I read a couple of answers?

THE CHAIR: Thank you.

Dr Brown: The first is in relation to the percentage of mental health spending on community sector organisations. It is 14.3 per cent. The other is in relation to hepatitis C. The advice I have is that 11 patients have been assessed by the primary healthcare team in AMC to be suitable, and referred through to the shared care program with TCH gastroenterology unit. There are currently seven patients on treatment. There are 10 treatment positions available at any one time. Only seven currently are under treatment. So no-one is waiting for that assessment.

THE CHAIR: We will go to public health, output 1.3. Dr Bourke.

DR BOURKE: Minister, could you tell us about the recent assessment by the independent Australian Council on Healthcare Standards which rated the ACT with the highest level of accreditation, I understand.

Ms Gallagher: We have just got the final report through. This was some work that was done last year. It is conducted over a two-week period—

Dr Brown: One.

Ms Gallagher: A one-week period. A team of surveyors come through and assess every aspect of your health system. Subsequent to that you get immediate feedback on what they have seen and how they are considering assessing you. A period of months goes by before they submit their final reports. That has just come in, and we have been awarded the highest level that you can under that, with no conditions on it, and for a four-year period.

I went to the feedback session. The health system is reported against on a number of measures by a number of authorities; the numbers are growing. This is probably the most in-depth individual assessment that is done of almost every area. So over a period of a day you will have an assessor that works in a particular area. They will meet with staff. They will review policies, procedures, take consumer feedback, visit the areas, and they are experts in their field. I think we had one from China—Hong Kong—who was part of the surveying team. It is made up of experts from other

jurisdictions. Health performed exceptionally well. I do not know whether Dr Brown has been involved in them as well. We should, on that assessment alone, be very happy with the hard work that goes on in our healthcare system.

Dr Brown: There are 47 criteria which they assess us against. They have a rating system that goes from LA, which is low achievement, SA, satisfactory, MA, moderate, EA, extensive achievement, and OA, outstanding achievement. For the mandatory criteria, you have to get a minimum of an MA. There are a couple of criteria where you can get an SA and still get full accreditation. We got one outstanding achievement, 18 extensive achievements, and the rest were the MAs.

Considering that it is a whole-of-organisation survey, and we had 15 surveyors on site for a week, it was very thorough, and that was really an outstanding result.

DR BOURKE: Congratulations. Are you able to tell me a bit more about the criteria?

Dr Brown: Yes. The criteria cover a range of areas. They cover clinical criteria, so there are things looking at our assessment, our admission, our engagement with patients' discharge, looking at infection control, medication, diet, nutrition, through to things like support functions, quality improvement, risk management, incident management, and then corporate, looking at things like security and emergency management. There is a wide range. It looks at our research, our population health planning. It is very broad. It covers just about all aspects of the service.

DR BOURKE: You mentioned research. What sort of research work do you do?

Dr Brown: We do quite a lot of research across the service. Obviously we are also partnered with our academic partners, the ANU, University of Canberra and others. I am probably not the best person to answer this. Professor Bowden might be able to speak to this. We have researchers across medical, nursing and allied health disciplines, and some of the biomedical et cetera. There are a wide range of topics. Professor Bowden might tell us a bit more.

Prof Bowden: As Dr Brown said, the range of research that we do in the territory is very wide. If we were to look at areas of international excellence, we have got, in hepatitis C in particular, people working at the Canberra Hospital. The work of Geoff Farrell and Narci Teoh is certainly always attracting NHMRC grants to the tune of millions of dollars. The work that Geoff has done establishes him as one of the world leaders in hepatitis C.

Matthew Cook's work on immunology, looking at people with immune deficiency, is developing one of the best population-based studies of immune deficiency that exists, certainly in Australia. This will be extended through the collaboration with ANU. Public health work has occurred in a number of areas. For example, Walter Abhayaratna's work with heart failure has looked at a whole cohort of the ACT population over 10 years, following them from their 60s into their 70s and beyond, and looking at the changes in people's cardiac function over time. This is an internationally recognised piece of work.

The Research Centre for Nursing Practice was one of the reasons that ACT Health

received its outstanding performance assessment. The work that they have done in an area which in some areas would not be seen as particularly high profile, yet is so important, is the area of pressure injury, which causes so much harm to so many people in hospitals. This group have some extraordinary work now behind them. They are currently looking at, again, something which sounds not so important and yet is fundamental to what we do—the disturbance to patients in hospital. Why can't people sleep at night?

Dr Brown: Dr Kelly is a researcher, and is part of an NHMRC partnership and work at the moment. The quality and safety unit are working in partnership with academic institutions interstate around some of our safety indicators and clinical handover, for example, which is then being translated into tools for teaching our staff. Allied health have a very strong academic foundation to the work that they are doing. It really crosses pretty much the whole directorate.

DR BOURKE: Going back to that work on heart failure, what sort of findings are coming out of that work? It is a major killer in the community, especially for people sitting on this side of the table.

Prof Bowden: Absolutely. People focus upon the very exciting acute heart attack stuff—people going in and doing angioplasties. That is something which has taken cardiologists' interest for a long time. Yet the area of real importance in a whole-of-health-service, whole-of-population area is heart failure, because as people have a heart attack and then survive, as is now the rule, they are subsequently prone to the chronic disease of heart failure. It is about trying to map that, to measure what the risk factors are for its occurrence in the first place, what the best management for it is. That is something that this study looks at. It is only one small part of a larger whole-of-life study.

MR GENTLEMAN: Minister, in May this year the Health Protection Service responded to a major salmonella outbreak in the ACT. Can you advise the committee of what steps were taken to manage this outbreak?

Ms Gallagher: I will hand over to Dr Kelly to talk that through. It is an ongoing investigation.

Dr Kelly: Thank you for your question, Mr Gentleman. You are quite correct; a large outbreak of salmonella was uncovered on the Mother's Day weekend or shortly after that. One thought would be, to any mothers in the room, not to go out for lunch on Mother's Day. It seems like a dangerous occupation!

MR SMYTH: You are not suggesting they stay home and cook, are you?

Dr Kelly: No.

MR SMYTH: I would be shocked!

Dr Kelly: Be pampered by their loved ones, I think, Mr Smyth. To recap on what happened, we were first alerted to the outbreak on the Monday, when we got some information from the Calvary emergency department. The first point I would make

about our health system working together inside and outside the hospital is that it was a very rapid assessment made by a clinician in the emergency department that something was going on, and involved our staff at the Health Protection Service to sort that out. They were alerted to the fact that several people had come with a similar illness and had been at a particular restaurant.

Things rapidly progressed in the next 24 to 36 hours, whereby a large number of people turned up to both the Calvary emergency department and to the Canberra Hospital emergency department. With the actual figures, we ended up identifying 162 cases of gastro from this particular outbreak. Of those, 78 so far have been confirmed as salmonella infections, and exactly the same type of salmonella. So the others had eaten at the same restaurant and had the same symptoms. Even though they had not had a positive test, at least we are certain they were part of the same outbreak.

Of those 162, we had 26 presentations to the emergency department at Canberra Hospital; 14 of those were admitted. At the Calvary hospital 111 people presented over that couple of days period. Fifty-eight were managed in the short-stay unit and five were admitted to the wards for a longer period. This represents a major stress on the health services within the ACT. It demonstrates why we have to have such a strong prevention approach to this, so that these things will not happen again, and also an ability to respond.

The response that we had from the public health side of things, of course, was that people who were sick and turned up were treated clinically and assisted in that way. From our point of view, the restaurant concerned agreed to close voluntarily. We had our environmental health people out there looking to see what was going on. We made fairly quickly the assessment that there was an issue with a raw egg product—in this case the mayonnaise in the potato salad. Steps were taken with the restaurant concerned about that.

We also had our staff working on the outbreak. So each and every one of the 194 people who had been at that restaurant over the weekend were all interviewed by phone. So you can start to see the picture of the amount of work that was happening in the preventive services. We had up to 30 people working on this issue at the peak.

By Tuesday night, given the numbers of people presenting to the emergency departments, it was quite clear that this was an unusual event which was causing major stress to the clinical services. A few weeks before that we had, together with my colleague Ian Thompson, the CEO of Calvary hospital and the chair of the Medicare Local, announced our winter plan, which included a plan for surge capacity when the emergency departments were really at their peak of usage. So we had initiated that plan, and it worked very well. We called it a code brown, which is, in the parlance of the hospitals, nothing to do with the director-general or the fact that it was due to diarrhoea. An unusual coincidence!

Ms Gallagher: It is the national—

Dr Kelly: It is the national colour, not chosen by us. With that, it brought about extra coordination across the services in terms of what we could offer from the clinical perspective. It also took pressure off the clinicians and, indeed, our health protection

service staff that were dealing with the outbreak by coordinating the media response and information to the rest of government and also to the minister. There were a range of other measures whereby we could look to see how we could assist with the logistics. We were also in close communication with our colleagues in southern New South Wales. There is more I could say but I might leave it at that.

MR GENTLEMAN: When you have a large event such as that, at what point would you activate the health emergency control centre?

Dr Kelly: It is really on a case-by-case basis. To take this as an example, Calvary hospital had already contacted the clinical care director at the Canberra Hospital to say, "We're overrun. We want to divert the ambulances and we want you to take care of these issues." As it happened, the Canberra Hospital were having, I think, their second highest ever number of presentations. Most of them were not diarrhoea related to this outbreak, but for other reasons, it was an extremely busy day, and they felt they could not cope with any extra without taking on these other coordination proposals.

It was really on that basis that I was contacted. I said, "I think we should go ahead with the plans that we have made." As I say, it worked very well. It only went for 24 hours. The actual winter plan is more about influenza, and that would potentially go for days or weeks. But at least for that 24-hour period it worked very well.

MR GENTLEMAN: You mentioned that you found out about it on the Monday. What was the actual response time for health protection?

Dr Kelly: We were out there that same day to the restaurant concerned, and working closely. We had started our interviews with the patients to get more information on that day. It continued on with the 194 people that we interviewed. It took us some weeks to complete that task. But the actual immediate "stop the source" happened on the same day.

DR BOURKE: How did you track down 194 people?

Dr Kelly: Booking lists. This was a very popular restaurant. It had just opened and it was a big weekend. At least one member of the parties had a mobile phone. The tables were for up to 20 people. We would contact one, get the information about the other people, whether they were sick or well, and interview them sequentially.

DR BOURKE: And why the mayonnaise?

Dr Kelly: That was interesting. This particular type of salmonella, typhimurium type 170, is very much associated with eggs. And whilst most eggs are quite safe, every so often there is one that is not. So every time that raw egg is used by anyone, in our own homes, we take that risk with ourselves and our family. But in a business restaurant where this particular mayonnaise was being made in six-litre lots using up to 30 eggs at a time, you start to increase your risk of getting a bad egg, so to speak.

I have previously described this as Russian roulette, in fact. Eventually, you are going to get a bad egg, and if you serve raw egg products in your restaurant, then you are dicing with death. I think we have got to take that seriously, as a public health

authority, and we have been very strongly putting that information out to restaurants about that.

DR BOURKE: Is there anything you can do to protect yourself if you want to eat raw egg products?

Dr Kelly: No. Have cooked eggs. That would be the only safe way. There is one thing that restaurants and, in fact, individuals could do. There are pasteurised egg products around. They can be used. These are eggs that have undergone a procedure which makes them safer, not 100 per cent safe, than a raw egg product.

MR SMYTH: The business itself has assisted fully with the investigation?

Dr Kelly: They have, yes.

THE CHAIR: In budget paper 4, page 91, there is a strategic objective, and it has the amount of money allocated against public health as a percentage. And I note that although we are doing better than the national average, we have got a declining rate of expenditure on public health activities. Could you give an explanation why that is please?

Dr Brown: That is largely a reflection of a change in the commonwealth contribution—and we do have a paper on this that has got the specific dollars in it—but, in essence, my recollection is that the commonwealth has reduced their contribution in the order of $5 million, and the territory contribution has actually increased during that time. But the result is an overall reduction.

THE CHAIR: When did that commonwealth contribution start declining?

Dr Brown: I will have to find the detail of that, I am sorry. If Mr Foster was here, he would be able to tell me, but he is not. In 2007-08, it was 2.2 per cent. In 2008-09, it was two per cent, and in 2009-10, it was 1.6 per cent. Sorry, that is all. A drop in commonwealth public health expenditure of around $5 million has been mostly offset by an increase to $4 million in the ACT public health expenditure over that period.

THE CHAIR: Have you had any discussions with the federal health minister about this and an explanation as to why that funding has been reduced?

Ms Gallagher: Not specifically around public health activities. We have had lots and lots of discussions about health activity in general and commonwealth contributions for that. I would have to have a look at what some of these were and whether they were time-specific programs that were funded for a period. I would have to take that on notice.

THE CHAIR: We all talk about the need to focus the health system on other than just the acute end, but then we see statistics like this that actually indicate that there is a reasonably significant decline in terms of expenditure. What does that mean on the ground? Have programs had to be cut or reduced as a result of a reduced percentage or have they stayed static while the rest of the system has grown?

Dr Kelly: Those figures that are in the budget papers are based on a report called *Health expenditure 2010-11* by the Australian Institute of Health and Welfare's public health expenditure project. They actually stopped doing that work in 2011. The AIHW is not producing that report, and part of it is because of the contentiousness of how those figures are arrived at. There are some particular issues here within the ACT, given our two-tier government responsibilities in public health. I would always be an advocate, as you would imagine, for increased funding for public health, but I think some of these figures need to be seen within that context of uncertainty about the actual numbers. In terms of your actual question about have things been stopped, they have not.

THE CHAIR: It is just the percentages are not as big as they could have been.

Dr Kelly: The other aspect is, of course, as a percentage it could, indeed, reflect an increase in the amount of money that is going to clinical services, for example, which is how it is here and mostly, I imagine, the same in other jurisdictions.

Dr Brown: But as I indicated, there has been an increase in territory contribution to public health over that time as well.

THE CHAIR: I wonder whether you can give me an update on the GP development fund. Is that still rolling out or has that ceased?

Ms Gallagher: It has got a number of different components. Our commitment, which we have talked about in previous budgets, was through the infrastructure fund. Then we have got the support for general practices taking on students. Then we have got the student placement subsidy, the trainee scholarships, the development fund, the GP aged day care service and GP PPP program. All of those are continuing. But I would say that we are looking at this program and how best we are going forward, particularly in the area of infrastructure.

A lot of money has gone out the door already. I think we have had four rounds, it might be five rounds, going out to 33 different projects. I think going forward we just want to make sure that the money that we were using in infrastructure is going to where we need it to go, because a number of practices have got what they wanted, and I just do not want to see this going on in perpetuity, with us continuing to spruce up GP surgeries that have benefited already from the fund.

But I have flagged working with the Medicare Local around that. They agree that we should be looking at this part of the GP initiatives and targeting it to make sure that it is money well spent. For example, they have come up with an idea about a fit-out for the early morning drop-in centre at Pilgrim House, which does the breakfast program, looking at how we could do something there that would enable general practice to go in there and provide a service. So they are the sorts of areas where I think we should head now.

In terms of the other parts of the program, scholarships is another one we are just having a look at. The Peter Sharp scholarship component, which we awarded to the first scholar yesterday, I think, will keep going. As to the other ones where we have had trouble making them work for students because of the taxation arrangements and

trying to make them indentured workers, basically tie them to the territory, there are some issues there.

But the training payment, which used to be called the teaching incentive payment but is now called the student placement subsidy, will be ongoing. The GPH day care service will be ongoing in our community and GP PPP as well.

THE CHAIR: Did you see the article in the *Canberra Times* this morning?

Ms Gallagher: Yes.

THE CHAIR: Have you got any views on that?

Ms Gallagher: This is, I think, the second time this data has been reported.

THE CHAIR: Is it the same data or is it updated?

Ms Gallagher: No, it is updated. There has been a slight change. I think it was the same in the first year where it indicated that people had put off visiting GPs because of cost.

THE CHAIR: Thirteen per cent of adults in the territory put off seeing a GP.

Ms Gallagher: Yes, and it shows that our hospitals are certainly well utilised. It confirms, I think, what we know is happening. Our capacity to deal with the cost issue is very limited. I do not think there is anything the ACT government can do on that. We cannot require GPs to bulk-bill. The commonwealth cannot require them to bulk-bill. We have seen a slight improvement, I think less than one per cent, in the GP bulk-billing rates in the last data I saw.

THE CHAIR: You do not think there is a supply and demand issue here because we increased the number of doctors per capita but—

Ms Gallagher: There is an argument around that. I have not seen the Medicare Local report yet. I hear that it is almost finished. We have funded them to do a piece of work, essentially to update the work that was done through the GP task force. Anecdotally, we have seen GPs advertising for patients. We know that the majority of them have their books open now. We have seen new clinics start. So based on what we can see physically, the situation has changed but this work is to make sure that we are updating it with the most relevant information. I have not seen that yet.

THE CHAIR: Just getting back to the task force, I think there were 29 recommendations out of that body of work.

Dr Brown: I cannot recall the exact number.

Ms Gallagher: We have had so many reports since then with, 64 or 65 recommendations here and 20—

THE CHAIR: Sixty-nine in one. I was wrong by four, but I think there was an

inquiry by the health committee that had 30 recommendations and then the task force had 29.

Ms Gallagher: Of those 59, how many have we implemented?

Dr Brown: We would have to take that on notice.

Ms Gallagher: Yes.

THE CHAIR: If you could provide to the committee an update on the directorate's progress in meeting the recommendations of both the health committee's inquiry into primary health and the task force as well, that would be great.

Ms Gallagher: Yes.

DR BOURKE: Minister, you mentioned the Peter Sharp scholarship. I believe you presented the inaugural award yesterday.

Ms Gallagher: Yes.

DR BOURKE: Could you outline for the committee the purpose of these scholarships?

Ms Gallagher: Dr Pete as he was known—and I think all of us knew him as that—was a general practitioner who specialised in Indigenous health at Winnunga Nimmityjah. Unfortunately, he passed on from cancer a little while ago. In memory of this doctor and, I think, the fondness for him for his contribution to health in general, public health and Indigenous health, we established the Peter Sharp scholarship program.

It has a couple of different components. One is to support cultural experiences. People go to workshops and different training environments around Indigenous health. It also has the Peter Sharp scholar who, in this case, is a young woman from ANU Medical School who is in her first year of medicine. She is actually a qualified physiotherapist who wants to work in rural health and believes that she will be more useful if she has a combined physio-medical degree. She has returned to university to do that. Ms Danielle Dries her name is. She is a very impressive young woman. I think Dr Pete would be very happy to have her as the first scholar under his program.

DR BOURKE: And what is the financial commitment to the program?

Ms Gallagher: It is $100,000 all—

Dr Brown: It is $18,000—

Ms Gallagher: The scholar program is $18,000 per year to the medical student but then there are a couple of different components to the program. So it is $100,000 a year for the program entirely.

Dr Brown: That has got three components. There is the Indigenous health stream

placement scholarships supporting students, then there are some recruitment initiatives and then there is the actual Peter Sharp scholarship which is an $18,000 stipend per annum for four years.

THE CHAIR: While we are talking about medical students, there has been an issue raised by the Medical Students Association with regard to students essentially being—if they do not put the ACT as first preference, essentially they are not guaranteed a spot in the ACT and so on. Can you give me an update on that—on your progress with discussions and whether there is any flexibility? I believe that there is a national system starting shortly that would resolve that issue.

Ms Gallagher: Hopefully. I think there is agreement that a national allocation strategy should be resolved, but there is not one in place for next year so we have made some changes to ours. I am very supportive of them. People put a lot of work into making sure that the system is fair and reasonable. I have also met with the national students—AMSA, I think they are, the Medical Students Association. I would say that my reading of this is that it is a campaign that is being run nationally, not necessarily locally. I listened to them, but we have not made any changes based on their concerns.

I think we are going to see pressure around this area, which is why a national allocation protocol would be good. For the first time in many years, there are more medical students graduating than necessarily jobs in hospitals. So the balance has shifted to the employer, as opposed to the student, and it is taking some time for some students to adjust to that. But I think that from us here the message is that we have ramped up our training places by 25 a year, which comes at incredible cost, not only financially but also in terms of demands that are placed on existing staff for training and support for those students. We think that Canberra should not be seen as a hardship posting. It should not be where you go after you have applied in other places.

THE CHAIR: I take it, as well, that there were a number of people who had indicated that they were going to take up an internship but then did not because they took up an offer somewhere else.

Ms Gallagher: Yes.

THE CHAIR: How many was that, and were those internships then left vacant?

Ms Gallagher: We were 20 short, were we not, at the beginning—

Prof Bowden: Every year where we have guaranteed a position to ANU graduates, they have taken that position, because we have been the only jurisdiction that says, "You will definitely have a position in this hospital." So the students like to work in Canberra. But those who have come from interstate would like to go back home. I can understand that and we are very sympathetic to that position. However, by doing that, you then create a situation where the student is guaranteed a job, signs a contract and then, as soon as they are offered the position that they want interstate, they take it and leave ACT in the lurch.

Because we have not been in a position to really set the market conditions before, we

have just had to wear that. This year, we knew that it was going to be incredibly difficult for them to get jobs interstate, but we would still find ourselves in a position where, in September, October or November, we would lose students who had already signed their contracts, so we would not know what the training program was going to look like and we would not know what the rosters would look like, which is what happened to us this year and the year before. So we said, "You have to commit to the ACT to be guaranteed a position."

The other group that we really wanted to look after—because, in the past, we have disadvantaged this group—is the ACT residents or those who completed their year 12 in the ACT and then applied and were successful in getting a medical position interstate. Each year we know that we have had a number of them who have applied to us in our June round and we have said, "I'm sorry; we're full." They have applied elsewhere and accepted a job and honoured that position. Then when we come back to them in October, November or December, they say: "Oh, look, I've taken this other job. I'm going to move." That is where we are. So we have lost those people who have a very good reason for coming to the ACT.

This year we said that number one would be those who put themselves down only for the ACT. The second group was to honour our commitments to the region and to make sure that we can, for the foreseeable future, ensure that we can send our interns to Goulburn and to Bega. So an arrangement was made with New South Wales to guarantee them five positions for their graduates. Then we would look at the ACT returners, and then the ANU students who had applied elsewhere would be category 4. The applications have now closed. The figures are that 76 ANU students only applied to the ACT, so they are locked in now. We can guarantee 76—

THE CHAIR: Of how many? About 90?

Prof Bowden: Out of 96.

THE CHAIR: That is good.

Prof Bowden: Eighteen students have applied elsewhere. We have 14 students who are ACT year 12s who have applied back to us. That takes us to 90.

Ms Gallagher: We do not do undergraduate, so they have gone and done their undergraduate degrees.

Prof Bowden: Although some of them would be Sydney.

Ms Gallagher: Yes.

Prof Bowden: It is not just the undergrads, because not everybody who applies to ANU—

THE CHAIR: No. I had a constituent in that space who left the ACT, went to Newcastle, got qualified and then could not get an internship.

Ms Gallagher: Yes.

THE CHAIR: And that was resolved.

Prof Bowden: We have now guaranteed those people a position. Experience tells us that almost all of those will take up their place. We have still got six positions. The five New South Wales people will be taken up within that, because six of those 14 ACT returners are from the New South Wales university, which gives us six positions to offer to the ACT students who just put us down at one. It is actually the best outcome that we could have possibly hoped for.

THE CHAIR: Yes. What about the foreign students at ANU? Have they been guaranteed a place? Where do they fit in?

Prof Bowden: This includes the full fee paying students.

THE CHAIR: So they are guaranteed as part of that 76?

Prof Bowden: That is correct, in line with Victoria and WA.

Dr Brown: And I think Tasmania.

THE CHAIR: How many of that 76 are foreign students?

Prof Bowden: That would be eight. No; I am sorry. I will take that on notice.

Dr Brown: That is assuming they only applied to the ANU.

Prof Bowden: That is right, and I have not actually got confirmation of that yet. I will take that on notice.

THE CHAIR: How many of those foreign students—it might be too early to tell—who go and do an internship in the Canberra Hospital end up becoming Australians and staying in the ACT? Is there a percentage doing that or a bunch of them going—

Prof Bowden: The figure across Australia is that between 15 and 20 per cent of the graduates from Australian medical schools are international full fee paying students, and approximately 50 per cent of those over the last 10 years have remained in Australia after their internship. The important thing to remember is that the Health Workforce Australia data, which has been modelling the future workforce needs within the medical field, factors in those full fee paying international students. So if we are going to be self-sufficient in 2025, we are working on figures that include that group. Therefore, as a nation, we have got to make sure that that group continues to be able to have positions.

Dr Brown: Because certainly at the moment—just to add to that—we do bring in overseas trained doctors all of the time, just to meet the workforce requirements. They are people who are trained in overseas universities, and we do not necessarily know the quality of their training. The opportunity with this cohort is that they are Australian trained.

THE CHAIR: Yes, absolutely. I am just going on discussions with the students and the dean: it was going to make it difficult for them to attract foreign students if they were not able to guarantee further employment and full qualifications. I am not being critical; I am just inquiring.

Dr Brown: It is an ongoing piece of work that AHMAC is looking at in terms of how we can appropriately provide for the international full fee paying students to take up their internships and junior years here in Australia.

THE CHAIR: Do you have a supplementary?

DR BOURKE: I do. What do the places cost? You mentioned they were expensive. How much?

Ms Gallagher: A training place?

DR BOURKE: Yes.

Ms Gallagher: A clinical placement?

Prof Bowden: Do you mean for the full fee payers?

DR BOURKE: Why is there a different price? Why would there be different prices? Isn't it the same intern training place that you are offering?

Prof Bowden: For intern training?

DR BOURKE: Yes.

Mr Thompson: Within the hospital, an intern place, with on-costs included, costs about $90,000 a year. Obviously, from the perspective of the territory, we have invested a substantial amount of money in expanding that in line with the numbers that Dr Brown was referring to earlier. This is about ensuring that we get best value out of that investment.

DR BOURKE: That includes their salary component?

Mr Thompson: Yes.

THE CHAIR: We are now in the position where we can either move to cancer services or continue. I do not know if you have any more questions in this area, Dr Bourke, or members?

DR BOURKE: I want to ask about tobacco. Minister, you released the government's future direction on tobacco strategy on 31 May. Could you advise the committee on the next steps with the initiatives canvassed in that strategy?

THE CHAIR: This falls within prevention, output 1.6, I think.

DR BOURKE: Really?

THE CHAIR: I am happy to let it go, but we probably—

DR BOURKE: Okay.

THE CHAIR: We can do this now if you want, but probably—

Ms Gallagher: I am in your hands.

DR BOURKE: Well, it is out of the bag.

THE CHAIR: It is out of the bag? It is too late? It is gone. There you go.

Ms Gallagher: So you want me to answer that?

THE CHAIR: Yes, we will have an answer.

DR BOURKE: Yes, let us have an answer.

Ms Gallagher: We released *Future directions for tobacco reduction in the ACT* on World No Tobacco Day. This was very much about providing information about where we go from here, following the changes we made in the last Assembly. We have done a lot—all governments since self-government here in the ACT have done a lot—around tobacco control. The strategy scopes a rough timetable for implementing those different measures, whether it is around the front of buildings, playgrounds or something else. We have got a lot of discussions to have around correctional facilities. That is in there, but we understand that is a hard one and we need to be careful with how we progress that.

So we have released that, and now people will be providing us with feedback through that. Obviously the public health groups are very supportive of the steps that we have outlined in that strategy, and I think that now it is over to doing it bit by bit. We will be consultative and all the rest of it as we progress.

DR BOURKE: You mentioned corrections. New Zealand has had a smoking ban in their prisons for, I think, some years now. Has there been much consultation on what the New Zealand experience is?

Ms Gallagher: There would be, as part of any progression of this. We did look at it when the AMC was being built—about whether it was a smoke-free environment, and it was not. The decision was taken at the time that it was not. I note there are comments about it being legal to smoke, that people are held in this environment and they cannot go anywhere else. That closed environment argument comes back. But I think the issue for governments is that it is also a workplace and we have responsibilities to staff as well. People individually may wish to smoke, but there are OHS requirements that governments need to take seriously.

We have been through this when we looked at the adult acute mental health unit where we have moved to a smoke-free environment. That did not happen easily and it did not happen without a lot of thought going into how to implement it. It has gone

pretty well. I am still getting the odd feedback from people, primarily carers of people who use the adult acute mental health unit from time to time, who are still concerned about it. I have certainly not been inundated, by any means, with concerns. In fact, feedback from staff has been very positive. I think the issues we saw in the mental health area are going to be similar to the ones that we would see in the jail. Again, we need to go carefully and we need to consult with the prisoners and the staff. There is a process to go through.

THE CHAIR: Do you not see the contradiction that, on the one hand, you are trying to facilitate people injecting heroin in the jail but, on the other hand, you are banning or attempting to ban the use of tobacco, which remains a legal product?

Ms Gallagher: I think the issue really comes down to the harmful effects of second-hand tobacco smoke, doesn't it? This is around protecting people who choose not to engage in a particular activity but are exposed to it. There is well-documented evidence that being exposed to it potentially puts you at risk of serious illness, potentially death. It is an easy public line to run and it sounds snappy to say, "She wants to give them needles, but she's going to ban smokes," but the issue for the government is primarily one around occupational health and safety.

THE CHAIR: But we have got legislation, for example, that within clubs and pubs there are designated outdoor smoking areas. Based on your legislation, the government is reasonably comfortable that, as long as there is an area whereby essentially smokers are amongst smokers, it is fine.

Ms Gallagher: That is right, and it took a long time to negotiate that around agreements being reached about staff not having to go into those areas and remove glasses and about no food being served and entertainment not being provided, which would therefore require those people who do not choose to smoke having to go out and clean up those areas. There is always potential for those arrangements. How that would practically work in a correctional setting would be something you would have to look at closely.

THE CHAIR: There is a lot of outdoor space at the AMC. I would have thought that there would be designated areas that you would have where people could smoke; certainly not within the buildings, but externally. There are a lot of times of the day when people are able to go out. You could have an area where they were able to smoke.

DR BOURKE: Yes, but the AMC is not the only correctional facility. There is also the transitional release centre. There is the weekend detention centre and a range of other facilities.

Ms Gallagher: The purpose of raising it in this strategy is, I think, to even be able to have the discussion. I know there are strong views around this. It is not going to be something where we just come in and ban smoking in the jail. That is not what we are doing here. But on World No Tobacco Day, with all the evidence before us, I think it was reasonable to point out those areas where we want to do further work about reducing exposure to tobacco and trying to encourage people to give up tobacco. One of the things we use in Health is nicotine replacement therapy as an alternative to

smoking. From doing nothing to a ban, there is a whole range of things that can happen in between and all of that is on the table.

DR BOURKE: How did you go with smoking in cars last year?

Ms Gallagher: How did I personally—

DR BOURKE: Not you. You made some announcements around smoking in cars last year.

Ms Gallagher: Yes, that has started. That is in place now in the Assembly.

DR BOURKE: Have you had any community feedback about that—positive, negative?

Ms Gallagher: No. I would say that we are in line with other jurisdictions. I think the Northern Territory is the only jurisdiction that does not have that law in place now. That has changed considerably over—

THE CHAIR: Has anybody been prosecuted under that law?

Ms Gallagher: Yes, there have been five infringement notices in the first six months. The police have always maintained that it would probably be an infringement notice if they pulled someone over. They were not going to be smoking police. They would pull over and if they came across this behaviour then the infringement notice would apply. I am not certain about the circumstances of those. Similar to seatbelt wearing, it is sending the message that is the important part.

THE CHAIR: Mr Gentleman.

MR GENTLEMAN: Minister, the budget includes $1.2 million to cover the growth in cancer outpatient services in 2013-14. What would these funds be used for?

Ms Gallagher: We touched on it briefly during the discussion on ED diversion. I think more and more services are being tailored to a modern way of delivering health care, which is that it is not all done as an inpatient; more and more the demand is going to need to focus on people going to the hospital for an appointment and the wraparound services, which is what the integrated cancer centre provides us the opportunity to do. This allows for additional outpatient services; essentially, the recruitment of further staff—five nurses, one medical officer, two allied health workers and an admin position—within that 1.2 million.

MR GENTLEMAN: What was the last position? It was allied?

Ms Gallagher: It is an admin position to—

MR GENTLEMAN: An admin position.

Ms Gallagher: Yes, to help.

THE CHAIR: Mr Smyth.

MR SMYTH: Minister, page 87, budget paper 4, strategic objective 3. The urgent radiotherapy services for cancer sufferers—the target was 100 per cent, you got 100 per cent and your target next year is 100 per cent. The semi-urgent—the target was 95 but you achieved 100 per cent. So well done there. Why have we back-pedalled and just set the target again at 95 per cent? And the same for non-urgent—the target was 95, you got 98 and you have re-set the target at 95, even though the long-term target is also 100 per cent.

Dr Brown: I think we are perhaps being unduly conservative in terms of that. That achievement in the semi-urgent and non-urgent, from memory, is significantly different to a couple of years ago. From memory, I think the semi-urgents were somewhere in the mid-50s to 60s a couple of years ago. Whilst it is a great achievement in the last 12 months, I think we just want to see consolidation of that before we commit ourselves to an even higher bar.

MR SMYTH: But in the 2012-13 budget, the outcome for 2011-12 was 99.8 per cent in semi-urgent and 99.2 per cent in non-urgent. You have done it consistently now for a couple of years.

Dr Brown: For two years.

MR SMYTH: Your long-term target is 100 per cent. You would almost appear to be there. Why not set yourself the target?

Dr Brown: It is a fair question, and next year we might take that step, Mr Smyth, particularly if we know you have got your eye on the figures.

MR SMYTH: I always have my eye on the figures. Why would you not set it at that target if you are there now? And if we are not able to maintain it at those levels, given what we are talking about, what needs to be done to keep it at that level?

Dr Brown: I think if we go back a couple of years when we were certainly much lower, that was an issue around being able to fully recruit to some of the radiation therapist positions. We struggled to actually recruit to the positions, and our results were much lower. We have probably come out of that era and just maintained our degree of conservatism. But I agree with you in terms of having achieved that and being able to maintain it; it probably is time in the next round to look at upping the bar.

MR SMYTH: If you look at page 95, the budget has gone from 64 million to 70 million for the coming year. To increase your budget by 10 per cent and then set yourself a lower target seems counter-intuitive.

Ms Gallagher: Which figure are you looking at now?

MR SMYTH: Page 95, cancer services, the actual budget.

Dr Brown: Some of that is indexation, of course.

MR SMYTH: Some of that is indexation, of course, but surely not 10 per cent.

Ms Gallagher: And not all of it is radiotherapy.

Mr Thompson: Equally, of course, the other factor is that outpatient services, for example, grew by eight per cent last financial year and are projecting to grow by 11 per cent this year. One of the factors that always has to be borne in mind in this area is that growth in cancer services is in fact very high and one of the highest areas. While we are investing in developing a new cancer centre, it is an area where, particularly with some of the challenges that we experienced around recruitment of radiation therapists, it is difficult to guarantee that we will be able to meet those 100 per cent targets.

MR SMYTH: Back to page 87, there is a note attached that says that with the introduction of a fourth linear accelerator and improved staffing levels this service has been able to better target wait times. What percentage of time is a linear accelerator normally available?

Dr Brown: Currently they work standard business hours, nine to five, except where we have increased demand when we extend the hours and operate longer hours each day.

MR SMYTH: In a mechanical sense, are they operational 100 per cent of the time when required? What is the down time required for routine servicing?

Dr Brown: I do not have the answer to that. I am not sure whether Denise has the answer to that or we would have to take it on notice.

Ms Gallagher: The four lin accs give us the capacity to manage demand if one is out, for example, from time to time. They do break down, and they do require specialised—

MR SMYTH: Servicing.

Ms Gallagher: Yes.

Dr Brown: Just in terms of the changeover between patients, you are also referring to in terms of how much are they operating versus—

MR SMYTH: Yes.

Dr Brown: taking that one out and—

MR SMYTH: When they are required to be used, what percentage of the time are they able to be used?

Dr Brown: We will take it on notice as to what you are actually asking.

THE CHAIR: I have a supplementary. I can because I am the chair. I have a

constituent who has got thyroid cancer who said that he had been advised his treatment was going to be delayed because TCH has a couple of lead-lined rooms where the treatment is done and only one is in operation. Can you explain what that might mean?

Mr Thompson: The treatment is with a radioactive isotope of iodine, iodine 131. When patients are receiving that treatment they themselves become radioactive and need to be isolated. We had a situation with one of the isolation rooms that there was a leak from some of the piping. It needed to be rectified. No-one was put at risk as a result of that leak but we did need to fix it. We did fix it and the room is now functioning again.

THE CHAIR: How long was it offline?

Dr Brown: It was relatively short. It was a matter of a couple of weeks, wasn't it?

Mr Thompson: Yes, I do not have the—

Dr Brown: Two weeks?

Mr Thompson: We will give you the specific information.

THE CHAIR: Yes, and when you provide the specifics of that if you could outline how many patients have had their treatment delayed and by what period, that would be good. I turn to budget paper 4, page 98, the number of breast screens for women. This seems to be a bit of an ongoing issue.

Dr Brown: The issue at the moment is that we cannot drum up enough business to actually fill all the available slots. We are taking very active steps to try and promote the availability of this service for women. We send out direct reminder letters. We have been liaising with referrers to advise them. We have been developing community-based education. We have done some advertising and media. We have looked at our promotional resource materials and updated those. We have contacted lapsed attendees. We have sent letters to GPs. We have had television and radio interviews. We have been out to women's gyms and government departments. We have targeted particular groups like Aboriginal and Torres Strait Islander women and culturally and linguistically diverse women. We have developed visual branding to try to promote that. There is a wide range of things that we have done to actually promote the availability of this service and try to increase the participation.

THE CHAIR: Good luck with it.

Dr Brown: Thank you.

DR BOURKE: So that is dependent upon the referring GP?

Ms Gallagher: No.

Dr Brown: We do not even need GPs to actually refer in. Women are able to present without—

Ms Gallagher: It is a well women's service.

Dr Brown: But we have slots going vacant.

DR BOURKE: Minister, can you update the committee on the progress of the Capital Region Cancer Centre?

Ms Gallagher: Yes, that is due for commissioning later this year—I think, in October. It is a centre that is being funded jointly by the commonwealth and the ACT. The commonwealth provided $27 million or $28 million. I think the total budget is $44 million now. Anyone who has visited the hospital will have seen the building emerging from the ground. We are looking forward, and I am sure everyone working in cancer services at the moment is much looking forward, to moving into some new premises.

The location of it was constrained by the fact that we have got the linear accelerator, the bunkers, built on that part of the campus. It is very close to where radio oncology is now. It will move into a state-of-the-art building towards the end of this year, I think. What we will have is medical oncology, chemotherapy, clinical haematology and immunology and specialist ambulatory services provided from that new centre.

DR BOURKE: It will be primarily cancer treatment rather than cancer support services?

Ms Gallagher: Yes, but we have worked with a lot of the non-government organisations around the design of the building and how it is to function. They are very much key partners in it.

MR GENTLEMAN: The key infrastructure component of that, of course, is the linear accelerator?

Ms Gallagher: No, that was done separately. If you put those two projects together, the bunkers were in the order of $30 million, if I remember correctly. When you put that with this new building, it is a much bigger project—$70 million-odd.

DR BOURKE: There was a commonwealth component to that?

Ms Gallagher: Yes, but not in the radiation oncology. It was $17 million for the bunker. I was sure it was more than that.

THE CHAIR: You are not by any chance inflating figures, are you, minister?

MR GENTLEMAN: Minister, what is the government's objective with the establishment of the centenary cancer chair, which has been funded in this budget?

Ms Gallagher: This is really a health initiative but hopefully it will cross into supporting the work of the clinical staff in the capital region cancer service. This is a partnership with ANU, with the John Curtin School of Medical Research. They put a proposal to the government about wanting to secure a chair in cancer research for the

John Curtin school. ANU would put in significant ongoing resources—the costs of establishing this chair—if we would consider giving them some start-up funding.

Our commitment is capped at $1.5 million payable over three financial years. That is really to support the recruitment, the establishment of a world-leading expert in cancer research and the ability to put a team around them at the John Curtin school with the capacity for whatever research that chair undertakes to be accessed by the capital region cancer service. It crosses nicely with the higher education medical research cancer centre of excellence that is being established.

MR SMYTH: I am not sure if we covered this earlier. For the enhanced cancer outpatient services you have got funding here of $4.7 million. But your election promise was $17 million over the forward estimates. Is there a reason for the missing $12 million?

Ms Gallagher: This is the first year of delivery of that commitment. You will see it against a range of others, even elective surgery. I think the commitment was for $80 million and we have funded $33 million in this budget. This is the first year's funding of that initiative.

MR SMYTH: But your promise for enhanced cancer outpatient services was $17 million in total.

Ms Gallagher: Yes, over four years.

MR SMYTH: Over four years.

MS GALLAGHER: Yes, so this is the first year. What you see is the first year's component of that.

MR SMYTH: Why in the outyears aren't the amounts totalling 17?

Ms Gallagher: Because next year we will allocate the growth funding in health along the lines that are outlined in the election commitment.

MR SMYTH: You are expecting the growth funding over three years to total $12 million?

Ms Gallagher: Sorry?

MR SMYTH: You are expecting the growth funding over and above what you have got there—

Ms Gallagher: The cumulative growth funding, yes.

MR SMYTH: to be $12 million?

Ms Gallagher: Yes, and I think you will see that against a number of health election commitments.

MR SMYTH: If you have those numbers, why would you not just put them in now?

Ms Gallagher: The custom and practice have been, and the approach I have taken to budgeting in health has been, to allocate the growth funding each year. That is what we will do.

MR SMYTH: But your election promise did not say that it was growth funding. It said you would put $17.1 million over—

Ms Gallagher: No, the election commitment was around the allocation. We were very clear in our costings to Treasury that this was coming out of the—

MR SMYTH: But you had taken from the growth funding $17 million.

Ms Gallagher: health funding gross growth envelope.

MR SMYTH: Why would you not put it in the document?

Ms Gallagher: It is a decision we have taken at the budget table that we will allocate year by year. That is what you will see in Health. You could run the same argument about elective surgery. You could ask me, "Your elective surgery commitment was $80 million and—

MR SMYTH: But there are a number—

Ms Gallagher: you have only allocated $33 million of that." I would give the same answer. Yes, and next year we will do the second year of that commitment, then the third year of that commitment and then the fourth year. By the time we get to the fourth year there would be the full allocation of that.

MR SMYTH: If this is a general thing that cabinet has decided, in some of your commitments—it is here in cancer, it is in tourism where there is one year's funding—you know what you have committed. You are either going to keep your promises or not.

Ms Gallagher: We are going to keep our promises, but we are going to deliver them—

MR SMYTH: So why not put it in the document?

Ms Gallagher: We are going to allocate them year by year. Next year, for example, in cancer outpatients, we may have a particular priority about where the next funding allocation goes within outpatients based on what we have seen and learnt through the redesign and the enhancement of cancer outpatients this year. Based on that, we will then prioritise the funding within that. I think that is entirely reasonable.

MR SMYTH: Where would we find the other $12 million in the budget papers?

Ms Gallagher: You will not find it. It has not been allocated.

MR SMYTH: Is this simply done by cabinet so as not to have all the funding in the outyears so that, for instance, in the—

Ms Gallagher: No, but—

MR SMYTH: fourth year you miraculously get a surplus.

Ms Gallagher: Actually, no, because the health funding is allocated through the allocation we make for health in the—

MR SMYTH: But I just asked you: where is it in the papers?

Ms Gallagher: Ron?

MR SMYTH: You have come back just at the right time, Mr Foster, as always.

Mr Foster: If you go to the appropriation tables, BP4, page 100, you will see there are budget amounts across the top and then what we are allocating. So built into the forward estimates is all of the health growth envelope growing each year. We add a new outyear, there is a new figure, and then there is indexation provided on that. In announcing these initiatives, the growth initiatives, if you look down that table, you will see we have an offset line where we take them out again, because they are already in those top lines. So this is the way we present it and have been presenting it for quite a few years, to show the decisions or announcements for that year, what is going to start, show them there, and have the offset line. So all of the health growth envelope is built into the forward estimates for Health.

MR SMYTH: In which line does the $12 million that will appear in outyears appear?

Mr Foster: It will not be one line with $12 million. It is in the top line, in the GPO line, the top starting point.

THE CHAIR: Minister, by way of a supplementary, while we are talking about measures that were announced and then looking for them in the budget, the Calvary hospital birth centre—

Ms Gallagher: Yes, that is in the budget.

THE CHAIR: Can you point that out to me, please?

Ms Gallagher: It is in the new capital.

THE CHAIR: In which budget paper?

Ms Gallagher: Budget paper 4, page 105, I think.

Mr Foster: It is included on 101.

Ms Gallagher: That is right; 101, sorry.

THE CHAIR: Page 101?

Ms Gallagher: Yes, on 101, "continuity of health services plan—essential infrastructure", within that $3,850,000.

THE CHAIR: So there is now an amount of $850,000 that has gone in?

Ms Gallagher: Yes.

Mr Foster: $850,000.

Ms Gallagher: Also within that will be the beds—

Mr Foster: Yes, $3 million to provide for the eight rapid assessment beds.

Ms Gallagher: Yes.

DR BOURKE: How is that birth centre coming along?

Ms Gallagher: We will wait for the money to be appropriated, so it is in the budget. It is a fairly straightforward refit of space already existing within Calvary hospital. It will be modifying a number of rooms into two birthing suites.

THE CHAIR: While we are talking about birthing, has the review of maternity services started?

Dr Brown: Yes, I believe we have the reviewers on board. We went to Women's Hospitals Australasia to seek appropriate reviewers. We have an obstetrician, a midwife and a consumer representative. They have commenced their work; that is my understanding. Our expectation is that we should have that concluded by the end of September.

THE CHAIR: Is there any reason for the delay? Previous statements were that this would be completed by the end of June.

Mr Thompson: It was on the advice of the reviewers. We approached them, requesting that they do it by the end of June. Their advice was that, given the terms of reference, they believed that they needed to take longer, and we accepted that advice.

THE CHAIR: How many reviews are being conducted? There were a couple, weren't there?

Dr Brown: There is a review in relation to the demand and the model of care, and in addition to that there is a commitment around a feasibility study for a stand-alone birth centre, which is part of the parliamentary agreement. Our intention is to seek, as a preliminary step, the advice of these reviewers in relation to a stand-alone birth centre.

THE CHAIR: Minister, you have been very clear about the fact that you do not support a stand-alone birth centre, but you have now commissioned a review to do it.

Ms Gallagher: It is forming part of some work that is being done for us, yes. But you will notice I did not agree to a $300,000 feasibility study into a north side birth centre; I agreed to a feasibility study. I indicated to Mr Rattenbury at the time that I did not believe that the advice back would indicate that a north side or stand-alone birth centre would provide a safe model of care within the context of how our maternity services are delivered here. He remains unconvinced. His view is that he wants to have a look at it further, so we have reached agreement on that, and that will form some of the advice that comes back.

THE CHAIR: But your view remains that that is not a good way to proceed?

Ms Gallagher: That is the advice to me from people who practise in this area. Again, if you listen to those who represent private midwives, they will argue very strongly that it is a model that should be looked at and in place. If you talk to obstetricians and some other midwives, they will say it is not. Perhaps I am a little bit risk averse on these matters, but I lean towards the advice that is given to me by the obstetricians that work within the public and private system, because I think the success of a stand-alone birth centre would rely on their support. If any woman had trouble in that, we would rely very heavily on the ability for some seamless support across the maternity service, and I do not think at this stage you would get that.

THE CHAIR: Who is doing the review?

Dr Brown: Professor Michael Nicholl, who is the Clinical Director for the Division of Women's, Children's and Family Health at the North Sydney and Central Coast Area Health Service at Royal North Shore Hospital, Ms Donna Hartz, who is a research fellow at the UTS Centre for Women's Health, Nursing and Midwifery, which is based at the Royal Hospital for Women at Randwick in Sydney, and a consumer, Leslie Arnott, who has 12 years experience as a representative of maternity consumers at the national level and in her home state of Victoria.

THE CHAIR: Will that review be released publicly when it is finished?

Ms Gallagher: Yes.

THE CHAIR: It will?

Ms Gallagher: Yes, I have committed to that. The only other thing I would add to that is to say that, again, it comes down to the smallness of our size. We already have a public maternity service on two campuses, on the north and south of Canberra. We have private maternity services. So the other question is about not just whether a stand-alone birth centre could work—and we know they could, because they work elsewhere—but about whether, with our number of births, with the range of services that are on offer, it would further fragment the services that are currently provided and things like workforce. All of those issues have to feed into it.

THE CHAIR: You will have the support of the opposition; I can indicate that, health minister. One of the issues in terms of the women and children's hospital has been midwives, staffing, and that is why you have had problems with some of the beds.

Can you give me an indication of where that is at in terms of recruitment of midwives?

Dr Brown: I might ask Elizabeth Chatham, as the executive director for that area, to come to the table.

THE CHAIR: Also, how many beds are operating now compared to how many really need to be in an optimal setting?

Ms Chatham: The first question was about recruitment of midwifery staff?

THE CHAIR: Yes, it is about the fact that the women and children's hospital is experiencing problems in terms of bed numbers. The explanation that has been given relates to a lack of staff. So it is a twofold question. Firstly, what is the situation in terms of beds and, secondly, how are you going in terms of the recruitment of midwives?

Ms Chatham: We have opened up all the beds that have been delivered in the new hospital that have been funded, and we are currently always recruiting for midwives. We have extra funding being given to us to recruit even more midwives in the current budget, and we are currently recruiting for those. We do suffer difficulty in attracting skilled midwives. We have a lot of first-year midwives in the service at the moment. So it is seeking skilled midwifery staff, which is quite challenging. We recently went to New Zealand but we did not attract anyone. We have advertisements across the jurisdictions currently as well.

THE CHAIR: How about the nurses who are coming out of UC and ACU? Are you putting a bit of a drive in there to—

Ms Chatham: Yes, we have 24 graduate midwifery positions currently in place. Almost all of those, I think, except for maybe one or two, came from UC.

THE CHAIR: In 2010 there was an issue within the Canberra Hospital with obstetrics and the management issues there, and there were a couple of reviews done. One remains undisclosed under the Public Interest Disclosure Act; the other one was released and there were a range of issues to be resolved. What is the situation in terms of resolving those issues? Have they all been addressed?

Dr Brown: A lot of water has gone under the bridge since that time. Again, Elizabeth might be in the best position to speak about the current state. We have a maternity services network that is operational. We have employed VMOs who work harmoniously with their staff specialist colleagues. Generally speaking, within the Centenary Hospital for Women and Children, I think you are fully staffed in terms of medical positions?

Ms Chatham: Not quite but we are with the VMOs. All of the VMOs are fully staffed, but we currently have some vacancies for staff consultant positions.

THE CHAIR: Minister, you previously described this as the 10-year war between obstetrics in this town. Does this mean the war is over, is the war ongoing or where

are we at?

Ms Gallagher: You know as well as I know that certain people left town. There have been some victims in this, Mr Hanson, and I would not say that either side has been right.

THE CHAIR: I am wondering what the situation is now. You talked about mudslinging between doctors, you talked about wars between doctors. Those were the words that you used—a 10-year war was one of your descriptions. Has that been resolved one way or another? I am not trying to—

Ms Gallagher: I have answered your question.

THE CHAIR: So it is resolved or—

Ms Gallagher: I have answered your question. I do not think there is anything further I can add to it.

MR GENTLEMAN: Minister, the budget allocated $1.6 million over four years to fund the mobile dental clinic. Which groups in the community will benefit from the establishment of this service?

Ms Gallagher: The mobile dental clinic will be targeted to people who live in aged-care facilities, in special schools, in Canberra College Cares. I think they are the three main areas. We are in the planning stages for the rollout of this initiative, so we are examining the best way to deliver the program. Essentially, it is a large van fitted out as a dental suite that travels around. So we have to work out whether Health wants to own a heavy vehicle or not, probably, or whether it is best done through another provider. Those decisions are yet to be taken.

It will be a good service. It is targeted to delivering dental services to those very vulnerable groups, and those where it would be difficult for them to get into a dental clinic, but where it impacts on their overall wellbeing. For instance, in aged-care facilities, if people's dental health is not looked after, it is going to affect their ability to eat certain foods, their nutrition can suffer and then they have other health consequences. So it will be very interesting to see whether this not only deals with improved access to dental care but whether it improves health outcomes in general.

MR GENTLEMAN: It was raised at the last Lanyon community forum that I attended. The members there were very interested in the service. There are some disparate aged-care living facilities around that area. Will you be looking at where best to service that community?

Ms Gallagher: Yes, absolutely. This is the time for people to get involved, so if you have any correspondence, forward it on so that we can put it into the development of the program. We have not run one of these before.

THE CHAIR: With this van, there is also a van that is going to be a health van, isn't there, as part of the Greens-Labor parliamentary agreement, for vulnerable people? Is that in the budget?

Dr Brown: No.

THE CHAIR: Minister, do you have a view on when that will come into the budget? You might be able to refresh my memory about what that one was.

Dr Brown: The commitment was by 2015, I believe.

Ms Gallagher: I would have to have a look at that. It is not in this year's budget. I cannot recall. I do not have the parliamentary agreement in front of me.

Dr Brown: I am almost certain it was by 2015. It is not in this year's.

THE CHAIR: Is there any preliminary work being done to scope what that would look like?

Dr Brown: Yes, there is some work underway. I am just looking at who can provide that information. Mr O'Donoughue? But yes, work has commenced in terms of the scoping for that.

Mr O'Donoughue: Thanks for the question, Mr Hanson. As Dr Brown indicated, within the policy and government relations branch there is some preliminary feasibility work being undertaken. We have been consulting with the Medicare Local and we have been looking at models of primary general practice type health vans that have operated in other jurisdictions, particularly some ideas about how this might operate. We have also got a piece of work as a result of a joint planning workshop with the Medicare Local recently; we agreed on a priority area of hard-to-reach populations, and we think this particular initiative might fit very well with that.

We are also engaging with some of the organisations in the territory who service hard-to-reach populations, including, for example, Directions ACT, Companion House, Winnunga Nimmityjah and Gugan Gulwan. In some ways, an alternate approach to the same issue might be to actually support those organisations and provide in-reach services, from either general practice or other health professionals, to support the work that is already being done through those organisations. At the end of the day, we might find a sort of hybrid model where both of those things operate—we support the existing organisations and we use the primary mobile van sort of approach to target more difficult to reach areas.

THE CHAIR: Thanks for that. We will have a break now. We will resume at 3.45. We will finish off cancer services and then move to rehab, aged and community care.

Sitting suspended from 3.28 to 3.48 pm.

THE CHAIR: It looks as though Dr Brown has got one of her notes.

Dr Brown: I do indeed. This is in relation to the Linac. The scheduling of maintenance to the Linac is done around patient treatment schedules, so it does not impact on patient access. I am advised that there are sufficient maintenance hours across the year to undertake the regular maintenance inspections, which occur on one

day each fortnight.

THE CHAIR: Can I just follow up, then, on maintenance. The question you had was about the linear accelerator, wasn't it, Mr Smyth?

MR GENTLEMAN: That was mine.

THE CHAIR: Did we talk about an MRI machine? I had a constituent who raised an issue about an MRI—that their child had come in and had to wait a long time because of an MRI that was broken. Does that ring a bell to anyone?

Mr Thompson: It does ring a bell. I cannot say specifically when it happened or for how long, but yes, we have had occasions where we have had unscheduled maintenance on the MRI machine as well.

THE CHAIR: Can you take that on notice and give me a bit of an update on how long it was for, how many patients were affected and so on—and whether that seems to be an ongoing problem or whether it was just an anomaly?

Mr Thompson: I do not believe it is an ongoing problem. It is unfortunately just one of the features of using this very high technology equipment. But I will give you the details.

THE CHAIR: If you can do that, I can get back to the constituent with an explanation. I would appreciate that. I noticed at the afternoon tea break that the biscuits and the buns seemed very popular, but there did not seem to be much of a take-up on fruit. I notice that we will be going to intervention and prevention later on this afternoon. You have got it in your bag, but it has not been eaten, Dr Brown, I note. I do not want to out you as one that was going for the sticky buns, either. Members, we are still on cancer services. Then we will move to rehab, aged and community care. Dr Bourke.

DR BOURKE: I am finished with this area, thanks.

THE CHAIR: Mr Gentleman.

MR GENTLEMAN: I am completed in cancer services, too.

THE CHAIR: Mr Smyth.

MR SMYTH: No; I am probably done.

DR BOURKE: I think we are ready for rehab.

THE CHAIR: Dr Bourke is ready for rehab. Over to you.

DR BOURKE: Minister, in budget paper 4, pages 95 and 99, the first strategic priority for rehabilitation, aged and community care is:

> … ensuring that older persons in hospital wait the least possible time for access to comprehensive assessment by The Aged Care Assessment Team.

How do you achieve that?

Ms Gallagher: How do you achieve that?

DR BOURKE: How do you achieve ensuring that older persons in hospital wait the least possible time for access to comprehensive assessment by the aged care assessment team?

Ms Gallagher: They have a target around time to assessment, which I think is two days. We regularly meet that. We can be 1.7 days to 2.1 days, depending on the quarter, from memory. That is the way you measure it.

Dr Brown: And we have a process whereby all of the referrals are triaged each morning, and they are prioritised. Again, there is a triage system based on the urgency. There is a time frame for each of those, and there is a team that is involved in undertaking those assessments. That includes nursing and allied health, from memory.

DR BOURKE: Who is doing the triaging?

Dr Brown: I might ask Linda Kohlhagen to come and speak to that.

Ms Kohlhagen: We have one of the clinicians who triages as part of the team leader role in the morning. The referrals are usually triaged at 9 am in the morning, every morning.

DR BOURKE: What does the assessment by the aged care assessment team involve?

Ms Kohlhagen: It is very comprehensive. It is a standardised assessment, a national assessment. It involves a discussion with the patient or client, and their family, reviewing the clinical notes and a discussion with the treating team. It looks at the functional issues. It is a sort of functional assessment and marries that up with the clinical picture of the individual. It looks at the types of supports that an individual might need at home and whether they can still remain in the community or whether they need additional support.

MR GENTLEMAN: I have a supplementary to that. On page 95 of BP4, it does refer to appropriate support when they return home. Are these supports ones that are provided by our health system or are you looking at supports that they have within the family unit?

Ms Kohlhagen: No; we do not provide the support. We do the assessment, which might say that you could have this type of package or that type of package. But part of the assessment would look at the support that the family or the family network may or may not be able to provide.

Mr Thompson: Typically this is about eligibility for commonwealth-funded programs as well. One of the important features is that—say it is residential aged care, community aged care packages or even the HACC program, although it is not officially for assessment for eligibility for the HACC program—frequently a referral

to a service provider may be one of the outcomes.

DR BOURKE: I think Dr Brown mentioned that this was a multidisciplinary team?

Ms Kohlhagen: Yes. We have nursing staff and allied health staff in the team. And we have administrative staff.

DR BOURKE: What sort of allied health staff?

Ms Kohlhagen: I believe there are social workers, but in the past we have also had someone who might have had an occupational therapy background or a physio background as well.

DR BOURKE: And it is purely a thorough assessment and then getting people to access the range of facilities which are either in the community or available through funding from the commonwealth?

Ms Kohlhagen: Yes.

DR BOURKE: Thank you.

THE CHAIR: Mr Gentleman.

MR GENTLEMAN: Minister, can you update the committee on the uptake of services through the GP aged day care service?

Ms Gallagher: I am sure we can provide you with some detail around that. Overall, we are very pleased with how the service is going. It was funded through the GP development fund commitments. I will just see if there is some more advice we can provide you in terms of the independent evaluation. From July 2012 to May 2013 the GPADS—GP aged day service—received a total of 993 referrals from GP practices with which they have a memorandum of understanding. The independent evaluation was completed in November 2012 and found that GPADS provides a useful service to ACT GPs, people in residential aged care facilities and home-bound patients. And there is some belief that it is providing some reduction in the number of ED presentations and potentially overnight stays in hospital.

The cost of it—I think we touched on this in annual reports just recently—is currently $358 per consultation, which is higher than a GP presentation, obviously, but it is very much lower than the average cost of an emergency department presentation, which is at $1,500—and an ambulance transfer. They were some of the issues that we were trying to address with this service. I think it has been good. One of the complaints that we have heard—I think we were looking at how we could resolve that—was around people who were in aged care but did not have a GP. I am not sure whether that was—

Mr O'Donoughue: No, minister.

Ms Gallagher: I am just trying to remember what it was.

Mr O'Donoughue: The service can provide an in-hours locum service to people who

are in residential aged care or are isolated at home. The issue is when people are trying to get out of hospital and get into an aged care setting and they do not have a GP at that particular point at all. That creates a barrier. Our GP liaison service at the hospital tries to assist by identifying potentially available GPs, but that historically has been a problem for people trying to access residential aged care. I think that was the problem you were alluding to.

Dr Brown: And at one stage, Ross, there was some discussion about whether an extension of the GP aged day service might actually pick that up. We have not actually gone there.

Ms Gallagher: Yes, that is right.

Dr Brown: But that has been discussed.

Mr O'Donoughue: The service at the moment does not provide ongoing care; it sees people where the regular GPs are unable to get there because they are, in a sense, tied to their practice during business hours. We have not at this stage envisaged a model where they would initiate care for a new patient, as it were, but that is something we have been looking at.

Ms Gallagher: Sixty-one GP practices have got an MOU with the service now. That is good.

Mr O'Donoughue: We funded in partnership with Medicare Local, and we have just offered an extension to that existing contract.

THE CHAIR: Mr Smyth.

MR SMYTH: Minister, on page 92 of budget paper 4, there is strategic objective 17, reducing the risk of fractured femurs in ACT residents over 75 years. It is odd that strategic objective 17 is almost identical with strategic objective 20 last year. It is a cut and paste. Do we have any up-to-date information older than 2010-11?

Dr Brown: We have the 2011-12 data, which was 6.6 per 1,000.

MR SMYTH: So it has actually gone up in 2011-12?

Dr Brown: Yes. It is slightly higher, but it is not statistically significant. It relates to the very small numerator in terms of the number of people over the age of 75 who consent.

MR SMYTH: Why don't we have that information in this document? If you have got a more up-to-date figure, why isn't it presented?

Dr Brown: I cannot answer that at this point in time. I will ask Dr Kelly to—

MR SMYTH: It has gone up to what?

Dr Brown: From 5.3 to 6.6. It was seven the year before that and 5.5 the year before

that. So you can see that there are fluctuations.

MR SMYTH: The year before that, in the 2012-13 budget, you have got 5.3. Are you saying that in the year before's budget it was seven?

Dr Brown: That is the information I have in front of me.

MR SMYTH: Sorry, but just for clarity, in 2010-11 it was 5.3?

Dr Brown: Yes.

MR SMYTH: In 2011-12 it was seven?

Dr Brown: No. Sorry; 2009-10 was seven. And 2011-12 was 6.6.

MR SMYTH: I do not think we have ever seen those numbers, and 5.3 has been in these books for quite a long time. Minister, I guess the question for you is: why would strategic objective 17 have out-of-date data in it and not have the most up-to-date year material?

Dr Kelly: Thanks for your question. I am certainly happy to provide to the committee the longer term data on this. I think, as Dr Brown pointed out, one of the issues we have in the ACT with a lot of data like this where there are a relatively small number of cases and a relatively small denominator population of over 75-year-old people living in the ACT, things fluctuate from year to year. It might only be a small number of cases. But the downward trend long term from 2005-06 to now, including that figure that you have cited—the 6.6 for 2011-12—is down. There was a bump up in 2009-10 to seven and a bump down and then a bump up again. But the general trend over that period is down.

The reason the most recent figures were not included in the budget papers is that that analysis had not been done at the time when those figures were being asked for. It has been done now. So that is the updated figure that we can provide.

MR SMYTH: So when is the calculation done?

Dr Kelly: I am not sure of the exact timing of it, but the most recent figure of 6.6 was prepared for the briefing for the minister at this point, within the last few weeks.

MR SMYTH: The budget is only two weeks old. Would it not be more appropriate to have that number ready for the budget papers?

Dr Kelly: We can certainly look at that for next year.

MR SMYTH: How many people over the age of 75 are there? How many thousands do we have?

Dr Kelly: I would have to take that on notice and provide the answer.

Ms Gallagher: As a proportion of our population?

MR SMYTH: The numbers are calculated by per thousand people. So there are 6.6 fractured femurs per thousand people over the age of 75.

Dr Brown: That is hospital admissions for fractured neck of femur.

MR SMYTH: So it could be higher?

Dr Kelly: Most people who fracture their femur go to hospital.

THE CHAIR: You would expect so, wouldn't you?

MR SMYTH: Could you make sure the numbers are up to date in the future? Minister, have you had, or has the department had, any approaches from groups who are interested in assisting with this problem with solutions to get the breakdown even further?

Ms Gallagher: The fractured hip?

MR SMYTH: Yes.

Ms Gallagher: In fact, Dr Kelly can probably talk about the work that he has been doing with the aged care sector on falls. We have had a component of our health promotion grants that has gone to falls, the falls program. In the last couple of years under Dr Kelly's leadership he has looked at tightening up, I think, how that money is used—targeting those areas where there were some concerns, perhaps, around falls. That is right, is it not? Or am I muddling that up with something else.

Dr Kelly: No, that is—

Ms Gallagher: I might hand over to you now before I start getting it wrong.

Dr Kelly: The reason we have a strategic indicator like this on fractured neck of femur is, firstly, it is something that can be measured. As was alluded to before, people that have this problem would generally end up in hospital and we can get good data on it. But really it is one of those other tips of the iceberg in a sense. A person who is elderly and falls over and breaks their neck of femur is a subset of people that are elderly and fall over and people that are elderly and fall over and that have brittle bones, if you like—osteoporosis and other reasons why they might fracture neck of femur.

There are a whole range of prevention activities that can take place well before that occasion. People who are more physically fit going into that age group, people who are less obese going into that age group, people who have good nutrition going into that age group, people who have good vitamin D levels and so forth are less likely to be in that situation of being frail. Then there are a whole bunch of prevention activities like the ones that the minister was referring to there that we have funded previously in aged care facilities to assist people to be less likely to fall and fracture neck of femur.

There is similar work that is done in the hospital sector that others in the room would be able to talk to more broadly. So there are a range of activities that we can do in prevention in relation to this, and it is an important measure to keep looking at this, for the reasons I have already said.

MR SMYTH: Would most of those who present get a hip replacement? What is the percentage who do not get a hip replacement and who do?

Dr Kelly: I am probably not the best person to answer that question. One of my clinical colleagues is.

MR SMYTH: Can that be taken on notice?

Dr Brown: We will ask Dr Hall if he might want to offer an opinion.

MR SMYTH: Right, and you are going to provide the committee with the seven or eight years of data?

Dr Kelly: I will take that on notice, yes.

Dr Brown: And I might just add while—

MR SMYTH: Before Dr Kelly goes, it was put to me from one of the drug and alcohol organisations that perhaps there is a sort of a crossover here of older people who might drink excessively for their age and who are falling down and that funding of a program for the education of older Canberrans who drink too much might be advantageous and you might see a decline in the 5.3 and you may save yourself some money. Has there been any investigation of the people who present—Michael might have to tell us here—and who fell as a consequence of alcohol?

Dr Kelly: I will defer that to Mike but, as a general principle, you are correct. As I said, there are a whole range of reasons that people may be more likely to fall—that and disorientation, dementia, a whole range of things that can underlie that—and then further back the kind of physical activity, strength of muscles and so forth is also a component. But it is certainly something we should look at.

Dr Brown: I might just add, accountability indicator 1.5(g) is around the number of people assessed in the falls clinic. The falls and falls injury prevention service do actually go out and market their program. Currently they do that by working with GPs and the emergency department. I am sure that it is a suggestion that they can take on board as part of that. But we might ask Dr Hall just to comment in terms of the percentage of people with a fractured NOF who go on to have a total hip replacement.

MR SMYTH: Mike, I do apologise but the note on No 4(g) says that this has been discontinued because the number of people assessed in falls clinics has been discontinued due to consistent levels of activity over recent years. So we are not going to report on this next year? You are not reporting here, and—

Dr Brown: It has been very stable. In terms of the value of that, we thought that there was not necessarily any value to be gained out of continuing that particular indicator.

MR SMYTH: So 5.3, 6.6?

Dr Brown: It is a very small denominator.

Dr Hall: Thank you for that. Fractured necks of femur is not my specific area of expertise, but patients that come with fractured neck of femur will all get an operation. There would be a very small percentage, a couple of per cent, for whom it is an end-of-life decision. Patients who are incapacitated and with no sign of mobilising may occasionally not. But that is only done if that patient is likely to be in the last two to three days of their life. Even in a bed-bound patient, the operation is done to prevent other complications and as a pain relief measure.

As to your specific question about hip replacement, about 80 per cent of the patients get, in simple terms, a rod put through the fracture to hold the fracture in place, and about 20 per cent of patients get the hip replaced. It depends on the nature of the fracture. There are different patterns of hip fractures.

As to the other question you alluded to, I do not have an idea of the data about alcohol. It is certainly a contributing factor in falls in the elderly, but I am not specifically aware of that.

The other clinical point to add is that some of the people with fractured femurs in fact spontaneously fracture and fall because of the fracture. The fracture is not always in relation to the fall. Sometimes people will just walk and break and then they will fall because of that fracture.

MR SMYTH: Is it possible to supply the committee with the number of operations for fractured femurs for over-75s in the last two or three years and what that cost was to the—

Dr Hall: I am sure that would be doable. We will just get the division of surgery to provide those figures.

MR SMYTH: Yes, and the cost to the system?

Dr Hall: I am sure that could be done.

MR SMYTH: That is very kind. Thank you.

Dr Brown: And we can give you the number of people in the ACT over the age of 75 in the 2009 census. There were 15,496.

MR WALL: Chief Minister—and it may be with some indulgence on the part of the committee because I am not exactly sure whether the Aboriginal bush healing farm falls under rehabilitation or drug and alcohol services—could you please provide an update of where this project is at?

Ms Gallagher: Yes, sure. It is currently still with the planning authority. We have submitted a DA. There have been some objections to that DA and I have not seen an

outcome yet.

Mr Carey-Ide: We have been advised by ACAT that three objections have been made to the DA decision in regard to the lease variation. We are yet to be provided the detail of those, which will only be provided after ACAT have made a decision as to whether they are going to pursue the objections that have been lodged with them.

DR BOURKE: In your experience, Mr Carey-Ide, if ACAT does proceed to a hearing, how long would this project be held up by, roughly?

Mr Carey-Ide: I am sorry, it is my first experience of ACAT.

Ms Gallagher: I think they like to resolve things within 120 days. Whether they can or do, that is another question. But that is what they inform us.

MR WALL: So what impact will that have on the revised completion date, if any?

Dr Brown: It will clearly delay the revised completion date. We cannot commence any construction work until such time as the DA has been resolved.

MR WALL: It seems that this project is turning into the proverbial pot of gold at the end of the rainbow. It was originally announced in 2008-09 and was supposed to be completed within two years. Now we have got a revised completion date of August 2015 and we are being warned again here today that it may exceed that time frame.

Ms Gallagher: Yes.

Dr Brown: That is correct, and we are very appreciative of the clear interest and support that you have in seeing this progress. It is a very important project, particularly for Aboriginal and Torres Strait Islander people in our community. There have been a range of factors that have contributed to the delay. It commenced in relation to finding appropriate land that met the criteria of the Aboriginal and Torres Strait Islander people. It needed to be culturally appropriate. There was then some delay whilst we actually established the advisory board of Aboriginal and Torres Strait Islander people.

There was then an issue around the scope and budget, and we needed to value-manage the project to ensure that we could deliver within the appropriated dollars, and we had quite a lengthy time frame in terms of the work on a model of care. Again, at the request of the advisory board, we went out to an external consultant. There was a lot of consultation. That process, I think, took about 12 months, but it was important to do it that way and get it right. And then more recently, of course, we have had the issues around the DA and, as I am sure you are aware, we submitted the initial DA and there was an issue with that; so we had to modify and resubmit that, and now we are dealing with the objections to that.

So there have been a range of contributing factors, but we are equally keen to ensure that this gets progressed in a timely way.

MR WALL: Dr Brown, you just mentioned there that one of the things that have

been done is that the project has been managed and rescoped to meet the budget restraint on the appropriated funds. The history of that was that we saw the facility go from a 16-bed facility down to eight, half the capacity. Yet the issue is that we have now seen the budget increase by just over $2.4 million. Is that going to see an increase in services being provided in this facility?

Dr Brown: At this stage the current proposal is around delivering on those eight beds but, as you can appreciate, with those delays which I think have been unavoidable, clearly there is cost escalation. It is just a fact of life.

MR WALL: Now this facility is going to end up costing a smidgeon under a million dollars per bed. Is that really—

Ms Gallagher: It is not just a bed. It is a treatment facility and there are a range of buildings, if you had looked at the design which has been released.

MR WALL: Yes, but obviously the facility is limited by the capacity of beds it has got for the number of people it can take through the program.

Ms Gallagher: In terms of residing there, there is the expectation that under this model, I have been informed by the advisory council, there would be more than eight people at a time because families will be involved. There are a whole range of other facilities as part of this program. I just do not want it to be equated to building an eight-bedroom house and that is what the cost is, because it is a much bigger, more complex project than that.

MR WALL: Much of the concern that I have had from members of the Indigenous community making representations to me is that, obviously, the project never seems to be getting any closer to completion, and as we continue down that road—

Ms Gallagher: I do not think that is fair.

MR WALL: we are seeing fewer facilities being available for patients to receive treatment out there.

Ms Gallagher: No. Again, I do not believe that is fair and it is certainly not what the Indigenous community have raised with me. They have not raised that concern with me, not the people on the advisory board or the Indigenous elected body who I met with and specifically spoke to about this project. They have not raised that it is providing fewer services and not going anywhere. The fact is, we are at the DA stage and we are ready to go and we are very committed to this project. But we have to work through some of those objections, just like every other applicant of a DA, and we need to go through that process.

MR WALL: The other question I want to ask in relation to this project is: we have seen the time frame blow out yet again. We are going to be waiting another two years before we see this project tentatively completed. What services are being offered to the Indigenous community who would have gone through this program had it been completed back in 2011 when it was first scheduled? What stop-gap measures have been in place to make sure that these people do not go through the gaps?

Ms Gallagher: Health fund, and work very closely with, Winnunga Nimmityjah as the main provider of Indigenous-specific health services in the ACT. Historically, as a government, I think we have worked very well with that organisation and prioritised Indigenous health through that arrangement. But yes, this is another service that we do not have at the moment and that we want to see in place as soon as we can. Do you want to add anything?

Mr O'Donoughue: There are a range of service providers who do provide residential rehabilitation programs in the drug and alcohol space in the territory. I guess the value out of this particular service is that it is clearly designed to be culturally appropriate for Aboriginal and Torres Strait Islander people, and that is something that is fairly unique around the country. There are very few such services provided anywhere. Historically people have travelled outside the territory to access services that they think are more culturally appropriate, but there are a range of service providers and treatment options that do currently exist in the territory and that people can access if they choose to.

MR WALL: Minister, you mentioned just a moment ago that Winnunga Nimmityjah has been providing a lot of the interim care in the absence of this facility. Has there been any investigation as to the cost of providing a not-for-profit cultural group such as Winnunga with funding, to the extent of $8 million to provide these services on behalf of the government, as opposed to going it alone and building your own facility?

Ms Gallagher: If we had somewhere where we could ask an NGO to run a facility like this, we would have done it. The issue was—

MR WALL: Were any conversations held with existing service providers to see whether they—

Ms Gallagher: Yes, and they were involved in the original identification of this project and how it might look. And the hope, the very genuine hope, is that once the model is established and in place, potentially this would be run by a non-government agency on behalf of the government. It is not so much the capital. The capital creates the infrastructure. I think the much more meaningful partnership will be about whether or not it can be managed by an Indigenous organisation, which is the desire, and I note it is what the advisory council would like to see.

Dr Brown: I might just add, it is my understanding that at the time of the original appropriation, that was allocated for either the refurbishment of an existing facility, if one were to be found, or to purchase and then construct. And clearly we had a look at both options. There was no existing facility that would have been suitable, and there was quite a process to actually identify appropriate land that was thought to be culturally appropriate.

DR BOURKE: Minister, why is it helpful in this program to have a culturally appropriate site?

Ms Gallagher: If you talk with the advisory body that was established for this, and indeed other representatives of the Indigenous community, they will go to great

lengths to talk about the rehabilitative and therapeutic connection that land offers to Indigenous communities. We did take a long time to identify a block of land that was suitable and indeed took members of the local Indigenous community to various sites around Canberra which were either given the thumbs up or the thumbs down.

In this case, Mirra Wirra was highly supported by local Indigenous communities as a place of cultural significance, a place that could be a place of great healing, and we accepted that advice from the different people that had been involved. There have been many different people, representatives of the local Aboriginal and Torres Strait Islander community, involved in this.

Dr Brown: For example, the location close to a river or a watercourse is considered to be one of the requirements from a cultural perspective.

MR SMYTH: But is it not true that the original proposal for this facility was that it be located at Ingledine Pines on the Murrumbidgee River, and that was, and still is, the chosen location or the desired location of the community?

Ms Gallagher: That pre-dates my time as Minister for Health. I know that there were sites looked at and, for one reason or another, they were ruled unsuitable. I would have to go back and have a look at what those reasons were. That was in 2008. I think it was before that.

Dr Brown: There were two sites previously. One was Ingledine, one was Jidbinbilla. One was considered unsuitable, Jidbinbilla, due to its previous use as a male initiation site, and the other was due to its lack of environmental integrity and the lack of a river or a watercourse on site.

Ms Gallagher: That was back in 2005.

MR SMYTH: There is more water in the Murrumbidgee than there is in Paddy's most days.

Mr O'Donoughue: It is not on the site. I actually was on that site with the advisory board members, and there was no water on the actual property that was being proposed, and they were not at all supportive of that particular site.

MR SMYTH: They are telling people different stories, then.

DR BOURKE: Minister, in the lead-up to the 2012 election you made a commitment to zero growth in overweight and obesity across the territory. What initiatives were included in the budget to support this commitment?

THE CHAIR: Again, this would probably be early intervention, which is the next program, but—

Ms Gallagher: Okay, we will wait.

THE CHAIR: But it is out of the bag now, is it not? That was based on precedent?

DR BOURKE: It is up and running.

Ms Gallagher: Yes, there are a few different initiatives in the budget, I think you will see, with the implementation of the commitment around—and I am not sure how they are shown in the budget papers in the end—delivery of water, putting water as the drink of choice in schools and health facilities, and that will be delivered through this budget. At the other end, of course, this is the first time we have started—

THE CHAIR: Whereabouts is that in the budget? Can you point to the—

Ms Gallagher: I am not sure, because I think it is funded internally. Health have agreed to fund it internally; so I am not sure just how it is—

Dr Brown: There are two elements to that. One, the water refill stations, I think we are funding internally, and the other is under Education.

Ms Gallagher: Yes, Education is funding theirs.

THE CHAIR: There is $100,000 across the board in the 2013-14 estimates for the refill stations. When you say it is funded internally, where actually is that?

Dr Brown: Mr Foster might speak to the specifics.

Mr Foster: The Health Directorate is cash-managing the cost of the capital installation of the water stations, and Education is managing the water stations for the schools. We are dealing with it out of our cash fund, providing $100,000 over two years to buy water refill stations.

THE CHAIR: Does that have any impacts that you are concerned about in terms of cash reserves? How big are you in cash reserves?

Ms Gallagher: Not big enough.

THE CHAIR: What else can we have? What is the size of Health's cash reserves?

Mr Foster: It varies, obviously, but the—

THE CHAIR: Right now what are your cash reserves?

Mr Foster: Right now our cash reserves are pretty limited.

Ms Gallagher: We are waiting for New South Wales to pay their bills.

Mr Foster: But in 2013-14 we expect to have the cash available to pay for the water stations.

THE CHAIR: What are you expecting in terms of your cash reserves in 2013-14?

Mr Foster: We do not end up having cash reserves of any significance, and the Treasury system is a cash buffer, and any surplus cash is Treasury's. But the issue of

$100,000 for the watering stations, we agreed through the budget process that we would manage that from cash that would come to us from moneys that came back from the workers compensation cases or whatever from prior years. So we were just going to deal with it from any fortuitous cash that came along.

THE CHAIR: So you are waiting for some cash to drop into the budget before you can buy this?

Mr Foster: No, we have an ongoing expectation of this cash, and we do receive cash annually from those one-off sources.

Ms Gallagher: In a $1.29 billion budget, I think there is an expectation, certainly from me, that we would be able to fund this without doing a specific budget initiative for it.

DR BOURKE: Of course, there is an additional budget allocation for 30 drinking fountains across Canberra in town centres, parks, sporting facilities and new schools as well, which will add on to that additional program.

Ms Gallagher: Yes. Pushing water as the drink of choice is an important part of, I think, the steps that we are going to have to take to gradually change behaviour across our community about healthy lifestyles. There is no doubt, when you talk to experts—and I met with the national health prevention agency. I cannot remember exactly what they are called; it always sounds weird "health prevention", but it is preventive health. They see sugary drinks as one of the main contributors, certainly in children, to becoming overweight, just because of the lack of understanding about how much sugar is involved in soft drink, sweet milk and things like that. It might not look to be a big initiative, but it is a really important part of the work that needs to be done.

The other issue is that last Friday the food ministers supported the implementation of a front-of-pack labelling system which has been in front of food ministers for seven years. We have now taken the decisive step that a voluntary scheme is to be implemented. Industry has two years in order to show widespread uptake of that system or food ministers will look for a mandatory scheme to be put in place. That is based on a star model similar to what is on the front of your washing machine and those electrical appliances that do those ratings now. The decision has been taken and I would expect, fairly soon, to start seeing those star ratings on the front of packs.

Again, I think this will be an important part of dealing with this. It is not actually Health's problem. It is not the Health Directorate's problem to deal with the initiative of zero weight gain. Health deal with the end problem of lifestyle choices, but in a greater way it is directorates that have more to do with kids. It is around parents primarily; it is around education for parents in giving their children the right food and drink. It is planners, it is transport systems, it is TAMS. It is very much a whole-of-government approach. The experts in this room will deal with the after-effects of poor lifestyle choices. They cannot solve them. I think this is my issue with the whole-of-government weight plan. While Health are leading that work, a much fairer approach is to have it under another directorate, perhaps a central agency.

THE CHAIR: Mr Foster, before you go, you said you did not have very many cash

reserves at the moment. Can you tell us what your current cash reserves are?

Mr Foster: Right now I cannot answer that question, but I can take it on notice. Right now we have to cash manage our business. $50,000 next year and $50,000 the year after is easily achieved from what we normally get from one-off sources that come through the year.

THE CHAIR: If you can just take it on notice and provide me the figure as at today's date, that would be great. Thank you very much. Mr Gentleman.

MR GENTLEMAN: Since we have moved on to intervention and prevention, I just want to follow up on the last question of Dr Bourke. Minister, as part of the government's strategic focus on the issue of obesity, health promotion grants have recently been reviewed. What is the status of that review?

Ms Gallagher: Around $2 million goes out to the various community organisations annually for the old health pact or health promotion grants rounds. I have asked that the directorate lead some work around consolidating or prioritising healthy weight as the key focus for that money. It will require some change, though, to how we have managed this grants round in the past. We have been out on a consultation strategy which got a number of submissions from NGOs. That has helped us to inform, I think, the decisions that I have signed off on.

THE CHAIR: Is SmartStart for Kids part of that program?

Ms Gallagher: We encouraged an application through that. There has not been an application by SmartStart within the health promotion grants round as it exists, but it is an option going forward for them to apply.

THE CHAIR: What discussions did you have with Robert de Castella either prior or post making your decision not to continue the funding for that program?

Ms Gallagher: I have certainly had discussions with him over the years. I have met with him and, I think, some researchers from the University of Canberra over the project of the work he has done. I have met with the Chief Health Officer and sought his advice on it as well. We funded it for four years. That funding came to an end. I do not mean to drop anyone in it, but I followed the advice of the directorate to me about whether or not we could support that project going forward in the way that Mr de Castella wanted. It was a $200,000 commitment over four years, a total of $800,000. Going forward, Mr de Castella was after $900,000 permanently—$900,000 a year permanently. That money had been funded for a four-year project.

We did not have $900,000 to put in. That is half of the health promotion grants round. We did not have that money to continue that. I did take some advice. I do not know how many meetings Dr Kelly and I had on SmartStart for Kids. Dr Kelly worked with Mr de Castella and took him to a number of other funding sources seeking support for that program, which was ultimately unsuccessful, including the National Preventive Health Agency and Medicare Local.

I think we provided a lot of extra support to work with Mr de Castella, including

refining the proposal and not having it as a sports science based program, which involved a lot of screening, for example. I think at one stage it involved the potential screening of 50,000 children in order to work with the top 100. I might have got those figures slightly wrong, but there was a suggestion put that the screening component not form part of the work, reducing the costs of what was being seen. But Mr de Castella was very keen that the screening part remain a focus of SmartStart for Kids. We worked over a number of months to refine and suggest alternatives and to look at other funding sources. Ultimately, when I asked the question, "Is this a project that is going to deliver the change that we need?" the advice back to me was that it was not.

THE CHAIR: Your intent that there be no growth in girth or whatever it is—

Ms Gallagher: Zero growth, yes.

THE CHAIR: Zero growth. How are you going to monitor that?

Ms Gallagher: We monitor it in a variety of ways. Enough reports have been done and we can very clearly get that 25 per cent of children under a certain age are overweight or obese. It is much higher for adults. Those measures are there and they are reported upon pretty regularly. Just saying "zero growth", I hate to say, is almost an aspirational target. That is where we are at. I saw the AMA in America yesterday release a statement that they have now listed obesity as a disease. That is how serious they are seeing it, and I think we are seeing exactly the same trend here. Zero growth is going to be hard, if not impossible, in the short term to deliver upon.

Dr Brown: In the latest global burden of disease study that was released only a few weeks back, obesity has overtaken smoking as a risk factor for chronic disease and the top 25 causes of disease burden in Australia and worldwide.

MR GENTLEMAN: I think we were just about to get an update on—

Ms Gallagher: I am sorry; I will hand over.

Ms Greenfield: The health promotion grants program has undergone a consultation process. There was a consultation paper put out and a public meeting, a mechanism for people to submit proposals and submissions. We had 39 submissions, which spanned over 200 pages, with a wide variety of views expressed across those submissions. They were synthesised and summarised and put up as advice and recommendations made. The minister has agreed the changes and the announcement is imminent. We envisage that the next grant round will be open by the end of the year.

MR GENTLEMAN: Excellent. Thank you.

DR BOURKE: Who made a submission? What sorts of people made submissions?

Ms Greenfield: A variety—non-governmental organisations; we had a few individual submissions. We had different people who had received grants over the years—so a wide variety, ranging from large peak bodies like the Heart Foundation to small groups or individuals.

THE CHAIR: Mr Smyth.

MR SMYTH: The amount for the Indigenous early childhood program has been rolled over. It is on pages 100 and 101 of budget paper 4. Why was that?

Dr Brown: Is that part of the closing the gap—Indigenous early childhood?

MR WALL: I believe it was the Indigenous early childhood development program.

Ms Gallagher: The national partnership?

Dr Brown: Yes.

Mr O'Donoughue: Under the commonwealth national partnership agreements, there is one generally on closing the gap and there is a specific one on Indigenous early childhood initiatives. The programs that we have been implementing under that relate to a core of life training program which is being conducted by a midwife who is based within my team in policy and government relations. That is a sort of train the trainer approach using a particular resource called core of life which teaches young pregnant women about risk factors and about healthy lifestyles.

That has really been the main initiative that we have been undertaking under that particular program. It has been very well received. There has been significant take-up of training opportunities. I do not believe I have the numbers in front of me. I am happy to take that on notice if you want me to get more details of the program.

THE CHAIR: Yes, that would be great. Thank you, Mr O'Donoughue.

MR WALL: Mr O'Donoughue, does that program also then feed into early parenting and things like immunisation for Indigenous parents? Or is it a prenatal—

Mr O'Donoughue: Not specifically; it is more the latter. It has two aspects. It is an antenatal and sexual health project with those two arms. To some extent we have been working through existing organisations, such as Gugan Gulwan, who have always historically had a young mums group. We have been working with them and then, as I say, through the funded midwife position that has been with my branch about two years now, I believe. There are other specific initiatives around immunisation which Dr Kelly would be better placed to speak to.

THE CHAIR: I have got some immunisation questions as well, so that might be good. Have you got any follow-ups?

MR WALL: Yes. Dr Kelly, would you be able to just give us a brief outline, in the interests of time, on how the current immunisation program for Aboriginal and Torres Strait Islander people is conducted?

Dr Kelly: Thanks for your question, Mr Wall. I guess the short answer to that is the same as it is for all ACT residents. There is a national schedule for immunisation for children. That is part of a national agreement that we have and the cost of the immunisations are funded by the commonwealth. We generally do very well and

mostly lead the country in terms of our rates at the three age points at which we measure these things.

The issue with Aboriginal and Torres Strait Islander residents within the ACT is that at the particular age points—so it is at 12 months, two years and four years or five years—there may only be as few as 100 Aboriginal and Torres Strait Islander kids in that particular age group. Even if one or two or five kids do not get their timely immunisations at exactly the moment when that is measured, it can decrease or increase the figures quite substantially.

If you look at the most recent data that is included in the budget papers then we have slipped down a little bit in our Aboriginal and Torres Strait Islander coverage, particularly in the younger age groups. In the 12 to 15-month age group and the 24 to 27-month age group, we are below where we would like to be. Interestingly, in the higher age group, the five-year-olds, we have 100 per cent coverage. I do not think anywhere in the country can get anywhere near that.

There are issues, but they are quite specific to small numbers of children. Often it is just one or two families. We have a very close relationship, as we do with immunisation, with the primary care sector—so ACT Medicare Local and Winnunga Nimmityjah—in terms of quite specific programs to go out and work with particular families to increase that. Again, those figures jump around a little bit because of the small numbers but, in general terms, one of the cohorts is doing well; the others we need to continue to improve.

MR WALL: The reason I raise this objective is that, although the 12 to 15 months is below your target, if you look back at the previous year's figures, the 12 to 15 months has had a 5.5 per cent slip and for the 24 to 27 months it has been a 6.4 per cent slip. So those early age groups seem to be trending in the wrong direction. I was wondering what is being done to make sure that they are being captured.

Dr Kelly: As I say, 6.4 per cent would be six children. So that is really a clinical problem rather than a public health problem. We are working with the community to identify those specific kids and specifically offer them the issue.

DR BOURKE: Dr Kelly, you know which kids you have immunised. How do you know which kids you have not immunised?

Dr Brown: We do have records of those who are overdue for immunisation, and we do actually undertake phone contact.

DR BOURKE: How do you know they are still in the territory? You are dealing with a small population. If a family is not in town anymore—

Ms Gallagher: They are some of the issues. They go to the heart of the issue.

DR BOURKE: Your data collection can veer quite markedly if a family or a couple of families leave town. The corollary is that if you do not know that another family has come to town. This is the problem with looking at this sort of data in very small populations. It is fraught with errors. So fluctuations of five, 10 or 15 per cent do not

mean anything. It is the time trends over five to 10 years which are of much more value.

Ms Gallagher: It is a marker. I would say we use it as a marker to alert people. Next time there is a discussion with Winnunga or Gugan, it is a matter of saying, "Have you followed up?" It is very closely watched here. Because everybody knows everybody, a lot of effort goes into making sure we are reaching those kids and families in need.

DR BOURKE: To paraphrase Dr Kelly, this is using a population health tool to deal with a clinical problem?

Ms Gallagher: Well, it identifies a clinical problem.

Dr Kelly: Yes, it identifies an issue, I think; that is correct. What we have is the data that we know about, and unknown unknowns is a difficult one. But the data we have is from the Australian childhood immunisation register, and we know who gets immunised and so forth. But you are quite right: with five or six children out of a population of 5,000, which would be the general childhood population of a particular age cohort in the ACT, you would not even see that change.

MR WALL: How do those figures compare to the non-Indigenous community?

Dr Kelly: The coverage rate for all children in cohort 1—that is the 12 to 15-year age group—in the ACT is 92 per cent. That leads the nation; 92.4 per cent, in fact. In the second cohort—that is the two-year age group—it is 92.9 per cent; again, leading the nation. And in cohort 3, the 60 to 63-month age group, so the five-year-olds, it is 93.7 per cent, which leads the nation. So I think we are doing pretty well.

THE CHAIR: An immunisation question in breaking news: I am not sure if you have heard, but New South Wales has passed the legislation requiring vaccination for infants in child care.

Ms Gallagher: Well—

THE CHAIR: With a number of exceptions.

Ms Gallagher: Yes, with exceptions.

THE CHAIR: There are other models across the nation. Are you monitoring this issue? Have you done any work to look at this, given that we are an island within New South Wales?

Ms Gallagher: Health ministers discussed this on Friday. No child is going to be excluded, as I understand it, under the New South Wales model based on non-immunisation, because of the exceptions that are in place. It is about information, really—knowing who is not immunised. I think that is an important part. We already have in place a requirement for immunisation records to be shown through child care and at school. I think it has been made a lot easier now that that information is available online through Medicare. If you register online for Medicare, you can click

on and print off your kid's immunisation records. Some of those issues around where the information is are being addressed through new technology.

We also do not have some of the issues that New South Wales are trying to deal with. Jillian Skinner talked about this on Friday. At a global level, their immunisation rates are okay, but it is when they have drilled down to particular localities within particular neighbourhoods, local areas, that they have been able to identify areas where it is getting to a point where there is the risk of a major problem. I think they are trying to deal with issues that we do not have here.

My preference is—and I think it was reflective of the meeting around the table—for more information for parents around understanding why children need to be immunised. That is an important part of anything going forward. All jurisdictions are looking at the issue. Some jurisdictions have our requirements about showing immunisation records; some do not. So everyone is at a different stage. We seem to be at the top in terms of those requirements. I think it is one that we just keep a watchful eye on, from my point of view.

There was overwhelming agreement around the table that no child should be excluded from school based on their immunisation status. One of the issues that Dr Kelly dealt with when we had a measles outbreak not long ago at a school where there were reasonably high levels of non-immunised kids was that those kids stayed at home while the outbreak was on. I think that is what we are going to have to let people know about. If your child is not immunised and there is an outbreak of something or other, your child will be excluded for the duration of that outbreak. I do not think it will take too long. For some families that would be very inconvenient, I would imagine, particularly if an outbreak goes for a period of time.

THE CHAIR: My understanding of the New South Wales legislation is that a parent needs an approved exemption, and they have to see a GP as part of that process.

Ms Gallagher: That is around education, yes.

THE CHAIR: Do you know what those approved exemptions are? Just saying, "I don't want to do it," is that—

Ms Gallagher: Yes, what is it called? Vaccination refusers.

Dr Brown: Vaccination refusers. That is the new terminology now. As I understand it, the requirement is for them to be counselled, to see someone who can actually provide them with information about the benefits of vaccination and the risks of not vaccinating, and then they will get their—

Ms Gallagher: Exemption.

THE CHAIR: Have you received any concerns from anyone about this issue and any lobbying?

Ms Gallagher: I think I have received one letter from an individual, not an organisation, around wanting to see similar laws in place in the ACT. When I looked

at it—and perhaps that is an area that we need to focus on; I think it was an issue that was identified in the measles outbreak—it was about how much information was readily available about who was vaccinated and who was not. It did take a period of time to work that out, and I think that is an issue we need to do further work on. But with the issues around populations where immunisation rates are 70 per cent or so, we are not seeing that.

THE CHAIR: Thank you, Minister. We are up to Mr Gentleman.

MR GENTLEMAN: I do not have any more on early intervention, but I have one for local hospital network, which is our next output class.

THE CHAIR: We are doing it as a group now. Does anyone have anything further on early intervention before we move on?

DR BOURKE: Yes, I do. Minister, under the accountability indicators for output 1.6, part c., on page 99, it refers to the "proportion of children aged 0-14 who are entering substitute and kinship care within the ACT who attend the Child At Risk Health Unit for a health and wellbeing screen". Could you tell me more about this?

Ms Gallagher: Yes. This is another issue that relates to small numbers of children. It relates to 73 eligible referrals, with 64 receiving a health and wellbeing screen service. From my understanding, it is about good communication with CSD and Health around the referral, management and assessment of these young people.

DR BOURKE: So working together across directorates?

Dr Brown: We provide this through CARHU and it is reliant on referrals coming from the office for youth and family services. There is regular liaison between them to maximise the uptake of this opportunity for these checks.

MR GENTLEMAN: Minister, I understand that QEII Family Centre recently celebrated its 50th anniversary. Can you tell us how QEII fits into the local hospital network, and what services are provided by the centre?

Ms Gallagher: Yes, indeed. I think Mr Smyth was there as well at the dinner. It was a great celebration going right back to the early years of the growing health service in Canberra. There were some quite elderly midwives and doctors who have provided a service to people over all of those years.

It is the fourth hospital in the local hospital network, or it is one of four—Calvary hospital, Canberra Hospital, Clare Holland House and QEII. QEII is managed by the Canberra Mothercraft Society, and it provides that early intervention, I think we could call it, or intervention in the early days of a child's life, particularly when there are stresses or concerns from the family about new babies—how they are sleeping, feeding, tearing the family apart and that sort of thing. They can go somewhere and get expert help in an inpatient facility.

That support and help are also provided once they leave. There is some continuity of support. I have had recent discussions with the chair of the board of the QEII service

around going forward. I think they accept that they have done a great job in 50 years, but they also acknowledge that the world is changing, health services are changing, families are changing, and they want to make sure that they are maintaining their relevance.

I think they would like to look outside just QEII and how they provide services. I have said we are very happy to talk with them around that. I think they have also been very keen in the last little while to focus on being seen as culturally appropriate for Aboriginal and Torres Strait Islander women and their babies accessing the service, and I think they have done a lot of work around that.

MR GENTLEMAN: How are new parents made aware of the availability of the service?

Ms Gallagher: In a variety of ways. Certainly, mothers are provided with a whole lot of information in the lead-up to having a baby and once the baby is born about services that are available, the connections with the MACH nurses who follow parents, new mums, after they have left hospital and do those home visits and create those relationships. They are great for keeping an eye on whether a woman needs a referral.

Anyone who needs help would be made aware of the QEII, whether it be through general practice, the MACH clinics or other child support services. I know if you ring the Tresillian hotline and you are from Canberra, they will quite often refer back to QEII.

THE CHAIR: Minister, you had an election commitment for a paediatric nurse consultant, as I recall. Is that in the budget?

Ms Gallagher: That is in here, yes.

THE CHAIR: Where is that? Where will that nurse consultant work?

Ms Gallagher: Canberra Hospital.

THE CHAIR: At Canberra Hospital.

Ms Gallagher: Yes—which is by far the majority of paediatric work.

THE CHAIR: Okay.

Ms Gallagher: Where is it in the papers? I am sure someone will be able to point me to it.

Dr Brown: Mr Foster will have the answer to that.

Ms Gallagher: He had better!

MR SMYTH: What are you going to do when Mr Foster retires?

Dr Brown: We have got his apprentice in training here.

THE CHAIR: Who is the apprentice?

Dr Brown: He wishes to remain anonymous.

Mr Foster: On page 100 of budget paper 4, very simply, it is part of the enhancement of services for women, youth and children—781,000 there. It would also be in budget paper 3; where each of the initiatives is dealt with, there would be some reference to that in the same dollar amounts.

THE CHAIR: That answers my question. Mr Smyth?

MR SMYTH: I am fine.

THE CHAIR: I have a number of questions—we are moving all over the shop a bit—but I want to go to e-health. Could you give me an update on the progress with e-health?

Ms Gallagher: I will ask Judy Redmond.

THE CHAIR: If you can keep it fairly non-technical, the members of the committee would appreciate that.

Ms Redmond: What would you specifically like me to discuss in relation to e-health?

THE CHAIR: The personal e-health record is of particular interest because that seems to be one step forward, one step back every year. So there is that issue, and then I suppose just how the rollout is going. There was $90 million put in the budget about three or four years ago. Just what is the progress with that, with the implementation?

Ms Gallagher: It is just a big project.

Dr Brown: I have to say that I do not think it is a fair comment to say that the personally controlled electronic health record is one step forward, one step back. I think there have been lots of steps forward in recent times.

Ms Redmond: I can talk to the personal electronic health record as it relates to the ACT. We have had a significant amount of traction in relation to the national e-health record. We are the first jurisdiction to actually connect to the national e-health record. We have been submitting electronic discharge summaries to the national e-health record since March of this year. We have submitted 85 discharge summaries so far for patients who have actually registered for a national e-health record.

We work closely with ACT Medicare Local in relation to this record. There are a number of GP practices that have committed to the national e-health record in the ACT, with 15 practices so far creating shared health summaries and contributing to the national e-health record. So from an ACT perspective, the health sector is embracing the national e-health record and we are seeing some really positive engagement with the national e-health record.

THE CHAIR: That is encouraging. And with regard to some of the other projects which were running within health, with e-health?

Ms Redmond: Since the inception of the healthy futures program, we have successfully delivered 20 significant e-health projects within the Health Directorate. Several of these have been rolled out to the Calvary public hospital. This is on top of our normal operational business as usual. We have had a number of significant upgrades also occurring in that time. We have totally upgraded the patient administration system; the radiology information system has been upgraded during that time. We have had a significant amount of projects occurring in that time.

We have seen some delays in delivery of some of the projects and we have had to reprofile some of the healthy futures program. This is predominantly around capacity. Part of it is the capacity of Shared Services ICT to be able to deliver the number of projects that are within the healthy futures program. But even if Shared Services ICT were able to ramp up and provide additional resources, it would be the capacity of the Health Directorate to actually absorb the number of projects that we are delivering under the program in such a short amount of time.

Twenty projects in a four-year time frame is a significant amount of change management and organisational change within the Health Directorate. We still have a number of projects to deliver, but it is really about making sure that we embed those. It is not just about introducing the technology; it is about introducing the organisational change, the adoption of the program, ensuring that, particularly in clinical areas, it functions effectively within clinical processes. The time frame has been extended for that reason.

THE CHAIR: Right. Do any of those projects include electronic prescribing?

Ms Redmond: Yes, definitely. That is a significant project that we are about to embark on. We are in contract negotiations at the moment with the preferred tenderer for that particular application.

THE CHAIR: Who is that?

Ms Gallagher: I do not think you can say.

THE CHAIR: You cannot say?

Ms Redmond: No.

Ms Gallagher: I do not know.

Ms Redmond: So yes; we are in negotiations at the moment for that. That is seen as a significant project within the Health Directorate. That is one of our big and important projects that we are going to be delivering over the next couple of years.

THE CHAIR: In terms of all of the systems that you are delivering, are they the same systems in Calvary and in TCH, or have you got different systems? I know that has

been an issue in the past, hasn't it?

Ms Redmond: We have established a really strong working relationship with Calvary. We have rolled out a number of systems to the Calvary hospital, so we now have the one patient administration system across both sites. We now have a unique patient identifier across both sites, which has enabled us to leverage off that and to deliver a number of other solutions. The radiology information systems are across both sites; the pathology information systems are across both sites. The mental health application—we have recently rolled out our clinical portal application across to Calvary public hospital. And more recently we have rolled out the ICU clinical information system across both hospital sites. So a number of our solutions are being rolled out to Calvary.

THE CHAIR: Do other members have any questions on e-health?

DR BOURKE: I have a question about something electronic, but not necessarily on e-health.

THE CHAIR: Let's give it a go.

DR BOURKE: Minister, the government announced on 13 June that it would be implementing a ban on commercial solariums from the beginning of 2015. What are the health risks associated with solariums?

THE CHAIR: I do not think that is e-health, is it?

DR BOURKE: It is electronic. I said it was electronic; I did not say anything about e-health.

Ms Gallagher: The concern that is raised about solaria is about increased risk of skin cancer. We did tighten regulations a couple of years ago now. They have not been unsuccessful; they have put some limits on who could access solaria and also around training for the use of tanning units and training about what the regulations were. But since that time, I must say that I have been lobbied by the Cancer Council and the AMA. I have also been mindful of legislative change in both Victoria and New South Wales, and they are moving to ban on that timetable. I thought we should move at the same time. This gives businesses—I think there are currently four businesses operating—a reasonable period of notice around their activities and this change. So it was a couple of things—the continuing representations I was getting from the professional organisations and also the moves by New South Wales and Victoria to ban.

DR BOURKE: There have certainly been some more publicised cases of people who have had some quite horrific skin cancers arising from the use of solariums.

Ms Gallagher: Yes.

DR BOURKE: Were there any major cases in the ACT?

Ms Gallagher: I am not aware of any. There may well be. Skin cancer is the most

prevalent cancer amongst young people, isn't it? I am looking for a doctor to start nodding at me. I am pretty sure it is. There is no doubt that using these tanning units can be very dangerous for people, particularly young people that are using them—especially when there is all that spray-on stuff you can do these days to get a nice tan.

THE CHAIR: Do you want to expand on that, minister—some advice for the committee?

Ms Gallagher: I think it is a much safer option. I have not used it myself, as you can see from my white skin, but there are safer options available if people want to have a tan.

THE CHAIR: Any further questions on e-health or things electronic that you might plug in? No? I have got some other ones. Diabetes services went through a restructure. There was a new service plan and a new position—the director of something?

Ms Gallagher: Diabetes?

THE CHAIR: Director of diabetes? How is that progressing? I do recall there was some problem in recruiting someone to that position. Could you give me a bit of an update on whether someone has been recruited, whether the diabetes services plan is in action, what feedback you have had and where we are at with that?

Mr Thompson: The diabetes service has a director, Professor Chris Nolan, who is an endocrinologist within the Canberra Hospital. He is now sharing his role, with half his time as the director of diabetes and half with his clinical work in endocrinology. He is leading the development of the service. They have recruited some additional social work staff; have established very close links with general practice and non-government organisations through their governance structures to develop services; and, in particular, are now looking at transferring some of their outpatient services from the Canberra Hospital campus to community health centres to provide a more accessible and expanded service capacity.

THE CHAIR: Have you had feedback from users of the service? I know that there were a few constituents who had been quite critical of it?

Mr Thompson: I am not aware that those criticisms have continued. I cannot recall receiving any.

Ms Gallagher: I have not had any.

THE CHAIR: That is good. Thank you very much for that. Are there any other issues on diabetes? No?

I want to go back to the review of the EDIS system and ED. There are a couple of issues I want to explore a bit further. One is that when the Auditor-General did her review, she found that it was likely that other persons have also changed EDIS records and said she was aware of changes being made by others that she could not identify. This is an issue that we discussed in the public accounts committee; it was the sort of issue where it looked as though other people had been involved but no-one could be

identified. Has the directorate taken any steps or have you had any further information that has come to light that would indicate who the other people were who may have been manipulating the data?

Dr Brown: Again, this is something that we looked at quite closely. As you will recall, we had the forensic data auditors in. I think I have reported previously that there is a difference of opinion between their interpretation of what they were seeing and the interpretation that the Auditor-General put on the same information. The Auditor-General was of the view that you could not rule it out. The forensic data auditors were of the view that there was no real proof or evidence that someone else was involved. So we have a difference of opinion between the two experts. We did take some steps to look further at what the data showed us; it did not take us in the direction of identifying any other individuals.

THE CHAIR: My understanding is that the misreporting of the data was referred to the police.

Dr Brown: Correct.

THE CHAIR: Are you aware of whether the police have concluded any investigations? Is the matter still under investigation?

Dr Brown: Certainly in the very recent past they have been continuing their investigation. I cannot say on this very day whether they have concluded it or not. They certainly conducted interviews with key staff within ACT Health. They requested a large amount of documentation. So they were certainly conducting a thorough investigation. I have not heard any outcome from that. As of just a few weeks back, it was certainly still an ongoing investigation.

THE CHAIR: I do not know if you are able to find out from the police whether that matter is still under investigation.

Dr Brown: I have to say that I do not believe the police would necessarily disclose that.

Ms Gallagher: I think that is a matter perhaps you could ask through estimates, but I do not think it is appropriate for Health to be asking the police when—

THE CHAIR: Whether it is still under investigation?

Ms Gallagher: We have referred it. The information comes back the other way.

THE CHAIR: Right.

DR BOURKE: In your experience, minister, do the police normally divulge to directorates the nature and scope of their investigations?

Ms Gallagher: No. My understanding of different processes, whether they be a coronial process or whatever, is that they would seek particular information or names of particular individuals, but not give a commentary on where they are up to.

Dr Brown: I suspect we will know if there is an outcome. If there is a charge laid, we will know that there was something conclusive. If there is not, we will make the opposite assumption.

MR SMYTH: With the information that the police requested, were you able to supply all that they wanted?

Dr Brown: I would have to take some advice on that. Mr Thompson might speak to it. It certainly was extensive.

Mr Thompson: We provided extensive information to the police. No, we could not provide everything that they asked for. But that was not because we declined to provide it; it was simply that we did not have that information available. They asked a few questions that we were not able to answer. But we have cooperated fully with their investigation.

THE CHAIR: Not knowing definitely, we will have to assume that that is a matter still under investigation. Probably we will follow up at a later date. If you do become aware from the police that they have concluded their investigations or if there is any further information, could you please advise the committee of that?

Dr Brown: Yes.

THE CHAIR: That would be appreciated. Dr Bourke, any further questions?

DR BOURKE: I am done, thanks.

THE CHAIR: Mr Gentleman?

MR GENTLEMAN: I am complete, thank you.

THE CHAIR: Mr Smyth?

MR SMYTH: Just to follow up on the Auditor-General's recommendations, they have all now been completed?

Dr Brown: In relation to the ED matter?

MR SMYTH: Yes.

Dr Brown: As I said, in terms of the recommendations, we put the recommendations from the Auditor-General and from PwC and developed an action plan that actually looked at both. I do not have in my head the specific number of how many are completed. They are substantially progressed and a number are completed. I would have to go back and get the specific figure for you.

MR SMYTH: Was that taken on notice earlier?

Dr Brown: No. Mr Ghirardello gave a fairly extensive answer about a lot of the

things that have been done and completed.

MR SMYTH: Is it possible to get a copy of the action plan and see which ones are ticked off and which ones are still underway?

Dr Brown: Yes.

MR SMYTH: Thank you. That is all on that matter. I am interested in Clare Holland House, if we are going there.

THE CHAIR: Clare Holland House, yes.

MR SMYTH: I notice that on page 122 of budget paper 4 the cost-weighted separations for Clare Holland House were a target of 618, and miraculously the exact outcome was 618. Is that just a coincidence?

Dr Brown: Mr Ghirardello will speak to this one.

Mr Ghirardello: At the end of March, Clare Holland House were on track against their targets. That is the estimate for the full-year target; they will reach it. They may be a few above or a few below, but they were on track at the end of March, so we have estimated a full-year outcome equal to the target.

MR SMYTH: What is the bed usage rate?

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

MR SMYTH: It is reasonably full, I understand?

Ms Gallagher: Yes, it is.

MR SMYTH: Is it greater than 85 per cent, do you know?

Mr Ghirardello: It fluctuates, but we can get you that figure.

MR SMYTH: All right.

Mr Ghirardello: It does fluctuate up and down.

MR SMYTH: Given that it is reasonably full, minister, are there plans to extend Clare Holland House?

Ms Gallagher: We have been doing some work around the palliative care plan. I have not seen any suggestion to me around extension of Clare Holland House. I have seen suggestions coming forward around planning for additional capacity in palliative care, but not to be delivered at Clare Holland House. People are after different types of palliative care. People are after home-based palliative care and a day program which we funded with the Palliative Care Society. There is some planning around some use of palliative care beds or palliative care provision within Canberra Hospital with additional beds that will be provided there. Decisions around expansion and change

will be informed by that palliative care strategy, which has not been finalised.

MR SMYTH: When is that likely to be finalised?

Ms Gallagher: I do not know. We can take that on notice, but I imagine it is relatively soon.

MR SMYTH: All right. Back on page 122—if I am reading this right, I am assuming notes 1 and 2 correspond to output 1.5, Clare Holland House?

Ms Gallagher: Yes, output 1.5.

MR SMYTH: It says that the measure is now reported in strategic objective 1. But if you go to page 118 where strategic objective 1 is, it is the percentage of elective surgery cases admitted on time. Am I going to the wrong place, or is that back in—

Ms Gallagher: I am sorry, we need to better—

Dr Brown: We have got strategic objective 1 for the LHN on page 118. I am just trying to find where the footnote is.

MR SMYTH: Here comes Ron. Ron knows. Is Ron ever allowed to go on holidays?

Dr Brown: No.

MR SMYTH: It is probably very wise.

Dr Brown: That is correct. Page 121, in 1.1 under "Calvary", item c. is where that footnote is. The note on that is that it is reported in strategic objective 1. Calvary is included in the whole of—

THE CHAIR: The local hospital network.

Ms Gallagher: The local hospital network.

Dr Brown: The LHN. Strategic objective 1 for the LHN provides the result for Canberra Hospital and Calvary hospital.

Mr Ghirardello: Yes, it should probably read accountability indicator 1, not strategic indicator 1.

MR SMYTH: I am sorry? So we go to page—

Mr Ghirardello: The footnote at 1, which is at the bottom of all the local hospital network indicators, relates to the elective surgery target, which is in strategic indicator, strategic objective, 1.

Ms Gallagher: Yes.

MR SMYTH: All right. So where do we find the data for Clare Holland House?

Dr Brown: There is no elective surgery at Clare Holland House. Footnote 1 is for all of the output classes.

MR SMYTH: They measure for all of them. Okay. So where it says "not available", where do I now find it? What page am I looking for?

Mr Ghirardello: On page 121 in output class 1, the ACT hospital network, all the activity from the whole of the local hospital network is now included in that table. That includes Canberra Hospital, Calvary Public Hospital and Clare Holland House activity. It has been put into the local hospital network as a total so that it matches the service level agreement that the local hospital network has with the Chief Minister about activity to be provided in the year.

MR SMYTH: Okay. So how do I find out which part of that is Clare Holland House?

Ms Gallagher: So then you ask a question of that. This is the first time we have reported in this way. If the committee has a view about how to make that clearer, elements of the LHN—

MR SMYTH: There is no way from that aggregated number that you can determine what Clare Holland House is doing.

Ms Gallagher: Without saying, "Of this, what is Clare Holland House?" yes.

MR SMYTH: Can you break that number down for us?

Mr Ghirardello: Yes.

MR SMYTH: Thank you.

THE CHAIR: That is on notice, is it?

Mr Ghirardello: My apologies; yes.

THE CHAIR: It goes to a broader point, though, and that is that the budget is quite difficult to read with the local hospital network, SPPs, NPPs and all the various bits of it. What would be quite useful for the budget is a simplified version in terms of what is coming from the commonwealth, because there is money coming from the commonwealth in a range of areas. We used to get funding that was NPPs and SPPs and it was easier to determine what that was. Now with the fairly complex—

Ms Gallagher: Yes, I agree. This is the first full year of national health reform changes being implemented in the budget.

THE CHAIR: Noting that we have only got four minutes to go, rather than go through them in detail, one thing I am particularly keen to see is this: what is the headline figure in terms of the change from what we used to get in money from the commonwealth to what we get now? I know all the systems have changed and there are cost-weighted separations and—

Ms Gallagher: It is not cost weighted; it is NWAUs.

THE CHAIR: Well, there you go. The system seems to be, as you appreciate, quite complex. We have created a whole new directorate to manage it, essentially. Could you provide me with a map of what commonwealth funding was over the last, say, four years and what it is in this budget project so that I can get a bit of a sense of what the total amount of commonwealth funding for health is? Maybe you can give me that figure right now; I do not know.

Ms Gallagher: It is to some extent explained in the financial tables, but, yes, I can certainly talk—

Dr Brown: It has not changed substantially. Obviously there are some minor changes, but the national health reform, in terms of delivering the increased commonwealth contribution to the growth, kicks in in 2014-15.

THE CHAIR: That is fine.

Ms Gallagher: It is two sets of financial statements. The grants from the commonwealth are identified in both the Health Directorate's operating statement and the LHN's operating statement. It is a matter of just combining them.

THE CHAIR: I am happy to take it on notice, but what I want to see is if you can provide the total figure over the last few years and then what it is expected to be over the next few years so I can get an understanding of what the gross impact of these reforms has been in terms of, when you add them all up, what are we getting? Are we getting any more? Are we getting less? And if we are getting more or less, what is the quantum of that?

Dr Brown: Mr Foster is directing you towards page 124 of BP3.

Ms Gallagher: BP3?

Dr Brown: BP3, table 4.9.

MR SMYTH: If the minister cannot find it, what hope have us mere mortals got?

Dr Brown: Page 124 has details of commonwealth government grants.

THE CHAIR: Right.

DR BOURKE: Bingo.

THE CHAIR: That is the summation of both lots, all the various bits? That is good. Thank you very much. It was worth it after all, wasn't it?

DR BOURKE: Coming back to the detail in the budget, I understand previously there was a budget line for palliative care in the community or in a hospice. Is it correct that there used to be a budget line for palliative care in the community or in a hospice?

Ms Gallagher: There is an agreement with Calvary through their performance agreement each year for the purchase of community and inpatient palliative care. When it appears as an increase to that, you would see it as a line in the budget.

Dr Brown: Internally, of course, we have our allocations around all the services. There has been, as the minister indicated, some funding to community organisations to establish day hospital palliative care services. There are things like that that are line items in our internal budget, but they do not show up in the budget.

THE CHAIR: We might hold it there. Just a reminder that the committee has resolved that questions on notice be lodged within three days of the receipt of the uncorrected proof of the transcript. Answers to questions on notice are to be lodged with the committee within five business days of receiving the question. Answers to questions taken on notice are to be provided within five days of the hearing at which the questions are taken.

Minister, officials, thank you again. May I also take this opportunity, as I like to do, to thank all of the members of the Health Directorate for the great work that they are doing out there. Keep it up. I know that estimates is a particular highlight for you, and I look forward to seeing you all again next year. I might see you at annual reports.

The committee adjourned at 5.28 pm.