LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2014-2015

(Reference: Appropriation Bill 2014-2015 and Appropriation (Office of the Legislative Assembly) Bill 2014-2015)

Members:

MR B SMYTH (Chair)
MS M PORTER (Deputy Chair)
MRS G JONES
MS Y BERRY

TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 20 JUNE 2014

Secretary to the committee:
Dr B Lloyd (Ph: 620 50137)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

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Amended 20 May 2013

The committee met at 9.30am.

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
- Thompson, Mr Ian, Deputy Director-General, Canberra Hospital and Health Services
- George, Ms Jacinta, Acting Deputy Director-General, Health Infrastructure and Planning
- Bowden, Professor Frank, Chief Medical Administrator, Canberra Hospital and Health Services
- Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
- Foster, Mr Ron, Chief Finance Officer, Financial Management
- Pengilley, Dr Andrew, Acting 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
- Hall, Dr Michael, Clinical Director, Emergency Department
- Greenfield, Ms Joanne, Director, Health Improvement Branch

THE CHAIR: Good morning, ladies and gentleman. Welcome minister, and all your officials, for the seventh day. Traditionally on the seventh day they rested, but that might not be the case until about six o'clock tonight. But we will see what happens.

Welcome to the Select Committee on Estimates 2014-15. In the proceedings today we will look at the expenditure proposals and revenue estimates for health and community care. The proceedings today are being recorded, transcribed and broadcast. After the hearings a proof transcript will be circulated to allow witnesses to request corrections if they are required, and they will be made at the discretion of the committee.

Witnesses are asked to familiarise themselves with the privilege statement. Could those at the table acknowledge that they have seen the privilege statement, read it and understand its obligations and protections? They have all nodded yes; fantastic.

If you take a question on notice, the committee would be grateful if you could say words like, "I will take that question on notice." That allows us to be confident as to who is doing what. By resolution of the committee time frames for questions taken on notice are five working days after the hearing, and questions on notice are three days after the transcript is available. Minister, would you like to make a brief opening statement?

Ms Gallagher: Thank you, Mr Chair. We welcome the opportunity to discuss the Health Directorate and the ACT local hospital network today with the estimates

committee. As members will see, the 2014-15 budget provides $1.39 billion across both directorates in annual and recurrent funding for health services for the people of the ACT. It also includes new capital funding of $122 million over four years, taking the capital allocation for the health infrastructure program to $877 million. This budget also includes growth and new initiative funding of $37 million, and $164 million over the four years.

Funding through those new initiatives will provide for an additional 129 full-time equivalent positions for the health recurrent initiatives, which includes accommodation of medical staff, nurses, allied health professionals and administration staff.

A number of new initiatives are outlined in the budget paper which cover new funding for both public hospitals—Canberra Hospital and Calvary hospital—and specific services within them. Also there is additional funding for important services in community health, and for supporting the introduction of legislation such as the mental health act and suicide prevention. Additional funding for our community health centres is included as part of that new recurrent spend.

In terms of the capital initiatives, this budget will provide for the construction of a car park at Calvary Public Hospital and refurbishment for more beds at Calvary Public Hospital. It will also see the construction of a secure mental health unit, the additional redevelopment works that are continuing at the Canberra Hospital, and the next stage of the development of the University of Canberra public hospital.

I should add, before we go to questions, that the federal budget did see a reduction in expected funds from the commonwealth to health under the national health reform agreement in the order of $240 million over the forward estimates period. That has an immediate reduction of the order of $47 million in this next financial year. As you will be aware, the government took the decision not to flow those reductions in costs through to the Health Directorate. But over the next 12 months we will be working with Treasury across government to look at how we manage these funding reductions into the outyears.

I think members would agree that, two weeks out from the release of our budget, a reduction in funding of that order would have had serious consequences for the health system. It would have meant a reduction in elective surgery or a reduction in workforce that was not part of our thinking or part of our planning. So we have continued to absorb that in the bottom line. Whilst there are savings in this budget for health that carry over from the previous year, we chose not to flow those on this year. I think that was the right decision.

As you can see, we are a packed room. All the officials stand ready and waiting and are eager to answer questions from the estimates committee this morning.

THE CHAIR: I am sure they do. Let us go to where you finished, Chief Minister. You referred to an "expected" $240 million reduction from the federal budget. Is it $240 million? What is the amount and how do you justify that number?

Ms Gallagher: I am very happy to talk through the reductions. They are shown in the

budget statement—the old budget paper 4—at table 53 on page 43, which shows that national health reform funding for the local hospital network is $47 million this year, $62½ million next year, $79.4 million in 2016-17 and $54.464 million in 2017-18.

THE CHAIR: Can I refer you to budget paper 3 on page 35. You are saying that you have lost $47 million this year. Budget paper 3 claims it is $39 million. What is the correct figure?

Dr Brown: The difference in those figures is the difference between the overall expected funding and the funding due to the guarantees under the national health reform agreement.

THE CHAIR: Since the budget have you confirmed these numbers with the federal government? I know the federal government has disputed the numbers that you are quoting.

Ms Gallagher: They are not disputing that they have taken away the funding guarantee. They are not disputing that. That is the large part of this. When we moved into national health reform there were commitments around the transition arrangements in preparation for the commonwealth taking a greater share of the health growth in 2017-18.

Dr Brown: 2014-15, 45 per cent; 2017-18 was set at 50 per cent.

Ms Gallagher: Yes. There were transition arrangements under the national health reform so that, as we transition from the SPP to activity-based funding, that allowed for essentially a no-disadvantage element and a funding guarantee element. In the budget they have walked away from those commitments.

Yes, I have raised it. I have raised it with the Prime Minister. I have raised it with the Minister for Health, and other ministers have raised it with the Minister for Health. So this is not an ACT issue. Every other state minister has raised the fact that the funding guarantee has gone. It is particularly difficult for small jurisdictions where we do a range of functions that cost us more because of our economies of scale. So for other small jurisdictions this is a real issue.

THE CHAIR: Has the federal government told you exactly that these figures are correct or is this your assessment of what they are?

Ms Gallagher: They are our assessment of the removal of those arrangements.

Dr Brown: We have requested their detailed workings. They have indicated to us they have them. Last week the Minister for Health indicated that he would agree to release them. Prior to that there had not been such agreement. But despite our best efforts we have not yet received those detailed workings. So all we can go on is our assumptions and our figures.

THE CHAIR: What is the basis of the assumptions? How did you come to these figures?

Dr Brown: Essentially we have historically had funding through the SPP and we assumed that that would continue to grow at some level of indexation, as it has in all previous years. In addition to that we expected there would be funding for growth on the activity-based funding basis of 45 per cent for efficient growth. Then there is a cross-border element as well, and the guarantee that no states will be any worse off through signing up to the national health reform agreement. So there were a number of different components to our calculations. We cannot tell what is in the commonwealth figures because we have not got their breakdown.

MR HANSON: Can I ask a supplementary? If we were to get the 2012-13 budget and the SPPs—all the national partnership agreements—and compare it with what is in this budget, what is the difference? It sounds like you are making some assumptions and it sounds like you are talking about things that are in the outyears of the budget—2017-18 and so on. When we take last year's budget—the 2013-14 budget—and we look at what was in there from the feds, and what is in this budget from the feds, what is the difference?

Dr Brown: The challenge with the previous budget is that the assumptions that we make have never been openly published from the commonwealth government in either of the budgets. This has been raised with the commonwealth previously.

MR HANSON: Sure, but there was an amount in the budget, the 2013-14 budget, which would have been under a series of line items, I assume, of SPPs and national partnerships which would have come to a total amount of federal funding. There is now a total amount of federal funding in this budget. What I am asking—and you may not have this here now—is for you to provide me with the delta between those two figures.

Dr Brown: Yes. I do not have that figure. We have the figure from the SPP but it is not the total.

MR HANSON: Sure. Could you take that on notice—total federal funding for health in the 2013-14 budget in the forward estimates comparative to what is the federal funding for health in the 2014-15 budget and what the delta is between those two. That is real money. That is not assumptions; that is what you are getting.

Ms Gallagher: If you go to the commonwealth budget and have a look you will see that next financial year their payments to the ACT decrease, unlike every other jurisdiction, and then on average grow in the order of about three per cent.

MR HANSON: Could you break that down, minister, by line item, so that I can see if there is a particular aspect that is going down or is being cancelled or whatever it is.

Ms Gallagher: There is only one SPP and it does not exist anymore. It is the national health reform agreement. There are NPs which were in place which expire, like the subacute, the elective surgery, the public hospitals—all of those.

MR HANSON: Was that subacute expiring anyway or was that—

Ms Gallagher: Yes, the subacute was expiring.

MR HANSON: Have you counted that in your $240 million—something that was expiring anyway?

Dr Brown: No.

Ms Gallagher: No. Then there are consequential impacts of the NPs that have been cancelled, which were not due to expire and which have been cancelled—the removal of reward funding, for example, has gone, and a whole range of things.

MR HANSON: Ultimately there was a bucket of money that was in the budget last year, there is a bucket of money that is in the budget this year, for forward estimates. I want to see what the delta is between those two.

Dr Brown: Could I clarify, in relation to that NPA on improving public hospitals which included the subacute, that it was due to expire; that is correct. But it was also due for review by the end of last year, with a determination to be made about what was to happen because the quantum of funds for services in that NPA was extensive and all jurisdictions said, "We built up services based on this funding that we will not be able to guarantee can continue unless that funding is received."

MR HANSON: You said that is not in your $240 million?

Ms Gallagher: No.

MR HANSON: When you say "funding guarantee", that was based on the fact that there were targets and population figures?

Ms Gallagher: No.

MR HANSON: What is the—

Ms Gallagher: No, that was a funding guarantee. For jurisdictions to move to activity-based funding, there would be a transition arrangement in place where no-one would be worse off. There was an acknowledgement that, in particular, for the small jurisdictions who do provide services that cost more because we cannot deliver them at the price that New South Wales and Victoria would, there would be a buffer provided so that you did not have this catastrophic situation where you just had the tap turned off and you just had to deal with it. That is separate from reward funding which has now also been taken out of the national health reform agreement.

MR HANSON: The assumptions that you have made as well when you looked at the $240 million, did they include assumptions for the 2017-18 financial year but which were never in the budget?

Dr Brown: I think they were reasonable assumptions given that the national health reform agreement clearly set out that the funding, the commonwealth contribution, would grow to 50 per cent.

MR HANSON: But that funding was never in any budget anywhere.

Dr Brown: It was a clear commitment set out and signed up to as part of the national health reform agreement.

MR HANSON: Sure, but what I would say—

Ms Gallagher: So we have just flowed it through because we have to pick up our forward estimate. We could not just have a zero in the 2017-18 year for this. We have not tried to manufacture anything. We have just flowed through the changes that were announced in the budget as they were announced and flowed them through our figures.

MR HANSON: But you take my point: the big increases in funding that were occurring at the federal level were in the outyears of the federal budget under the previous government.

Ms Gallagher: No, there were additional—that is for the year they would have kicked in the additional—

MR HANSON: That were never there.

MS GALLAHER: I do not think that is something for this estimates committee to worry about. I know you are speaking to defend Peter Dutton here but—

MR HANSON: No, I am seeking to examine. You have been putting out—

Ms Gallagher: we are not worried—I am not arguing about the $80 billion cut there. I am worried about the $240 million cut that starts on 1 July. What happens in 2017-18—

MR HANSON: Sure, but you have been putting out press releases trying to whip up a little bit of a frenzy around this. I want to get to the bottom of what is going on.

Ms Gallagher: Along with Campbell Newman, Mike Baird and all the other Liberal premiers. You are the only Liberal in the country that does not seem to be worried about this.

MR HANSON: I want to get to the bottom of what is going on because as we have seen before, you are not always honest with your figures.

Ms Gallagher: No, I totally reject that, Mr Hanson. If your job in Canberra is to be a chief investigator for Peter Dutton, then be up-front about that.

MR HANSON: My job is to see if you are telling the truth. My job is to see that you are telling the truth because you have a history—

Ms Gallagher: Okay, so what are you suggesting here?

MR HANSON: of not telling the truth.

Ms Gallagher: No, I do not have history—

MR HANSON: Yes you do. You have a history—

Ms Gallagher: No, I do not have a history.

MR HANSON: of releasing figures that are dodgy; so let us get back to the figures—

Ms Gallagher: That took all of five minutes to get to.

MR HANSON: rather than you playing politics, could we?

Ms Gallagher: You are going to have to find a new issue, Mr Hanson. The issue here is—I would expect your role as shadow health minister should be to stand up for the health system in this city—that we have had a cut in the order—

MR HANSON: My job, minister, is to ask you the questions—

Ms Gallagher: of $240 million.

MR HANSON: not for you ask me the questions—

Ms Gallagher: Yes, that is right.

MR HANSON: and to get to the bottom of the truth about what is in the budget.

Ms Gallagher: And we are answering. That is right.

THE CHAIR: Right, one at a time, please.

Ms Gallagher: And we are answering the questions for you. You are casting aspersions on the accuracy and the intent of the information that is included in our budget papers—

MR HANSON: In your press releases.

Ms Gallagher: of which you have no evidence. The press releases and the media statements match the advice from the ACT Treasury and the Health Directorate about what those reductions in funding are expected to be. If you think those figures were cooked up in my office for some political purpose, then show me the evidence to prove that. This has come from the ACT Treasury in analysing the federal budget, its impact and flow-on effect to health, and that is the end of the story. There is a $240 million expected reduction in funding and we are going to manage that.

We are seeking to manage it and it is something that is happening around the country. Every other jurisdiction—I was on a phone hook up with Peter Dutton last week—and every single minister in the country raised cuts that come on 1 July with the minister; every single one of them. So it is not a Labor Party conspiracy. Every single one of them did.

THE CHAIR: In regard to the numbers, on your chart on page 43 of the portfolio

statement you list $47 million. What is the breakdown of that by component?

Ms Gallagher: We can provide you with that, with the majority of it. I mean, part of our issue is that we are trying to work out from the commonwealth what has informed their allocations. In response to a question I asked, as Dr Brown said, for their funding breakdown, he undertook to give it to us; so hopefully he will give it because—

THE CHAIR: So at this stage you do not know that this number is true?

Ms Gallagher: We know how much is coming from the commonwealth. That is clear in their budget papers. How they got to that being the right figure we do not know and there is a question, I think, for us around cross-border activity and payment for cross-border activity, which we are trying to verify with them.

THE CHAIR: So the $47 million breaks down into what?

Dr Brown: The $47 million is the difference between what the ACT expected and what is in the commonwealth 2014-15 budget paper. Now, the ACT's figure is built up on the basis of the commonwealth ABF funding, the commonwealth block funding, the cross-border funding and public health funding. That comes to a total of $318,438,000. The commonwealth budget published figures have a total of $271,100,000, the difference being $47 million.

Ms Gallagher: In this year it almost entirely matches the cross-border component.

THE CHAIR: So can you provide that as a written reference to the committee?

Dr Brown: I am happy to provide this table to you.

THE CHAIR: All right; that is fine.

MR HANSON: I have a supplementary. The cross-border component, that is the money paid—

Ms Gallagher: The commonwealth share of largely New South Wales activity.

MRS JONES: So is it possible that that is an error—

Ms Gallagher: I do not think so. I think it is just probably—

MRS JONES: given that that is an unusual type of funding and it is not necessarily attached to the outyears funding that has been cut?

Dr Brown: The challenge with this is that it would be easy for us to know whether our assumptions are incorrect if the commonwealth would give us their figures.

Ms Gallagher: Which they said they would do—

Dr Brown: They did say one week ago that they would. We have not yet received them but we asked for them the morning after the budget and up until last week the

answer had been no, that they could not release them. We are awaiting those figures and we will be happy to provide more detail once we have them.

THE CHAIR: Page 263 of budget paper, table 7.1.3, lists the federal payments. The health reform in 2014-15 is at 271. Is that what was estimated or has that changed?

Dr Brown: No that is the commonwealth budget figure—$271,100,000. Our estimation in the 2013-14 ACT budget was $318,438,000 for the 2014-15 year.

THE CHAIR: So where is that shown in the 2013-14 budget papers?

Dr Brown: I will have to go back. It is not in the 2014-15 budget. It is out of the 2013-14 budget. I will have to actually—

MR HANSON: What paper have you got, Mr Chair?

THE CHAIR: Our good friend, Mr Foster, there might be able to help. On page 263 of budget paper 3 of the 2014-15 budget. In the previous year's budget paper in the section called "federal finances" it just lists national payments as $26 million for the coming year.

Dr Brown: Sorry, could you repeat that?

THE CHAIR: In the previous year's budget papers, table 4.6, commonwealth NP payments for the ACT, it has just got $26 million. That seems to be the only figure that appears in last year's budget paper for the coming year.

Dr Brown: I do not have that in front of me, I am sorry, so—

Ms Gallagher: Yes. We have to have a look at that, because that would have been catastrophic.

Dr Brown: But even if—

THE CHAIR: Sorry, there is a different chart. In the 2013-14 budget the commonwealth national specific purpose payments to the ACT are listed as $270 million and in this year it is $271 million.

Ms Gallagher: Yes, so an extra one million in a health system that is growing at eight per cent.

THE CHAIR: Where is the cut?

Ms Gallagher: That is the cut.

Dr Brown: The difference is that the SPP figure last year we expected to grow. Historically it has grown at—I think in the last three years it has been in the order of 10 to 11 per cent and the cross-border funding was in addition to that SPP figure last year.

THE CHAIR: That is fine.

Dr Brown: This year's figure is said to be inclusive of the cross-border activity.

THE CHAIR: But the figure in last year's budget papers is that you expected this year—your own estimate for this year is $270.5 million and you have got $271.1 million.

MR HANSON: You have actually got more than was expected.

THE CHAIR: If you expected more, why was there not more in last year's budget papers?

Ms Gallagher: I am not fully understanding where you are going.

Dr Brown: You are saying the SPP has grown by about $600,000 on what we anticipated in—

THE CHAIR: I am saying your estimate last year for the coming year's budget was $270.5 million and this year it is $271.1 million.

Dr Brown: Which means there has been a growth of $600,000 on the estimated figure from last year—

THE CHAIR: Yes, that is right.

Dr Brown: but as I indicated to you, that figure last year was exclusive of cross-border. This year's figure is said to be inclusive of cross-border and we anticipated that there would be some national guarantees over—

THE CHAIR: So it is unclear?

Dr Brown: That is what we have been saying from the outset, that there is—

THE CHAIR: No, your press release is saying there is a cut of $240 million.

Ms Gallagher: Well, there is. The $270 million that you refer to in that previous year's budget does not include the cross-border, which equals in this year in our estimation about $47 million; so—

THE CHAIR: That is last year's?

Ms Gallagher: That is right.

THE CHAIR: Sorry, the current year's budget does include cross-border?

Ms Gallagher: That is right.

THE CHAIR: You think the coming year's budget does include cross-border?

Ms Gallagher: Yes.

Dr Brown: That is the advice we have had.

Ms Gallagher: That is the advice we have had. Whatever way you look at it, to suggest that the commonwealth share of growth—can you imagine if we increased our health budget by $600,000? I think you would all be screaming that there would be a health cut.

THE CHAIR: There are a number of portfolios this year, in your own budget, that received well less than CPI, and we have asked those questions.

Ms Gallagher: One, they are not the largest part of our budget with the highest level of growth, but we are trying to constrain growth under eight per cent at the moment, and the commonwealth has reduced our cross-border funding and tossed us $600,000 to get through. Any way you look at it, you should be concerned about it. You should not just be—

THE CHAIR: I think everybody is concerned about health funding.

Ms Gallagher: You should not just be disbelieving the ACT government, that we are wrong.

THE CHAIR: No, no we are asking for an explanation.

MR HANSON: It goes to a broader question, if I can. When we were here last year and we were talking about education funding, we had exactly the same situation when we compared the previous year's budget to the current year, the anticipated. It had been reduced by $30 million and you supplemented it by $30 million and you claimed that a success. I am struggling to see the inconsistency here.

Ms Gallagher: No, you are talking about two completely different things.

MR HANSON: I am talking about two blocks of federal funding that came in. When you had a reduced amount from the previous Gillard government, you supplemented it and said it was a success. You are claiming there is a reduced amount from the current government and you are going out and putting out press releases saying it is a problem.

Ms Gallagher: No, it is an entirely different thing. I can see how incredibly comfortable you are as the biggest apologist for the commonwealth government here today, but they are two completely separate issues. One was around the better schools and the issue around the indexation of that was because the state and territory governments had reduced their funding to public schools and, therefore, it had lowered the indexation arrangement, which flowed on to everybody.

The issue with the health system is that they have walked away from key components of the national health reform agreement that made it stack up for the ACT, a small system, and that has had this impact on us in this budget and it will flow through unless those decisions are changed. But to conflate those two and say they are exactly the same is absolutely incorrect.

MR HANSON: It is exactly correct.

THE CHAIR: We will move on to a new question from Ms Porter.

MS PORTER: I am referring to page 98 of budget paper 3 and also mention is made under output 1.1, acute services, on page 12 of the little budget statement. It talks about expanding elective surgery—and you made some reference to this in your opening remarks, I believe, minister—by 500 procedures per annum to improve elective surgery waiting times. It goes on and elaborates it still further on page 12 of the budget statement. Can you update the committee on the progress of this particular initiative and how the ACT is utilising the private sector in elective surgery tasks?

Ms Gallagher: Yes. We have put in, as you can see, an extra $34 million in elective surgery over the forward estimates. This will allow us to perform more operations, and we are growing them across the budget to 12,000 operations. When you try to put that in perspective, in 2001 we were doing around 6,800 procedures a year. We are expecting to perform 12,000 this year. So we have seen about a 50 per cent increase in elective surgery against a population growth of about 17 per cent. That is just to show you how rapidly we are trying to grow the elective program.

The extra money in this budget will focus on those people who are waiting too long for care, again. That has been a theme in the last couple of years. Again, to show you the progress that has been made there—and there are people in this room responsible for the leadership of that who have been working very hard—four years ago there were over 2,000, about 2,300, people waiting too long on the elective surgery list for care. At the end of April, that number was down to 679. Again, whilst perhaps it does not sound as big as it is, that is a huge reduction, about a 71 per cent reduction, in people who are waiting too long for their operations, which is a fantastic outcome.

The extra money will be largely used for high volume, like ENT and orthopaedics. There is some extra money in there for the bariatric service as well. That is a small component, and we will continue to use the private sector where it stacks up, where it works. Part of that is trying to alleviate some of the pressure from Canberra Hospital to free up the theatres there and there are some negotiations underway around that for private sector involvement there.

In the 2013-14 year, 329 procedures were done privately. It is a small component but it can be very useful, particularly if it frees up and allows the theatres at Canberra, which is the emergency centre, to be used more effectively. But overall it is a very positive story on elective surgery. We are doing more operations. The overwhelming percentage of people are getting their operations done within the clinical time frames, and the long-wait patient list is reducing dramatically.

Our partnerships with the private sector are good. It is an efficient and effective way of utilising the private sector, and we have got some other work underway around delineation across the hospitals which is being led at the moment, and discussions with the surgeons have to date been positive.

MS PORTER: With regard to what you were talking about before, the cross-pool of

money, numbers of these people would be coming from across the border. Also you alluded—

Ms Gallagher: About 30 per cent, I think, on the elective list, yes.

MS PORTER: About 30 per cent are coming from across the border. You alluded to the fact that Canberra Hospital is a trauma hospital. Also we are getting a number of people coming across the border to utilise our emergency for serious trauma. That is the reason why, from time to time, theatres are tied up with that, which causes pressure.

Ms Gallagher: I think on any day half of the theatres at Canberra Hospital, is it, would be used solely for emergency work, which does place pressure on the elective program, which is why the work that is being done across the hospital with Ian's area is looking at a better delineation. That will, in short, mean more surgery being done at Calvary and, where we can, in private arrangements, to take some of the pressure off. A lot of elective work will still be done at Canberra, but it will just be done in a more manageable way.

THE CHAIR: Supplementary, Mr Hanson.

MR HANSON: The private surgery, as you said, was 329 last year. In order to take 12,000 off the list, do you reckon that is going to go up, or it is about that level, or—

Ms Gallagher: Yes, up.

MR HANSON: To about? Have you got a specific number?

Dr Brown: We do not have a specific number at this point in time. We are looking at some new arrangements around the routine provision of elective surgery that incorporates a greater role for the private sector, and then in addition we have the capacity, as the minister has indicated, to look at those that have the longest waiting times and the needs there. We supplement that as we need, and go throughout the year.

MR HANSON: What is your contracting process with that? Do you put out a tender, or are you dealing directly with a couple of day surgeries, or with John James, or how does that work?

Dr Brown: We went out, for an expression of interest a number of years ago, to private hospitals, private providers, who would seek to be on our panel of providers and we put out work orders to individual providers, not to individual surgeons but to the private hospitals, around a quantum of work that we required to be done.

MR HANSON: With those 329 procedures that were done, have you done a cost comparison to see whether there are efficiencies in doing it in the private sector? Is it cheaper to do in the private sector? Is it more expensive? Is it about the same?

Dr Brown: Historically, we have paid identical to what we pay in the public sector for the work in the private sector. So there is no cost difference. I alluded to the fact that we are looking at some reorganisation of our elective program, and that does

incorporate the private sector and we are seeking in that to actually achieve efficiencies.

MR HANSON: I thought there would be some overheads that you have got to deal with in the public system that the private system, you would think, might be able to do in a competitive sense.

Dr Brown: We are certainly seeking to achieve that, going on.

MR HANSON: Good luck.

THE CHAIR: We are back to Ms Porter.

MS PORTER: In relation to surgical procedures, minister, on page 12 it talks about the key strategic priority for acute services is to deliver timely access to effective and safe hospital care services. I was wondering if you could tell us the numbers of people who need to return to hospital after they had a procedure performed in the hospital, re-admitted and—

Ms Gallagher: It is very low. It is in the order of—

MS PORTER: How is the ACT public hospital system performing in relation to unplanned return, from the ward to the theatre?

Dr Brown: The percentage is well below the national target. There is a differential between Canberra Hospital and Calvary hospital. I will get you the figures. The expected outcome for Canberra Hospital return to theatre was 0.7 per cent in 2013-14, and at Calvary it was 0.3 per cent. They are both below the national target, the target being for Canberra Hospital less than one per cent, and Calvary less than 0.5 per cent. The reason there is a difference between the two hospitals is that they actually fulfil different roles. Canberra Hospital, being the major tertiary referral hospital and the trauma centre, takes the more complex cases and those that are more likely to have complications and require a return to theatre, but they both perform very well against the target.

Ms Gallagher: That equates, I think, to less than 1 in 200 operations returning to theatre, because of the high-quality care that is provided.

MS PORTER: Until you open someone up you do not know sometimes what you are going to find there. Being a person who used to work in theatre in Wollongong, where of course we used to have the mining accidents, I can relate to the fact that this hospital is a trauma hospital and your theatres can sometimes be taken up with very bad accidents.

I also notice there has been a campaign across the whole of the health system around hand washing. I know that that has been something of a focus for you.

Dr Brown: Yes, hand hygiene is a focus for us, as it has been nationally, driven particularly by the Australian Commission on Safety and Quality in Health Care. The national benchmark is set at 70 per cent, and I am pleased to say that our outcomes at

both hospitals have surpassed that benchmark figure. Calvary is currently expecting to reach 76 per cent this year, and Canberra Hospital, 73.

MS PORTER: That is fantastic. I do not think the general public realise how important that aspect is. It is a simple thing, but it is really important. Thank you very much, minister.

THE CHAIR: A new question from Ms Berry.

MS BERRY: Minister, the budget continued on the government's commitment to increase the number of beds across the ACT's public hospital system. How many additional beds will be funded this year?

Ms Gallagher: In terms of beds—just checking my notes here—in last year's budget we funded an extra 44 beds. Some of those have already opened at Calvary, as you would have seen. In the 2014-15 year there will be 31 extra beds and six bed equivalents in the hospital in the home program.

Dr Brown: And on top of that, if I could just add, there are an additional three intensive care beds across the territory, and five additional beds in the Centenary Hospital for Women and Children.

MS BERRY: And how many extra staff will be employed by ACT Health as a result of this increase in the number of beds?

Dr Brown: There are an additional 39 staff at Canberra Hospital associated with just the additional 16 beds. We do not actually count the FTE for Calvary hospital. I am sorry, I do not have the additional FTE figures for the ICU and Centenary Hospital for Women and Children, but ICU is a labour-intensive environment, as reflected by the high costs of each individual bed, which is about $1.3 million per annum, $1.2 million or $1.3 million. So there is certainly additional staffing in both of those initiatives as well.

MRS JONES: Are you able to provide that on notice?

Dr Brown: Yes.

Ms Gallagher: On the staffing numbers? And in the acute beds, they will be shared pretty evenly between Canberra and Calvary hospitals and the ICU beds, two at Canberra, one at Calvary.

MS BERRY: And how has the nurses union responded to the increase in numbers? Have they been—

Dr Brown: Sorry, could you repeat that?

Ms Gallagher: The nurses.

MS BERRY: It is probably a tricky question, I know, because you can always have more nurses, but it would be interesting to hear what their views are.

Ms Gallagher: The nurses union have been largely positive about the budget. They will always keep us on our toes around workload. They are pleased that we are investing in employing more, but it will be an ongoing discussion with them around management of workloads in particular parts of the hospital.

MS BERRY: I spent some time with my own family in the emergency department and within the surgery in the hospital, and I wondered about the management of surgery that has to happen in a couple of weeks after an injury occurs and the elective surgery. Because when you are sitting in the recovery room and you see all the different things happening around you, you sort of go, "Our surgery has to happen within two weeks of the injury happening." That must happen all the time particularly with sports injuries.

Ms Gallagher: The hospital runs an emergency list and an elective list. For those who require surgery within that time frame, the majority of them would remain on the emergency list with different categories within that emergency list. Some could move into category 1 elective, but the majority of them would be done through the emergency program. That is managed day-by-day and hour-by-hour sometimes depending on what comes through the door.

I know it is a source of frustration for some, particularly those who have to fast for a day and they head into theatre and they almost get there and then they are cancelled. That would be because someone more urgent had come in and moved them out of the way, and that is very difficult. That is difficult for staff to manage that as well as for patients who have been waiting.

My observation is that the hospital manage that as well as they can within the confines of a very busy hospital and peak times. For example, with the ski season opening they will expect a few more injuries, and the weekend with sports is busy. That is why the delineation of some of our surgical work is important, so that you do not have the elective surgery putting as much pressure on as the emergency. For people on the elective list it is just as important that they get their surgery as well. They have probably been working up to it for months, the surgeons want to do it and everyone is ready to go—

MS BERRY: And then somebody comes in with a broken nose.

Ms Gallagher: Yes. So the solution to this in the long term—and it will not be a perfect solution ever—is to move, where we can, some of that more predictable work into other areas and free up Canberra for that emergency work. The hospital watch it really closely. I see on the reports coming from the hospital how long the emergency surgery list is. When it gets to a certain point it triggers a range of responses—whether we need to do more, run the list later, extend the list over another day, look at who is being discharged out of the hospital. It is an incredibly complex logistical exercise.

Dr Brown: Could I just respond to the previous question in relation to the additional FTE?

MS BERRY: Yes, sure.

Dr Brown: It is an additional 16.9 FTE for the intensive and critical care beds and an additional 15.4 FTE for the Centenary Hospital for Women and Children.

MS BERRY: Just on the emergency surgery list, I hope the ACT has a high level of sports injuries as opposed to other injuries? I do not know how to phrase that question. Do you get what I am trying to say?

Ms Gallagher: They are a component of the emergency list.

MS BERRY: The ACT budget provides increased funding for hospital in the home bed equivalents. Could you outline for the committee how the hospital in the home program works and what services this provides?

Dr Brown: I will ask Mr Thompson to speak to that.

Mr Thompson: The hospital in the home program is an alternative to inpatient care for people who require acute care, frequently involving intravenous antibiotics or some form of intravenous medication, but who can do it safely in one of two settings. One is in their own homes, in which case the program is an outreach program where someone visits them in their homes on a daily basis and manages their care there. The other is within the hospital in the home area in the hospital, which provides day treatment. So they come in for their treatment and then they go home again. The main difference is that rather than staying in at night, 24 hours a day, they are in for a defined period of time and then they are able to safely go home.

MS BERRY: Is it just intravenous medication when people are at home or is it—

Mr Thompson: That is the distinction; that is one of the things that drives the hospital in the home eligibility criteria, although other forms of care are, of course, provided by the hospital in the home program.

MS BERRY: Just back to Mary's question about improving hand hygiene, I might have missed it when you were responding, but how do ACT public hospitals perform in relation to hand hygiene compared to national figures?

Dr Brown: Yes, we responded to that. We have now surpassed the national benchmark.

THE CHAIR: Mrs Jones, another question.

MRS JONES: I have a supplementary to part of Ms Berry's question around staffing. In the emergency department, has the staffing increased at all in the last five years? Were people replaced when they were on maternity leave? If so, how many went on maternity leave and what were their replacements? I know you may not have those figures here.

Dr Brown: Again, Mr Thompson might want to expand on this, but certainly there have been increases in staffing in the emergency department over the past five years

with expansion of the space. I would expect that, generally speaking, being a high traffic area, we would always seek to replace any staff when they are absent or have left. I do not have any figures, but I am certainly happy to take that on notice and provide you with what we can.

MRS JONES: My substantive question goes to the planning around the secure mental health unit. I would like to seek to understand the changes. My understanding is that in 2008 the idea was a 15-bed high security facility at $11 million. That was put in the budget around 2009—tell me if I am not right here—and then there was a complete rethink of the whole project and we are now looking at a 25-bed medium security facility at a cost of $44 million delivery.

Ms Gallagher: Yes.

MRS JONES: Can you explain, first of all, how the high security patients can be catered for? I know we have had new legislation around transferring of people from corrections into mental health, but if we have, for example, someone who is unpredictable in their behavior rather than being just depressed and who is coming across into the mental health facility, how will they be managed and what happens in the case of a severe situation? My understanding from the public consultation is that you have an area they come into which is more the high end and then you have got your recovery side of that facility once it is built, assuming the pictures are what we are going to get. Is the idea that people coming out of corrections will go across from one area to the other? Can you explain a little more how that is going to work?

Dr Brown: There are several parts to your question, but I am very happy to speak to it. You are correct that there was an initial allocation of funds a number of years ago when the plan was to co-locate a secure unit adjacent to the new adult mental health unit on the campus of Canberra Hospital. When we brought the architects on board and they actually had a look at the site that was available and what was required in both facilities, they gave the clear advice that we did not have sufficient space to provide an adequate facility for both. It was clearly very important to have the adult acute facility on the campus. Secure facilities generally speaking around the country are not on the campus of an acute hospital so, therefore, the decision was made to look for a site elsewhere. That immediately gave us an issue of delay.

In terms of the plan to change from a high secure facility to a medium and low secure facility, the original thinking was that in the event that we had the very rare consumer who needed high security, we needed to be able to provide for that. However, when we looked at the costings and the pragmatics, in terms of needing a high secure environment in the ACT, it is an extremely infrequent event.

MRS JONES: But was the idea to provide that in corrections or in the facility that is being built?

Dr Brown: In the facility that is being built.

MRS JONES: By staffing up or something?

Dr Brown: Well, there are different aspects to security. One, of course, is the physical

security. A high secure facility, for example, will have double fencing with a monitored space in between. A medium secure facility may have double fencing but it may not be of the same order as a high secure facility and it may not have the monitored area in between. It may not have the same visual monitoring, that sort of thing. Then there is also the security provided by your level of staffing and the relational security, which is about the interaction of the staff with the patients.

Our current plan in terms of the facility we are now planning is to provide as much as possible within the ACT. In the very infrequent event that we need a high secure environment, we will look to seek assistance from New South Wales in that. We have had ongoing dialogue with them in relation to that. The challenge we have in that is that New South Wales also has fairly extreme pressure on its secure beds, both medium and high. So that is a continuing piece of dialogue we are having with them.

In terms of your question about the access to the facility, you are quite right. We are currently referring to the beds as "acute" and "rehabilitation," reflecting the types of treatment that will be provided there. There are 10 acute beds and 15 rehab beds. It is most likely that someone coming into the facility will go into the acute section and transition to the rehab when they become less acute and their focus of care actually moves to the rehabilitation aspects.

MRS JONES: And is there going to be a seclusion possibility in that facility?

Dr Brown: Yes. It is currently designed with a seclusion area.

MRS JONES: I am not expert in this area, but I am seeking to understand it. If you have got someone who is struggling to cope and manage their own behaviour, that will be used like it is in the adult mental health facility that we have got with supervision and so on?

Dr Brown: If it is required to be utilised, the capacity certainly will be built in. The ACT has made very significant progress over the last five years or so in reducing the use of seclusion in our mental health facilities. Our current estimated outcome for 2013-14 I think is less than three per cent. Nationally I think the average figure is still somewhere much higher than that. We aim to utilise a range of alternative approaches rather than seek to seclude people as a way of managing agitated or aggressive behaviour. But it will be there and available if, indeed, all those other alternatives have been used.

MRS JONES: Are conversations going on with the different medical unions about staff safety and so on in that facility? Is that part of your process at the present?

Dr Brown: Yes. We have had our model of care developed and we have consulted on that. That is the stage 2 model of care. We have now got to move into the more detailed operational model of care. That includes the development of policies and procedures and actual detailed staffing numbers, that sort of thing. Staffing this facility is going to be a challenge, there is no question about that. It is a highly specialised area of work. We have a plan in terms of how we are going forward with that. We have allocated some funds internally to progress that work over the next 12 months. That includes looking at additional training for our staff and also

potentially relationships with some other secure facilities interstate in terms of how we might expose people to best practice.

MRS JONES: Just on the funding for that—I do not know if the Chief Minister needs to comment—but $11 million is a lot different to $44 million. We have obviously had a CPI increase in that time but not nearly to that extent. I know the facility is going to be bigger, but is that not a similar amount of money to that which it was going to cost to refurb the tower block?

Ms Gallagher: No, the tower block refurbishment would be considerably more. It is a completely different project to the one that was originally intended to be near the adult acute mental health unit—completely different. It will not have any of the shared facilities that we envisaged then. It is bigger. Instead of 15 beds it is 25 beds. It has a rehabilitation focus. It is on a separate site. The site itself is a difficult site in terms of cost of demolition and construction on that site. We stopped the project when we were still considering a 15-bed facility and the cost got to about $35 million, and that is what kicked in with some of the work that Dr Brown was just talking about.

One thing I am acutely aware of with this project is that it will not solve everybody's issues. I really want people to understand that when this opens and everyone says, "That person has to go to the secure unit," in most cases it is more than likely they will not be eligible. One, it is not going to solve all the issues and, two, a very small facility, when you speak with other people who have had practice in these areas, is a very difficult workplace environment because it is so small and is such a high pressure area. So I was very conscious of building a facility that is going to last the long term and have the most positive experience for staff and for the people who need to live there. That is where, in the end, we agreed on the acute and the rehabilitation focus so it is not like a small pressure cooker and that is has a broader remit. With those values underpinning it, the place itself has a much more positive outlook and it will be easier to staff. It will be a better environment for the people who have to spend time there, and some people will spend a long time there.

THE CHAIR: Ms Berry has a supplementary.

MS BERRY: Thank you. It is an acute hospital or a combination?

Dr Brown: Acute and rehabilitation.

MS BERRY: How many subacute mental health beds do we have in the ACT?

Dr Brown: Currently we have Brian Hennessy rehab centre, which has 30 beds. Ten of those are low secure beds. They will be transferring when we close Hennessy; they will transfer into the secure unit. The other 20 beds are currently rehabilitation beds. When we move to the new University of Canberra public hospital, the rehabilitation beds, other than for secure clients, will go over to UCPH.

MS BERRY: That is what I was going to ask. Will the healthcare beds then move over to the new Belconnen hospital?

Dr Brown: Yes.

MS BERRY: Does the demand for the beds currently ever exceed supply?

Dr Brown: For rehabilitation?

MS BERRY: Yes.

Dr Brown: Yes. I would need to take advice as to whether or not we currently have a waiting list for Hennessy. Most times we do have a waiting list. Again, that is part of the focus in moving to Hennessy. I think it is fair to say that at the moment, with those clients who currently reside at Brian Hennessy, some of them have got an active rehabilitation program. Some of them have been resident there for a number of years; to be the most kind, you could be describing it as very slow stream rehabilitation. But really with a lot of them it is more a supported accommodation type of support.

Our aim is to ensure that we can move to a strong focus on providing rehabilitation services. The new UCPH will have a very strong focus on rehabilitation service. That means a throughput through those beds greater than what we currently have through Hennessey.

Those people who are in Hennessy at the moment will presumably become eligible for funding through the national disability insurance scheme, so they will not necessarily just be put out into the community with no supports. We will be working with those individuals, and their carers and families, over the next two to three years, looking at the particular arrangements for each individual who will not be transferring to the new facility but who will have ongoing care and support needs.

MS BERRY: I have one other question: what is the cost to the government of having a patient in an adult mental health unit as opposed to subacute care in Calvary?

Ms Gallagher: The difference between an acute mental health bed and a lesser or a—

MS BERRY: Yes.

Dr Brown: I would have to take that question on notice. However, Hennessy, as it currently is configured, because it has three distinct blocks, is a more expensive facility to staff than the new facility is likely to be. The comparison is probably higher than it may otherwise be, because of the design of the current Hennessy facility. But I can get that figure.

MS BERRY: Thank you.

THE CHAIR: We have been joined by somebody who might have some knowledge about the waiting list for Hennessy house, I assume.

Ms Bracher: There are people waiting to go into the active part of the rehab program in Brian Hennessy. As Dr Brown has already alluded to, there are people that have been there for a long time, meaning that the flow and the translation of people out into the community are very slow through that unit. In the adult mental health unit, at any point in time there are two or three people waiting to be transferred into the rehab

program. And there are some people in the community that have been seen by the community mental health teams that have been referred for assessment for an inpatient rehabilitation stay—not needing an acute care stay, but needing a rehabilitation focus.

MS BERRY: Thank you.

THE CHAIR: A new question, Mr Hanson.

MR HANSON: Thank you very much. Minister and Dr Brown, with the issue of bed occupancy, I know that that has been evolving, because the targets used to be 85 per cent and they have changed. I have seen figures as high as 97 per cent, I think, for the hospital.

Ms Gallagher: Yes.

MR HANSON: We have discussed this previously, and you talked about other jurisdictions that have run hospitals deliberately at those higher rates whereas—

Ms Gallagher: Have run higher ones. They have to, to meet activity-based funding.

MR HANSON: Yes, whereas you have got a target of 90 per cent—

Ms Gallagher: Ninety for the long term, yes.

MR HANSON: but an aspiration of 85 per cent. You might be able to give me that updated figure, but can you give me a bit of an update on whether, over the longer term, you think that 85 per cent is realistic. Or do you think that, looking at the way the hospitals operate, 90 per cent or even higher might be a better way to go? There seems to be a bit of a theoretical argument, a philosophical argument, about what bed occupancy should be. I am just wondering if you have given any more thought to that. Obviously it significantly affects the number of beds that you want to bring online if you are going to be—

Ms Gallagher: It impacts on cost, yes. I think 85 per cent—it depends what you are after, I guess. If you are after running your hospital at the most efficient point you can, making every bed pay for every minute of every day, you would be running bed occupancy as high as you can, really, because that means you have never got them vacant; they are always being used. But if you want to ensure that you have got options available when the hospital gets busy, when the emergency department gets clogged, you have got to have some capacity to move people through the hospital. That cannot just be met by discharge; you have got to have available beds.

I think it is a balance. I am not opposed to the 90 per cent target being the long-term target. I would not agree with one higher than 90 per cent. But ultimately I think it will come down to a decision about resources and the outcomes that we are after. At the moment we are really trying to support the work the emergency department is doing to see people, and to see people in a very timely way. They are doing an incredible job there. We have got Dr Mike Hall here able to answer questions on that front, which I am sure we will get to. He has got a shift starting at 1 o'clock, I am

advised, so if we can do it before then, that will be really good.

MR HANSON: We had better get on early with that.

Ms Gallagher: Therefore, having the ability to move people through the hospital is important. But yes; it is a judgement call in the end.

MR HANSON: I accept that, but I am just wondering whether you are going to commission a body of work to make a decision on that. If you make a long-term decision that it is 85 per cent, that would, I would have thought, affect your longer term planning for the number of beds you are going to bring online, infrastructure and so on, and longer term staff numbers, compared to if you were going to make a long-term decision that it is going to be 90 or 95. When are you going to make a decision? Having an aspiration of 85 that you never achieve might not be the way to go.

Dr Brown: Our current planning is based on the 85 per cent; that is planning up to 2022. Obviously we do review that periodically as we go along. If we move it to 90 per cent, it means simply that we will need a few less beds per year, but the growth ultimately will still be utilised.

MR HANSON: What is it at the moment, approximately?

Ms Gallagher: It changes week by week. I think the report you sent me through yesterday was at 92?

Dr Brown: It was 96.

Ms Gallagher: Ninety-six? It must have been 92 the week before. It changes.

MR HANSON: How do you manage the risk then? If 85, from a risk point of view, is more often, how do you manage the risk? Do you have an overflow net cap, or how are you doing it?

Dr Brown: In the past we have purchased beds from private hospitals when we have required them. This year, for example, we have brought online the medi-hotel, which is in building 5 at the hospital. I think that is eight beds. That has provided us with some additional capacity for people who, for example, would otherwise need to remain in hospital, although they do not necessarily need the acute level of care. They are people who might come from the South Coast and are not able to go home that day because someone is not there to pick them up, or it might be that they just need some treatment that does not require them to be in an acute bed. So we have done some things like that to assist us to manage the demands whilst we are also getting the additional beds available. We have 32 beds that will come online at the end of August.

MR HANSON: At TCH?

Dr Brown: At TCH.

MR HANSON: When did you last purchase beds off the private hospital?

Dr Brown: It has been a couple of years. It has been, in fact, several years, I would think.

MR HANSON: How many? Can you give me a breakdown of when you purchased those beds, how many there were and what the cost was?

Ms Gallagher: Yes. I think we have done that for previous committees, so we will just have a look at what that was.

MR HANSON: It has not happened for a little while.

Ms Gallagher: No, it has not, and that is because we have been bringing on beds across the hospital. Those 30-odd beds that will come online cannot come soon enough. The reason they are coming on now is that paediatrics are moving out. We have been able to refurb that part of the tower block, which has given us the space.

Dr Brown: We currently are purchasing eight beds from Goodwin; therefore, nursing home type patients are waiting. That was through the NPA on approving public hospitals.

THE CHAIR: While you are taking the numbers on those, do you calculate a weekly percentage of what the bed occupancy rate is?

Dr Brown: We do give it weekly.

THE CHAIR: Could we have the last year's breakdown week by week, please?

MR HANSON: I am quite interested in this area and the longer term, because of the subacute hospital. Would that be all right, Mr Chair? I do not know if the others would be interested in subacute and how that might impact on decanting all the beds.

THE CHAIR: I have a number of infrastructure questions, so why don't we go to infrastructure at large? Perhaps you could give us a brief rundown on what is happening. There was to be a major refurbishment of the tower. Is that still happening? There is not a great deal about the subacute hospital in the budget papers, including prices, so when is ground likely to be broken there, and when is it likely to open?

Dr Brown: If we start with what is happening in the tower block, we have done some refurbishments up on level 8 in previous years. Currently we are refurbishing level 5, which, as the minister indicated, was previously occupied by paediatrics. They moved over into the Centenary Hospital for Women and Children. That space will ultimately give us about 60 beds, 32 of which, as I indicated, will come online at the end of August. There are further plans to do work on levels 4, 10 and 9.

THE CHAIR: Level 2, level 9, level 8, level 10.

Mr Thompson: It is levels 4, 8, 9 and 10. That is following the completion of the works on level 5. They are expected to be completed at the end of July, to open at the end of August.

THE CHAIR: There was a grand plan, I thought, that had something like $800 million attached, to refurbish the whole of the tower. Is this now being done incrementally?

Dr Brown: No; we are doing this work to give us the capacity that we need in the years—

Ms Gallagher: Now.

Dr Brown: Yes; essentially now and for the next five years or so whilst we undertake the further work on rebuilding new tower blocks.

THE CHAIR: When was the decision taken to change that process?

Ms Gallagher: It was before last year's budget.

Dr Brown: There was 41 million appropriated.

Ms Gallagher: Yes.

Dr Brown: But that has always been in the planning—this sort of staging and decanting, maximising the space available within the current infrastructure as we build additional capacity as well.

THE CHAIR: And the subacute hospital?

Dr Brown: The subacute hospital—

MR HANSON: Further on the tower block, if I could, the $41 million that was in the budget and has now been taken out was for the design and preparation for a new tower block, a new $800 million tower block; we have talked about that before.

Dr Brown: Yes.

MR HANSON: Is any of the money that is in this current budget involved in design of that new tower block or is that all on hold?

Dr Brown: No, we have some work underway. Ms George might be able to speak to that in more detail. A couple of pieces of work are being looked at. One is in relation to expanding the space available to the emergency department and the other is in relation to—

Ms George: Essentially there are three pieces of work going on. There is the paediatric stream work in the emergency department; we are doing a proof of concept on what was the master plan for the new tower blocks at the Canberra Hospital, so that we are sure we are able to progress with the preliminary sketch plans for the new tower blocks; and the work in building 1 is being undertaken as staging and decanting space and to provide for growth at the present time.

MR HANSON: What does proof of concept mean?

Dr Brown: We had a master plan done. It is now a more rigorous analysis of basically whether the master plan will stand up. Is the space right? Are the services able to support the design in the master plan? Then we will move to detailed planning, preliminary sketch planning—

MR HANSON: It seems like we have gone back a step, because when we had a master plan, there was $41 million appropriated to do that design, and then we have taken that money out and we have gone back to proof of concept to make sure that master plan is right.

Dr Brown: Part of what was a decision in between was to look at how we could "chunk" the building in stages, in terms of the new tower blocks. The original had been looking at doing it all at once, and now we are looking at it—I think "modularised" is the word that the planners use. Taking it in those different modules, we need to ensure that we have the planning right, so we are going back and rechecking.

MR HANSON: Our peak demand hits in around 2020 to 2022. So in terms of whether it is one tower or modular, what is your anticipated time line for bringing this online?

Dr Brown: We do not have a decision yet to proceed, so we do not have that firm. Our planning basis, I guess, is for the first tower to be completed and available for operation before we hit that peak demand.

MR HANSON: That would then operate in conjunction with and in addition to the current tower?

Dr Brown: Yes.

Ms Gallagher: For a period of time.

MR HANSON: So the idea is that you bring that online and then you bring others online and you decant then? What do you do with the old tower block, or is that still being—

Dr Brown: The decision about building 1 has not been finally taken. At the moment it is being utilised. It will continue to be utilised when we build the first of the new towers, and then we will look at its ongoing use at a future date.

MR HANSON: In terms of the master plan, that sounds a little bit different from the original master plan. Have you drawn up a new master plan that we can have a look at?

Ms George: That is what will come out of this proof of concept phase, showing what changes we need.

MR HANSON: When do you anticipate that might be?

Ms George: That is underway at the moment.

Ms Gallagher: It will have to start feeding into budget decisions next year.

MR HANSON: Could I ask that when that proof of concept is ready for public display I get a briefing on that?

Ms Gallagher: Yes, sure.

MR HANSON: That would be useful, just to see where we are at.

Ms Gallagher: Yes.

MR HANSON: Have you worked out what you are going to do with the body of land over the road? I know there were some thoughts at some stage that you would build stuff over the road that would be part of that whole tower block arrangement. Is it all on the—

Ms Gallagher: No, all the services side would be on the current site. The opportunity on the Yamba Drive site—it is one of the existing car parks—is that there is potential there for a community health centre or medi-hotel facility. There are opportunities to do hospital adjunct services. It is on a difficult block. It is in a 100-year flood plain.

MR HANSON: Is it?

Ms Gallagher: Yes. If you did, you would have to build up over the car park. So there are some constraints. That is certainly something that I imagine in time will happen. As we build a much busier hospital and the region grows, there will be a need for adjunct facilities on the other side. Nat Cap are doing quite a big refurbishment of their site as well.

MR HANSON: That is right, and opening soon, isn't it?

Ms Gallagher: It is starting soon. They have all the approvals in place now.

THE CHAIR: What happened with the master plan which meant we then had to go back to a proof of concept? Weren't contracts almost exchanged with an architect on the tower? Or hadn't a preferred tenderer been selected?

Ms George: There had been, yes. What happened was that due to the financial environment, it became apparent that we needed to have an approach where we were able to undertake what is a significant amount of capital works in chunks or modules to provide some options for moving ahead.

Ms Gallagher: As we pursued the subacute facility at the same time. So the commitment around the financial impact of the health infrastructure project remains the same. As I said in my opening statement, it is about $877 million now that has been allocated. That will continue to roll out over the next five to 10 years, and every budget in between.

The other issue that informed it—and it was ultimately the cabinet's decision, not the Health Directorate's, in terms of staging of the health infrastructure program—was the serious impact of brownfield redevelopment on the continuation of services. We have learnt from the women's and children's, the adult mental health unit and the cancer centre that it is very challenging to run an extremely busy hospital at the same time as you are building up facilities. If we have been inconvenienced by building on the end, managing the building in the middle becomes even more critical, because we are not only running services but we are expanding them on a site that is also a major construction site. All of that fed into the cabinet's decision. But the financial commitment will exceed the original commitment of government, which was in excess of a billion-dollar program.

THE CHAIR: So it is not being delayed to free up funding for, for instance, capital metro?

Ms Gallagher: No, not at all. It has absolutely nothing to do with it.

THE CHAIR: Ms Berry had a supplementary. I think Ms Porter had a supplementary.

MS BERRY: I was going to ask about the medi-hotel. I know it has only been a few months, but I was wondering what sort of feedback you had got from people.

Dr Brown: I had some feedback just yesterday that it has been very well received, particularly because it is taking that pressure off the acute beds at a time when we have quite a high level of pressure, as evidenced by the occupancy levels. The feedback from the consumers and families who have utilised those beds and that service is that it is a very good service. They have appreciated the environment, not necessarily taking up the acute bed that is needed for someone else. They like having the staff there who have the time to sit down with them at the particular phase of their illness. Often, as I said, it is people who might be going home but are waiting for someone to come and pick them up. So there is a nursing staff member on shift in the facility, and they have a bit more time than they have in the acute wards to sit down and work through with them around their continuing health needs. So it has been very positive.

MS BERRY: It sounds really good, thank you.

THE CHAIR: Ms Porter has another infrastructure question, as do I, and then we will continue down the row on infrastructure.

MS PORTER: Thank you, chair. You mentioned in your introductory remarks, minister, the Calvary car park. Obviously, you are committed to building that Calvary car park on the campus there. We all know that that is really, really necessary. Can we have an update on the timing, the size and all those kinds of things so that we can get an idea of how it is going?

Ms Gallagher: Yes.

Dr Brown: There are approximately 700 car spaces in the new facility. It will give us

an increase in the order of about 515 spaces once we allow for the spaces that will be lost that are currently on the upgrade space. In terms of the progress with it, the development application was actually approved at the beginning of April. It is expected that we will be awarding the contract for the construction of the car park at the end of this month.

Ms Gallagher: We are ready to go once the budget passes.

MS PORTER: Fantastic. You mentioned the loss of some car parking. Is this because that is where you are building the actual building there? What will happen in the interim? Those of us who live over that side spend quite a lot of time in that precinct and we have a lot of difficulty. We can really empathise with our constituents because we have difficulty finding a car park. What will happen? How much disruption will there be, I guess is what I am trying to say, and how will you make allowance for that?

Dr Brown: There will undoubtedly be some disruption. We have two things that we are doing. One is that there are currently some gravel spaces that are being utilised by people for car parking. We are actually upgrading some of that. But in terms of the space that we are taking up to construct the car park on, we have actually made an arrangement with CIT to access some of their car parking space and we will be running a shuttle bus.

MS PORTER: I was going to say that it is a fair distance.

Dr Brown: That will be primarily for staff. We will utilise the car parking spaces at Calvary and make them available for the general public. But we will actually have a shuttle bus running between that car parking space at CIT and Calvary in the period that the car park is being constructed.

MS PORTER: Physically, could you give me a sort of word picture about where it will actually be built in terms of where the front door of the hospital is and that sort of stuff?

Ms George: If you are looking towards the main entrance at the hospital, there is a car park in front. It would be on the lower side of that, at the lower end of that existing on-grade car park.

MRS JONES: Down near the traffic lights end.

Ms George: Towards that end, yes.

MRS JONES: Will parking be paid parking after the building of the facility?

Ms Gallagher: Not at this point. No decision has been taken by the government. It will be paid car parking of some type at University of Canberra public hospital, because they have brought in paid car parking as part of their—ultimately, it is going to be a decision. I see it as an inevitability. The taxpayer cannot continue to fund millions of dollars for this type of car parking at our hospitals. But I say that knowing how problematic it is. I think the first thing is to get the parking in order. That is what

we are doing with this car park.

MS PORTER: It is obviously a question for the future, but my experience of visiting people in other hospitals interstate is that often you have an arrangement where you pay as you leave. It is much simpler that way, if that is a possibility.

THE CHAIR: We have been here before.

Ms Gallagher: No-one envies me that discussion, I am sure.

MRS JONES: We are all getting more experience the longer we live.

MS PORTER: But when you are building something new and you have only one exit and entrance, that makes it much easier than—

Ms Gallagher: I do not think you would see a government or councils anywhere else in the country paying for car parking of this type at hospitals. When multi-storey car parking is put in now, without exception it is paid car parking, but—

MS PORTER: That is my experience, anyway.

Ms Gallagher: We have got issues. It is an industrial right; I think in the nurse's agreement they have access to free car parking. When the largest part of your workforce is exempt, I think it calls into question why you would make ill, elderly patients pay. So it is complex.

MS PORTER: A vexed question.

Ms Gallagher: It is vexed.

THE CHAIR: Ms Berry had a supplementary.

MS BERRY: I do. I have a memory, when the car parking was talked about at Calvary, of some people being concerned about the habitat behind the existing car park now and about frogs particularly.

MRS JONES: Everywhere you go in Canberra there is something.

MS BERRY: There is and that is what is great about Canberra.

MR HANSON: There will be a legless lizard there somewhere.

Ms Gallagher: There is. There is more than that, I reckon; more than a legless lizard. There are whole contingents of endangered species. It backs on to Bruce Ridge; so it is a very sensitive environmental area. I think that has also informed some of the decisions we have taken. For example, there was a proposal a couple of years ago to have a young person's mental health unit locate there, but on environmental grounds because of the nature of that site it would be very difficult. So it is constrained and at the moment people are parking in the bush on the dirt.

MS BERRY: Yes, making a mess.

Dr Brown: And those considerations are clearly part of the development application. As I indicated, that has been granted for the Calvary car park. So it has been looked at.

MS BERRY: Thank you.

THE CHAIR: Any more supplementaries on the Calvary car park?

MS PORTER: No.

THE CHAIR: It is one minute to 11. We might stop here. It has been a bit broad-ranging this morning. Before lunch time, could we finish acute services and mental health services and any infrastructure questions? We can then give some certainty to the officers and particularly those who have shifts at 1 o'clock. We will break now and resume at a quarter past 11. We will then finish up infrastructure, acute services and mental health before lunch.

Sitting suspended from 10.57 to 11.16 am.

THE CHAIR: We will recommence. I did a straw poll outside at the tea station and everybody thought Dr Hall should come to the table and tell us everything. Dr Hall, would you like to come to the table. We might do ED to start with, ladies and gentlemen. We will try to bring forward anything else on infrastructure and the local area of the hospital network in the directorate because that would match a lot with the acute services. If we could get through that and mental health and start on public health services by lunch time, I think we will be doing very well. Does anybody have a question for Dr Hall?

Dr Brown: Dr Hall is the clinical director of the emergency department at Canberra Hospital.

MS BERRY: There has been some additional funding for Canberra's emergency departments to assist with meeting the growing pressure of demand for these services but I just wanted to know if you could tell us the detail of these services that are going to be included in the emergency department and how that will affect the work that is going on there.

Dr Hall: Sure. My understanding of the growth money is essentially to provide extra consultant services within both emergency departments. We are not changing what either emergency department does. The fact is that emergency departments are growing at a very large rate. You have probably seen the figures that suggest that across the two emergency departments, I believe, in the last 12 months we grew at about six per cent, which is significantly more than the population growth for the territory.

We are also seeing an older population and a sicker population. So our admission rates are creeping up. The presentation rates are creeping up. The job gets busier and more complex, at a rate that becomes difficult to sustain, and six per cent growth rates across the two emergency departments is a lot of staff and potentially a lot beds and a

lot of activity. So it is really to help us to reflect that activity.

We have a relatively unique situation in the ACT in that, although we are reasonably well prescribed in terms of medical FTEs, we have a relatively junior medical staffing mix. So an aim at both hospitals over the next few years is to transition that slightly to be running with more senior staff in the emergency department to help us maintain both the clinical activity and the teaching and training activities that we have for the number of junior doctors that come through the hospital.

MS BERRY: And how does the hand hygiene work that is being done throughout the hospital? I guess in the emergency department there are so many more people there that there is more opportunity for cross-contamination?

Dr Hall: Most of you who have heard me know I like to talk up the emergency department. Hand hygiene is probably an area that I struggle to talk up.

MS BERRY: I would talk it up. I have always had very positive experiences there.

Dr Hall: Hand hygiene is a challenge across the hospital. It is a giant challenge in emergency. When you look at how emergency doctors and nurses work, at the junior level I think they actually do a very good job because they are classically looking after one or two patients and they have the time. The senior doctors and nurses might be, at times, seeing four or five patients within a 10-minute period because they hop from one to another to review things.

We have signs everywhere. We have ongoing education. We have a gentle—it is not a punitive measure—public naming and shaming when people are noted not to do it. But are we as good as we could be? No, we are not. Nationally people really struggle in emergency department environments to be really effective in hand hygiene and we should be better at that than we are.

MRS JONES: Do you study why people are not taking up the opportunity because there may be some—

Dr Hall: To a certain extent there is an aspect of relative risk in this in that to wash your hands properly as a clinician is one to two minutes. Many of the reviews by a senior doctor of a patient may be as short as 30 seconds. If a junior doctor has discussed a patient—and it is a similar model with nursing—sometimes we are simply checking a single physical sign, a single look at a wound and that couple of minutes in people's heads is a perception that they almost do at times feel like they do not have the time. The worry is that then communicates a safety risk.

I do not think people are making an active decision not to do it but emergency people, I guess, live a spectrum between what happens in the community and what happens in a hospital and as such, at times, are probably prone to feel themselves a little aloof from the requirements that should be there. It is not what it should be, and we do continue to work on it and it has dramatically improved but I think we can still get better in what we are doing.

MS BERRY: A little while ago now, probably about six months ago, I was asking

some of your staff in the hospital how long they had worked there—it probably feels like they live there sometimes—and what the turnover was like in the emergency department. I found that there were quite a few people there that had left and then come back because they actually enjoy working there and enjoy that kind of work.

Dr Hall: We get very few people leave the critical end of the system. Once staff members who have got medical or even an allied health skill get involved in the critical end of nursing they do not tend to leave. But the skills that you get in an emergency department are such general skills that you are, I guess, priority for recruitment in other areas.

If you look in our hospital at components of the medical emergency team, the organ donation team, even within the administrative roles within the hospital, a lot of those people have experience and background in emergency. Many of them will come back. Some of them will stay in those other roles but the role we do is a generalist role, which is a dying thing. Hospitals are becoming more specialised. We are probably the biggest generalist group within a hospital. Those skills will always be used in other areas.

MS BERRY: It cannot just be the pace of the work. I do not think exciting is the right word for it—the work that is being done in emergency is ever changing, and a new thing happens all the time—but it has got to be more than just the work. It has to be a culture as well.

Dr Hall: I think you are right. I think we have all worked really hard to promote our positive culture. The ACT Health culture survey would reflect that. We are consistently the highest or the top one or two of the clinical units across the last two of the ACT Health culture surveys. We, I believe, recorded the highest ever score by a public hospital emergency department in the previous culture survey that was done. In an environment that is classically a stressed environment I think we work very hard to maintain the staff's enjoyment and to a certain extent to protect them from the pressures that they are always going to feel in that environment. So I do think you would find our medical and nursing staff are very supportive of the environment that is there, although at times they are overwhelmed by the workload that exists.

THE CHAIR: Just to follow up on the ED, there was some drama about doctoring of presentation numbers and times, and some reforms were put in place. The minister might have something to say as well. The updated system is working well and has not hindered the operation of the ED?

Dr Hall: There has been a series of changes to systems since the performance data issues. The biggest day-to-day system that we use is called EDIS, our emergency department information system. A brand new version of that went in last week in fact. That commenced operating last week. We have had a small teething problem but it is not major. It was fixable within an hour or so, and considering the size of that information system that is perfectly okay. That has a lot of extra security features designed to, I guess, protect the staff from themselves at times, designed to make sure that everybody has confidence in that data that exists.

I would point out that the changes that did or did not happen were not said to have

anything to do with clinical staff within the emergency department, which is my remit of what we are talking about. So those security features are there.

There are also a lot of background security features that now exist—looking at reports, looking at interim changes and ability to track, I guess, patterns that existed which were part of the previous data issues that were identified by an acknowledgement of certain data patterns that were coming through. So those things are there. A signed-off security plan is in place.

I have not cross-referenced in the last little while specifically to each one of the Auditor-General's reports. I will have to perhaps refer back to others to be able to answer that but I believe that most of them are certainly covered off in the specifics and I think all of them are now covered off in the spirit of that report.

THE CHAIR: And one of the problems was the use of a general logon by people. Each staff member in ED now logs on and logs off as themselves?

Dr Hall: "Almost" is the right answer to that. That was always dependent on moving to this new version of EDIS, which has only gone in last week. Because generic logons had been part of our culture for so long, it was decided effectively that the generic logons would need to remain for a couple of weeks in the process of changing over, because we could not bring in a new system and take the generic logon away on a single day.

But every staff member has their own individual login. Every staff member, if a data element was to be changed, has to use their own individual login to do that, but there are still a couple of computers which are the most-used computers within the emergency department that are required to be logged in generically as the computer. Data entry on it will be individualised, but the computer itself remains in a generic login because our IT has not been able to yet provide a solution that is quick and dynamic enough for those workstations to be able to be used.

THE CHAIR: Ms Porter had a question.

MS PORTER: It is in relation to the emergency departments. On pages 97 and 100 of budget paper 3 reference is made to the funding for support services at Belconnen and Tuggeranong health centres for the walk-in centres. As these are not located on the hospital grounds but further away obviously, are you anticipating this will have an effect on the numbers of presentations to emergency departments at both hospitals?

Dr Hall: The simplest answer is: we do not know. It is no secret that some of the emergency physicians believed that the walk-in centre being placed on site at Canberra Hospital potentially increased certain types of patients coming to emergency. I have no doubt that there were certain patient numbers that were decreased by the emergency walk-in centre being on site. We have complete confidence in the care provided in the walk-in centres and the protocols of that care, but what it will do to our presentations remains unknown, I guess is the answer.

Ms Gallagher: Particularly in light of some of the issues around the co-payment.

MS PORTER: I was about to ask that question actually.

Ms Gallagher: It is going to complicate the matter.

Dr Hall: It will.

MS PORTER: That was my next question, minister. Obviously we do not know whether that legislation will pass and that co-payment will be introduced. I have had representations from pharmacists and people who work in pharmacies that they are concerned that they are going to have more presentations through their doors. Are you anticipating that to be the case?

Dr Hall: I think everyone in the country is looking at this space and being unclear. The natural assumption would be that we would get an increase in presentations. I think as a jurisdiction, if any place is less likely to see it, it will be Canberra rather than other places around Australia. Many of you have heard me speak before that the "GP-style presentation" is not really an issue for Canberra Hospital emergency department. It is a bigger issue for Calvary at the moment. They see higher levels of those kinds of patients.

If GP care becomes either less affordable or less accessible, I suspect it will over time become a problem for us, and certainly internationally those types of presentations are a problem for major emergency departments. The reality is that it depends on how you define the problem. If the problem is perhaps measured timeliness targets, those things will place pressure on us.

If the problem is an ability to provide a quality of care, they place very little pressure on us really. The sickest patients will always be seen to the same level of care. The less sick patients, I believe, are seen well. Whether they can always be seen in a timely fashion will depend on the balance of those presentations that we see and the changes that any of these new policies bring in.

So I do not think it will affect the quality of care. It may affect our ability to report on timeliness of care for some of those lower acuity groups, would be the best answer I could give.

THE CHAIR: A question on the ED?

MRS JONES: I do not mind if we have this question on the ED or under mental health.

THE CHAIR: We will get to mental health. Mr Hanson?

MR HANSON: Dr Hall, the paediatric stream—

Dr Hall: Yes.

MR HANSON: Could you give me a briefing on the status of that, please?

Dr Hall: Sure. The paediatric stream has passed PSP, preliminary sketch plan, phase.

It is essentially designed to be a dedicated, specific paediatric area within the emergency department. Just in case there is confusion, it is not a separate paediatric emergency department; it is a stream within our current ED. We have designed it around the experience for the children and the families being much like a separate ED. In simple terms, under the current design there is a single entrance that people will walk into; basically you will turn left for adults and turn right for kids. From then on, the experience for the vast majority will be completely separated—a separate waiting room, a separate assessment area, a separate doctor treatment and write-up area, separate procedure rooms. All of those parts will be separate.

The bit that we cannot separate is the resuscitation room. We physically cannot put a paediatric resuscitation room within that area—plus resuscitation is a highly skilled subspeciality even within my own field, and we just do not have the staff trained to split the resuscitation facility. So it is a shared room.

In terms of spaces, in its current design it has six spaces plus a treatment room which is more like a GP-style consult room. Although that does not sound like a big increase in our current paediatric spaces, the model should be able to be much more effective in seeing kids in a timely fashion, because the waiting room is integrated into the treatment spaces. Instead of the old-fashioned concept that we have now, where the waiting room is out the front and the treatment spaces are 50 metres away and unseen, the waiting room here is intimately integrated with the treatment spaces, which effectively sit around the waiting room. The hope is that children with minor injuries that are waiting simply on an X-ray or response to treatment may be able to go back to the waiting room, which will have play areas, computer connectivity, paediatric-friendly television content and that sort of stuff, to enable us to effectively actively manage more children at a time than we do at the moment.

MR HANSON: Up to what age?

Dr Hall: There is always going to be a flex. We have planned it around basically 14 and below. Some 14 to 16-year-olds are very appropriate for that area; some are not. It depends on the presentation and the child. We have always said that we have to retain the ability to flex children into the adult area. We are really not planning on an ability to flex adults in the children's area, but we do have times—the adult presentation rate is relatively static across a 24-hour period, but the paediatric one varies dramatically. From midday until 11 pm, we get about 80 per cent of our children, in that 11-hour period. To build a department, we have to retain the flexibility, if we want to get kids seen in a timely fashion, to see some of those children through the adult spaces.

MR HANSON: So you can surge out?

Dr Hall: We can surge out into the adult areas. And we have made a decision that all of our staff will rotate through so that we retain that flexibility. We have discussed having specific paediatric-only staff and adult-only staff, but that becomes dangerous when you start flexing out of that paediatric area if you have to do that.

MR HANSON: Have you got a time line for when this all will start?

Dr Hall: My understanding, and Jacinta might be able to give a slightly more

upgraded version, is that we are looking at starting construction in late October or early November, and we are hoping to have it finished by about this time, slightly later, next year, with a view to moving into that. We do not believe there will be a lot of disruption to current services. Most of the construction is outside the current footprint. There will be a period when the current triage and entrance have to be remodelled, and we are working through a staging plan for that. That is going to be the significant disruption. But the clinical areas will not be disrupted during the building.

MR HANSON: The only other thing I have is congratulations on your results in the cultural survey.

Dr Hall: Thank you. That was a previous one. I am not sure when the next culture survey is due to happen. Dr Brown?

Dr Brown: Next year.

THE CHAIR: Further questions for the ED. No? Dr Hall, thank you. Good luck with the shift at 1 o'clock, and perhaps, on behalf of all the members of the committee, you could pass on our regards to all your staff. I think everybody appreciates what they do. We may have the occasional tiff with the minister over policy, but we are all 100 per cent behind the doctors and nurses.

Ms Gallagher: It is not usually over policy; it is usually over timeliness.

THE CHAIR: I remind you, members, that we will try and do the ACT local hospital network as well as other acute services, mental health and infrastructure. You might like to have a mental health question, Mrs Jones.

MRS JONES: Thank you. Obviously we have got some reporting that has come out overnight as well in the medical officer's report, I believe.

Ms Gallagher: Chief Medical Officer.

MRS JONES: The Chief Medical Officer's report. I was just going to go to mental health and the way we are dealing with it in a broader sense. Professor Anthony Jorm has put to me that mental health affects one in five, and the burden of injury—not just the burden of death, which is probably a more common measure, but the burden of injury—puts mental health as the third most weighty issue that we have to deal with as a community.

Ms Gallagher: Yes.

MRS JONES: Obviously milder forms of mental health can be quite debilitating for people on a daily basis. He put it to me that 20 per cent of cases can be prevented, but we put most of our effort into treatment as a society in Australia. Canberra would not, I presume, be much different. The officer's report that came out said that mental health problems in Australia were at 15.5 per cent of the population. I am just wondering what measures we are implementing that we can point to in the budget to deal with the main burden. Apparently it mostly hits between 29 and 45 years of age,

which is also quite a productive period for our lives and our community. And what are we doing in prevention? There is a 62 per cent treatment gap, from what I have been told, between what could be treated and what is being treated—and that is not even in prevention; that is just in treatment. Would you support a national prevention strategy? What are we doing? What else can we be doing?

Ms Gallagher: I will ask one of the nation's leading experts in that field.

Dr Brown: Thank you very much for the question. I think that there is undoubtedly a need for a focus on prevention in the mental health space as well as promotion and early intervention. That has been part of the national mental health strategy from the outset. In the early 1990s, it was specifically listed as a focus in the second national mental health plan, and it has continued to be listed as an area of focus, albeit that it—

MRS JONES: Yes, but I think the results are not coming up yet. We are not seeing any decrease.

Dr Brown: No. I was just going to say that I think there undoubtedly could be a renewed focus on mental health promotion and preventative activities in the ACT, as well as around the nation.

We do undertake a range of initiatives in this space, particularly in collaboration with the community sector. We do have some investment in a range of activities, whether it is infants and the peri-natal space or something else. There is some enhanced funding in this budget around peri-natal and infant mental health services. There is work in relation to children in schools. There is work that we do in relation to people who are at risk of suicide. There is additional funding in this budget around suicide prevention services—awareness raising. So there is a wide range that we do—as I say, particularly working with the community sector in this space. But there is undoubtedly more that could be done.

MRS JONES: Can you get back to us with a breakdown of what those services are where we work with the community, where the money is spent and how much is spent? Also—this is more of a policy question for the minister—what can we do to actually see a shift in the numbers? The numbers are not changing—the presentations, the effect of this on the community. There has been a big change amongst the younger generation, certainly, in our attitudes towards this area. People are more willing to seek out specialist help, but it is just not coming off the incidence and the effect yet. If we really want to see change, there have to be some measurables.

Dr Brown: We currently do have a plan for the ACT that is around promotion, prevention and early intervention. That plan is due to finish this year, and we are currently working on what will be the successor for that. We are looking at a plan that goes across the whole of the ACT government, not focusing just on mental health around this area. But certainly we can get you some information.

MRS JONES: Can I get a briefing on that as well if you undertake that work?

Ms Gallagher: Sure.

MRS JONES: Thank you.

THE CHAIR: Ms Berry with a supplementary on this issue.

MRS JONES: Just to clarify, you will get back to me with those figures?

Dr Brown: Yes.

MRS JONES: Thank you.

MS BERRY: I just wanted to check something. We have been talking to other groups around mental health issues, early intervention and identification, and how they get support. I understand from the previous conversations we have had here over the week that some of these people might not have had access to services previously, but under the NDIS they will be able to have access to ongoing support programs.

Ms Gallagher: They might not have had necessarily a support package attached to them; they would have had access to services.

MS BERRY: So a package. So that is ongoing rather than maybe having patches of treatment. Also, the human services blueprint is another way that people might be able to be identified and then be able to access services. I am talking about people who might not know that they have anything going on and then they can—

Dr Brown: Certainly the national disability insurance scheme does incorporate mental health within the definition of disability, but people do need to meet certain criteria in terms of either the severity or the duration. That will not necessarily pick up people particularly at the earlier stages.

In terms of the human services blueprint, that really is about trying to ensure that people can access services no matter which door they enter, and that we facilitate the access. Certainly that is our aim—to ensure that we make the services available to people at the earliest opportunity.

THE CHAIR: I would like to go back to some of the infrastructure and particularly look at the UC public hospital. There was $8 million in the current year's budget for the design work. Has that been completed?

Dr Brown: In terms of where we are at with the University of Canberra public hospital, we have out at consultation the service delivery plan that sets out essentially what is going there; we have had the facility planning work underway; we have recommenced all the user groups with people; and we are about to award the contract to the principal consultant later this month. I believe that now we have done work on a preliminary sketch plan, and that consultant, when they come on board, will take that preliminary sketch plan as a reference point, do the further design work and then go on to the construction.

THE CHAIR: When do you expect to have a DA to seek approval for the design?

Ms George: Our current program shows development application approval in

February 2015.

THE CHAIR: When do you expect to get into the ground and when do you expect to take in the first patient?

Ms Gallagher: That is dependent on a few things, isn't it?

Ms George: It will be dependent on the DA, et cetera—

THE CHAIR: But you must have a timetable?

Ms George: Construction commencement on the main works in August 2015.

THE CHAIR: Expectation to open?

Dr Brown: Completion is the end of 2016—

Ms George: It is 2017, but we do not have construction funding.

THE CHAIR: So the end of 2017.

Ms George: It will be dependent on the model of delivery for the procurement for the construction delivery as well. That might have some impact. But based on our usual contract form, that is the program that we have.

MR HANSON: Do you have a price range? I know that you are loath to give a specific dollar amount that you are going to be held to, but do you have a bracket that you can give us?

Ms Gallagher: Yes, we do and provision has been made in the budget.

MR HANSON: Are you going to tell us, in the spirit of open and accountable government?

Ms Gallagher: I think the decision the cabinet has taken in this budget is not to broadcast our expected price to the market, as the preferred way of managing our large capital infrastructure projects at this point in time. But once all the—

MR HANSON: Except for light rail.

Ms Gallagher: We have not put a price on that, as you know, and I am happy to go back there.

MR HANSON: I thought 614 million was the—

Ms Gallagher: We have made provision in a capital provision fund for our large infrastructure projects.

THE CHAIR: The role of the estimates committee is to look at the appropriations in the budget documents. It is very difficult for this committee to have any opinion on

the public hospital at UC when we have got a row of "not for publication". How do you expect the committee to satisfy itself with regard to the TAFE at Tuggeranong, the new court facility and, indeed, capital metro—

Ms Gallagher: As those agreements are entered into, which the estimates has no role in, that information will become available. The decision at this point in time as we are in the early stages of the financial delivery of this project in particular is not to broadcast what we expect it to cost. I think that is entirely reasonable, but there will be appropriate transparency and accountability to the Assembly and through the budget papers as those projects roll out.

THE CHAIR: So when would you like that scrutiny to occur?

Ms Gallagher: It will be an ongoing scrutiny role, I imagine, through this project. That is my experience of estimates committees.

THE CHAIR: But the process normally has been that the government would bring forward—as it has this year—pages of proposed works. Why are not all of the projects in this document not for publication, because surely you want to achieve the best price you can on each of these projects? Under that rationality, you would publish a capital works program that just consisted of a single number and say it is all commercial-in-confidence so you can get the best value.

Ms Gallagher: We have taken a decision for our large capital works program, where there are different methods of delivery and contractual arrangements, not to broadcast it at this point in time. For those projects that are more determined in their cost—I think the secure unit is one of those—then the appropriate transparency has been provided to the committee. It will be ongoing. When we enter into the arrangements on the UCPH, the financial accountability on that will be clear. I am not sure it hinders the estimates committee in any way, as far as I can see, from your role that you have performed in the years that I have sat here.

THE CHAIR: With regard to the three projects that have "NFP" against them on pages 188 and 189 of budget paper 3, there is no financing this year. Will there be a number next year in 2015-16 as financing for the Canberra Hospital redevelopment?

Ms Gallagher: I would expect so, yes.

THE CHAIR: So we will have an opportunity to look at those numbers before the contracts are signed?

Ms Gallagher: That is right.

THE CHAIR: Or will we only get to look at them after the contracts have been signed, therefore making us a superfluous body in regard to that contract?

Ms Gallagher: Well, do you have a role before other projects are signed? No, not normally. I mean, it is not how it usually works.

MR HANSON: You have given us a price on light rail and other projects, and it

seems that you have—

Ms Gallagher: You do not have a price on light rail, Mr Hanson. You have an indicative figure that you have memorised.

MR HANSON: Can you give us an indicative figure then, please?

Ms Gallagher: But there is a provision in this budget.

MR HANSON: Could you give us an indicative figure, please?

Ms Gallagher: It will not be as much as you promised at the election.

MR HANSON: A bargain.

THE CHAIR: For instance, the secure mental health unit at, say, $43 million: why would you not have a row of "not for publication" there? You have not got a final design, you have not gone to tender, you do not know what people will bid for it. What is the difference between the secure mental health facility and the University of Canberra public hospital?

Ms Gallagher: Maybe Jacinta can update you on the difference there.

Ms George: We have gone to tender for the head contractor for the secure unit. That is the difference.

Ms Gallagher: So it is in a much later stage of development.

THE CHAIR: So you have architectural plans and you have done the costings on what the secure mental health cost facility will cost?

Ms George: We have the preliminary sketch plan and a cost estimate and we have gone to tender for the head contractor for construction.

THE CHAIR: So because of that the numbers can appear in this budget, and next year we will see—

Ms Gallagher: I would expect you to see the same for UCPH, yes.

THE CHAIR: You will see the same next year for the public hospital at UC?

Ms Gallagher: Yes.

THE CHAIR: All right. The specifications for the University of Canberra public hospital: how many beds?

Ms Gallagher: It is 140 overnight beds and then about—is it a 75 day capacity?

Dr Brown: Seventy-five days.

Ms Gallagher: A 75 day capacity. 120 of those would be rehabilitation-type beds and then 20 mental health rehab beds.

THE CHAIR: All right.

Dr Brown: Of the 75 day places, there are 25 mental health, 25 rehab and 25 aged care.

THE CHAIR: All right. Ms Porter.

MS PORTER: In the mental health area, page 13 talks about the focus on providing health assessments and care for people detained in corrective facilities. That is the AMC, I presume. Minister, can you tell the committee about the purpose of these assessments and how many AMC detainees usually complete these assessments in the target time?

Dr Brown: Those assessments are mandated in legislation and they are an assessment of both general health status and mental health status.

MS PORTER: For every person?

Dr Brown: For every person who enters the facility at both AMC and Bimberi. Where it is indicated from that initial assessment that there may be a further in-depth mental health assessment required that is followed up. We have a target of 100 per cent for both facilities. We met that target, or expect to meet that target for AMC. For Bimberi, I think the figure is slightly below that. I think we have had one or two occasions when we have not been able to complete the assessment within the mandated time frame. Katrina is ready to speak. It relies on the individual working with us to complete that assessment. Certainly in one case at Bimberi the individual did not.

Ms Bracher: That is right. At the Alexander Maconochie Centre there is a process where all of the people being detained, whether on remand or sentenced, come through the same entry point and wait there to be assessed by both our health staff and the custodial staff for their needs. Because the process really churns through with higher numbers, we can be there. We have staff there all of the time to see those people. We achieve 100 per cent assessment of all of the people at Alexander Maconochie Centre without any problems.

MS PORTER: So this is assessing their current mental health status but also their mental health history? Is it doing both?

Ms Bracher: It is a general health assessment. We assess their current health utilisation in the community. So if they have got diabetes, if they have got epilepsy, we offer them blood-borne virus screening at that point in time and we also do a mental health screen, which is around acute risk at that time. If there is acute risk, ACT Corrective Services houses the person in an appropriate place. If the person is already being seen by our community mental health services and comes into the Alexander Maconochie Centre, the continuation of care happens with our forensic mental health team out at the AMC.

So it is a general, holistic health assessment. We do sexual health screening. For the women we do women's health screening as part of that. It does not all happen at that point in time, but there are flags when we need to follow up on mental health care or diabetes care or blood-borne virus screening with the health team over the course of the next few days. We get the medications sorted on that night, we get the risks sorted within 24 hours, and then the ongoing care is in a more ordered way with an appointment schedule up to the health centre.

MS PORTER: By way of clarification, did you say that if they are already in the public mental health system you will be able to obtain more information and more background on that person from their history? What about someone who is under private mental health care?

Ms Bracher: We screen for that. If the person discloses that they are seeing their GP and are being prescribed antidepressants or anti-anxiety medication in the community, that is noted at that time and then the general practitioners in the Hume health centre would continue that care.

If the person deteriorates in the AMC or has additional mental health concerns as a result of being detained, which many people do, our forensic mental health team and the psychiatrists that are part of that team would provide the specialist services that are required.

Certainly with the people that are in the public mental health system, the clinical records are available in the community and in the AMC so that there is no problem with clinical handover. With people that are having private health care, whether that is mental health care or diabetes management or whatever, with their GP, our general practitioners at the Hume health centre make contact with the person's declared general practitioner for a handover as well.

THE CHAIR: Thank you very much. A supplementary, Mrs Jones.

MRS JONES: Just on that, when we toured through the facility, my understanding was that much of that health screening is voluntary. Which elements are voluntary and which elements are mandated?

Ms Bracher: In legislation it is mandated that we need to do a health assessment. There is no legal capacity for us to make somebody answer the questions. We document if the person is unwilling, but, having said that, most of the people most of the time answer most of the questions.

MRS JONES: Do you feed back to the minister the level of compliance or the level of interaction at that point so that you are finding out whether you really do have a 100 per cent accurate, or as accurate as can be, picture of who is, for example, suffering mental health issues inside the prison?

Ms Bracher: I monitor that monthly at the divisional level and report it up, in fact, to the director-general. It is not an accountability indicator to the Assembly. The broader one is just ensuring that we are assessing people, the quality of those assessments and

the information that is gleaned from those assessments and the care plans that we then roll out in response to individual needs.

MRS JONES: On your experience, what proportion of people are being mental health assessed on entry to the facilities?

Ms Bracher: They all are. They all are having the screening assessment.

MRS JONES: The general health assessment?

Ms Bracher: A screening assessment for mental health care, which is at a primary health care level. It is not a specialised mental health assessment. If a person discloses that they have a concern in the community then the forensic mental health team will see them the following day.

MRS JONES: If they are willing to participate, yes.

Ms Bracher: Yes.

MRS JONES: What is the level of compliance? You have got 100 per cent, did you say?

Ms Bracher: Yes. All of the people are assessed. If they are unwilling to answer questions on a suicidal ideation and the staff are worried, we always take a very risk-averse approach to our advice to Corrective Services for the placement of those people until forensic mental health can do a full assessment the following day.

THE CHAIR: Ms Berry?

MS BERRY: What are we doing; mental health still?

THE CHAIR: We are doing acute care, the local hospital network, mental health and infrastructure, all to be done by 12.30. So short sharp questions and short sharp answers.

MS BERRY: The questions are short and sharp; it is the answers that might be longer. I want to ask questions about seclusion and restraint. It is a very difficult area in mental health that I understand requires a balancing of interests, but I wondered whether the ACT Health Directorate has a policy on seclusion and restraint.

Ms Gallagher: This is a strategic indicator in the budget papers—if I can find it—and it shows you just how well staff in mental health and justice health—

Ms Bracher: We are estimating 2.7 per cent.

Ms Gallagher: Yes, and I think the national average is in the order of 14, is that right?

Ms Bracher: It is about 14 per cent.

Ms Gallagher: So the ACT is leading the way here. It was a piece of work started under Dr Brown when she was the Chief Psychiatrist. Not many people focus on this area of health and this subset within mental health, but it is a real credit to the people that work in this area that they are able to deliver this. It is very easy to put that figure on paper and go, "Well, that looks reasonably good," but you have to break it down and think of the people they are working with and supporting so that they are not placed in restraint or seclusion. When I read it in the budget papers I always think it never quite does that area justice for the work that is involved and the huge improvement they have driven and maintained over the last three to four years. It is a credit to Dr Brown down that that has been achieved. Katrina might want to add to that.

Ms Bracher: Your specific question was do we have a policy. Absolutely we do, and policy has been driven nationally and is based on national policy. It is also being developed at an operational level with consumer and carer groups very actively involved in describing that policy and the procedures that are undertaken, including the de-escalation, and that is what the minister is alluding to. There is a lot of preventative work in the de-escalation space and the care that the staff provide to prevent a seclusion episode. But in the event that the situation deteriorates to that level, there are very clear guidelines around how the staff need to respond, including assessment and validation by a psychiatrist and reassessment within four hours if the person is still in seclusion at that point in time.

Dr Brown: In addition to that, there is also a review after each event of seclusion. Mental health has a seclusion and restraint review committee and there is consumer participation on that committee to actually inform the review of each event of seclusion. I think that is really a strong driver in the cultural change that has brought about significant success in this area.

Ms Bracher: We are actually using that committee further to that to review incidents of aggression and violence in the unit, too, and aggressive behaviour, so it might not have resulted in a seclusion episode but we are doing a clinical review of those situations with the view to preventing them all round for the person involved, their family and the staff.

MS BERRY: As part of that policy, is the ACT looking at minimising further seclusion and restraints, similar to the moves in Victoria and Queensland? Or does the policy pretty much outline that right now?

Ms Bracher: My understanding is our performance actually is—

Ms Gallagher: Way ahead of anyone else.

Ms Bracher: Yes, way ahead of all of the other jurisdictions.

Ms Gallagher: They are learning from the work that is being done here.

Ms Bracher: At the end of last year Dr Norrie, the Chief Psychiatrist, was instrumental in leading the national seclusion and restraint conference here in the ACT. Our results and those of all the other jurisdictions were discussed at that forum,

which included advocacy groups, consumer and carer groups and clinicians.

MS BERRY: I imagine it must be, as you were saying, incredibly traumatic for everybody involved, and the staff must be fairly specialised in that area and get lots of support for some of the things that might happen on their watch.

Ms Bracher: Yes, that is right. As Dr Brown said, each incident is reviewed formally, but debriefs happen at a number of stages during a process, so staff are supported and there is a peer review process—do we actually need to do this, do we actually need to move to the next step? There is cross-checking all the way along.

THE CHAIR: All right—

Ms Bracher: Could I just correct the record? I think I said that the estimated performance was 2.7 per cent. It is actually 2.1 per cent in the budget papers.

THE CHAIR: And the national average was what?

Ms Bracher: About 14 per cent.

THE CHAIR: Well done. Mrs Jones, a new question.

MRS JONES: I want to go to the general purpose of the Health Directorate as per the budget papers and the report that we had from the Chief Medical Officer in promoting health and wellbeing. There are a couple of elements where we can improve I think. Obviously there has been some discussion this morning on the serious injuries to cyclists and that obviously we have a high number of cyclists in the ACT. What measures would be considered to reduce this number? Falls in the over 60s requiring hospitalisation has increased, so what are we doing to promote the good health and wellbeing of the over 60s? There is also a significant increase in HIV as a result of unprotected male-on-male sexual intercourse and unprotected anal sexual intercourse. We also have very high rates for stroke and vascular disease. Is there—

THE CHAIR: Mrs Jones, that is probably under public health services, which I suspect we will not get to until after lunch. If we could concentrate on the local hospital network, the acute care, mental health and infrastructure it would probably be better.

MR HANSON: I have a question, Mr Chair.

THE CHAIR: Yes. Mr Hanson.

MR HANSON: The VMOs as opposed to salaried medical officers is an ongoing public debate.

Ms Gallagher: It is for some. I do not think it is really a debate.

MR HANSON: It is amongst the VMOs.

Ms Gallagher: Well, the VMOA has a particular position, but I do not think there is a

debate.

MR HANSON: I speak to a number of VMOs, and I suggest it is a concern to a number of VMOs. Looking at the number of VMOs compared to salaried specialists over the previous few years there is certainly a trend in reducing the number of VMOs, it would appear, and increasing the number of salaried specialists. I have some questions on that. What is the change of number? The information I have been provided by the VMOA is that there has been an increase of about nine per cent over the last few years in staff specialists and a decrease in VMOs relatively. Have you got the statistics on that?

Dr Brown: I do have the statistics, Mr Hanson. I preface providing the statistics by saying that it is difficult for two reasons. One is that the numbers I have include locum contracts not just at a point in time. It is also challenging for us to get the figures out of Calvary, not because they are being difficult or resistant but just because their systems do not provide for them to be able to provide this information easily.

Currently we have 208 salaried specialists at Canberra Hospital and we have 188 VMOs, the majority of whom work across TCH and Calvary. If I look at the previous years and the figures that Dr Hughes and the VMOA have referred to, there have been significant changes in the numbers of VMOs particularly at Calvary. So we dispute his claim that there has been a reduction in overall numbers.

MR HANSON: There is an overall trend, though, towards increasing the number of staff specialists, is there not?

Ms Gallagher: There is an overall trend to increasing the number of doctors, and the view of the government is that the employment arrangements to enter into are the ones that benefit the community. If that is delivered by staff specialists, then good; if it is better delivered through VMOs, then great. There is no policy in place to reduce one or the other. My own view is what works for the people of the ACT is the employment arrangement that should be entered into based on our requirements for availability, teaching, the skill set, the private arrangements with a doctor—whatever. There are so many different variables to it. Reading into some of the concerns the VMOA have, they seem to think there is some concerted push to squeeze out VMOs. That is not the case, but we are seeing changes. The oversupply of doctors in the next few years may change that even more when it becomes largely an employer's market and we will be able to get some efficiencies out of that.

MR HANSON: It might be difficult to quantify, but have you done any analysis on cost per hour or cost per procedure or whatever it may be of staff specialists compared to VMOs? I appreciate that it might be depend on the specialty.

Dr Brown: Yes, we have, and again it is quite a difficult comparison. Some of our VMOs are employed on a sessional basis, so for a period of time. Some are paid on a fee-for-service basis. We have done some calculations comparing the sessional with the salaried, which is by far the easiest comparison to do. One has to make some assumptions, but across the board, VMOs would appear to be probably 30 per cent more costly to us than the equivalent specialist employed on a salary.

Cost is one factor we take into account. It is not the only factor, however, and I am on the record saying I believe our system should have VMOs and I will always support their engagement in our system. Often times they are more senior practitioners and they bring a particular skill base and a particular range of experiences that sometimes our salaried specialists do not necessarily have. For exposure to training et cetera that is a very valuable thing. But we have to look at what we require to efficiently run the whole system. That might be around the hours on call, it might be around the training and the supervision requirements et cetera. There are some circumstances where you need to have salaried specialists available. We look at a range of factors in determining whether we look for a salaried or a VMO person to fill any particular vacancy we have.

MR HANSON: What is the negotiated position with VMOs? Is it done on an individual contractual basis? You have a body of work to do. Do you tender for that body of work? How are VMOs engaged?

Dr Brown: When we have a vacancy we advertise that vacancy. Sometimes it is for salaried and VMOs and we will see who applies. Then we enter into a contract with the VMO, and part of that contract actually sets out in a schedule what work we are asking them to do and then the payment arrangements.

MR HANSON: When you are doing that cost comparison, you are looking at all the oncosts for a salaried as against a VMO I assume?

Dr Brown: Yes. But VMOs, for example, have the indemnity provisions that our salaried people have. They have superannuation provisions. The costs that historically have been there for salaried staff but not for VMOs have changed over the last decade or so.

MR HANSON: When you talk about the fact that we have more doctors in the ACT, can you give me an update on how that is progressing? I know there were some concerns about training positions and that was addressed. But if you could give me an update on how that is progressing for training and then in the longer term what that is going to mean. Is undersupply going to become oversupply?

Dr Brown: I am not sure what you are referring to in terms of problems about training positions. There was a focus on the number of intern positions.

MR HANSON: The ability for graduating medical students to stay in Canberra and everyone to be essentially given a position.

Dr Brown: Currently we have 96 intern positions. We are anticipating having the same number next year. We have given an undertaking that we will contract the interns for two years, and we anticipate that the vast majority of people graduating from ANU will seek to work here, but last year not all did. Our proposal this year I think is out in the public space now. The students have to apply for their intern positions and state their preferences, and our position for 2015 will be the same as it was last year, which is that we give preference to ANU graduates, whether they are commonwealth supported or international full-fee paying students, if they indicate they want to come to Canberra Hospital and are not applying elsewhere in the country.

MR HANSON: Have you mapped where we are at in terms of shortages and where we are looking at maybe oversupply of interns coming through and the number of appointments?

Dr Brown: We do not necessarily have an oversupply in terms of the output from the ANU Medical School and our positions here in the ACT. Nationally there are some continuing challenges with the numbers of medical graduates and the numbers of positions.

MR HANSON: But that has not washed down here yet?

Ms Gallagher: All it has done is change the bargaining position for the employer in the sense that there are not as many opportunities for ANU graduates elsewhere.

Dr Brown: I think it is fair to say, though, that two or three years ago we significantly increased the number of intern positions available in Canberra. We currently have 96 and I think last year it was 96 or 95. We had increased that from about 72 or 75. We actually put an investment in to be able to match the numbers of people coming out of ANU. That has not necessarily occurred elsewhere.

There is potentially a challenge in the doctor pipeline after the PGY1 and PGY2 years—that is the first two years post-graduation—with the increasing numbers nationally and the available numbers of training positions in the various speciality training programs. Work is being doing nationally on that.

MR HANSON: Finally on this area, with the internships, I have been told anecdotally that it is a little bit haphazard what the interns do. I have been told that some are in a surgical rotation but they get to do very little. Is there an assessment of what they have been taught?

Ms Gallagher: They do do very little to begin with, for good reason.

MR HANSON: What are the metrics around it? Is there a requirement for them to be under a period of supervision? They are doing an internship in a particular area, so what are the key performance indicators?

Dr Brown: There are specific requirements in that first year as an intern—I am sure Professor Bowden will be able to speak to that—and there are supervision requirements. But there are also people watching us who accredit our program to make sure we are actually meeting the requirements. Professor Bowden can speak to the detail.

Prof Bowden: The issue that you are talking about, Mr Hanson, with regard to surgery is an important one because what we have tried to do is to make sure that people are not placed—with the increased numbers of interns—into positions where they do not get the kind of experience that they need.

This has led to some substantial changes in the way we roster the young doctors. A constant theme throughout Australian hospitals has been the lack of cover outside the

nine to five hours. The difficulty when you move from nine to five is getting training and supervision for those junior doctors. Mike Hall alluded to some of that because of the increased numbers of juniors. But it does not take much tweaking of the system to move training and supervision into a slightly different time from where it has been in the past.

For example, our peak period in the hospital is 3 o'clock in terms of admissions from the emergency department to the ward. Yet traditionally the hospital has rostered people in the wards until 4.30 or 5 o'clock. So we have tried to move people into different rostering arrangements. It has been a bit slow in some areas for people to see that change and to adapt to it. In large parts of the hospital we have been able to lead to good overlapping so that we now have good clinical handover going into the evening.

Some of the areas have not quite taken that on in the way that they might and we are working with them. We have been going through each of the various departments of the hospital, including the surgical areas, to fix that to a point that we make the surgeons who are dealing with those interns feel satisfied that they are providing a service as well as getting the kind of supervision that they need.

Your comments and the issues that you might be hearing from people are real. We have attended to those sequentially. There might be a few people who are still a little unhappy about that, but overall the feedback that we have got directly from the interns who have been surveyed systematically is that greater than 75 per cent of people—this is six-month-old data—were very happy. Our understanding is that that is even better than it was before. We have to make the interns happy, of course, but also we have to make sure that the people who they are working for are happy with the kind of provision they have got.

The other really important issue here is that the quality of junior staff in the Canberra Hospital is now on such a level that when we find someone who is not performing well we are slightly shocked by that. If we went back 10 years ago, and I would remind everybody that this is the 10-year anniversary of the ANU Medical School, we would struggle at times to even get interns for the Canberra Hospital. We would have to seek interns and junior doctors of all levels across the entire country, and overseas in particular.

I think we are now in a wonderful position where we can say that the baseline quality of our junior staff is at a level that we have not experienced before. It is to me a really good problem to be facing us, that we are saying, "How are we going to provide the training for these people?" This is because it meets a need for senior staff in the future. However, we have got to get over a little bit of a hump at the moment where we have got so many junior staff feeding into it.

MR HANSON: Great.

THE CHAIR: We will go back to Mrs Jones for a question, given that she skipped the last one, and see where that takes us.

MRS JONES: Thank you. Minister, can you update us, in the area of mental health

and rehabilitation, on the situation with the Aboriginal and Torres Strait Islander residential alcohol and other drug rehabilitation facility, which has been pushed out again until 2015-16.

Ms Gallagher: Yes, also known as the bush healing farm.

MRS JONES: Also known as the bush healing farm.

Ms Gallagher: Yes.

MRS JONES: Thank you.

Ms Gallagher: That is still currently before ACTPLA. There are two DAs. We have had one DA finalised through ACAT. Then there is another DA, which was the siting and design DA on that site. There are just a few, I think, outstanding matters in that. It might have been finalised by the end of this year?

Ms George: Do you mean the land management—

Ms Gallagher: Yes.

Ms George: It has been finalised, the land management agreement. It is with TAMS and we are expecting that to be approved by the end of this month.

MRS JONES: So once it is approved, what is the expected time frame for delivery?

Dr Brown: We will need to go out to tender for construction then. We do not actually have a timeline as yet. We have been awaiting, obviously, the finalisation of the DA process.

MRS JONES: How long does a tender process for that type and size of facility normally take?

Dr Brown: Tender processes can take a number of months to years. It crosses over—yes, six months for a tender process but then you actually have to undertake the construction. Our current timelines were for the DAs to be approved very soon. We are looking at a completion date in 2017 for the Ngunnawal bush healing farm.

MRS JONES: Will the construction take over 12 months?

Dr Brown: Yes.

Ms Gallagher: Yes.

MRS JONES: Is it a very complex construction from go to whoa for over 12 months?

Dr Brown: There are two aspects. Again, I believe we have an indicative plan for this facility, but when we go out to tender we will be seeking for the contractor to look at the innovative design. However, because we have had very close work with the advisory board on this, we would need to run any proposed changes in design through

the advisory board. That will add to the timelines.

Then also incorporated in the contract when we take it out to tender will be some remediation work around the old—the contamination from the previous sheep dip on this rural facility. That will also need to be done before the construction is undertaken. That adds to what might otherwise be a less complex build. So it is 2017.

MRS JONES: So you are hoping to cut a ribbon in 2017?

Dr Brown: Yes. We are forecasting—that is if the DAs—

MRS JONES: Go through.

Dr Brown: go through in the near future. We are looking at a first half of 2017, but if there are continuing delays, and we have had a lot of delays, then that time frame could change.

MRS JONES: Thank you.

THE CHAIR: I have as a supplementary to that. On page 23 of the portfolio statement it does have all the funding listed for completion in 2015-16. Are you now saying that is out of date?

Dr Brown: Yes. My understanding of that is that we were not anticipating—well, we were trying to anticipate when the DAs would be resolved; so we indicated the funding in that year, but knowing that the DA is yet to be finalised.

THE CHAIR: All right; so expect it open in early 2017 or late—

Dr Brown: The first half, yes.

THE CHAIR: First half of 2017. Ms Berry, a new question?

MS BERRY: Thank you. Minister, I know that you have been a very strong supporter of the step-up, step-down model. I had a question about how much it is costing per person per day. How do the costs compare to addressing people's mental health needs in a hospital setting? Why has this additional model been offered in the ACT?

Dr Brown: I do not know that we could give you the actual figure, a comparison of step-up, step-down versus acute. We would have to take that on notice and come back to you with that. However, it would be considerably less than the intensity of an inpatient bed. But it is not just about the cost.

MS BERRY: That is what I was going to get to. I know that we are always putting a price on things but maybe it is the outcomes that we need to find a way to measure better.

Dr Brown: Yes. Step-up, step-down is essentially not there to be an alternate to an inpatient bed when, indeed, an inpatient bed is what is required. But sometimes when people are becoming less well and need additional support, they may currently be

admitted to hospital when they could be managed in the community if they had that additional support available to them in the community. That is the step-up component.

The step down is when people who may have had an inpatient stay but are transitioning home need an additional level of support before they go and live in their own house. That is the step-down capacity.

It is actually about providing a more appropriate level of support that people need in an appropriate environment. Inpatient mental health facilities are generally very busy places. Most people would choose not to be there if they had a choice and a viable alternative. We believe that step-up, step-down offers that alternative in terms of providing appropriate care in an appropriate setting.

THE CHAIR: A supplementary?

MS PORTER: How many step-up, step-down facilities do we now have? Do they vary for the type of person—young people, older people or—

Dr Brown: We have three at the moment, three different facilities. We have one for adolescents up to the age of 18. We have one for young adults, which is 18 to 25. Then we have one for adults over the age of 25 up to essentially 65. I do not think we have too many over 65s go into that facility.

MS PORTER: By the time we get to 65, we have to look after ourselves.

Dr Brown: We sort it out—

MS PORTER: I think my mental health should be very well adjusted by this time.

Dr Brown: No, it is not that, but generally—

MS PORTER: No, it is a joke.

Dr Brown: We have a very, very excellent community-based older person's mental health team. The bulk of their work and support is provided to people at home. So we do not have the same level of need for that supported—

MS PORTER: Have you found that those three facilities are meeting the demand?

Dr Brown: It is a how long is a piece of string type question, really.

MS PORTER: Yes.

Dr Brown: I dare say that if we had more they would be utilised. Certainly the current beds that we have available are well utilised. I think, as I said, it is meeting a need that has always been there. It certainly complements the inpatient beds that we have available across Canberra Hospital and Calvary hospital.

THE CHAIR: We might call a break there for lunch. At this stage we will assume that acute services, mental health services and ACT local hospital network are

covered in the main. I did have some questions relating to gastroenterology and hepatology but I was not sure—

Ms Gallagher: Yes, outpatients.

THE CHAIR: whether they are in public health or—

Ms Gallagher: They are, yes.

THE CHAIR: It is public health?

Ms Gallagher: No, they are in the hospital.

THE CHAIR: If the staff that are responsible for those areas can come after lunch—

Ms Gallagher: Yes.

THE CHAIR: we will start with that. Then we will move to public health and shuffle the others back a little bit as well.

Ms Gallagher: Okay.

THE CHAIR: Thank you for your attendance so far.

Sitting suspended from 12.29 to 1.59 pm.

THE CHAIR: We will recommence the afternoon session of the select committee's inquiry into the estimates for the 2014-15 budget. We will go back to where we left off.

Dr Brown: Before we commence, can I read an answer into the record?

THE CHAIR: Why not.

Dr Brown: In relation to the emergency department staffing issue, we had in June 2010—and I will give the years sequentially after that—142.96 FTE and we had 2.31 FTE on maternity leave. In June 2011 we had 189.66 FTE, with 2.78 on maternity leave. In June 2012 we had 202.99 FTE, with 2.86 on maternity leave. In June 2013 we had 215.45 FTE, with 5.76 on maternity leave, and as of May 2014 we had 232.43 FTE, with 4.84 on maternity leave.

MRS JONES: The figure of the FTE is without those people who are on maternity leave?

Dr Brown: I will have to take some advice on that.

MRS JONES: Total including? Okay, thank you.

THE CHAIR: I would like to follow up on a question that Mrs Jones asked before the break on the secure mental health facility. When will the DA be ready for that?

Dr Brown: We anticipate that there will be two DAs on the secure. One will be for the demolition of the existing Quamby building and the other will be the development application for the new facility. We anticipate both of those going forward in August.

THE CHAIR: August this year. Demolition would be as soon as it is approved and construction on the new facility is to start when?

Ms Gallagher: March 2015, with a planned physical completion date of October 2016.

THE CHAIR: If the commencement date for construction of the new facility is March 2015, why do we have to have special legislation to vary the territory plan?

Ms Gallagher: To provide certainty.

THE CHAIR: There is obviously plenty of time to have the normal process between now and March 2015.

Ms Gallagher: No, there is not. Look at the Ngunnawal bush healing farm. That is the normal process working out this way for you. It has been a couple of years.

THE CHAIR: So you want special legislation in anticipation of objections to it going there?

Ms Gallagher: Yes, without a doubt. If anyone thinks there would not be objections—I do not think you would find someone who knows anything about the project that would say that.

MR HANSON: Do you think it is a bit unfair when the delays have been caused in many regards by a continual change of scope, in effect? So you have been spending three or four years changing the scope, changing the budget and then, because you are now up against a time line, you are going to remove any chance for objections or the proper process to be gone through. Any delay so far has not been through community objections; it has all been through faffing around by you lot.

Ms Gallagher: We have taken the decisions that need to be taken. As I explained earlier, this is in a sense to ensure that the facility is for the long term. Once those decisions were taken, and the decision about the 25-bed facility was only taken in 2013, we have moved swiftly with the project. We could not build this for another two years, but I think it is important that we do get it built and, now that we have taken all the decisions that need to be taken, that it is built without delays through the planning system that would invariably come. They would have come if we had stuck with the original decision for 15 beds. They would have come on the Canberra Hospital site if we had proceeded with that one on that site. For anyone to suggest that there would not be delays—

MR HANSON: You said this would be open in 2011.

Ms Gallagher: No, I never said this 25-bed medium and low-secure facility would be

open in 2011.

MR HANSON: The original scope—that is the point—was that the secure mental health facility would be open in 2011 and would be operating—

Ms Gallagher: The project has changed. We are dealing with two completely different projects and to characterise them as one is disingenuous.

MR HANSON: I am sorry; it is the secure mental health facility. That is the project. You have changed the scope a bit, from 15 beds to 25 beds, but—

Ms Gallagher: From a maximum secure forensic unit of 15 beds to a medium secure––

MR HANSON: To say this is not the same project is—

Ms Gallagher: Well, it is not the same project.

MR HANSON: Talk about being disingenuous!

Ms Gallagher: It is not the same project. It will have different people using it. It will have more staff working in it. It is going to have a long-term rehabilitation focus. It is not the same project.

MR HANSON: It is the same site. It is still a secure mental health facility—

Ms Gallagher: You and I can argue that till the cows come home, Mr Hanson. I do not think anybody particularly cares, other than we need an appropriate secure unit—

MR HANSON: A lot of people do care.

Ms Gallagher: in place as soon as we can get one. We are taking all the steps. Indeed, Mr Hanson, in your own amendment in the Assembly on 7 August last year you moved that we expedite the planning process and build the secure unit on the Quamby site. And you are now saying that we should not be doing exactly what you proposed to the Assembly.

MR HANSON: I am saying that the reasons that you have come up with are not justifiable.

Ms Gallagher: You proposed it to the Assembly, Mr Hanson. Your amendment said, "Expedite the planning process." That is exactly what we are doing.

MR HANSON: I know what my amendment said and your justification is not there.

Ms Gallagher: We are doing what your amendment suggested we should do and we are providing the project with certainty. The Quamby building will be demolished in the later parts of this year and the building will start formal commencement in the first quarter of next year.

MR HANSON: I have some supps on other infrastructure programs, if we are still in the infrastructure area.

Ms Gallagher: I would also add that the special draft variation was released yesterday for the secure unit by the planning minister, which is allowed under the new project-specific legislation. That allows for quite an extensive consultation process, which is ongoing, that Health have been undertaking in consultation with the community. There have been a number of community meetings—some well attended and others not so much. We have brought in experts on forensic health. We have had a forum chaired by Norman Swan. We have done a lot of work to keep the community informed on the deliberations about this project.

I see Mr Doszpot is letterboxing Narrabundah saying that we are not going to consult and we are ramming through things. I think that is unfair. Just for the record his letterbox said it is a 40-bed unit, so that probably needs to be addressed in any further updates from the Liberal Party.

THE CHAIR: Could we go to the gastroenterology and hepatology unit report from the Auditor-General. Minister, what has gone wrong that the Auditor-General would deliver such a damning report?

Ms Gallagher: The Auditor-General has come in and audited the gastroenterology and hepatology unit. She has had a number of recommendations around that. Importantly, she sees it as a matter of internal governance rather than resources. Health was already working on some of the issues identified well before the audit. So I think we are in a pretty good place to respond. Ian has been doing a lot of the work in this area for me.

Mr Thompson: There are probably two main areas that I would highlight. Firstly, the unit, as the audit itself demonstrated, has experienced very rapid growth. The number of outpatient services doubled in the six years until the last financial year. The arrangements, business processes and workflows that are suitable for a unit that has seen 3½ thousand outpatient occasions of service a year do not necessarily—and in this case did not—particularly effectively respond to that rapid increase in demand. What we have got is increasing demand that has outstripped our population growth and our expectations—quite out of step with what we would normally project—and the ability for the processes within the unit to respond to it.

The other area that is highlighted in the audit report is that the communication between the executive at the hospital and the unit itself was not as effective as it could be, even prior to the audit commencing. Change management arrangements have been put in place within the unit to have the relevant executive of the division in medicine much more directly involved in the management of that unit and steps have been put in place to try and improve that communication flow.

THE CHAIR: In the conclusions in chapter 1, the very first sentence, under "Governance", reads:

> Governance of the GEHU is inadequate and this compromises its ability to align its activities with the strategic direction of the Health Directorate and to be held

accountable.

How has the governance been allowed to become inadequate?

Mr Thompson: That is what I was referring to, in terms of the communication and the business processes within the unit. There was not effective communication from the hospital executive and the unit and the business processes have not been updated to respond to the increase in demand. On both occasions it was not resulting in the most effective management of the service delivery or working with the more senior executive within the hospital.

MR HANSON: Was the poor communication from the hospital executive down to the unit or from the unit up, or both ways?

Mr Thompson: It was a little bit both ways. It is something that happens from time to time. There were regular meetings with the director of the unit and the executive director and clinical director of the division. There were expectations about the degree to which that information was then being relayed on to the unit and vice versa. On investigation, it became apparent that that information flow was not as good as we thought it had been.

MR HANSON: Comms has been a bit of a problem in the hospital before. We have seen it in other Auditor-General's reports.

Ms Gallagher: What has?

MR HANSON: Communications—upward and downward, and laterally. Have any steps been taken to address this, not just with this unit but more holistically across the hospital? What are you doing about that?

Dr Brown: It is fair to say that if you go into most organisations people will say the communication could be improved. It is a very large organisation. We have over 6,000 staff plus contractors, VMOs et cetera, and we work across 18 different sites. So it is not surprising that communication comes up as an issue. It is something that we focus on. We have a communication marketing team. We have them located across different sites as well. We have an internal and an external communication strategy that we are working on, and we will finalise that when we get our social media strategy incorporated into that.

But we are also looking at how technology can assist us in communication—for example, better use of SharePoint and things like that, so that people can actually go into information that is stored and access minutes of meetings. For our tier 1 meetings we do try to send out communiques, to communicate to staff the essential decisions and information that come out of those tier 1 meetings. I do a weekly D-G bulletin. We have ways in which we communicate key decisions. With new policies et cetera, we send out specific decisions that outline those.

There are a lot of things that we are doing to try to improve that communication, but it is a constant issue in terms of trying to get across the breadth of the decisions and the information that flows in such a busy and complex organisation.

THE CHAIR: The report goes on to say:

> Patients of the GEHU have not been receiving treatment within the timeframes recommended by the Health Directorate's triage categories. Addressing this will help the GEHU provide the best possible care to patients.

Why have they not been meeting the time frames?

Mr Thompson: It has been a combination of the demand that I was referring to earlier and business processes within the unit. We have reworked the processes around triaging and follow-up and we are seeing substantial improvements in the timeliness with the new processes. So things are looking better now. Yes, those are the primary reasons.

THE CHAIR: Again:

> Delivery of Services
> The GEHU outpatient waiting list has not been managed effectively due to inadequate strategic management rather than a lack of resources. The GEHU's service delivery is likely to be improved through focusing actions on …

Then it goes on to triage and clinical organisation. So why was it not being managed effectively, and had the Auditor-General not done this report would it have just continued in the way it was going?

Ms Gallagher: No.

Mr Thompson: No. As we were explaining earlier, changes in the way the unit was being managed had preceded the Auditor-General commencing her investigation. And steps were in place to address that.

In terms of your question as to why this has occurred, I believe it is predominantly around the fact that the unit had not adapted to its rapid expansion in terms of service delivery with their response to demand. In circumstances where demand increases very rapidly and business processes are not updated quickly enough, it can result in delays.

THE CHAIR: So when did these problems come to your attention? And when you say that the changes predated the Auditor-General, when did the changes start?

Mr Thompson: In October last year was when the management arrangements changed within the unit.

THE CHAIR: That was after the receipt of the public interest disclosure by the Auditor-General. Were you aware of them before the letter of the 27th that prompted the investigation?

Dr Brown: We had the unit director of the gastroenterology and herpetology unit resign last year and we had a change of arrangements subsequent to that.

THE CHAIR: So when did that resignation occur?

Dr Brown: I cannot—

Mr Thompson: That was October.

THE CHAIR: So after the letter was received, after the allegations were made public?

Mr Thompson: It was not in response to the letter or the allegations—the resignation or the change in management.

THE CHAIR: So nobody was aware before September last year there were problems with the GEHU?

Dr Brown: I do not think it is fair to say that. As Mr Thompson has indicated, there has been a growing demand for these services. The figures are that there has been an approximately 25 per cent increase in the total services over the last five years, and there have been increased dollars committed for additional endoscopy services. There was additional funding—

THE CHAIR: Which the auditor acknowledges. There was more money but less management.

Dr Brown: It is something that we have been looking at over at least the last couple of years in terms of tracking and monitoring the actual services that were provided and what was occurring. It has been an ongoing piece of work. I think the Auditor-General has sharpened the focus and we have had the changes in the administration that have supported, I guess, the direction of the Auditor-General's recommendations. We are actually seeing results out of that sharper focus.

THE CHAIR: So how will reporting be improved? The auditor says that the majority of reporting is focused on endoscopy activity. Obviously the area does more than that. She makes particular reference to triage times. What reporting will now be expected and how often will that be made?

Mr Thompson: They are now providing weekly reports on triage times, and it is being monitored.

THE CHAIR: I have a final couple of questions. On incident reporting the auditor says:

> Not all adverse events, that may be the result of poor referral, triage or scheduling practices, appear to be reported.

How is that allowed to happen, that events are not reported?

Dr Brown: The reporting of incidents is voluntary for staff. We ask staff to report all incidents, but at the end of the day it is up to the individual staff whether or not they submit an incident report. We strongly encourage them to.

THE CHAIR: How can that be? How can an incident report be voluntary?

Dr Brown: An event happens. We strongly encourage staff to report it on the formal incident reporting system, which is RiskMan. That allows a couple of things to happen. It allows for the manager to have their attention drawn to it straight away. Then there is a requirement for a response to the person who submitted the incident report. In addition, it allows us to actually track any trends or patterns in the incidents. But the reality is that some staff still do not comply with reporting incidents.

THE CHAIR: So what percentage of incidents are not reported?

Dr Brown: I do not know what I do not know.

THE CHAIR: But if you know things are not being reported, what have you done to ameliorate that, and how can you say you are measuring trends if you actually do not know the accuracy of the numbers you have got?

Dr Brown: I am talking general incidents across the whole system here. We believe that staff report the majority of incidents, but we also know that some staff tell us there are occasions when they do not report. We know, for example, that our senior doctors are not particularly good at reporting incidents. Partly that is because they tell the junior doctors to do it and they can have the incident reported that way. But some staff say to us that they find the system still a bit too complicated for them. So we are looking at how we can simplify the system. We have got a working group looking at that at the moment. We are doing what we can to ensure that we maximise the reporting of incidents, but we cannot be there every minute of the day to know exactly what is happening.

THE CHAIR: When you say "a general incident", can we have a scale of incidents? We used to call them sentinel events. Do we still them refer to them as that?

Ms Gallagher: RiskMan covers everything. It can cover a staff member falling over at work.

THE CHAIR: So how many levels of incidents are there? If there is a general incident, what else is there?

Dr Brown: We have significant incidents. We have high-risk incidents. And I think there are a couple of others—moderate and insignificant.

Mr Thompson: Yes. Insignificant, minor, moderate, high, extreme are the primary categories of incidents under the responses.

THE CHAIR: And how certain are you that you are catching all of the high and the extreme?

Dr Brown: I think we have reason to believe that we capture the vast majority of those. If there is a very significant incident, senior staff will become aware of it, and they will be looking for that in the incident reporting system. If it does not come up,

they will go looking for it. So I have a relatively high level of assurance that the high-risk incidents are reported on RiskMan but it is the lower level incidents that the managers may not know about and that I cannot say to you there is 100 per cent compliance with that.

Ms Gallagher: And there are other processes in the hospital like a clinical review. If there is a sentinel event, for example, that would have other processes wrapped around it. It would not just be reported on RiskMan and then left, for example. So it is—

THE CHAIR: So is sentinel then above extreme or high risk?

Ms Gallagher: I think that is in the extreme.

Mr Thompson: A sentinel event is a particular group of incidents, defined nationally, and while there is a tendency for sentinel events to be classified within the RiskMan classification system as the more serious, it is not actually necessarily that.

THE CHAIR: Just a final one, let us stay with the sentinel event. What is the number of sentinel events that have occurred this financial year and say the last two or three years?

Dr Brown: Zero in 2013-14 to date, two in 2012-13, two in 2011-12, one in 2010-11, five in 2009-10, zero in 2008-09 and two in 2007-08.

THE CHAIR: Could you take on notice, then, for instance the high risk and the extreme category and provide the details for those for the same year ranges?

Dr Brown: I can tell you now.

THE CHAIR: Give them to me now but it would be nice to have them in writing.

Dr Brown: Okay. There were 28 significant incidents from 1 July 2013 to 23 April 2014. They were broadly in the categories of death unrelated to the natural cause of an underlying illness, death of a client in custody, breach of patient confidentiality, and permanent loss or lessening of function. And there were 20 high-risk incidents, if you want that data for the same period. They related to incidents with potential to attract significant media attention, possible significant incidents and a number of other miscellaneous—not miscellaneous in incidental, but a range of different incidents.

THE CHAIR: You were able to rattle off the statistics for the seven years for sentinel. Could you just take on notice and give us the sentinel and the extreme and the high risk for the same period, for the last seven years?

Dr Brown: Sure.

THE CHAIR: Thanks very much. Ms Porter, a new question.

MS PORTER: So we are now in—

Ms Gallagher: I do not know where we are.

THE CHAIR: We were just finishing off gastroenterology and herpetology, which led us to sentinel events. We are moving into public health.

Ms Gallagher: Are we going to public health now?

MS PORTER: I believe so. Do we need to get anybody? No?

Ms Gallagher: No. We have got the acting Chief Health Officer here.

MS PORTER: I noticed this morning, as you probably did, minister, an article in the *Canberra Times*.

Ms Gallagher: Yes.

MS PORTER: Nearly eight out of 10 ACT children do not have enough physical activity, and most Canberrans are not eating enough fruit and vegetables, according to a report that has been brought down by the ACT's Chief Health Officer for 2014. I note that in budget paper 3, on page 83, you mention the healthy weight initiative, which I think is in light of that. Obviously, you are quite aware of this, and I know you have been talking about it in the Assembly over time.

Ms Gallagher: Yes.

MS PORTER: I was wondering if you could update the committee on the role of the Health Directorate in implementing that initiative, and what other initiatives you will be putting in place to support the healthy weight initiative.

Ms Gallagher: The healthy weight initiative is not an initiative that is led by the Health Directorate; it is an initiative that is going to be led by the Chief Minister's directorate. Health, obviously, will have a role in pursuing some of the initiatives contained in the towards zero growth healthy weight action plan. But I am very keen to make sure that it does not come to Health to answer questions that have to be answered around other areas. I think it is too easy to send it to the Health Directorate and expect them to solve the problems that are created in other areas. So Chief Minister's will be leading that.

MS PORTER: So this is a whole-of-government initiative? Is that what you said?

Ms Gallagher: Yes, whole of government, and there are working groups established under the healthy weight action plan. I met with the working groups last year to talk with them about what is going on. It seems to me that every directorate with responsibility for a particular area is pretty focused on seeing some change.

It comes to things like planning, the role of active transport, how we involve schools and things like that. Then there is a role for Health in terms of doing some of the evaluation, looking at some of the regulatory responses. Health are a part of it, but they are not leading the work. Even though, even across government, at times it is easy to send it back to Health, I am trying to make sure it is pulled out of there.

The Chief Health Officer's report, if anything, just adds weight to the need to respond across government. In fact, it was the Chief Health Officer's previous report that really started off the whole-of-government thinking about how we deal with the issue that we have got now of unhealthy weight and unhealthy lifestyles.

MS PORTER: The whole-of-government approach is obviously a very wise one, and best; otherwise Health will end up with the end result.

Ms Gallagher: They have got that already, yes.

MS PORTER: Which costs a lot of the public dollar.

Ms Gallagher: Yes.

MS PORTER: So thank you for that.

Ms Gallagher: The money that is allocated in the budget for the healthy weight initiative will go to a number of different areas, but looking at basically community programs; working with the schools on the food and drink policy; increasing the focus on physical activity in education programs; planning, with active living principles being incorporated into urban design; providing nutritional information so that people can make healthier choices when they are out shopping; and looking at how we evaluate and monitor some of the impacts of what we are trying to do so that we actually are measuring whether we are making any difference. There will be some web-based information as well.

I will be attending the food ministers meeting, I think next week, in Sydney, where we will discuss issues around the work that is being done on front-of-pack labelling and the website that was to go along with that. Hopefully, there will be some progress on that as well, which would help feed into some of the work we are doing.

THE CHAIR: Ms Berry had a supplementary; then Mrs Jones.

MRS JONES: Mine was just answered.

MS BERRY: Going on from what was reported in the *Canberra Times* today from the Chief Health Officer's report, I wondered, minister, if you could take us through some of the key findings.

Ms Gallagher: I think the acting Chief Health Officer should take this.

Dr Pengilley: The report obviously covers a wide range of measurements of population health, but overall it indicates that Canberrans enjoy a very high standard of health. We have the highest life expectancy in Australia, and the Australian life expectancy is high by world standards. About 88 per cent of adults report good to excellent health.

MRS JONES: I am just having trouble hearing, Mr Pengilley. Sorry.

Dr Pengilley: That is all right. I will speak up?

MRS JONES: Yes.

MS BERRY: You will have to use your outside voice.

Dr Pengilley: Fair enough. About 88 per cent of Canberrans describe their health as good or excellent. The purpose of this report is really to provide a snapshot, to help identify concerns for the future and the drivers of disease and health in the future. The one that we have just been discussing, which is very prominent in the report, because it is probably one of the most prevalent risk factors in the community, is the rate of obesity. About two-thirds of the adult population is overweight or obese; 25 per cent are in the highest obese category. We know that this is a risk factor for a number of other illnesses, such as cardiovascular disease, diabetes and renal disease, and that this is likely to lead to lost years of life, decreased quality of life or increased rates of chronic disease in the future. That is why we have recommended that the government take strong action on it. And we are; we have.

There is a range of other important things. There are some very encouraging signs in the continuing decrease in the rate of smoking. The ACT already has a low rate of smoking, but it has continued to decrease over time. There is a decreased use of alcohol amongst teenagers aged 12 to 17, although one of the worrying trends is a worryingly high level of adults drinking above recommended levels; that is a risk for both chronic disease and injury.

It is a useful report from the point of view of addressing where we need to target our efforts, and we work in that context. Overall, it is the picture of a population doing very well in terms of its health.

MS BERRY: One of the good trends that you talked about just then that you found in the report was adult physical activity. Can you reflect on what you think might be driving that?

Dr Pengilley: There has been an increase in adult physical activity since the last report. These reports are not causal, so it is an indication, but I think that people are beginning to get the message that being physically active is of benefit to their long-term health. Why is that being taken up right now? There have been a number of programs over the last couple of years, which will continue to be run, to help people take up physical activity.

The important thing we are focusing on in that space is really the opportunity for what we call active travel, which is that in a time-poor environment—Canberrans are relatively time poor—there are opportunities for people to take different options for going to and from work. Where people might drive, we encourage them either to walk or catch a bus, which usually involves walking, or to ride a bike. Those are the opportunities we are looking at. We are also looking at that in the childhood space, with ride or walk to school. We hope to increase the amount of physical activity, although I would add that diet is equally important, if not more important, for the issue of overall obesity.

MS BERRY: I was looking at figures, data, the other day that suggested that nationwide 61 per cent of Australians aged between 18 and 34 did little or no exercise. I thought that was quite a scary number. Do you know what the outcome for that demographic is in the ACT?

Dr Pengilley: I would have to look it up.

MS BERRY: While you are looking that up, has ACT Health done any work to understand why it is that young people are not exercising?

Dr Pengilley: We have certainly looked in children. The recommendation there is that we want kids to be getting an hour of physical activity. One of the things we identified there was the amount of passive entertainment, screen-based entertainment, that kids use these days—both television and computer games. There was a program which will be further integrated into upcoming social marketing, the LiveLighter campaign, which is about promoting going out and doing physical activity as opposed to playing computer games.

In terms of young adults or adults in general, it is harder to know, but I think it is time poverty and the tendency to drive; we are a very car-based city. Providing opportunities for people to use other forms of transport, both public transport and riding, is important. But I think there are less clear ideas as to why that is.

MS BERRY: You mentioned some of the healthy workplace programs that are going on. Do you think that because of being time poor and because of people working longer hours, that is playing a role?

Dr Pengilley: Yes; I think it is reasonable that you would think that it would. If you have a very long commute or you are not getting out of work at all, that cuts into the time you can do physical activity. One of the things we are working for in the workplace is to try and deliver programs where people have access to physical activities at lunchtime or you try and get sports teams put together in a workplace. You can encourage people to do physical activity around the work day. But certainly it is a factor that people have busy schedules, and the amount of time they can take out to actually go to the gym, go for a run or go for a ride is limited.

MS BERRY: That flows on, I guess, to children, getting children active. If the parents—generally both parents these days—are working incredibly long hours, then picking up the kids from school and going straight into dinnertime or homework—

Dr Pengilley: Yes. This is why we are interested in trying to promote kids riding and walking to school. One of the changes, certainly since when I was a kid, is that people do not ride or walk to school anymore, and that is an opportunity to get some exercise in the day.

THE CHAIR: Supplementary, Mrs Jones?

MRS JONES: Yes. On the obesity matter, we are starting to understand much better the psychological aspects of "overweightness" and that it is not just a matter of doing some exercise, although obviously that does have other long-term health benefits even

if you remain obese, if you get fitter rather than less fit. But there is self-medicating with food for depression and anxiety, which again goes to the matter of the mental health of the community. There is the psychological resetting of neural pathways which have been developed in adults for maybe 20 or 30 years. I think a lot of people would like to know how to get better at this problem, but if, for example, they have lived a diet which has a lot of carbohydrates in it and do not realise that they do not need any, or need very little, that is a huge psychological change to make.

I just wonder if the action that we are taking is taking into account the psychological changes that are required. Time-poor people obviously have their issues, but also once you have established adult behaviours it can be extremely difficult to break them. I am sure everybody would like to see a better outcome, but it is about knowing that we are going to get the results. Otherwise we are just putting people under extra pressure—pressure which can then increase their depression and their anxiety to become healthier, fitter or more beautiful in the world's eyes when really they do not have the capacity.

Dr Brown: I might respond to that briefly, and then Dr Pengilley might as well.

MRS JONES: Yes.

Dr Brown: I would just say that eating and the consequences of eating in terms of getting to obesity are a very complex matter. It is certainly not a simple solution or a simple fix when there is overweight or obesity. We have recently launched the obesity management service, which is running out of the Belconnen community health clinic. It takes a multidisciplinary approach, acknowledging exactly the sorts of things that you are saying—that it is not just about what you eat; it is about all the triggers about what you eat, lifestyle modification, behaviour modification—

MRS JONES: And what you were told as you grew up and what you think is normal.

Dr Brown: That is right. It is certainly a complex solution, and we are aiming to be able to assist people by having a multidisciplinary approach.

MRS JONES: Is there a focus in that towards women and mothers? We are becoming increasingly aware that a mother's health is not always a high priority when there are so many other priorities in their lives as well and that people need to give them a break essentially and say, "You need time out". I know it is just about public education and it seems a bit flippant, but it is a big problem. People then also suffer depression and so on, on top of the issues that they are already dealing with in their lives, with time management, child management and—dare I say it?—partner management, and getting the food into the house, let alone getting the right food. And then the cost of living is going up.

Dr Brown: The obesity management service is in its early days. It was only launched, as I said, at the beginning of the year. I do not think it has a specific focus on any particular demographic; it is looking at people at the more severe end of the obesity spectrum. But I very much acknowledge the—

MRS JONES: Even a service where people could seek information about what has

worked for other people in their circumstances. People do not know where to start. Even with the internet and everything that we have got, a lot of very well-meaning people would like to be able to reduce their weight but it is so hard to know how to begin.

Ms Gallagher: That is part of the initiative—putting together a useful information resource for GPs and also for—

MRS JONES: For the general public.

Ms Gallagher: Yes, the community, basically to give opportunities for physical activity. I think nutrition is the big one for parents. We all do the grocery shopping. Even for someone in my position who sits around the food ministers table and actually understands the history behind the back-of-pack labelling and what that means, it is really hard to actually identify what is good food and what is bad. You might have low fat but it is high sugar. Or if you do not have high sugar it is high salt and you are giving your kids three times their daily allocation of salt by putting one sauce over their meal. It is really difficult. That is partly the reason for the idea behind that front-of-pack labelling which gave the star rating. It is so that you can say, "Okay, it is a three star; it is not really great, but it is not terrible." It is giving that kind of information quickly to busy people who have three kids in the car waiting for their mum to come back. I accept that it is really hard.

MRS JONES: Yes.

Ms Gallagher: I have a lot of sympathy for people in trying to make that information understandable.

MS BERRY: Just on the healthy eating, one of the challenges is that everybody is so busy and we are all just a bit buggered at the end of the day. For some families, it is easier just to go and get some probably not very nutritious takeaway or fast food. But there is the other side to that; they do not actually know how to cook a fast, healthy meal, a cheap dinner. And that is the other challenge. I do not think some people these days, some kids, even know how to cook. It was compulsory when we were growing up, but these days I do not think—

Ms Gallagher: Home ec.

MS BERRY: Exactly.

MRS JONES: Yes, home ec.

MS BERRY: I do not think that is an option so much anymore for young people; their option is fast food.

Dr Pengilley: You are right; health literacy, or food literacy, is an issue. That is covered, particularly in children, in a program across the states which includes education about exactly that: this is a vegetable; this is how you cook it.

MS BERRY: Yes.

MRS JONES: It is like doing a degree; it really is.

MS BERRY: That is true, though. Some kids do not even know what they are.

THE CHAIR: Members, perhaps can we let the doctor answer before we keep interjecting.

MS BERRY: We are in mad support, yes.

Ms Gallagher: Dr Pengilley is too polite. He thinks that it works by us listening and it is really just us listening to each other.

THE CHAIR: Otherwise, if you have got so much commentary, we will let them ask the questions and you lot can answer them.

MRS JONES: I have got my own ideas.

Dr Pengilley: Just to cover off a few issues: we are aware that we do not want to make people feel bad in this process.

MRS JONES: Yes, because that can just compound the problem.

MS BERRY: Yes, that is right.

THE CHAIR: Members, please!

MRS JONES: No, I do not think you can actually silence us. I am half-Italian, you know.

Dr Pengilley: But it is also true that obesity and diabetes—once you become diabetic, it has a multiplying effect depending on how overweight you become—are a real physical health problem. You know, people die. It is not something you can be inactive on because of mental health issues. We are aware of that issue. We are not trying to stigmatise people. Essentially, we are trying to make it easier for people to make decisions which are healthy.

Now, in doing that, we took the view that you have knowledge, you have opportunity and you have incentives. Yes, you can educate people, but you also then have to give them the opportunity to act on that education, which means you have to make available the right sorts of foods or less of the wrong sorts of foods and then you have to provide incentives, if you can, such as the food is not right there—to take an example which is in the action plan—in the checkout aisle. These are examples of how we are trying to change the environment people encounter such that it is easier and, therefore, those mental health issues are not quite so confronting.

I believe your question was about food literacy. Yes, that is an important one. There are programs being done in populations who have particularly bad food literacy. Probably the main one is in schools, and that is trying to get people to understand that what they eat has an effect on their health and to start making those choices in a bit

more of an informed way.

With that, though, what is very important is the amount of information that is available to people. The front-of-pack labelling, I think, is an absolutely pivotal national issue, as are things like eventually the amount of advertising. People's decisions do not exist in a vacuum and it is not true that there is only us telling people to eat well; there are people telling you to eat not well, and that is an important health issue. It is a battle at the moment, and we are not the ones with the biggest guns.

That is how we are trying to structure this. It is not necessarily a personal approach, because if you look at the figures, it is two-thirds of the population—it rolls off the tongue, but that is 180,000 people—and you cannot run an individual counselling program for 180,000 people quite as easily as you have to change the landscape. You have to change the overall environment people encounter, and slowly you will change their behaviour. That is what happened. That is how we got to this state. It was a change in the environment we lived in which made certain decisions easier to make.

THE CHAIR: Ms Berry, any final questions in that area?

MS BERRY: I do, but I will leave it for the moment.

THE CHAIR: Supplementaries or a new question?

MRS JONES: No, I have done my substantive. I could talk about this all day. I think it is so important, especially for women's health. I just want to go back to my medical officer question, if you do not mind, about the purposes under the Health Directorate's portfolio statement about promoting good health and wellbeing and improving access to appropriate health care. Would you like to give us some ideas on your reaction to some of the adverse findings of the report being, in particular, heart, stroke and vascular disease, cyclist injury in the ACT, rates of falls in the over-60s—hopefully not associated with the state of the footpaths—and also an alarming increase in HIV due to unprotected male-on-male anal sexual intercourse? Those are some of the things that we are just wondering about; what the reactions are going to be like.

Dr Pengilley: I will try and remember those in order.

MRS JONES: Stroke and vascular disease.

Dr Pengilley: We have a relatively high rate of vascular disease reported in the report. It is a complex issue, because there are a lot of cardiovascular diseases. There is cerebrovascular disease, cardiovascular disease and so on. Largely, we think that one of the issues on this is the relatively older or more rapid ageing of the ACT population. Unfortunately, with the best medical treatment and with the best prevention, the biggest risk factor for disease is still getting old—well, for most diseases it is still getting old. It is true that the ACT population has aged relatively faster than the rest of Australia, and I think that is one explanation as to why that is the case.

MRS JONES: We do have the highest stroke and vascular disease rates.

Dr Pengilley: As I say, that may reflect a higher risk across the population.

MRS JONES: So you will need some time to respond.

Dr Pengilley: Well, no—

THE CHAIR: Sorry; as a supplementary to that. If you go to strategic objective 10 on page 7, the proportion of the population diagnosed with some form of cardiovascular disease is 18.4 per cent in the ACT and the national rate is 16.9 per cent. You have got it here as one of your strategic—

Dr Pengilley: I think it was cardiovascular deaths.

Dr Brown: No, it is cardiovascular disease. It is true that our rate is above the national rate. However, when you look at the comparisons, for example, for angina, heart attack and other ischaemic heart disease, stroke and cerebrovascular disease and hypertensive disease, the ACT is actually equivalent to the national average.

It is in some other categories that we have a slightly higher proportion of the population, and that is in oedema and heart failure, diseases of the arteries, arterioles and capillaries, total heart, stroke and vascular disease and tachycardia. The largest difference is around having low blood pressure, haemorrhoids, varicose veins and other diseases of the veins, lymphatic vessels and other diseases of the circulatory system.

That is probably more information than you wanted to know, but the reality is that in the major categories of angina, heart attack, ischaemic heart disease, stroke, cerebrovascular and hypertension or high blood pressure, we actually are not higher than the national average.

MRS JONES: So it is just the way things are.

Ms Gallagher: And it is our rapidly ageing population, I think, as a component.

MRS JONES: More rapid than the rest of the country?

Ms Gallagher: Yes, we are.

THE CHAIR: But we do not have the same age profile as the rest of the country. If age is a factor, we should actually be better off, but in some of these cases we are worse off.

Ms Gallagher: We are ageing faster than the rest of the country.

THE CHAIR: That is right. So we are only catching up to where they are.

Dr Brown: That is true.

THE CHAIR: Yes. So our performance should be better because we are younger and, hopefully, healthier.

Dr Pengilley: I guess I was referring to the trend over time becoming worse.

MRS JONES: Okay. The next one was injury to cyclists on our roads.

Dr Pengilley: That figure is the rate of serious injuries to cyclists. As I said, this report is a snapshot that gives you the figures; it does not necessarily give you a complete causality. I do not have a piece of data that tells me exactly why that is happening. But one could infer that it may reflect the fact that we have a relatively higher rate of cyclists, which is actually good from a physical activity point of view, but it also means that there is an issue in policy and we must make sure that it is safe. It may also reflect a relatively high rate of on-road cycling in Canberra, as opposed to off-road cycling and the speed.

MRS JONES: Or the speed of the drivers.

Ms Gallagher: So when they collide it is serious.

MRS JONES: Falls for over-60s requiring hospitalisation?

Dr Pengilley: Again, that is a snapshot figure. The rate of falls you would expect to increase in the elderly, as people get older. There are some prevention programs run in the hospital. There are not, as far as I know, ones run in the community and that is perhaps something we can look at. It is a worrying issue, though, because once people have a fall it can often be a serious injury which limits their ability to go back home or their future life. It is a valid concern, but it is again a figure that we do not have a clear causality for all of those falls. Some of them will actually be people who are very frail and have fallen in hospital or at home.

Dr Brown: Again, if we look at the strategic indicators, strategic indicator 17 is around the rate of fractured neck or femur, so a broken hip, essentially, most commonly after a fall in elderly people. Our rate has fluctuated a little bit over the years. That is possibly because of the small number of people, relatively speaking, in that age cohort, because this is in the over-75s. It has not actually increased overall; it has been relatively stable.

MRS JONES: Would you be able to provide us with the fractured hip data?

Dr Brown: I can again read it to you. In 2005-06, it was 5.5 per 1,000 over the age of 75 and then in subsequent years it was 5.4, 5.7 and 5.5. It was seven in 2009-10 and then 5.3, 6.6 and 5.5 in 2012-13. We actually have some programs in the community that we run that are around improving mobility for elderly people or older people and are aimed at reducing the risk of falls.

MRS JONES: Can you maybe on notice give us the details of what those programs are?

Dr Brown: Sure.

MRS JONES: Do you want to do elderly before I go on to my last point?

MS PORTER: Yes, I just wanted to ask a supplementary about the falls, Dr Brown. Do those programs that you are running in the community, and also in places where people present with falls, include any kind of tool that drills down into whether or not, as people age and are on a number of medications, medication might have been a feature or the combination of medications may have been a feature in their instability? Also, they may be self-medicating or enjoying more alcohol as they age because they have more time on their hands. I am not necessarily talking about them taking too much alcohol, but a combination of the medication and the alcohol. As we know, we are all more unsteady on our feet as we age. Is there a tool that is used by GPs? That is not necessarily your area, of course, but for those that are seen in the health clinics and also in the emergency department is the message getting out into the community, and are we talking to people about their medication and how to handle the risk of falling?

Dr Brown: I would need to take that on notice in terms of any specific tools that are utilised. I know that education is part of the broad approach, and certainly there is a fairly strong awareness, I think, of the risk of medication in anyone, but particularly in the older population, and the impact that might have in terms of balance and the risk of falling, and I guess we know alcohol can interact with medication. I will get specific information about what approaches are taken and bring that back.

MS PORTER: There is a program down in Melbourne called "older wiser living". You would be familiar with that, Dr Brown. They have some tools and things there and some work—

Dr Brown: Yes, I have heard of that.

MS PORTER: that they are doing. Some health professionals are reluctant to raise the issue of alcohol for fear of closing off the conversation.

Dr Brown: I am not specifically aware of whether or not we have got that in place here in the ACT, but we will get some information back to you.

MS PORTER: Thank you very much.

MRS JONES: Just on the last indicator, there has been a significant increase in HIV rates for male-on-male unprotected anal sex. It has been a long time since the grim reaper campaign and perhaps people are forgetting what happened in the past. Also I think HIV medication has got a lot better now. Can you discuss the public health response to this health problem increase?

Dr Pengilley: Sure. Firstly I would say it is a relatively small number of cases. So it is hard to derive any long-term trend there.

MRS JONES: But I do not think it is just in the ACT that this has increased.

Dr Pengilley: No. That is a valid point, that this is a trend which people are talking about in public health, but it is not clear how big a trend it is. In terms of causality, obviously the CHO report again is a snapshot that simply tells you there are a number of cases. So we are looking at why this might be. The public health response has been

to write to GPs and reinforce the need to test because I think one of the barriers to treatment is people not wishing to really address that conversation about people being at risk.

The ministerial advisory committee that deals with sexual health, hepatitis and other diseases, is formulating a response as to whether we need to actually look at a more targeted or a different marketing campaign or whether the messages need to be different. As you say, it has been a long time since the grim reaper. Certainly, talking to other people in public health and sexual health they say that there is a generation of people coming through who have not been exposed to those messages.

MRS JONES: Or the consequences either?

Dr Pengilley: Indeed, and that there is better treatment now so that people do not necessarily become unwell and there is either a perception that the problem has gone away and therefore people are not at risk or that the disease is trivial or not as serious as it once might have been and therefore that risk is not as important.

Regarding condom use or unprotected sex, basically yes, that is also a concerning figure. I would note that almost half of the respondents did actually regularly use condoms—it is not a universal trend—and that those figures are comparing 2000 to 2011. So it is a fairly long time base. Those figures did not actually increase between 2009 and 2011. So we are not sure if it is a consistent trend. But it may well reflect a similar change in people's risk perception in the community.

There are some technological changes that have also occurred in that time with point of care testing particularly, which might also open some avenues for different ways of managing the disease in the community. It may be possible to get more immediate testing or push testing further out into primary care than has been the case. But it is a concern. It is something we need to make sure does not become a major public health issue and people are definitely looking at it in HIV control all around Australia.

Dr Brown: There is a huge international conference in Melbourne in July focusing specifically on this. Professor Bowden, of course, is a man who wears many hats and he now puts on his infectious diseases hat.

Prof Bowden: I used to chair the national HIV committee for the commonwealth a number of years ago and at that time there was a small increase in the number of HIV cases. It is sitting at around a thousand. It has gone above a thousand and has been—

MRS JONES: Nationally?

Prof Bowden: Nationally and has been sitting there for some time. That is an important public health problem, but it is one that is very difficult to change at the moment because of the need for people to have absolute 100 per cent safe contact through sex or through injecting drug use. What we forget, though, is that we have had the most extraordinary public health response to HIV through injecting drug use.

MRS JONES: What do you mean by response?

Prof Bowden: The response that we had back in the late 1980s, early 1990s, with the introduction of needle exchange completely transformed the HIV epidemic in Australia and made it unique across the world in that we did not have an epidemic of injecting drug users. That remains true to this day. We have got a hepatitis C epidemic across injecting drug use, but that was already present in the community before the needle exchange started. But the introduction of needle exchange, which is a bipartisan Australian response, has probably saved more lives and more money than anything, apart from vaccination. It is as cost effective as vaccination in terms of response.

I guess the only thing I was going to add to what Andrew has very comprehensively summarised was that we have to continue to educate the population about these sorts of things. As new cohorts move through, you do not do it once; you have to continue to do it. It is like saying, "I wish we only had to teach kids at school once and then we never have to do it again." Of course every year we come and start again with the new kids that are coming through to learn whatever it is they have to learn.

So it is with sexual health that you have about a five or six-year window where you catch people and teach them about things or expose them to the information they need to have and then have to do it again.

MRS JONES: But I think there is a fair bit of that in our community.

Prof Bowden: It is not enough. It is absolutely clear that there is not enough sexual health education in schools. Across the country there is a need for people to get very serious about this. And it is not—

MRS JONES: What is lacking? There are sexual health programs in the schools. So what is lacking?

Prof Bowden: There are, but in most places it is not integrated in the way that it should be. Every state and territory is different, but for example it is often devolved to people who may not be in the best position to give the sex ed. I am not talking just about the mechanics of reproduction but the other issues that go around that, and often it is the phys ed teachers in some places who end up doing this. We have had, in the ACT, I think, a very enlightened, consistent and comprehensive approach to it.

The only other thing I was going to point out—and this shows how important advertising can be and why we do need to listen to the lessons of the past—was that you mentioned the grim reaper campaign. It went for two weeks. It was only a two-week campaign, and within those two weeks it not only left an indelible mark upon everybody in this room, it left an indelible mark upon people who never were even alive at the time. And it is interesting that the rhetoric around health promotion 10 years ago was: "Do not go near the grim reaper, it is terrible, it is something we should not do, it is frightening." Yet whatever the message was, it came across, and outside of health promotion circles at that particular time, in advertising circles it was seen as one of the great campaigns in international advertising.

So I think it really is an issue for us to reconsider how you get those messages out. You do not want to frighten people. That is not the idea. But you want to have

something which is powerful and gets across to everybody. And I think Andrew is talking about some of those things we can do.

MRS JONES: I think we are evolving all the time.

THE CHAIR: Can I say thanks very much for the work you did back then. I think it was one of those great successes, and we need to make sure we keep replicating that. But members, we are going to have to move on. Hopefully by half past three we are going to have finished our discussion on public health services and cancer services, which we have not touched on yet, as well as getting to rehabilitation, aged and community care. Mr Hanson, over to you.

MR HANSON: You mentioned that I could duck back to infrastructure.

THE CHAIR: Yes.

MR HANSON: I appreciate that we are a bit short of time. Last estimates, minister, you provided an answer to a question on notice which was very useful.

Ms Gallagher: And you would like us to update it for this year, would you?

MR HANSON: Yes, I would, rather than go line by line.

Ms Gallagher: I thought so, yes.

MR HANSON: If you are happy to basically use the same information in the same format, the same headings and give us an update where it has changed, for what reason, that would be—

Ms Gallagher: Yes.

MS BERRY: What was the answer, for those of us that were not here?

MR HANSON: What it was—and I can perhaps show you—

Ms Gallagher: It is like the health infrastructure program for dummies.

MR HANSON: It is a column like that. It went through the whole infrastructure program with what the project was.

THE CHAIR: Line by line.

MR HANSON: It was the purpose of the project, the scope, stages and time frames, budget, expenditure, scope changes. It would be the same program but updated.

Ms Gallagher: Yes.

THE CHAIR: It is taken on notice. Thank you very much. Perhaps I will show some leadership. Have you a question on the cancer services field?

MR HANSON: Cancer? I will have to refer to my notes.

THE CHAIR: While you are doing that, minister, can you give us an update on where all the projects on the cancer centre are? I notice there are a lot of project transfers in the portfolio statement on page 22 and then on page 23. So where is the project at? Is it on time? When will it be completed?

Ms Gallagher: It is not on time. It depends which time you are looking at. It had the big flood. So with the remediation work that was required for that, it must be almost complete now, yes.

Dr Brown: It is. We now have the certificate of occupancy, I believe. We anticipate having a community open day on 9 August and we will then become operational within a fortnight after that.

THE CHAIR: If go to output class 1.4, there is an almost $3 million increase in the total cost for this area. What are the ins and outs of the $3 million?

Dr Brown: There is a range of issues in that. We had some delays, as you might recall, at the commencement of the project. There was a period where we had significant rain and the cancer centre actually became like a swimming pool. That led to some delays. There were also some issues associated with the ground rock being harder than was initially anticipated.

THE CHAIR: Yes, that is on the—

Ms Gallagher: That is on the infrastructure, yes.

THE CHAIR: capital works. But on page 14, the cancer service, output class 1.4, you have got an almost $3 million increase in the total cost of the budget. I am assuming that is not capital works.

Dr Brown: You have been waiting for Mr Foster, haven't you?

THE CHAIR: Those magic words. He thought he had got away with it.

Ms Gallagher: He has been waiting for the call.

Dr Brown: That is just the growth in the—

Ms Gallagher: I think it is a new initiative.

Mr Foster: Indexation.

Ms Gallagher: Indexation on new—

Dr Brown: Indexation on new initiatives in cancer—I beg your pardon; I thought you were talking about capital works.

THE CHAIR: No, you are right.

Mr Foster: Yes, it is just indexation and the growth initiatives that were announced in the election commitment for outpatient services.

THE CHAIR: Any supplementaries on cancer services? Ms Porter and then Mr Hanson.

Ms Gallagher: Are we on cancer now?

MS PORTER: Yes. I did have another question on public health, but I will stick with cancer at the moment. In relation to the same output, output 1.4, it mentions breast screening and the increase in the proportion. But it is my understanding that there are women who live in New South Wales but work in the ACT who can access the free breast screening. Does this include people who are doing voluntary work in the ACT over the border?

Ms Gallagher: We have allocated 20 places a week for New South Wales women. I do not know if we specifically covered volunteers, but I think if there was an appointment available and they were working, they would be able to use it—but of those 20 places.

MS PORTER: Is there any opportunity in future budgets for you to expand that service for people who do not necessarily travel here for work, either voluntary or paid, but who live just over the border and have to travel quite a long distance otherwise to get breast screening?

Ms Gallagher: The history of this is that we used to do that and provide the service to New South Wales and they would reimburse. It just was not cost-effective for us to be providing it so we negotiated our way out. New South Wales agreed to provide the service. We focused on ACT women. Then this issue arose and we engaged with—are they BreastScreen New South Wales? It is a different service.

Mr Foster: Cancer New South Wales.

Ms Gallagher: Yes, Cancer Institute NSW, which run the breast screen service to negotiate this. But they are still providing services to Queanbeyan and Yass. They have a visiting service that goes there. They are paying for that, and then we have negotiated an allocation. I think it would be crazy to duplicate the service. But we accept that there is a small group of women who are working in the ACT and it is more convenient for them to get their mammograms done at lunch and we can assist there.

MS PORTER: So you might look to see that voluntary workers—

Ms Gallagher: No, they are covered.

MS PORTER: Volunteer workers?

Ms Gallagher: Yes.

MS PORTER: Terrific.

THE CHAIR: Mr Hanson had a supplementary?

MR HANSON: Yes, I do. The centenary cancer chair—I cannot remember the name exactly of that position—

Ms Gallagher: Yes, the centenary chair in cancer research, which is a partnership with the ANU. They are going through the final stages of a recruitment process. It has taken longer than expected because the original applicant was unable to come; he was from overseas—for whatever reason—so they have gone back out for another recruitment round. The last time I spoke to Professor Ian Young and Professor Chris Parish they were hopeful of a finalisation of the appropriate arrangements soon.

MR HANSON: Is that going to be a research position?

Ms Gallagher: Yes. It is not funded through Health. It is funded through the budget appropriation, which is $1.5 million over three years. ANU put in, I think, about $5 million as part of that arrangement. Ours was really the establishment cost of the chair, the professorship to sit at ANU, and then ANU would essentially run it from a salary and the research team. Our support did allow just that original establishment cost because it would not just be the chair; it would be then a research team around that person.

MR HANSON: Was there any direction as to what research is going to happen or is it pretty loose: as long as it is in the field of cancer, it is not specifically aimed at any particular cancer?

Ms Gallagher: I think we would leave that up to ANU. Through the work they do at the John Curtin School they are probably in a better position, but there have been discussions. It makes sense that the person appointed would have good links and connections with the cancer services that we are providing here. They may want to partner on some research or use some of the patients. I would hope so. I hope that is how the partnership would develop, but we would not be seeking to dictate research areas.

MR HANSON: More generally, with cancers, which are the areas which you feel we are getting ahead in, I suppose? Where are the concerns? Would it be breast screening, cervical screening or prostate cancer? Is there an area of particular concern where you see the incidence is increasing or is it a steady rate across cancers?

Dr Brown: Probably the answer to that is that, as our population ages, we are going to see more cancer. People are living longer and cancer tends to occur more as people live longer. So I think we are anticipating an increase relatively across the range of cancers.

MR HANSON: So there is no specific spike in any particular area?

Dr Brown: Not to the best of my awareness.

MR HANSON: Are you reasonably confident with the new facility and the staffing profile you have got that you are going to meet that demand?

Dr Brown: Certainly, we have increased the staffing capacity in line with the anticipated growth in demand, so there are enhanced resources in this year's budget and last year's budget. Our aim is to provide as much as possible in the outpatient capacity, or the ambulatory capacity, and along with that support the research and teaching and training capacity as well.

MR HANSON: I remember a couple of years ago that radiotherapy was an issue where you had problems recruiting and retaining. I remember it was resolved then; you had a spike in recruitment. Is that now settled and you have got the staff that you need?

Dr Brown: I am looking at Mr Thompson, but I believe that we do not have any issues at the moment. Certainly, our indicators on that would not suggest that we have any particular problem because we are meeting all of our indicators, I think, at 100 per cent, or close to.

THE CHAIR: If I could go back to my initial question. Mr Foster has said that the growth in the output total cost is growth plus initiatives. If you take the initiatives, and there only appear to be two—more services and more staff in the lymphoedema service—it only means that the indexation on last year's budget is at 0.7 of one per cent. Is that appropriate, minister?

Dr Brown: I might ask Mr Foster to come back to answer that question.

Mr Thompson: I can provide one aspect. The lymphoedema service has not been flagged specifically for this output at this stage, so it will not have been included in those figures.

THE CHAIR: If lymphoedema is taken out that takes it up to about 0.9 of one per cent growth against the previous year.

Mr Foster: Generally you are always going to see increases because of indexation and growth. With all of the outputs, to understand them, their direct functions also have added to them overhead costs—so where we identify overheads and distribute those. We also take out early intervention amounts, which are self-assessed by the areas. If a cost centre would spend so much, we say that early intervention might be this much percentage. So in that process each year there are adjustments for other things like that. It might sound complicated; it is a complicated spreadsheet. It is not just a simple 'business is this, plus indexation, plus growth'. If a particular cost centre spent less this year than last year, or whatever, and then you are applying a percentage to it, there will be a different figure coming in for the distribution of overheads or the changes for the early intervention.

THE CHAIR: The health price index this year is?

Mr Foster: Labour is 1.9 for most of the workforce and 2½, I think it is, for indexation.

THE CHAIR: WPI is 2½ and CPI is 2¼. So the health index is 2½.

Mr Foster: I have a piece of paper there with those rates on it; the various amounts which apply to whichever components. Do you want me to get that?

THE CHAIR: That would be a good thing. They are quite happy for you to be here, Mr Foster. The more time you take the less time or likelihood that they will get called up. If you could give us those figures, that would be kind. But could you give us a reconciliation on how the total cost for the 2014-15 budget was constructed?

Mr Foster: For that particular one?

THE CHAIR: Just for cancer services. You have been instructed to do that.

Mr Foster: Now?

THE CHAIR: You are offering to take that on notice, are you?

Mr Foster: Yes.

THE CHAIR: That is very kind, Mr Foster.

Mr Foster: Salary indexation: the 2014-15 budget is 1.9 per cent; non-salary is 2.5 per cent; NGO indexation is 2.9; and the super guarantee is 9.5 per cent—if you would like that as well.

THE CHAIR: That is kind, and you will do a reconciliation of the cancer services? Thank you. A new question in this area, Ms Porter?

MS PORTER: Mention was made of immunisation. We have had some really good success in that. Table 32 on page 19 talks about the high rates. Are we currently doing some work to target at-risk groups where immunisation rates may not be so high and do we anticipate any deductions being mooted in the media in relation to the suggested co-payment?

Ms Gallagher: Yes, there is work done to target particular groups. We have very good rates of immunisation. Usually, if we are not number one we are second in the country against all of the age cohorts. Sometimes we dip to three but that is usually just for a short period of time and it might relate to a small number of children.

The group that we keep a very close eye on is Aboriginal and Torres Strait Islander vaccination. Winnunga Nimmityjah have primary responsibility there, in partnership, and even then the results are very good. It can change year by year, so you do see a drop-off maybe in one age cohort and then discussions are had with Winnunga and with GPs if there is an issue identified to try and focus on it. Letters are sent out as well if children are missing their vaccinations. I think that is another good reminder that we need to get it done.

Overall, I am pretty pleased with how our immunisation strategy is being

implemented. I know there is a desire from GPs, in particular, and perhaps organisations like Medicare Local to do more of the vaccination work than the public health provider. That is an area they would like to do more in. There is speculation that the co-payments issue might affect that.

This is an area that we will keep a close eye on to make sure that we are not seeing any drop-off in people thinking they will not go because they might be charged. I am not sure how big an issue that will be here in the ACT because we do provide a public service and GPs are already currently providing a lot of immunisation at no charge. People are going to the GP; they are used to paying to go to the GP in the ACT.

MRS JONES: And they send you a reminder letter so that you do not forget when you are doing the immunisation for your fourth child.

Ms Gallagher: I know. Poor third and fourth children!

MS BERRY: Regarding the immunisations, anecdotally there has been growth in the number of people choosing not to immunise their children as opposed to people not immunising due to lack of information. Do you know if that is true?

Ms Gallagher: There is definite truth to it. In large jurisdictions you can see pockets where—

MS BERRY: In New South Wales there are some places—

Ms Gallagher: The New South Wales minister is very big on pursuing increases in vaccination. They do have some geographic problem areas, and problem areas you would not traditionally think would be a problem area. Because of the small size of our community, we have not seen that type of problem exist, but we have had an outbreak of measles, wasn't it?

Dr Pengilley: We had an outbreak of measles in a school which did not have a high vaccination rate.

Ms Gallagher: Yes, in a school where there were low vaccination rates, and that certainly was factored into our response regarding those kids having to stay home from school for a long period of time.

MS BERRY: Minister, could you update the committee on the services that would be provided at the new Canberra region cancer centre?

Ms Gallagher: Yes. In this budget there are extra services to grow the service rather than doing anything new, although there is an expansion of the lymphoedema service at Calvary, which is linked. This extra funding will go to more services and more staff, as the initiative is called.

The Capital Region Cancer Service already does a range of different things, like screening, assessment, diagnostic, treatment and palliative care services. This money will go to ensuring that they are able to grow their services, because the demand is increasing. It is not necessarily about doing anything new, although I think there is

going to be a focus on outpatient services as part of this year's budget, which we know is popular for people who have cancer—that more services delivered in an outpatient environment is optimal.

MS BERRY: I cannot remember where I saw it, and I hope I did not dream it—

MRS JONES: If you are dreaming about the budget then—

MS PORTER: That would be a bit of a worry.

MS BERRY: It means I am committed. Regarding vaccinations of young women and teenagers with the HPV vaccine, I cannot remember where I saw those figures in here—no, cervical screening.

Ms Gallagher: Yes, there is a strategic indicator on cervical screening. We will have to look at this strategic indicator because in the next couple of years I expect there will be some changes to that screening program which are currently being discussed now in light of the vaccination program and also what the appropriate screening regime is. I think there is a view about having an HPV test every five years.

Dr Pengilley: It is a triaging HPV test and the screening period will change to being longer.

Ms Gallagher: Yes, so not having to go every two years, which I am sure will be welcomed by thousands of women.

MS BERRY: With cervical screening, that is 57.6 per cent—

Ms Gallagher: Yes.

MS BERRY: Of women in the ACT?

Ms Gallagher: Yes.

MS BERRY: Women of a certain age or all women?

Ms Gallagher: Women who are on the screening program.

MS BERRY: Who actually have had tests done? So it is not all women; it is just people who have had—

Dr Pengilley: Joanne Greenfield is the program manager for this area.

Ms Greenfield: It is 57.6 per cent of the target group, and at the moment that is young women after they have first had sex or are over 20 years of age, up to 69 years of age. We are expecting under the new recommendation that that target age range will change, the tests will change and the space in between the tests will change.

MS BERRY: I was interested in that, because I am continually reminding my friends to have their tests done. It is something that women need to get better at as well.

Ms Gallagher: There might be less of it.

MS BERRY: That would be something to hopefully motivate them.

THE CHAIR: Ms Porter has a supplementary.

MS PORTER: You mentioned palliative care amongst that list of things you were talking about just now, minister. Could you give the committee on notice an update on the implementation of your new palliative care strategy—the plan? To give it its correct title, it is the ACT palliative care services plan 2013-17. That is linked in to advance care planning. Do you expect this work that Medicare Local have been doing on advance care planning to be affected at all by any changes in the future that may be brought about with regard to Medicare Local's role?

In relation to that, they raised at the forum that I held here in March the difficulty that some people have in completing their advance care plan because of the complexity, in that they do not believe it is a very user-friendly process. Some even said they thought there was some cross-over between the different forms of legislation we have that may perhaps be brought together or harmonised in some way in order to make it easier. Could you take those on notice, given the time frame—

Ms Gallagher: Yes.

MS PORTER: and bring us back some answers.

Ms Gallagher: I will answer the one on Medicare Local. I think there is a chance it will be affected. Medicare Local essentially are going to trade down for the next 12 months because they have absolutely no certainty on their future.

MS PORTER: They have been doing some really good work in this area.

Ms Gallagher: Yes, they have. They do have some partnerships with us, but the majority of their funding comes from the commonwealth. They have 70 staff and they have no certainty for that. So they do not feel they are in a position to accelerate or do anything other than wind up the organisation. I think that is a shame.

MS PORTER: That would be a pity. Anyway, if we could have answers to those other matters on notice, that would be fantastic.

Ms Gallagher: Yes.

THE CHAIR: Members, we will break there. I am going to say that we have now covered output classes 1.1 acute services, 1.2 mental health, 1.3 public health and 1.4 cancer services, as well as ACT local hospital network. When we return we will complete 1.5, rehab, aged and community care and 1.6, early intervention and prevention.

Sitting suspended from 3.30 to 3.49 pm.

THE CHAIR: We will now start with output class 1.5 rehabilitation, aged and community care as well as 1.6 early intervention and prevention. In an act of extreme generosity, I am going to give my question to Mr Hanson.

MR HANSON: Minister, you received a letter from Julie Tongs from Winnunga.

Ms Gallagher: I did, yes.

MR HANSON: For the edification of members who may not have seen that, I will quote a couple of extracts from it:

> I am writing to express my deep disappointment with the announcement of the 2014-15 ACT Budget. Over the last 12 months I have been paying attention to and actively participating towards the ACT Government's rhetoric commitment to Aboriginal and Torres Strait Islander people and communities, noting key guiding principal statements particularly around reconciliation, whole of government agreements and health and wellbeing. As a result of this 'commitment' I was not expecting Aboriginal and Torres Strait Islander people to be so blatantly excluded from the 2014-15 budget.

It goes on to give some details. At the end it says:

> I encourage you to consider what the actual commitment by the ACT government is to its First Australians. Is it a tokenistic commitment …

And so on. It is a pretty strongly worded letter, I am sure you would agree.

Ms Gallagher: It is.

MR HANSON: Have you got any response you care to give?

Ms Gallagher: Well, I will respond to the letter formally—

MR HANSON: I suppose I am raising it—

Ms Gallagher: in particular, to address the issues that Julie has raised. Julie is a fierce advocate for Winnunga Nimmityja Health Service, and that is exactly what that organisation needs. They have had a lot of uncertainty around their own funding from the commonwealth, and there is a lot of anxiety around that. In relation to our funding commitment to them, our funding commitment exceeds just over $2 million now—

Dr Brown: $1.6 million.

Ms Gallagher: $1.6 million? I am sure I saw $2 million somewhere. We will check that. But it is a significant commitment. It would be the largest amount of funding that we provide to a non-government organisation for delivery of programs, and it is in the primary care area, which, under national health reform, rests with the commonwealth. As I understand it, Julie Tongs is angry with the commonwealth and she is angry with the ACT government wrapped up in that in what she sees as governments at territory and federal level not providing her with the financial support she needs to do what she wants to do. We will continue to work with Winnunga and look to help where we can,

but we do not have funding responsibility for primary health care. And the ACT government cannot afford to take over in that space.

MR HANSON: Have you sought a meeting with her in response to this letter, or are you just going to write back?

Ms Gallagher: I will see Julie. I see Julie pretty regularly, and I have seen her since the federal budget. She came to the roundtable that I held with the community sector. The dialogue is there. Peggy went out and met with Julie and others just recently. We are aware of the accommodation pressures, which seem to be the biggest issue, or one of the biggest issues now that they have got other issues with the co-payments and other things. One of the areas where we will look to work with them is around accommodation. But in terms of extra funding from the ACT government, what Julie's letter does not acknowledge is that we took a massive hit in health funding in this last budget from the commonwealth. We do not have any money lying around.

MR HANSON: So are you saying that you reduced your funding because of—

Ms Gallagher: No, we have not reduced any funding to Winnunga; we just have not given them more. We have maintained it, and it will be indexed to grow so they will get more money from the ACT government. There has been no reduction, but we have not increased financial—

MR HANSON: Were you planning to increase it?

Ms Gallagher: Were we planning to increase it? They put in a budget bid and it was considered, but within the confines of the money available, it did not get through. The area where we will seek to look at how we can support them is around accommodation. I think that case has been well made. I do not know if you have been out there recently, but the space is incredibly tight. I am not sure what the options are. There are plans to extend that they were hoping to get money from the commonwealth for, which they did not, but that is in the order of $1 million. We will look to alleviate some of the pressure in that regard, if we can.

THE CHAIR: Ms Porter, a new question on this area.

MS PORTER: With regard to discharge planning to minimise the likelihood of readmission and the adequacy of checking what a person has in the way of being able to live independently once they leave the hospital setting, could you talk more about that, please?

Dr Brown: We might ask Linda Kohlhagen to speak to that.

Ms Kohlhagen: Sorry, could you repeat the question?

MS PORTER: The second item under key strategies in output class 1.5 talks about improving discharge planning to minimise the likelihood of readmission or inadequate support for independent living for a person coming out of hospital.

Ms Kohlhagen: Our division has three inpatient units, and we hope to start the

discharge planning from the time the individual is admitted into the ward. We have a very multi-disciplinary team, so we have a range of allied health professionals who work closely with the nursing staff and obviously the medical officers. In each of those different wards we have either a discharge planner that works on our aged care ward or our rehab care coordinators who work on our rehab wards. Their role is to be the liaison or the conduit between what happens in the inpatient setting and then the range of community services and the types of supports that our clients or inpatients need—community nursing, community allied health as well as supports from the community sector and residential aged care facilities. They work very closely with that range of individuals. We have regular case conferences and team meetings to be able to discuss the planning, and we also have regular family meetings with the individual and their immediate support as well.

MS PORTER: In your experience, is there enough support for them once they leave the hospital? Are there any blocks? Would a person have to stay in hospital because something is not there for them to help them leave?

Ms Kohlhagen: Sometimes it a little bit more challenging to find the supports they need. We work very closely with the community providers and individuals and their families to look at what kind of supports they can have. Some of the rehab outpatients may have interstate families, so that obviously is a little bit more challenging to have everybody in the room or to do it over the telephones as well. It is quite a lot of effort and work to do it, but we hope it is a smooth transition from an inpatient to a community setting. We have teams that can follow up individuals once they are home. We have a transitional care program for the older patients. We have our community nursing team that can start seeing individuals the next day if we plan it appropriately. And for our rehab service, we have a community rehab team so the clients can transition from an inpatient setting into the community as well.

THE CHAIR: Ms Berry, a new question.

MS BERRY: How do we care for people in the community and what are the benefits for caring for people in the community rather than in hospital?

Ms Gallagher: Just at a general level, that is where people would prefer to be cared for, but from a financial point of view there are a lot of reasons why it is a good idea, too. I think that goes to the heart of the importance behind the primary health care system. And that is why, even though we are not the funder of primary care, we have an interest in primary health care working efficiently and effectively. If the primary health care system is doing that, then it is reducing pressure off the tertiary system.

To a large extent, I think that is what we have got. We have a good primary healthcare system, but there are other indicators. If we are looking at GPs specifically, only 50 per cent of our presentations to general practice are bulk-billed, and there are people who would avoid going to those services because it costs money. There is enough research to show that we have the highest level of avoidable presentations—is that what you call it?

Dr Brown: GP-type presentations—generally speaking, categories 4 and 5 patients who do not require ambulance transport to hospital and who do not get admitted.

Ms Gallagher: But then we have a subset that does not seek out care at all and avoid having any care at all. It has got a funny name.

Mr Thompson: I do not know a particular name.

Ms Gallagher: I think it is "avoidable presentations".

Mr Thompson: The group we are talking about are people who defer attendance at a general practitioner because of cost. Routinely, surveys of ACT residents indicate that we have high numbers compared to other jurisdictions.

MR HANSON: It is the highest in the nation.

Ms Gallagher: We know that is a factor, even though we have higher than average incomes across the board. There is still a large group who would find financial hardship—

MR HANSON: We have the highest costs for GPs and the lowest rates of bulk-billing as well.

Ms Gallagher: We have got 50 per cent. Now GPs will tell you that they bulk-bill the people who need to be bulk-billed, that they charge the people they believe can afford to pay, that one out of two people they see is bulk- billed and that it is their decision. Where someone can afford to pay, they will charge them. If they have seen mum and dad and one child and then the second child, when there are repeat presentations, they will bulk-bill those even for people who are on higher incomes. That is an issue that impacts here—our preparedness to pay and our capacity to pay—and it is why you have seen our responses, which are targeted entries into the primary healthcare area, for example, the walk-in centre and the GP aged day care service where we are funding GPs seeing people in nursing homes. That is us entering a space where we probably should not be in a clear delineation of financial responsibilities, but we know elderly people presenting very unwell from a nursing home tend to have longer stays in hospital, come in an ambulance and have a high-cost experience, let alone the unreasonable position that puts them in as well.

The preference is, where we can, we look at how you provide the services in the community, but when you need it you need to have your hospital ready to go to deal with those cases that should be in hospital. Part of the work we are trying to do with the healthy infrastructure program and some of the planning work we do around our services is to make sure people have access to care in the place that is most convenient for them and most efficient for the health system. That has informed some of our decisions about some of the services that are offered in the community health centre in Belconnen, for example, where we are putting services that have been traditionally provided in a hospital into a community-type environment.

So the different elements are all integrated with the fundamental principle being to care for people where they want to be cared for and where they can get the best care but make sure that the hospital is there if they need it at the end.

MR HANSON: A supplementary, please.

MS BERRY: I have just got one more question on that. I know, Chief Minister, you have been asked about hydrotherapy before, but could you reflect for us on the availability of that service?

Ms Gallagher: I think this came up on the Chief Minister talkback with somebody talking about access to hydrotherapy. A number of different services are on offer in Canberra. There is the service that we have at Canberra Hospital, there is a hydrotherapy pool. There is also one at John James, and there are others in private facilities as well. I think the people who use those facilities would like more of them, but, again, for us in providing service it is about balance. It really is trying to find resource and balance up to the highest need. So that would be something that would be nice, but it is not a priority.

THE CHAIR: A supplementary from Mr Hanson and then new question from Mrs Jones.

MR HANSON: At the Belconnen Health Centre, which is a very impressive facility, there is a cafe. Who runs that cafe?

Ms Gallagher: Belconnen Community Service.

MR HANSON: Belconnen Community Services?

Ms Gallagher: Yes.

MR HANSON: Was that put out to tender?

Ms Gallagher: Yes, it is a social enterprise hub. So it would have been a restricted tender because it has got a social enterprise element to it.

MR HANSON: Right.

Ms Gallagher: They employ people—

MR HANSON: Yes.

Ms Gallagher: who require support in terms of the jobs. I think that was at my request.

MR HANSON: Was it?

Ms Gallagher: Yes.

MR HANSON: So was it given as a—it was an open tender or it was not? Or did you give—

Dr Brown: Mr O'Donoghue might speak to the details of that.

MR HANSON: How are you going, Mr O'Donoghue?

Mr O'Donoghue: Well thanks, Mr Hanson. There was a specific requirement that this particular cafe be conducted as a social enterprise. We conducted through my branch a select tender process to a number of providers who were able to fulfil that criterion.

MR HANSON: And they came up with the—

Mr O'Donoghue: There were a number of proponents and we selected one particular organisation to go forward with that operation.

MR HANSON: Thanks very much.

THE CHAIR: Mrs Jones, a new question?

MRS JONES: Thank you. I turn to strategic objective 5, about waiting time for in-hospital assessment by aged care assessment teams. It is on page 5. For the past six years the target waiting time for aged persons in hospital for the ACAT assessment has been two days. The target for this year, and the long term, is still two days. Why is the action or the objective only to maintain wait times?

Ms Gallagher: I think that is—

MRS JONES: And why did we not get 2.5 in the previous year? Obviously this year we have got an estimate of two days.

Ms Gallagher: Yes.

MRS JONES: But we have been coming back down by the look of things?

Ms Gallagher: Yes, there are some additional staff for the hospital assessment, as I understand it. When you look at this figure, it relates to the context of actual work, year-to-date, 3,020 referrals, of which 2,618 are complete.

MRS JONES: Yes, but given that, it has been possible to get it down to 1.6, 1.7 days. Why two? Is there a rational theory behind that?

Dr Brown: Because we think two is pretty good.

MRS JONES: Okay.

Dr Brown: The national time frame is within three to 14 days.

MRS JONES: Right.

Dr Brown: We have been achieving around about two. It was slightly higher, I think, last year. It has been slightly lower in some previous years. I think the number of assessments, as the minister said, it is quite substantial. We had an 11 per cent increase over previous years in referrals.

MRS JONES: Yes.

Dr Brown: So I think that achieving a two-day outcome for those assessments for people in the hospital setting is actually pretty good.

MRS JONES: Thank you.

THE CHAIR: Mr Hanson, a new question.

MR HANSON: Thanks. I turn to diabetes services. There was a new service model. A director was going to be appointed. At this stage last year, he or she had not been. I cannot quite recall. But it was an ongoing issue—

Dr Brown: It might have been the year before.

MR HANSON: with both the healthcare providers but also with the consumers. Where are we at with diabetes services, the new model and the new director?

Mr Thompson: There is a director who has been in place now for some time. I cannot remember exactly how long, but he is well established in the role. It is Professor Chris Nolan. A revised service model has been developed. He has worked very hard to engage with non-government as well as general practice and specialised services in the development of that model and the rollout of it.

We have expanded the locations where we provide our clinics from. We have now got clinics operating on the northside out of Gungahlin and Belconnen health centres. So we have got an expanded range of services and stronger links with the non-government and primary care sectors. Overall, the service has developed well.

MR HANSON: Have you received any feedback from the community?

Mr Thompson: Not recently that I am aware of. I can ask and get more details of that.

MR HANSON: You are taking it on notice?

Mr Thompson: In terms of the sorts of issues that would have been raised three or four years ago, none of that.

MR HANSON: So you think that broadly that has been resolved?

Mr Thompson: I believe so, but I can give you the detail.

Dr Brown: Certainly the GPs are very complimentary about the enhanced range of services and their capacity to work collaboratively with our services. I think that, as Mr Thompson has indicated, going back a couple of years we certainly had more issues raised. I do not recall having seen any issues really coming across the desk in relation to diabetes services. So I take that as a positive sign.

MR HANSON: Okay.

THE CHAIR: Minister, on page 14 of the portfolio statement for output class 1.5, there is a 16.8 per cent increase in the total costs. What is driving that?

Dr Brown: I think we need Mr Foster again. I do recall asking him that question specifically.

THE CHAIR: Has somebody been too generous?

Dr Brown: No, but Mr Foster can explain it.

THE CHAIR: I know he guards each one of those dollars very carefully.

Dr Brown: He does, indeed.

Mr Foster: There are a number of reasons for the increase. Indexation accounts for $3 million-odd; the growth initiatives, $3.4 million. We also discovered that after an internal restructure where we had combined community services into a management structure with acute services, several functions stayed in the overhead—they were moved into overheads rather than being explicitly put into this output. That included some NGOs, NGO management and health centre administration. That was $6 million-odd, those two items. They have come out of being spread across all of the outputs through an overhead model. Now they are directly in here.

I also mentioned earlier that we go through a process of asking people to assess their cost centres to identify what items would relate to early intervention and prevention. This year advice back to us was that there has been a change in both cost and the percentage in some cost centres. That took $2.7 million out.

Then, by having more in their base—we apply that base against the level of overheads—they got an increase in the level of overheads attributed to this output as well. It was another $2 million-odd; so that is about $18.5 million.

THE CHAIR: All right, that is kind. While you are there, output class 1.6 has seen a slight decrease of about $300,000. Why has that gone down?

Mr Foster: Sorry, in the GPO?

THE CHAIR: In the total costs.

Mr Foster: Not all things are funded through—not all costs—how do I explain this? When we looked at how the early intervention process works—

THE CHAIR: Because the GPO has gone up almost $5 million.

Mr Foster: Yes, the cost is flat.

THE CHAIR: But the total cost has come down.

Mr Foster: GPO has gone up 26 to 30. I will have to think about this explanation. I

have done that review.

Dr Brown: Some of it came back—

Mr Foster: Yes, I would say—

Dr Brown: as you were indicating when there was a re-allocation back into—

Mr Foster: We moved some out from—there was some early intervention that came out of acute services and RACC. Then there was some that went in, which was some GPO stuff that was funded. There was an increase there. So the ones that came out for some of the acute and RACC were third-party revenue funded. Some things had gone in in this review of the early intervention that are GPO funded. Not everything is GPO funded. We have third-party revenue. In that exercise of reviewing what sits in early intervention, again it is a self-assessment by the line areas. In those adjustments, some that have come out are GPO funded or third-party funded and some that have gone in are GPO funded.

THE CHAIR: On 1.6, can you give us a written reconciliation of what has come in and out? In both classes—1.5 and 1.6—nothing has been discontinued or finished?

Mr Foster: No, there is no services—look, apart from things that might have been funded this year because they were rollovers from a prior year and a catch-up, that is the only situation where you would see that there is a change. That can happen, of course. Those rollovers can be through either GPO or cash rollovers. But, yes, there has been no discontinuation of services through any direct decision.

THE CHAIR: Thank you.

MS PORTER: What is RACC?

THE CHAIR: I would think that RACC is rehabilitation, aged and community care.

MS PORTER: I see.

THE CHAIR: A new question, Ms Porter?

MS PORTER: Yes, thank you, chair. Under output 1.6, item b, table 32, page 19 of the budget statement on health, under the accountability indicators, it talks about the women's health service providing a well women's check service. Can you tell us what that is specifically? The item talks about attracting more women from culturally and linguistically diverse backgrounds to attend for this check. Can we be told how that is going to be done? How are you going to make sure that you attract these particular women?

Ms Gallagher: They have very good contacts in place. Year-to-date to March, there have been 447 well women's checks. Of those, 183 are from culturally and linguistically diverse backgrounds.

MS PORTER: When it says "well women's checks", is it a check to keep you well or

is it a check of well women?

Mr Thompson: It is both, actually. In other words, it is a check of well women with the objective of keeping them well. In other words, it is a general health check as opposed to a response to an identified problem or symptom, like GP services typically are.

MS PORTER: Do we have a way of encouraging—I think women are fairly good at coming forward and having checks. They have various reasons why they need to do this. They are reminded a lot, I think, about the various things that they need to do on a regular basis. Do we have a similar kind of focus on encouraging men who are—I am not trying to be sexist here—not so likely to turn up for a regular check on things that are important, like prostate cancer, for instance?

Dr Brown: Yes, this indicator is particularly focusing on the culturally and linguistically diverse background and, yes, women. But I think that there is a focus more broadly on looking at services available for the culturally and linguistically diverse group. We have recently endorsed a new multicultural health framework in ACT Health, again, trying to raise the level of awareness and focus on people for whom English may not be their first language. Within that, the focus on services is for men as well as for women. I cannot say specifically that we are doing that for well men but, more broadly, we are looking at how we can actually improve our services to—

MS PORTER: Or men who think they are well.

Dr Brown: Indeed, yes.

MS PORTER: Thank you very much.

THE CHAIR: Ms Berry, a new question?

MS BERRY: Minister, there has been a fair bit of talk about alcohol-fuelled violence across the country and also here in the ACT. Do we keep data on the percentage of admission violence, for example low-level admissions like rolled ankles after a night on the town? Do we record whether it is an injury that occurred as a result of drinking alcohol?

Ms Gallagher: Traditionally, the admission is for what the injury was, and in the notes it may have that that person was intoxicated or whatever. Increasingly the emergency department is collecting information around presentations that are directly related to alcohol, and I think there is some in the Chief Health Officer's report—is there not?—on admissions or accidents due to alcohol.

Mr Thompson: There is information certainly on the level of risky drinking.

Ms Gallagher: I am sure I have seen a table somewhere about the admissions to hospital with alcohol as a contributing factor. But the emergency department is doing more. Is that the report, at a glance?

Dr Brown: Yes, it is.

Ms Gallagher: I have not seen that.

THE CHAIR: Do you have to catch up?

Ms Gallagher: Yes. You take over.

Dr Brown: Alcohol was a contributing factor in injuries leading to hospitalisation, with 61 per cent being male and four per cent under the age of 18. The number of alcohol-attributable injuries in people aged 15 and over being treated in ACT hospital emergency departments also increased. So it is a growing problem in terms of—

MS BERRY: And does the data that is collected say where they had their last drink?

Dr Brown: I would not—

Ms Gallagher: No.

Dr Brown: I would think that is unlikely. It is the sort of level of detail beyond our data capture systems.

Ms Gallagher: But we do know that presentations with alcohol as a contributing factor do rise Thursday to Sunday. It is night life, often, related.

MS BERRY: But I just wondered whether ambulance officers collect that data or have that data. They would obviously know where they were going to pick somebody up, if it was that severe.

Mr Thompson: The ambulance officers would very definitely have the information about where someone was picked up and, in most cases, where the injury occurred or the particular problem occurred that is requiring transfer to the emergency department. I do not think—we can confirm that—that they would necessarily go into a history at the site in terms of understanding where the last drink was had. It is much more that they know where they picked someone up, they know the condition, and they make the decision as to whether or not to transport to hospital.

MS BERRY: And I am sure they can probably tell us anyway, without having the data, where the most problems occur.

Ms Gallagher: The only other thing I would say to that is that it is not always venue related. A lot of it is parties at home, particularly for young people and people under the age of 18.

MS BERRY: Pre-loading and things like that?

Ms Gallagher: Yes.

MS BERRY: Is it something that the ED is considering keeping and keeping as on-line data somehow? I do not know how—I am not a data expert—but keeping track of

where it is happening in different parts of the ACT, whether it is in the suburbs, which suburbs it is more likely to happen in and whether that kind of data would help us to effectively implement preventive measures around alcohol consumption?

Ms Gallagher: At the moment, it will just be on watching the presentations and getting data from that. I think there is probably more work that can be done across government and is being done in terms of some of the reforms to the Liquor Act and some of the changes that have been put in place around there that are worthy of more consideration. But I think the data that is important to the health system is making sure we understand fully the impact that alcohol is playing on presentations and at what time and things like that. It would be hard. You see an ED doctor, you see what they have got to do. I do not think adding, "Where have you had your last drink?" or, "Where have you come from?" is necessarily going to add anything to the health response to it. But from a community-wide issue, I think there is probably—

MS BERRY: I guess that is what I am looking at, not necessarily at the treatment end but at how we can map it and how we can measure it. You are putting your hand up: "Can I answer the question?"

Dr Pengilley: There is no doubt that alcohol is an issue for injury and also for chronic disease just in its own right. We have done work with Justice and Community Safety in terms of regulation to reduce exposure to alcohol-related advertising and to excess alcohol. The industry group, ADOTA, is also working to provide education on safe drinking. That is the preventive side of things.

I know we would like to think that the EDIS database can be the oracle for all things, but before you went and started collecting that sort of database you would have to think about how you were going to structure it. When somebody turns up inebriated in emergency, from experience, that is not really the best time to be asking them a lot of complicated questions, because you get long and irrelevant, complex answers. It is probably written in the notes, but it may not be coded electronically in a successful way. So I think what you are envisaging is really some sort of study or retrospective study. It could be done.

Is the place where the person drinks as relevant as the fact that they had access to alcohol? It is probably not. Is the last place they drank as relevant? A person might have been to five venues and the last one where they fell over is not really the story of the night. What is relevant, I guess, is the ages and the reasons, and those are more complex sociological questions than you are going to get from purely a medical database. So it is something which is worth looking at, but it is not something which I think is going to come out of a computer system directed largely at the sharp medical end. As has been pointed out, the doctors are usually trying to actually treat the person as well as going to their social history.

MS BERRY: I understand that. And I am not suggesting that any data would be the solution to the issues around alcohol-fuelled violence or injuries. But I just wondered whether there was a way of collecting that data that we do not already do—or do we already do it?—and is there some way to use it to address all of the issues outside of the treatment?

Dr Pengilley: As to the severe end, I think we have already said there is a fairly good indication that it is a significant factor in motor vehicle accidents and severe injuries. I think you could extrapolate that to more minor injuries. It would be very difficult to count every time somebody fell over and grazed themselves. Most of those people will not come to medical attention anyway. The timing, as you would expect, is on the weekend.

But the issues, I think, in terms of prevention, from my point of view, are looking at access and the reasons people drink to excess and the groups that drink to excess and trying to get some messages as to how that should not happen or how to modify that. That is something we are working with industry on. It is something to do further work on.

MS BERRY: I guess that was why I was suggesting where the people who are drinking alcohol to excess live. Perhaps where people are living and the social demographic of that area are affecting their—

Dr Pengilley: It would be fair to say it probably—

MS BERRY: I am not trying to clutch at straws. How do we target the prevention work?

Dr Pengilley: You would target it to particular groups, but it may not be location, that is all I am saying. I think it would probably be age based, it would be time based. You might say university students on Saturdays sort of thing rather than people living in that location. There probably are particular places where people drink. The Private Bin used to be a place where we got a lot of work on a Saturday night in emergency. But the point is not that that was worse than anywhere else; it is just that was where this behaviour was. The reason why it was important was: who was going there, why were they going there, why were they drinking to excess.

MS BERRY: Is the data that we are able to collect useful in any way in developing preventive measures around—

Dr Pengilley: I think it is useful in telling you that there is a problem. And I think it is useful in tracking the scale of that problem over time, but not in absolute amount. It is trend data, like most population data. If you want to go into causality, then I think you need additional work done on studies and it may be that it will involve—

MS BERRY: So research more than just data collection?

Dr Pengilley: Yes, indeed, and it involves looking at things which are not going to be immediately accessible in that database. You may then build it into the database, but it is not really accessible there at the moment.

THE CHAIR: Mrs Jones, a new question?

MRS JONES: Thank you. I want to go back to immunisation and talk about the gap in Aboriginal immunisation. Strategic objective 14 on page 9 of the portfolio statement puts us up above our target of 90 per cent. Just for a start, is it 90 per cent

compared to non-Aboriginal children, or is it 90 per cent of the whole population of Aboriginal children being immunised?

Dr Brown: Sorry, could you just repeat the question? The 90 per cent target—

MRS JONES: Is the 90 per cent target that they are 90 per cent as immunised as the rest of the population, or is it 90 per cent of the population—

Ms Gallagher: No, 90 per cent of their cohort.

MRS JONES: How does that compare to the rest of the population? What is the gap? That is what I am asking, I guess.

Dr Brown: The coverage rate varies in the ACT. For the 12 to 15-month cohort, currently we have 93.5 per cent of Aboriginal and Torres Strait Islander children immunised and 92.7 per cent of the total ACT population.

MRS JONES: So it is higher there.

Dr Brown: For cohort 2, which is 24 to 27 months of age, we had 100 per cent coverage in March 2014 for Aboriginal and Torres Strait Islander children and 92.9 per cent for the total ACT population. And for cohort 3, which is 60 to 63 months of age, it was 89.3 per cent for Aboriginal and Torres Strait Islander children in March 2014 and 92.2 per cent for the total ACT.

MRS JONES: So it is in some ways ahead and in some ways behind?

Dr Brown: Yes. There is—

MRS JONES: Just marginally.

Dr Brown: Yes, a marginal difference. You need to keep in mind, however, that the numbers, particularly for the Aboriginal and Torres Strait Islander cohorts, the children, are small numbers, so a difference of a few can make a significant change in the percentage.

MRS JONES: Are we going to try and aim above 90, though, given that it can be achieved?

Dr Pengilley: Certainly increasing Aboriginal and Torres Strait Islander childhood vaccination rates is one of the objectives of the immunisation strategy. We would like all people in an eligible cohort to be vaccinated, but you have to have some benchmarks as to how you are going, and we chose 90 per cent. You will see that the difference is mainly in the early cohorts, so first vaccinations, and then they rapidly catch up. I think that is why it is 86 up until 92 later. But yes, it is a focus of vaccination, because it is a group which it is important to vaccinate because there is a high risk of chronic diseases.

MRS JONES: What kinds of measures are put in place to increase that cohort's participation? Is it going through the Aboriginal medical services and so on?

Dr Brown: Yes. We do liaise with Winnunga, in particular. We have been having discussions with other stakeholders. We are looking for opportunities to promote immunisation. And of course the Health Protection Service does follow up those who are overdue for their immunisations as well.

MRS JONES: Maybe we can aim for 100 per cent one day if parents are agreed.

THE CHAIR: Mr Hanson, a new question?

MR HANSON: I hope this has not been covered in my absence, but I want to ask about the status on e-health.

MRS JONES: No, we have not done it.

MR HANSON: I note that some stuff has been rolled over.

Dr Brown: We have been making some good progress in the e-health area. I might look for the chief information officer to come and give you the detail. There is a lot happening in that space.

Ms Redmond: We have substantially rolled out all the IT infrastructure component of the healthy futures program. That includes the underlying technologies, the underlying infrastructure—the network components, the medical grade network, the wireless infrastructure associated with the program. We have also largely rolled out the support applications that underpin the healthy futures program of work, including the patient administration system across the Canberra Hospital and Health Services and the Calvary Public Hospital. We have a unique identifier across both sites. We have rolled out the MyMeal program, which supports dietary management and food management across Canberra Hospital and Health Services.

The component of the project that we are still in the process of continuing to roll out is in relation to the clinical systems component. We are yet to deliver the electronic medication management program and a number of the clinical systems components.

MR HANSON: Are you in a contract for the electronic medication management program?

Ms Redmond: We are very close to finalising contract signing with the preferred vendor. What we have done over the last six to eight months is work very closely with that vendor in relation to completing an implementation planning study.

Before we went through to the formalised contract, because it is such a significant component of the healthy futures program, such an important initiative, what we wanted to do was make sure that we had determined with that vendor that from both sides, from both the Health Directorate's side and the vendor's side, there was a quite clear mandate for what we are delivering as part of that program.

They also had some gaps. For example, we want to have the ability to use medication management over mobile devices. We need it connected with our identity and access

management system. There is a whole range of things. Perhaps we as a health directorate are a bit more advanced than some of the other health jurisdictions that are using that application. That has all come into the implementation planning study and is coming together in the contract.

MR HANSON: When the e-health stuff was first announced, there was $90 million, I recall. How far are we through that $90 million in terms of what has been rolled out?

Ms Redmond: We have rolled out—

MR HANSON: Are we at a third—

Ms Gallagher: In an expenditure sense or in a program sense?

MR HANSON: I am just trying to get a sense in terms of—I suppose in an expenditure sense, and then what that has delivered. Have we rolled out about a third of it or—

Dr Brown: Fifty-four per cent—

MR HANSON: Rolled out 54 per cent in expenditure?

Dr Brown: Fifty-four per cent at the end of April has been expensed.

Ms Redmond: From an expenditure perspective, but we have delivered over 20 to 25 actual projects and applications.

MR HANSON: Do you feel that you are ahead of the game on expenditure versus programs, or do you just keep spending until you reach the $90 million and then that is where you cut off the program? Do you have a whole long list of things you have got to roll out and stop at the programs, or how is it going to play out? Or is each one of those individual programs funded independently?

Ms Redmond: We have a clear range of projects that we are going to be delivering as part of the $90 million that align with the e-health strategy that we have within the Health Directorate. One of the challenges that we have had with delivering the program is the capacity for Shared Services ICT, as a whole-of-government support mechanism, to deliver the program. It has taken us a bit longer than we first would have anticipated. Equally, it is a large program of work. As I said, we have delivered over 20 applications so far. The ability for the Health Directorate to adapt to that level of change is another consideration. So it perhaps has not occurred in as timely a fashion as we initially anticipated, but we are very carefully rolling it out. There is a considerable amount of change management that is involved in implementing these new applications into environments and changing people's work practices.

Dr Brown: I think it is fair to say, however, that when we get to the end of the $90 million the need to continue to develop in this ICT space is not going to suddenly disappear. As part of the work that we have been looking at recently, I have asked for some advice, a couple of years ahead, on how we might go forward beyond the $90 million.

THE CHAIR: Does the 54 per cent of the expenditure which equates to 20 applications cover 54 per cent of the scope of what you had intended to do with the $90 million?

Ms Redmond: No, because some of the initiatives we are yet to deliver. Electronic medication management is an example which we are planning to deliver across the whole of Canberra Hospital and Health Services. Calvary Public Hospital is considered one project, but is quite significant from the point of view of both work effort and expenditure level.

THE CHAIR: Could we have a list of the 20 applications that have been developed, and is there a list of what is outstanding?

Ms Redmond: Yes, absolutely.

THE CHAIR: Then, beyond that, is there a wish list that Peggy Brown wishes to see?

Ms Gallagher: That will come to me first before it comes to the estimates committee.

THE CHAIR: The committee can ask for the wish list, minister. Is there a wish list that you might provide to a minister or to the head of the service that you might be wanting to share with the estimates committee?

Ms Gallagher: We will see how helpful we can be.

THE CHAIR: That does not sound very helpful, minister.

Ms Redmond: It is a work in progress, but I can certainly provide the list of projects under the program.

MR HANSON: When you do, can you provide a little explanation about what they are?

Ms Redmond: Absolutely.

MR HANSON: In simple terms.

Ms Redmond: Yes, in non-technical terms.

MR HANSON: Thank you for putting this into simple laymen's terms today, too. There were occasions when I used to struggle with this with Mr Smalley, who was very technical in his briefings, I recall.

Dr Brown: He used to win the award.

MR HANSON: Yes, he did.

Ms Gallagher: For the longest continuous answer.

THE CHAIR: The award is still up for grabs today.

MR HANSON: Yes, you could go on for hours. When you are a bit worried about the line of questioning—

THE CHAIR: Mr Whybrow got the award two days ago for exactly that; a 10-minute expose on ACT-commonwealth—

Ms Gallagher: He is a consummate professional Mr Whybrow.

THE CHAIR: Across two portfolios. Minister, on a more serious note: page 100 of budget paper 3, there is an initiative of $500,000 a year over the next four years for suicide prevention. Could you explain what will be undertaken there and how you will measure the success of it, given the numbers are still relatively small that we attribute to suicide in the ACT and they do fluctuate? How will you measure the success of this expenditure on such an important issue? I congratulate you on having that initiative in the budget.

Dr Brown: Thank you. In terms of what the budget provides for this year, there will be funding for a counselling service to be run in liaison with the Coroner's Court. This is particularly to support people who have experienced the traumatic death of another person and who are involved in the ACT coronial processes, many of whom of course may well be suicides. That will be a procurement process for a community service provider rather than a service that we directly provide.

There is additional funding to provide an additional 1.5 clinicians in the mental health community policing initiative, particularly targeting younger people under the age of 18 who may be presenting with suicidal ideation or self-harming behaviour and who come into contact with the emergency services.

There is also funding for a research project into suicide and its contributing factors in the ACT. That is being run through Professor Beverley Raphael at the ANU. That will look at the factors that have contributed to people suiciding in the ACT who have been in contact with health services over the past five years and also look at what are the predictors of suicide. Obviously that is very important for our ongoing planning.

Then the last element that this funding provides for is an expansion of the "let's talk for suicide prevention" campaign which we have been running now for several years and, I think, has been very successful.

In terms of how we actually measure the outcomes of that, as you say, the numbers are low and it is sometimes challenging to just rely on the suicide numbers or the rates that change in the rate of suicide. We can, however, take other factors into account such as community feedback in terms of starting a new service like the counselling service. We have had good feedback around the community policing initiative. Obviously we will see whether we will get the product of that research and what it is able to tell us in terms of informing our planning of services as we go forward.

It is a combination of looking at numbers and also some qualitative feedback. As I think I indicated earlier, we currently have a suicide prevention plan that is due to

come to its end this year. We are looking at a renewal of that and, again, looking at that as a whole-of-government approach.

THE CHAIR: Thank you for that. The number of suicides attributed in the current financial year: I know sometimes there is a lag in determining it?

Dr Brown: I do not have the exact number with me. I can get that for you. It is usually around 35 to 40 in the ACT, and we are slightly below the national rate.

THE CHAIR: In the last couple of years what are the numbers—perhaps the last five years?

Dr Brown: We can get that for you. The figures published by the ABS are a five-year average, I believe, because obviously sometimes the data takes a couple of years to come through. My understanding and recollection of this is that we have remained below the national average over that period, but we will certainly get the data for you.

THE CHAIR: All right. The trend is hopeful; it is static; it is increasing?

Dr Brown: Our trend, from memory, has been relatively static. We are, however, aiming to see that reduce over time.

THE CHAIR: Is there a particular focus on suicide amongst older Canberrans? We often talk about particularly young males being overrepresented, but as part of the suicide prevention plan is there a focus on older Canberrans?

Dr Brown: People tend to think of younger people when they think of suicide, but there is, in fact, a real issue to do with suicide in the older population. So, yes, I think that is an area of focus. I cannot specifically recall off the top of my head what has been in the old plan, but in the new plan it will undoubtedly be a focus for us. Again, I can seek to get some details on that.

THE CHAIR: If you would take it on notice that would be kind; and well done on that. Ms Berry?

MS BERRY: I just have one very quick question about the Belconnen Community Health Centre. I just wondered what the feedback has been so far. Have you had any feedback so far on how awesome it is—in my view?

Ms Gallagher: To me, just from people who have used it, it has been very positive.

MS BERRY: There you go; that is all.

Ms Gallagher: It is a lovely building.

THE CHAIR: Mrs Jones, any questions?

MRS JONES: Yes. Regarding strategic objective 18—reduction in youth smoking—on page 11, what is the target for this objective for this year?

Dr Brown: We have not set a target specifically for this year. Our long-term target is to get this down to about five per cent. Our outcome in the latest data we have—and this comes from surveys that are conducted every year—the latest result was 5.8 per cent, which is lower than the national rate.

MRS JONES: That was the 2011 result. Was that the last time the survey was conducted?

Ms Gallagher: That is right.

MRS JONES: Or did you say it is an annual survey?

Ms Gallagher: No, I think it is every two years.

Dr Brown: It is the Australian secondary schools survey.

Ms Gallagher: It might be longer than that, actually.

MRS JONES: Would you like to get back to us on when that is due?

Ms Gallagher: Yes. It is not done every year. It is done in conjunction with the department of education.

Dr Pengilley: We might just ask Joanne.

MRS JONES: Do you have a target to coincide with the year?

Dr Brown: Joanne will be able to tell us.

MRS JONES: Thank you. I also want to ask what public health initiatives are in place to address the issue of smoking in young people, apart from raising the taxes on cigarettes, obviously, and plain packaging.

Ms Gallagher: Which are not the responsibility of the ACT government.

MRS JONES: That is right.

Ms Greenfield: This particular data comes from a survey of secondary schools. The last time it was run was in 2011. It is in the field at the present time in secondary schools.

MRS JONES: When will we see the results of that?

Ms Greenfield: Assuming that we can recruit all the necessary schools, we hope next year you will get the results.

MRS JONES: So we run that survey?

Ms Gallagher: Yes, Education and Health.

MRS JONES: It is a combined survey, and it involves more than youth smoking, I would imagine.

Ms Gallagher: Yes, it covers a whole range of things. It looks at things like sun protection—

Ms Greenfield: Alcohol, drug use.

Ms Gallagher: Yes, a whole range of things.

MRS JONES: When do you hope to achieve the five per cent target? Have you got an idea of the time frame you would like that to occur in—apart from yesterday?

Dr Pengilley: It is 5.8, 5.8 in 2011, so it is getting close.

MRS JONES: No, my question was: when do you intend to reach the target?

Dr Brown: We would like to reach it next year, but realistically when will we achieve it? It has come down from 6.7 in 2008, so that is 0.9 per cent. If we drop 0.9 per cent over the next three years then we may hit the five per cent. That would be this year, 2014.

MRS JONES: So hopefully 2017 or something like that.

Ms Gallagher: Twelve years ago it was at 20 per cent. So it shows you how much change has happened in a relatively short time.

Ms Greenfield: This last bit is the hard bit.

MRS JONES: It is like weight loss. Thank you.

THE CHAIR: Mr Hanson.

MR HANSON: Thank you very much, Mr Chair. I have a question about the ACT equipment loan service. It states that the loan service applies to a range of equipment to clients in the ACT community seven days a week on hospital discharge. I have been out there and had a look. It is a good service. I have a constituent who has been admitted to a private hospital. In effect, they have taken the burden off the public system. But my understanding is that they have been advised that that service is not available for them on discharge. Firstly, I am wondering whether that is correct. If it is, how might they be able to access that service?

Dr Brown: Again, we might ask Linda Kohlhagen to speak to the specifics of that.

MR HANSON: I am looking at the website. There is a community health intake or the independent living centre. Whether you are getting out of private hospital or a public hospital, I do not see why one would access the service in one case and not in the other.

Ms Kohlhagen: The L scheme is a short-term loan scheme up to three months. It is

not means tested, unlike our equipment subsidy scheme. Also, it is only available for ACT residents.

MR HANSON: But only if they are in a public hospital?

Ms Kohlhagen: That is what we have at this point in time, yes.

MR HANSON: I suppose the point with the constituent that I have is that they have gone into—we are trying to encourage our community to access private hospitals and use their private health insurance. But this is a situation where someone is coming out of that hospital. They have saved the community money. They are being told now that they are not able to access community infrastructure—a service—that would otherwise be provided to them if they had gone to the public hospital. Can you explain how they could access that? Is there another entry into that through the community health system? Can they be referred by a GP or are they just excluded?

Ms Kohlhagen: Certainly GPs and clinicians in the community can refer individuals to our equipment loans scheme.

MR HANSON: They can?

Ms Kohlhagen: Yes.

MR HANSON: So if this individual on discharge then sees their GP—you can appreciate that it is not ideal if someone is coming out of hospital in a situation where they need a wheelchair that they cannot access. They are going to be at home and it is going to be difficult for them to get to a GP perhaps. But if they go to a GP, they can get it?

Ms Kohlhagen: Yes.

MR HANSON: Is there no way that the private hospital can refer them to the service?

Ms Kohlhagen: At this point in time that is the process that we have in place. We would hope that if it was an elective admission, as part of the discharge planning the private hospital would have talked about the sorts of supports that an individual might need post the discharge as well so that the family might have been able to look at what they might require.

MR HANSON: That they have then got to pay for?

Ms Kohlhagen: Potentially, yes.

MR HANSON: So basically we are saying that if you try to save the taxpayer money and go and use the private system, when you are released from hospital you will not be able to access this service. Is that not a disincentive? Is that not going to encourage people next time to use the public system?

MRS JONES: Is it a gap that can be closed?

Dr Brown: I think it is an area that we are happy to have a look at and come back to you with advice on.

MR HANSON: How quickly can you look at that?

THE CHAIR: When is he being discharged?

MR HANSON: That was the phone call I just took outside, incidentally.

Ms Gallagher: If you can send the person's details through, I am sure that they will—my experience is that Health—

MR HANSON: There is a broader principle as well. It is not just about an individual. It is highlighting an issue that I am sure affects many hundreds or thousands of Canberrans. It is not particularly about one individual; it is about the whole system.

Ms Gallagher: Yes.

Dr Brown: Yes, I appreciate that. But, equally, the ACT public purse cannot pay for everything. We have a system that is trying to find some level of balance. The question is: have we got the balance right in this? As I say, I am happy to have a look at it.

MR HANSON: Yes, I suppose it is one of those situations in which we are trying to encourage people to use the system, a hospital, but once you get back out into the community, I am not sure why, having ticked one box instead of another box, you would then be disadvantaged.

Dr Brown: The question, I guess, I would ask is this: if the private health insurance is paying for the private hospitalisation, is it not unreasonable to be asking the private health insurance also to be—

MR HANSON: It depends what cover you have got, does it not?

Dr Brown: Yes, I appreciate that. But I do not think that we should leap to the assumption that it should then be up to the public purse to pick everything up.

MR HANSON: I am not sure that—often people just get hospital only; they do not get extras.

Ms Gallagher: You would think that this would be covered as part of the hospital admission. Anyway, without opening up the eligibility—

MR HANSON: I think when you get released from hospital under private care, that is pretty much it, is it not? I do not think that private health insurance, if you have only got hospital cover, would include—

Ms Gallagher: There is rehabilitation cover as well for people in private health.

MR HANSON: I do not know much about it. Each case would vary, I suppose.

Ms Gallagher: Yes. Without opening necessarily the eligibility widely, because we would just have to know what that would mean, but happy for your constituent if that could be dealt with.

MR HANSON: For that individual, probably their best route is to get an appointment with their GP and then get a referral through the GP at this stage?

Dr Brown: If you provide us with the details, we are certainly happy to have a look at what would be the best option for that individual.

MR HANSON: Thanks.

THE CHAIR: We might work back down the row. Mrs Jones.

MRS JONES: I wanted to go to some of the previous strategic measures that are now not strategic measures. There are two in particular. In the 2011-12 annual report, one strategic objective was the proportion of a class of aged clients discharged with a discharge plan. This was being measured. You did reach at that point 100 per cent of the target, but I am wondering why that is not being measured now.

Also, 15 was maintaining consumer and carer participation in relevant mental health committees. I guess that is an internal decision you are making. But, again, because 100 per cent was reached, it has now dropped off as a target. Is that what we do when we get to 100 per cent? I imagine you are perhaps still checking.

Dr Brown: We have very strong consumer and carer participation across the whole service and mental health is part of that. I think if you check back over a number of years we achieved 100 per cent each year. We did not necessarily feel that it was telling the community anything new, certainly as a strategic indicator.

MRS JONES: And the same with the discharge plan?

Dr Brown: Yes.

MRS JONES: Can you update us on notice whether we are still at 100 per cent on those outcomes, assuming that they are still being measured?

Dr Brown: We will certainly have a look at what we can provide to you.

MRS JONES: Thank you very much.

THE CHAIR: Ms Berry, any further questions?

MS BERRY: No, I am right.

THE CHAIR: Ms Porter?

MS PORTER: No, thank you.

MRS JONES: I have got one more.

THE CHAIR: Mrs Jones, one more.

MRS JONES: Thank you. It relates to Indigenous health. No, we have already asked that question. I apologise.

THE CHAIR: All right and Mr Hanson has left the room. On behalf of the committee, I would like to thank the Minister for Health and her officers for appearing today. Congratulations, you have got an early mark. As mentioned at the commencement of the hearing this morning, there is a time frame of five working days for the return of answers to questions taken on notice. I remind members of the committee and other members that you have got three days after the production of the transcript for questions to go on notice. The committee's next hearing will be on Monday, 23 June 2014 when the Minister for Education and Training and Minister for Minister for Racing and Gaming and her officers appear.

Today's award—I know you all wait for this—goes to Katrina Bracker. She gets the first part of the award. Following up the minister's and the Director-General's very, very complete answer, everybody looked at her and she simply said, "That is correct." It shows great astuteness in career promotion and enhancement. Also, we all appreciate Dr Andrew Pengilley's answers today and his incredible politeness in the way he responds. We thank you for that. It made today far more enjoyable. Ladies and gentlemen, we have now done seven-twelfths of the estimates hearing processes for this year.

The committee adjourned at 5.01 pm.