LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2015-2016

(Reference: Appropriation Bill 2015-2016 and Appropriation (Office of the Legislative Assembly) Bill 2015-2016

Members:

MR B SMYTH (Chair)
MS M FITZHARRIS (Deputy Chair)
DR C BOURKE
MS N LAWDER

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 17 JUNE 2015

Secretary to the committee:
Mrs N Kosseck (Ph 620 50435)

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 9.30 am.

Appearances:

Corbell, Mr Simon, Deputy Chief Minister, Attorney-General, Minister for Health, Minister for the Environment and Minister for Capital Metro

Health Directorate
- Feely, Ms Nicole, Director-General
- Thompson, Mr Ian, Deputy Director-General, Canberra Hospital and Health Services
- Kelly, Dr Paul, Chief Health Officer
- Foster, Mr Ron, Chief Finance Officer
- Carmody, Mr Paul, Deputy Director-General, Health Infrastructure and Planning
- Croome, Ms Veronica, ACT Chief Nurse, Canberra Hospital and Health Services
- Bowden, Professor Frank, Chief Medical Administrator, Canberra Hospital and Health Services
- Abhayaratna, Professor Walter, Acting Executive Director, Division of Medicine, Canberra Hospital and Health Services
- Lamb, Ms Denise, Executive Director, Cancer, Ambulatory and Community Health Support, Canberra Hospital and Health Services
- Chatham, Ms Elizabeth, Executive Director, Women, Youth and Children, Canberra Hospital and Health Services
- Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services, Canberra Hospital and Health Services
- Centenera, Ms Liesl, Acting Executive Director, People Strategy and Services Branch

THE CHAIR: Good morning, and welcome to the fourth day of public hearings of the Select Committee on Estimates 2015-2016. Today the committee will look at the Health portfolio, as outlined in portfolio statement C.

Please be reminded that the proceedings are being recorded and will be transcribed by Hansard for publication, and the proceedings are also being broadcast and webstreamed.

It would be appreciated if responses to questions on notice could be provided in five working days.

Before you on the table is the privilege statement. Would those at the table please indicate that they have read the privilege statement and understand the implications of privilege?

Mr Corbell: Yes, thank you, Mr Chairman.

THE CHAIR: It is so acknowledged; thank you for that. Before we go to questions, would you like to make a brief opening statement, minister?

Mr Corbell: Thank you very much, Mr Chairman. Thank you to the committee for the opportunity to provide you with a brief opening statement this morning.

This year the 2015-16 budget provides $1.462 billion in annual and recurrent funding for health services for the people of Canberra. It also includes new capital funding of nearly $34 million for capital projects, including a new sterilising service at the Canberra Hospital, 20 more beds at Canberra Hospital and Calvary public, with 16 of these beds to be available from 2016-17 onwards, theatre upgrades, and medical imaging equipment at Calvary.

This new capital allocation takes the health infrastructure program expenditure to over $900 million to date. To date we have delivered as a government the Centenary Hospital for Women and Children, the Canberra Region Cancer Centre and the Gungahlin, Belconnen and Tuggeranong health centres.

Over the next three years the health infrastructure program will deliver a new rehabilitation and subacute hospital at the University of Canberra, a substantial expansion of the emergency department at the Canberra Hospital, a new secure mental health facility at Symonston and the redevelopment and upgrade of a number of other areas in our health and hospital system.

The budget also includes growth—new initiative funding of just under $34 million, or $128 million over four years. The budget will see the opening of a further 16 general inpatient beds, six hospital in the home places and two additional intensive care unit beds. It will continue this government's effort to manage elective surgery with a further 12,500 operations in 2015-16. This will mean the employment of a further 58 nurses, an extra 23 doctors and an extra 40 allied healthcare staff.

The budget will also see more services provided in the community. There will be a record spend of $1.462 billion, an increase of five per cent on funding in the last financial year. We will see a strong focus on outpatient services, particularly in areas around cancer, women's health, children and youth health. The government will increase its support for end-of-life care, with $2.4 million over four years, providing home-based palliative care packages, more staff and education for healthcare professionals. We will also raise awareness of advance care plans and the provision of palliative care services.

The budget also continues this government's strong focus on preventive health, and in particular tackling the challenge of obesity in our community. It will fund a range of programs to promote and support healthy lifestyles, including kids at play, ride or walk to school, fresh tastes, it's your move, and healthier work, with a total of $1.1 million over four years and a further $1.4 million through Access Canberra.

These are some of the excellent examples of preventive health programs which we know we need to continue to implement to target overweight and obesity in our community. Sixty-three per cent of adults and one in four year 6 kids in the ACT are overweight or obese. These rates are rising and I am committed as minister to doing everything we can to tackle this growing public health problem.

We continue to make excellent inroads in the fight against smoking and are

undertaking further work through our future directions for tobacco control in the ACT.

I am particularly pleased to say that this budget sees the single largest increase in funding in mental health services since this government was elected, with $26.1 million over the next four years. We will provide more adult community mental health services, including a local service for the Gungahlin region, additional intensive psychogeriatric care for people who live in residential care settings or who are transitioning from an acute inpatient unit, a self-harm diversion service, a 24-hour supported accommodation service, more in-home support for people experiencing acute mental health problems, and the redesign of the adult mental health services focusing on clinical management, psychological therapies, crisis care and home-based care.

I am committed to seeing a significant decrease in the stigma around mental health in our community, and increases in funding to meet this growing area of demand are part of that response. There will also be funding for specialised services for patients at the Canberra Hospital in the alcohol and drug and mental health consultation and liaison services and the establishment of a new program of early identification for children presenting with emerging mental health illnesses or disorders.

Thank you very much, Mr Chairman. I and my officials will be happy to try and answer your questions.

THE CHAIR: Thank you for that. Minister, with the Health staffing, there seems to be a discrepancy between the budget papers and the annual report. The budget papers have the FTE for 2013-14 at 5,873. The annual report for 2013-14 had the FTE at 5,979. Which number is correct?

Mr Corbell: They relate to different periods, Mr Chairman, but I am happy to ask—

THE CHAIR: No, in the 2015-16—

Mr Corbell: If you could cite where those figures are then we—

THE CHAIR: In the 2015-16 budget papers the FTE for 2013-14 was 5,873 and in the 2013-14 annual report the FTE was 5,973. So the period is the same.

Mr Corbell: I would have to ask my officials to do some analysis of that. I will take it on notice. If we can address it later this morning, we will endeavour to do so.

THE CHAIR: All right. Ms Fitzharris?

MS FITZHARRIS: Thank you. I have a supplementary on staffing issues. There is a significant workforce in Health and training that workforce is obviously an important part of maintaining a current workforce. Are you able to talk us through any issues or concerns you might have about the health workforce, particularly in training, across the country, and in particular here in Canberra? What are you doing at the moment on that front?

Mr Corbell: Thanks, Ms Fitzharris. It is the case, as we know, that there have been a

number of issues raised nationally when it comes to the training of junior medical specialists. Junior medical specialists undertake training in our hospitals to become consultant specialists in their own right. We have seen, for example, the recent reporting from *Four Corners* about poor behaviour on the part of certain specialists in hospitals interstate when it comes to the training environment they provide for junior medical officers.

We have seen similar concerns raised here in the ACT. The maternity services concerns are a good example of that where there was significant discord and what I would characterise as not healthy relationships at that time between trainees and the senior medical staff involved in the training.

I believe it is absolutely critical that we ensure that we have a positive and respectful training environment for our future medical specialists. The issues in the maternity services area are an example of where that environment can go wrong. So today I am announcing, Ms Fitzharris, that I have instructed my director-general to commence an immediate review of the training culture inside the Canberra Hospital to make sure that respectful and professional relationships are being sustained and maintained, and that our existing policies and programs are being effectively implemented—and, if they are not, to look at what we can do to make sure that they are.

We train at the Canberra Hospital in excess of 200 doctors at any one point in a year. So those are 200 junior doctors who are moving through into specialty training across a whole range of specialties. We need to make sure that the environment in which they are receiving that training is respectful and is effective in ensuring that they can get the training they need, and that our policies—for example, our respect, equity and diversity framework and other workplace policies—are being effectively implemented.

I do not want to see some of the problems recurring that we have seen in some parts of the hospital, such as maternity services. Nor do I want to see the sorts of culture that we have seen reported on media like *Four Corners* in other parts of the country.

This review will get underway immediately. It will be an independent external review. It will look at the effectiveness of the training culture at the Canberra Hospital. It will look at management and leadership skills. It will closely examine the training culture and consider behaviours across training programs and make recommendations to ensure that the training culture remains a positive one, productive and develops the clinical and professional skills that we need to see in our future clinical leaders.

I want to be proactive on this issue because I am very concerned that we are not an island. The problems we have seen in other health and hospital systems around the country I am sure exist in some way inside our hospital, and we need to address those issues in a proactive way. That is why I have asked the director-general to commence this review.

MS FITZHARRIS: Are you able to give us any information on time frames at this stage?

Mr Corbell: I will ask Ms Feely to give you some detail around those processes.

Ms Feely: I have asked for an intensive review to be conducted over the next three to four weeks, with recommendations to be forthcoming back to me at the conclusion of the review. If further time is required once the consultants are in the health service then I am happy to consider that, but that is the time frame. I want it to be fast, deep and responsive.

MS FITZHARRIS: I have a substantive question.

MR HANSON: A supplementary.

THE CHAIR: A supplementary, yes.

MR HANSON: Minister, is this an acknowledgement of a toxic culture of bullying at the Canberra Hospital?

Mr Corbell: I think the use of that sort of emotive language is unhelpful because what we—

MR HANSON: It is not my language, though; that is what has been said by a number of people.

Mr Corbell: I am answering your question. I believe that we do see within the medical profession across the board, not just here in the ACT but elsewhere, pockets of a culture which is not conducive to the effective development of future medical specialists. We have seen that documented in reporting nationally in hospital systems in Victoria and elsewhere. I am confident that we are not an island in this respect.

I want to make sure that the policies we have, which are about respectful, professional, collegiate, collaborative workplaces, are being effectively implemented. I want to make sure that, where there are problems with that, we identify those problems and work proactively to strengthen and improve our policies and practice so that junior doctors are able to be trained in a collaborative and effective environment.

What I would say is that this is not, in any way, to characterise the whole of the hospital in this light, because it is simply not the case. There are many parts of the hospital where training is collaborative, professional, effective and respectful. But we know there have been areas where it has been less than ideal. Maternity services are an obvious example of that.

We are now well on the way to responding to those issues within maternity services, but I want this to be a deep analysis across the whole of the hospital. For the first time let us go and have a look at the nature of the training environment. How collegiate, how collaborative is it? How professional and respectful is it? Where there are deficiencies, let us address them, and let us be proactive about it, because it is very important.

MR HANSON: Will that review be released publicly?

Mr Corbell: I see no issue with not releasing it, but obviously I would need to see exactly what it concludes.

MR HANSON: You see no issue with not releasing it? That means you will not be releasing it?

Mr Corbell: No, sorry—

MR HANSON: Do you see no issue with releasing it or no issue with not releasing it?

Mr Corbell: No, that is not what I am saying. I see no issue with holding it back. I want to make it public.

MR HANSON: You see no issue with holding it back?

Mr Corbell: Let me be clear, Mr Hanson.

MR HANSON: Please.

Mr Corbell: I have no problem with releasing it, subject to seeing what is in the document and the conclusions that it draws. Obviously, there may be a range of issues that I have to have regard to, but as a matter of principle I have no problem with releasing the document.

MR HANSON: The staff culture surveys are documents that have been done most years. Are they going to be released at some stage?

Mr Corbell: I think the previous minister explained the position around those reviews. That position is unchanged.

MR HANSON: A final one: the accreditation of obstetrics is ongoing?

THE CHAIR: It is a supplementary, not a—

MR HANSON: Do we have a date on that?

Mr Corbell: Our maternity services obstetrics area remains an accredited service. It is subject to ongoing work with the college to ensure that we maintain that accreditation.

THE CHAIR: We will come back to the substantive question from Ms Fitzharris.

MS FITZHARRIS: Could you explain for us in a little more detail the initiative relating to more general hospital beds? I think there are four more beds at Calvary, 10 at Canberra Hospital and two more intensive care beds announced in this year's budget? Could you explain for the committee what the impact of those new initiatives will be?

Mr Corbell: This is a very important response to meet ongoing demand, Ms Fitzharris, first and foremost. The government have significantly increased hospital beds since coming to office and we continue to build on that very strong record. There will be additional bed capacity in general wards across the Canberra

Hospital and Calvary public. There will be additional intensive care beds. These are probably some of the most expensive capabilities that we have to deliver for our health service. Additional intensive care beds will meet a particularly critical need in the growing numbers of people who need that life-sustaining care following a serious illness or injury.

It is worth highlighting as well that the funding being provided also provides for an additional neonatal intensive care bed, an additional NICU bed. NICU services have been under particular demand in recent years, particularly because of our role as a tertiary referral centre and the large number of premature births and high-risk births that are referred to the hospital from the surrounding New South Wales region. We have seen pressures in that area and I am very pleased to say that we are providing additional bed capacity for neonatal services as well.

MS FITZHARRIS: Is that an additional neonatal intensive care bed?

Mr Corbell: Yes, it is.

MS FITZHARRIS: How many altogether are there?

Mr Corbell: I would have to take some advice on how many we have, but it is an additional bed.

THE CHAIR: A supplementary from Dr Bourke.

DR BOURKE: Thank you, chair. Minister, could you expand on the health budget media release statement relating to the $3.1 million development at Calvary hospital to enable 12 new acute beds? Can you walk us through what that $3.1 million is going to deliver?

Mr Corbell: I will ask Paul Carmody to give you some detail on that, Dr Bourke.

Mr Carmody: The $3.1 million for Calvary is to provide the funding for 12 additional acute care beds at the hospital. That is part of the ongoing—it is year 3 of additional beds for Calvary hospital.

THE CHAIR: New question, Dr Bourke?

DR BOURKE: Whilst we are also talking about hospital beds, minister, you will recall back in annual reports hearings we talked about hand washing and failure to comply with hand washing. There was a Productivity Commission report that estimated there were 180,000 cases of hospital-acquired infections in Australia per year, causing an additional two million bed days in Australian hospitals. So that would translate into what—50 to 100 bed years in the ACT system?

Mr Corbell: Sorry, is that a question, Dr Bourke?

DR BOURKE: Yes, that is a question.

Mr Corbell: I honestly could not tell you without some further advice on that,

Dr Bourke.

DR BOURKE: All right. Perhaps you have somebody there who could provide this—

Mr Corbell: I will have to take it on notice.

DR BOURKE: Take it on notice. Okay, thank you. If you are taking that one on notice, I might step along to the next one.

THE CHAIR: Ms Lawder, a new question.

MS LAWDER: Minister, last year in a question in the Assembly to the health minister, we asked who sets the strategic and accountability targets, the objectives, the indicators et cetera. The health minister at the time said, "Every year ACT Health reviews its strategic and accountability indicators." Does the minister sign off on those targets?

Mr Corbell: Yes.

MS LAWDER: So the directorate comes up with the indicators and then puts them forward to the minister?

Mr Corbell: Yes.

MS LAWDER: Do you think that is the best way to do it? Many of the indicators remain, I guess, the same. Are you looking for improvements? How are you going to achieve them without setting higher targets?

Mr Corbell: We do often adjust our targets and lift the level of performance if we have reached, for example, a target in a previous year. But it will depend on the circumstances in each individual case. There are many accountability targets and indicators. Each is assessed on a case-by-case basis but it is the case that targets are adjusted to reflect our knowledge of circumstances, the capacity for improved delivery over and above existing targets or other factors that need to be taken into account.

MS LAWDER: When these indicators and targets come to your office, have you so far in your tenure as the minister ever asked for adjustments of what the directorate has put forward?

Mr Corbell: Yes, I have.

MS LAWDER: Are you able explain in which areas you have asked for adjustment?

Mr Corbell: In general terms, what I can say is that their recommendations have been made to me to revise down targets. I have not accepted some of those recommendations.

MS LAWDER: Can you give an example?

Mr Corbell: Yes. In relation to elective surgery times; I do not believe there is any justification for downgrading performance in that area, in terms of targets.

MS LAWDER: Who is to be held to account for the achievement of the target? Is it the directorate or is it the minister?

Mr Corbell: We have a system of executive government which is accountable through the processes of the Assembly, including this committee.

MS LAWDER: Does that mean the minister?

Mr Corbell: The minister and his portfolio have responsibilities and are accountable through the parliament.

MS LAWDER: Thank you.

DR BOURKE: I will take a supplementary, if I can.

THE CHAIR: Supplementary, Dr Bourke.

DR BOURKE: How many surgeries are you expecting to perform in 2015-16 and how does that compare with previous years?

Mr Corbell: Some 12,500 surgeries this year, this coming financial year. That is an additional 500 on the provision made in last financial year. So we continue to grow the number of elective surgeries. It is worth highlighting that at the end of the 2016-17 financial year, there is considerable uncertainty around our capacity to continue to deliver a range of services at the existing level. The reason for that is the very significant reduction in funding from the commonwealth. That takes particular effect in 2016-17 when current funding agreements come to an end. The commonwealth has indicated that there is a reduction in funding to hospital services here in the ACT, as there is around the country.

It is worth highlighting that, in the current budget over the next three years, the budget estimates account for $228 million less in funding received from the commonwealth than would have otherwise been received under the national health reform agreement arrangements. Obviously, the impact is magnified significantly beyond that period out to approximately 2025, which was the overall term of the broad agreements with the commonwealth. When we look over that period, it is up to $600 million or $700 million less than would have otherwise been anticipated from the commonwealth.

So we have made significant provision for additional elective surgery, but we recognise in the budget papers that there is significant uncertainty at the end of the 2016-17 financial year, unless there are adjustments to the commonwealth budget that properly support the states to provide these essential services. The commonwealth has indicated that there are estimated savings in their budget of $57 billion less in health funding over the next decade. This has a real and practical impact. You can see that in the figures, for example, for elective surgery after the next two years.

DR BOURKE: Minister, what is going to be the impact on waiting times for surgery as a result of these foreshadowed changes to the health budget?

Mr Corbell: Unless the commonwealth adjusts its funding formula to recognise growth in the health sector properly, then there will be real impacts on access to a whole range of services.

DR BOURKE: Do you agree with AMA New South Wales President Saxon Smith, who said on Tuesday:

> We have a federal government whose commitment is to defund health, to gouge health, to take money out of the health budget.

Mr Corbell: Yes, I do agree with that. That is the real prospect. It is now very clear in our budget papers. We cannot sustain growth to the level we need to sustain it in elective surgery, in access to emergency departments, in a whole range of other activity unless there is a fundamental re-think on the part of the federal government when it comes to the health budget. Over the next three years there is $228 million less than would otherwise have been projected under the health funding agreements.

Over the next decade, we estimate approximately $600 million less. We just cannot sustain that type of hit on our budget. All the other states and territories are saying the same thing. We will be working very hard over the next 12 to 18 months in particular to secure a better deal from the commonwealth to properly fund our hospitals and health systems. I know that all the first ministers—chief ministers and premiers—are doing exactly the same thing. Obviously, it is a key issue around the federation discussions, particularly when it comes to tax and taxation policy.

We have to get this right, but right now our budget papers do indicate that at the conclusion of the 2016-17 financial year, there is real uncertainty as to whether or not we can sustain existing levels of service because of the commonwealth's cuts to our hospital funding arrangements.

MS FITZHARRIS: Can I have a supplementary?

THE CHAIR: Yes, you may, but I will have one first. At a recent Senate estimates hearing, officials were asked about these supposed cuts and were unable to reconcile the figures that you are quoting. So who is right? Are you right or is it the departmental public servants at the federal level?

Mr Corbell: Yes. I noted that exchange in the Senate estimates. What, of course, was not made clear by the questioner in particular, who I think was our local Liberal senator, is that the $600 million projection figure that I have been citing and the government has been citing relates to the period post-2016-17 out to the conclusion of the long-term national health reform agreement time frame, which is 2025. Mr Seselja was asking about between now and the end of 2016-17. It is a case of apples and oranges in terms of the questioning on that.

THE CHAIR: Are you comparing apples with apples when you make your claims?

Mr Corbell: Absolutely. This is our projection based on what is in the commonwealth budget papers. The commonwealth budget papers say $57 billion less for health compared to the NHRA agreements. That is our extrapolation of the ACT share that is now forgone as a result of the funding cuts the feds have made. In addition, we have now been able to properly quantify, based on the most recent commonwealth budget papers, what the impact is next financial year and the year after that. That is approximately $228 million less than what was otherwise expected because there are cuts occurring in the federal budget now.

THE CHAIR: Can Mr Foster give us a run-through of the ins and outs of this?

Mr Corbell: I am very happy to provide a very detailed reconciliation around that. We have done that work and I am happy to provide that.

THE CHAIR: Is it possible to have the run-through now? I am pleased that you will provide that; so we will have that as a question on notice. But can we have a run-through by Mr Foster to justify the numbers that you are quoting?

Mr Corbell: I am sure that Mr Foster could give you a summary of that.

THE CHAIR: Then a supplementary to Ms Fitzharris, and a supplementary to Mr Hanson.

Mr Foster: I think the minister has been quite clear in the issues that are affecting the ACT and other jurisdictions around the country because of the changes to the national health reform agreement. The national health reform agreement was signed with the explicit intention of the federal government of the day to increase its contribution for its public hospital costs. The first live year of that was to be 2014-15. With the change of federal government it was announced in that year that those agreements would not be honoured.

The first part of the agreements that were not being honoured was the guarantees that were provided that no jurisdiction be worse off by moving from the old SBP funding to ABF funding. They had $16.4 billion built in to be spent through to 2020 to do with growth and guarantees. They have abandoned those guarantees.

Then they announced—at the same time they announced—that they will therefore cease moving from 45 per cent of the cost of public hospitals as a contribution by the federal government to 50 per cent, which was a plan from 2017-18. That has gone. And from 2017-18 they move back to a specific purpose payment based on population, which is raw population rather than allowing for the demographic factors as well. Their own figures are the $57 billion saving from that going forward from 2017-18. No question; they were clearly published in the 2014-15 documents.

In respect of the issue of the current years, the fact is that the guarantees have been taken out. ACT Treasury has done the analysis. Their advice is that the guarantees that we would have expected would have amounted to the $228 million figure that the minister has mentioned. We have got no other—that is the work that has been done: the analysis of what the agreement was intended to do and then what the commonwealth actually publishes in its budget paper figures.

An example of the change that continues to happen is in the 2014-15 budget. In the first attempt by the federal government for the 2017-18 funding for the ACT, they advised 311 million. In this latest budget they have advised $296 million as the first year of the SBPs. That is a $15 million reduction just on that alone, which is them changing from one year to the next in what the share of the SBP would be for the ACT. I mean, that is the position. The position is that the agreement has been abandoned. The agreement was intended to deliver more money from the commonwealth into the states and the territories for public hospital services. That is clearly not happening by their own admissions about the $57 billion.

THE CHAIR: And that includes all the variables? It is comparing apples with apples?

Mr Foster: Absolutely.

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

MS FITZHARRIS: The Treasurer on Monday also made clear the impact of this on health service delivery and the overall budget and we asked him questions around what this shift to a population-based funding model means in practice for the person on the street. How would they come to understand it? He suggested we ask you. Are you able to put that in everyday language that we can talk to the community about?

Mr Corbell: Yes, certainly. The previous agreement that the federal Liberal government have abandoned was a commitment to fund on the basis of activity. You were funded based on the level of activity—how many procedures, how many occasions of service we deliver in a whole range of areas across hospitals and health services. They have walked away from that and said, "No, we will fund on the basis of your population."

There are two big problems with that. The first is that it has no regard for the level of acuity in the community; that is, how sick people are. If you have an ageing population, which we do, older people get sicker more often and the level of care becomes more complex as they get older. Population-based funding has no regard to the level of acuity of care—it is a fundamental failure—whereas activity-based funding would properly capture the fact that if you have to do more expensive procedures more often you will be appropriately compensated for that from the federal budget.

The federal Liberal government have walked away from that. Regardless of our ageing population, regardless of how many more complex procedures we have to undertake or complex occasions occur and we have to provide, we are not compensated for that. We are simply compensated per head of population.

The other big problem with a shift from activity-based funding to population-based funding is that it does not properly have regard to the circumstances in a health system where a quarter or more of your patients are coming from across the border. We are being funded based on our population but, as we know, our hospital service and our health service provide care to a big region in New South Wales. The commonwealth's

answer to that is, "Go and strike an appropriate cross-border arrangement with New South Wales to be compensated for that." But again, unless there is a common approach which is activity based, we still have the fundamental problem of an ageing population with more expensive and more occasions of care.

My real concern is that if there is not a preparedness to revisit that decision around activity-based funding our future cross-border arrangement with New South Wales will be done on the same basis as the commonwealth, population only, and that will not properly compensate us for the expensive and frequent levels of service that we will have to provide for not just an ageing population here but an ageing population in the border region. So those are the two big problems.

MS FITZHARRIS: New South Wales, therefore, are being funded for people who in a lot of cases live over the border from us and who are not receiving care over the border but are receiving it in the ACT. It is now up to you to negotiate that with New South Wales?

Mr Corbell: It has always been the case that we have a cross-border funding agreement and that has always been the principle of the Medicare agreements as they were then called. But New South Wales, I am sure, will say, "If we are only being funded by the commonwealth on a population base, then we are only going to compensate you on the same basis." So it is a double-whammy for funding to the ACT hospital system.

MS FITZHARRIS: And has there been any explanation by the commonwealth either before or since this fundamental shift why, apart from their budget, apart from the health rationale, there has been this shift?

Mr Corbell: No there has been no explanation. There is no clear public health or health policy reason to shift away from activity-based funding. Activity-based funding is the most equitable model because it means everyone is paid. Every jurisdiction across the country is paid on the same basis; that is, paid on a relative proportion of the cost of the care episode rather than just per capita. Per capita assumes that everyone has the same level of health and needs the same level of health care but that is not the case.

Older people get sicker more often; they need more complex occasions of care. So we need a funding model that reflects that ageing demographic and we simply do not have it because the federal Liberal government has walked away from those agreements.

MS FITZHARRIS: So in the meantime the ACT government is picking up that gap until 2016-17?

Mr Corbell: Yes, we are, but we have made it clear that we cannot sustain that indefinitely, and 2016-17 is the crunch year. As the Chief Minister has said, every first minister around the country will be dealing directly with the PM and saying to the Prime Minister, "This must change; we cannot sustain it." Mike Baird is saying the same thing in New South Wales. Every other premier around the country is saying exactly the same thing.

THE CHAIR: Mr Hanson has a supplementary.

MR HANSON: For that crunch year, 2016-17, how much money is in the budget that is coming from the federal government in SPPs and other funding models? What is the total figure that we are getting from the commonwealth?

Mr Foster: Are you asking about from 2017-18?

MR HANSON: No, I am saying 2016-17.

Mr Foster: In 2016-17 it will still be activity-based funding.

MR HANSON: But the minister just told us that is the crunch year.

Mr Foster: That is the end of the activity-based funding year. From 2017-18 the commonwealth is advising—

MR HANSON: No, that is not my question. In 2016-17 how much funding will be coming from the commonwealth?

Mr Foster: The figure, just quickly, in 2016-17 from the commonwealth is $343 million.

MR HANSON: And is it the case that the figure in 2013-14 was $233 million? Can you confirm that?

Mr Foster: In the 2013-14 budget?

MR HANSON: Yes.

Mr Foster: For 2016-17?

MR HANSON: No, for 2013-14. How much did we get back then?

Mr Foster: This document starts at 2014-15.

MR HANSON: I am sure it does but you are the CFO, are you not? You would know how much we got from the commonwealth?

Mr Foster: I have got lots of numbers.

MR HANSON: You were the CFO then?

Mr Foster: I can remember certain numbers from a long time ago. I have got no problem remembering that.

Mr Corbell: We can take it on notice unless Mr Foster has it to hand.

MR HANSON: He has got it there.

Mr Foster: In 2013-14 it was $233 million, which, to be very clear, was an SPP amount. To that they added a notional amount for cross-border activities that would be paid. The 2012-13 and 2013-14 years were transition years moving into the ABF funding that started in 2014-15.

MR HANSON: So we have gone from $233 million—

Mr Foster: The $233 million was SPP. The other one is an ABF figure.

MR HANSON: We have got $233 million at the end of the Gillard-Rudd government, up to $343 million now, which is an increase of 46 per cent. Is that right?

Mr Foster: It was an SPP figure in 2013-14 of $233 million.

MR HANSON: So the funding in the budget has gone up 46 per cent in three years?

Mr Foster: That same document talks about 233—

MR HANSON: That is something to be cheering.

DR BOURKE: Chair, I would ask Mr Hanson to stop badgering public servants please.

THE CHAIR: I do not need your assistance. Mr Hanson, if you would let him finish.

MR HANSON: Sure. He is finished. I have got a new question, if we are moving on.

Mr Corbell: If I can just add to Mr Foster's answer, as Mr Foster has indicated, the issue at play is what the commonwealth promised in a written agreement with the states and territories that they would fund us, compared to what they actually are funding us.

MR HANSON: That was never in the budget was it, Mr Corbell?

Mr Corbell: The commonwealth budget papers are clear. The commonwealth budget papers indicate that for all the states and territories there is a reduction of $57 billion over the next decade.

MR HANSON: Was that ever in our budget?

Mr Corbell: That is the commonwealth budget's own figures. As Mr Foster indicated in his earlier answer, even in the current year we are getting $15 million less than we would have otherwise received because of adjustments made in the most recent commonwealth government budget just for the forthcoming financial year. ACT Treasury have done this analysis. They have compared what was locked in in a written agreement with the commonwealth to what has actually been delivered and the difference is negative $228 million.

THE CHAIR: We look forward to seeing their analysis. Dr Bourke has a

supplementary.

DR BOURKE: Thank you, chair. Minister, is there a significant demographic difference between the 25 per cent of people who come out of New South Wales and the ACT population which may place an additional burden on the ACT health system?

Mr Thompson: We are the tertiary referral centre for the surrounding area of New South Wales, so the people that come here are the people who need a level of care that is not available in the surrounding region. Accordingly, on the whole, they come for more serious and complex procedures than the bulk of the health care that is provided by the southern area local hospital district.

DR BOURKE: Thank you.

THE CHAIR: Sorry; you had a question, Mr Hanson?

MR HANSON: It is in relation to the University of Canberra public hospital. I will just start with a quote. This was from the minister—yourself—on 12 May on the ABC, talking about the University of Canberra hospital. You said: "215 beds is what is provided for in this new facility. That is 140 overnight beds and 75 day beds. There are spaces that people can use during the day. They are beds. They are not designed for overnight use." And so on. You went on: "So the bottom line is no change in the number of beds. 215 beds. A mixture of overnight and day beds will be provided at the University of Canberra public hospital." I could probably go on with about a dozen quotes from the media and from the Assembly where you have given this figure of 215 beds.

You then tabled in the Assembly documents on the University of Canberra hospital—functional briefs, a review and a whole range of other documents that make it very clear that the number of overnight beds is 140. There is reference to 30 bed equivalents, but you are saying repeatedly "215 beds". That is significantly more that the 140 overnight beds, but even being generous there, if we are to use the bed equivalents, where does this 225 figure come from? Can you explain in detail what each of those 225 beds will be?

Mr Corbell: I have tabled that information in the Assembly, so I will refer you to those documents. The government has been very clear about this from the outset. The previous minister and I as the minister have always indicated that the total overnight bed capacity would be up to 200—that is overnight bed capacity—but the exact mix between day beds or day spaces and overnight beds was to be determined following finalisation of the model of care.

The reports that I have tabled in the Assembly have made clear that the expert advice received by ACT Health, including from people such as Associate Professor Christopher Poulos, who is the Hammond Chair of Positive Ageing and Care at the School of Public Health and Community Medicine at the University of New South Wales, is that a mix of overnight and day beds or day spaces was appropriate. That is the model that we have delivered. So the total capacity based on what the government said is unchanged; it was always the case that it would be a mix of overnight and day beds.

The point to be made is that improving day bed capacity actually improves throughput. It improves throughput because the people who are utilising those day beds or day spaces are often only admitted, to put it this way, for less than a day. On many occasions, they will only be admitted for half a day. That means you double your capacity in terms of the number of people that can be treated.

So there is no discrepancy; there is no contradiction in any of this. The government has always been clear—up to 200 beds, a mixture of overnight beds and day beds and day spaces, but we are well and truly over the 200 figure when you take that combination of capacity, overnight and day bed or day space, into account.

MR HANSON: But the documents you have provided make it very clear that they are not beds. You have been out there saying that these are beds. The documents that you have been provided with and the expert evidence, the functional brief, make it explicit that they are not beds. You are saying that this is going to be a 225-bed hospital, and it makes it very clear that they are not beds. What are you counting?

In the functional brief it talks about where the bed equivalents are, but beyond that you have got a figure of 225, which is 55 beds that simply are not accounted for in any of the documents that you have tabled and are not consistent with the description in the AIHW of what a bed is. Can you explain to me what you are counting as a bed? None of the documents that you have tabled describes any of them as beds.

Mr Corbell: I think you have to be clear—through you, Mr Chairman—that the government's focus is, and the government's commitment was, delivering up to 200 beds—a mixture of overnight and day beds or day spaces. I am not particularly interested in getting into a discussion as to some sort of silly semantic argument on what a bed is. What we are talking about—

MR HANSON: Mr Chair—

THE CHAIR: Just let him finish.

Mr Corbell: If I can finish my answer.

THE CHAIR: You can come back to it.

Mr Corbell: I am not interested in some silly semantic argument about what a bed is. What I am interested in is the capacity of the hospital to treat the appropriate number of people. That is what we should be focused on—how many people can be treated in the subacute facility. It is well and truly over 200—well and truly. That is for a range of reasons, including the reasons I mentioned, which are that day patients are not admitted overnight; they are often only admitted for a shorter period than a full day and they may be undertaking treatment therapy, which includes rehabilitation, gymnasium, hydrotherapy and consultation rooms.

It is about capacity; it is about being able to treat the appropriate number of people. That is what I am focused on as health minister, and I think that is really what the community cares about—how many people can be properly treated. It is well and

truly over 200 a day.

MR HANSON: The point is, though, that you have said it is 225 beds. That is the commitment that you have made; that is what you stated. I am not getting into an argument about how many people are treated. People are treated at GP clinics; people are treated at community health centres; people are treated at nurse-led walk-in centres. This is not an argument about whether people are being treated or not; this is a point where you have said to the community consistently that there will be 225 beds and that is simply not true.

Mr Corbell: That is not correct.

MR HANSON: I ask you to explain what you are counting as a bed—if you can go through each of those 225 beds to explain whether you are counting things like exercise equipment in the gymnasium or a hydrotherapy pool as a bed?

Mr Corbell: No, I am not.

MR HANSON: That is what the statement said that was released by your directorate.

Mr Corbell: That is not what I am saying, and that is not what my directorate said either. What—

MR HANSON: It was released through your office.

Mr Corbell: What the directorate is saying is that treatment in a subacute facility does not necessarily involve someone lying in a bed.

MR HANSON: Clearly it does not.

Mr Corbell: Anyone who has an understanding of a subacute facility and a rehabilitation facility will understand that the purpose of rehabilitation is not to let people lie down in a bed, but to get them moving, to get them mobile again—to get them up on their feet, active, recovering in an appropriate care setting following serious accident, illness or surgery. That is exactly what this facility delivers.

MR HANSON: But not everybody treated—

Mr Corbell: The contrast is very clear. What the opposition are saying in this place is that they want only 200 beds, which means that the maximum number of people to be seen every day is 200. Our position is that—

MR HANSON: That is not what I am saying. You are verballing me.

Mr Corbell: Let me finish. You have had your point. Our position is that we want a flexible University of Canberra public hospital and, because we have day patients, who are admitted for less than a day, we can see more people than if there were just 200 admitted. Once you are admitted in an overnight bed, you are staying for at least a day, so that is only 200 a day. We are saying that it is not just about overnight beds; it is about the number and about the capacity to treat people during the day as well,

because that will be the client base that we need to respond to with this facility.

MR HANSON: You are conflating the arguments, though—

THE CHAIR: If we may, Ms Fitzharris has a supplementary and I have one. Then we will come back to you.

MS FITZHARRIS: In terms of UCPH, can you just remind us what it means for the health system as a whole to have this capacity in a subacute facility?

Mr Corbell: Sure. This is a very important capability, because it is about redirecting care away from our tertiary treatment hospitals and into a more appropriate care setting. It is about making sure that there is less pressure being put on other parts of the health system, particularly our acute care hospitals, where currently some of this rehabilitation and subacute care are provided. It is about providing also fit-for-purpose spaces—so better hydrotherapy spaces and, particularly importantly, fit-for-purpose spaces for people with mental illness who are still needing a level of care and supervision but are not at the acute stage of their treatment.

These are the types of spaces and places that are being created at the University of Canberra. At the same time, its placement at the University of Canberra allows us to leverage the very important training work that the university does in the nursing and allied healthcare professional space. UC is the leading training provider for nursing in the ACT—and also for allied health: physiotherapy and other allied health specialities like that.

By co-locating on the campus, we are providing greater access for training programs to integrate into the care setting and better opportunities for the professional development of those students, further growing the reputation of UC as a place to train if you want to be a nurse or an allied health professional, because right on campus you can get experience in an appropriate training environment at a subacute hospital.

That is a great outcome for the university. It is a great outcome for increasing its reputation as a place for people to come and train. It is also very effective in the care environment at UC itself. There are real synergies around that, and clearly having this dedicated facility takes away pressure and also frees up physical capacity that is currently being utilised for subacute care inside our acute care hospitals.

MS FITZHARRIS: It is probably fair to say that most people, unless they have to be, do not want to be in a hospital overnight. Would that be the clinical experience?

Mr Corbell: We certainly know that the outcomes for many people are improved.

MS FITZHARRIS: As good as it is, if you can be at home or just enjoying the day—

Mr Corbell: Health outcomes are improved if you are able to rehabilitate more quickly in a more familiar environment. Obviously, a subacute hospital that has a large day population in terms of patients facilitates that care back into the community and that integration back into the community and familiar settings like a person's own

home.

THE CHAIR: As a supplementary to what Mr Hanson was asking, you can say things like "silly semantic arguments on what a bed is", but it was the government announcement that there would be a 200-bed subacute hospital constructed at UC. What is your definition of a bed, and when did the government shift away from actual beds to exercise machines and hydrotherapy pools in that count?

Mr Corbell: We are not saying those are beds. We have never said that. I have made very clear in—

MR HANSON: I am happy to table it.

Mr Corbell: I have made it very clear in all the documents that I have tabled in the Assembly, and we as a government—myself and my predecessor as Minister for Health—have made clear that it was up to 200 beds and it would always be a mix of overnight and day beds or day spaces. Nothing has changed in that respect.

THE CHAIR: Dr Bourke has a supplementary and then we will finish Mr Hanson's question.

DR BOURKE: Whilst we are still on the subject of University of Canberra public hospital, could you expand on the announcement in the health budget media release of a grant to help fund 400 extra car parking spaces at the hospital?

Mr Corbell: I will ask Mr Carmody to come up and give you some more detail on that, Dr Bourke. As he does, I would just make the point that work on the University of Canberra public hospital is progressing apace. The funding that is provided in this year's budget finalises the last substantive issue around the agreement between UC and the government that needed to be resolved, and that was who would be providing the car parking spaces and where they would be. Would they be solely on university land with a payment by the government to the university for the provision of those spaces? Would they be solely on the UCPH site proper, in which case they would be ACT government spaces? Or would they be a mix?

We have determined that it will be a mix and that there will be spaces provided by the university as part of the agreement with the government. In addition, there will be spaces provided by the territory directly on the University of Canberra public hospital site. We have determined that 260 vehicle spaces will be provided by the government directly at the University of Canberra public hospital site, and the balance, 400 vehicle spaces, will be developed by the university on their land and made available for the purposes of the hospital with an up-front capital contribution, an annual fee, for those spaces to be paid for by the territory. Perhaps Mr Carmody can give you some detail.

THE CHAIR: Can Mr Carmody also tell us when the design will be completed and be available to be seen? When is construction expected to commence and when is construction expected to finish?

Mr Carmody: I will just handle those last few questions first, if I may. The tenders for the project will close tomorrow. Two weeks ago we saw the completion of what

we call the interactive bidding sessions. That involved the three nominated tenderers sitting down and presenting to the project team their design ideas for the project after they had considered the reference design documentation.

DR BOURKE: Sorry, Mr Carmody; you are talking about the hospital, not the car park?

Mr Carmody: No, I am talking about the hospital. The interactive bidding process has been going on for the last couple of months. The tenderers will submit their tenders tomorrow and then there will be a process over the next two to three months of the evaluation of those tenders. It is quite a comprehensive process because this contract is what we call a design, construct and maintain contract. It is a first for a health facility or hospital.

THE CHAIR: Is it just design, construct, maintain or is it design, construct, maintain, operate?

Mr Carmody: It is what we call DCM—design, construct and maintain. That process will go through to, we expect, about October-November, when a submission will then be provided to the government recommending the preferred tenderer. On the basis of that being approved, construction is expected to commence early next year and be completed early in 2018.

THE CHAIR: 2018. So the time frame is now slipping.

Mr Carmody: Slightly. I think the end of 2017 was talked about—the end of 2017-early 2018. Early 2018 takes in what we call the gross completion date. There is a net completion date, which is 90 days earlier, but for the purpose of the exercise—because anything can happen. We are still in an interesting stage of the contract; it is always the procurement. Firstly, it is the design, coming up with a reference design. Then it is the procurement process, which has a little uncertainty. Once we get to the point where we appoint a contractor then a lot more certainty will come into the project. One of the things that we will see in the tenders that come in tomorrow will be the contractors' expected time frame to deliver the project. That will be one of the criteria on which they will be assessed.

THE CHAIR: Just for clarity: it is a DCM, not a DCMO, that you are tendering for, because the Treasurer told us on Monday that it was a DCMO.

Mr Carmody: The "O" you could probably say is part of maintaining the facility. They will be maintaining the facility. They will not be operating it as in providing clinical services. They will be operating the facility as a facility manager type of activity.

THE CHAIR: Thank you.

DR BOURKE: So just to clarify: what will be the parking arrangements for staff at the hospital?

Mr Carmody: At this stage we have not defined what the staff parking arrangements

will be. What has been the subject of discussion over the last six months—as the minister mentioned—has been the number of car park spaces to be provided by the university. Under the acquisition deed that was signed back in December 2013, one issue that had not been resolved was exactly how much car parking would be required to be provided by the university as compared to how much would be provided on the site.

The actual deed had a very limited number of car parks on the site because that was a preference of the university. However, late last year the university, somewhat unexpectedly, announced that they were happy to relax that requirement and they would be happy to see more car parking on the site if that suited the territory. That then started a series of discussions: "Well, if that is the case, how much should we put on the site? Where should we put it on the site and what should be the financial contribution to the territory?"

Where the design was at that stage begged the question: if we are building a facility like this, why do we not put some of the car parking under the facility? It will make it a far more usable, practical facility, particularly given the sub-acute nature of the facility. It would effectively mean people could go there, park under the facility, walk to the lift, go up the lift and effectively end up at the reception centre. That is a major improvement, in my view, of the design for this facility.

That is where we have got to at the moment. The intention is to put up to 250 spaces under the building, in the basement, and have minimal on the surface. Because that was already a concern of the university's, and I think it was also a concern of the territory's, that we did not want to have acres and acres of car parking surrounding the hospital on the hospital site. I think that is one of the reasons the number of spaces on the site was limited before people realised, "Why don't we put them underneath?" It does cost a bit more money to put parking under the facility, but I think for the purposes of the facility and the functionality of it, it will be a far better outcome.

What that means is we have now got to a stage where the university are going to provide 400 spaces in car parking facilities—either one or two; yet to be finalised—immediately across the road from the hospital, with 260 being on site and with most of those being in the basement, subject to the final design of the facility.

DR BOURKE: Which road?

Mr Carmody: To the north is Ginninderra Drive, but there is also a road to the south to be constructed and also to the east. I am sorry, I just do not remember the name of those new proposed roads. That is the one on the east which is the front entry of the facility. So straight across from there will be the car park.

DR BOURKE: You are talking about a surface car park to the south of the facility?

Mr Carmody: Possibly one to the south and one to the east. That is something for the university now to decide on, how they want to provide the 400 spaces. Two sites have been identified in preliminary concepts. At the time of signing the deed it was anticipated that there would be two structures, but the university do not want to make them any bigger than they have to be as far as height. They will not be so much

surface; they will be car park structures.

DR BOURKE: So that is 400, in addition to the 250 underneath?

Mr Carmody: Yes.

DR BOURKE: So 650 all-up?

Mr Carmody: All-up 660 is the number of car park spaces that have been identified as needed for the hospital.

THE CHAIR: More car parks than beds. We will go back to Mr Hanson to finish his original question.

MR HANSON: Thanks. Mr Carmody, you might be able to answer this one. What is the actual floor space of the hospital?

Mr Carmody: I am sorry, Mr Hanson, I do not have that answer. The reason I do not have that answer is that, whilst a reference design has been prepared for the hospital, taking into account the functional requirements for the hospital, that reference design, which was out on consultation that closed a couple of months ago now, was then used by the three bidding consortia to develop up their preferred proposed design for the facility. I have not been privy to what their designs are.

MR HANSON: What was in the functional brief, though? What was put out in the functional brief?

Mr Corbell: We can get you an exact number, Mr Hanson, but we would have to take that on notice.

Mr Carmody: We can take that on notice.

MR HANSON: Okay. Just looking at it here, it says it was 20,745 square metres. Has that been cut from the original design at all?

Mr Corbell: No.

MR HANSON: So it has always been 20,745 square metres?

Mr Carmody: To the best of my knowledge there has not been any adjustment to that figure. I have not seen that figure, but I will take that on notice.

MR HANSON: Sure. That is from the functional brief.

Mr Carmody: If that is what was in the functional brief—

MR HANSON: That has always been the figure, has it?

Mr Carmody: If that is what the figure was, that is what the figure was, but one of the benefits of this interactive bidding process is to get the best outcome for the

territory and the best value for money. That is the whole point of short-listing down to three major construction organisations and their teams—to take that initial design, which gives them what is required by the territory for the purposes of the hospital, and then say, "How can we deliver a facility which will represent best value for money, best design—best all out?"

MR HANSON: The figure for the gross floor area that is in the functional design is actually significantly less than the gross floor area that was in the original site selection that was released by the previous minister in 2012. Can you explain why the original design that was put out said 200 beds and an area of 26,750, whereas now the functional brief says 20,745, which is a reduction of about 25 per cent in the size of that floor? The original document in 2012 said 200 beds and 26,000 square metres, and now the functional brief says 140 beds and 20. So we have had a reduction of about 25 per cent both in terms of the number of beds and the floor space. Can you explain why that is?

Mr Corbell: In relation to the bed issue, my officials and I have already answered that quite comprehensively. There is no reduction in capacity, and I have made that clear. In relation to the gross floor area, I will ask Mr Carmody to clarify.

Mr Carmody: I am sorry, I cannot explain why—

MR HANSON: Why has the hospital shrunk?

Mr Carmody: that 26 has gone down to 20.

MR HANSON: It has shrunk.

Mr Carmody: I can only assume that, in the development of the user briefs and working out the functional relationships required for the facility on how different parts of the structure would be used, it has resulted in an efficiency or refinement.

MR HANSON: Sure. I have looked through that myself and it seems that the—

Mr Corbell: I am sure, Mr Chairman, that Mr Hanson would welcome a more efficient expenditure of taxpayers' dollars for the same capacity, and that is exactly what Mr Carmody has alluded to.

MR HANSON: But the capacity is different. It seems that the number of beds that have been cut between the two documents—one says 200 and one says 140—is about the same percentage as the size of the floor space that has been cut. It seems that the hospital has been cut both in the number of beds and in the size of the hospital. The physical size of the hospital has been cut and the proportions are exactly the same. But we are saying that, no, there have not been any cuts. I am at a loss.

Mr Corbell: Mr Chairman, the shadow minister can speculate or seek conspiracy around every corner if he wishes, but my answers are very clear on this and the government's advice to the committee and the Assembly is very clear on this. There has been no reduction in capacity at UCPH. It would not be unusual if, as you go through an iterative design process, you refine the amount of space that actually needs

to be undertaken in a building project. It is entirely unexceptional and unremarkable in the design process.

MR HANSON: There can be some explanation perhaps, minister, and you can check as to why I was just told that there was no previous figure that was any bigger than that. Mr Carmody was unaware that this had been cut in size and why the original document that shows that size—the original size that was not revealed—was not released in the information that you provided. When I have attempted to FOI it your department has knocked that back and demanded a fee of close to $1,000. Perhaps that could be explored as well.

Mr Corbell: Mr Hanson, if you are unhappy with FOI request decisions, you know what the avenues are for review of those decisions.

THE CHAIR: We might finish there and start the round again. Mr Carmody, you said the hospital would be completed in early 2018. When will it become operational?

Mr Carmody: At this stage I would be anticipating mid-2018. Again, chair, the completion date of the facility will depend on who the final successful tenderer is. As I mentioned earlier a key part of the evaluation of those tenderers is to see the programs that they put forward to construct the facility. I am sorry I cannot be any more definitive than that. Honestly, if it can work to our best case scenario, the facility would be finished towards the end of 2017, but it will depend on what the final selected contractor comes up with as far as his program is concerned.

THE CHAIR: How many staff will the new facility require?

Mr Thompson: That is a process we are working through at the moment. We do not have a final figure on that but there is a detailed planning process as part of the preparation for transferring services and commencement of the new services at the hospital.

THE CHAIR: Is that detail contained in the report *The new north Canberra hospital* that was finished in 2012?

Mr Thompson: I do not know exactly what is in that report. Any staffing figures that were included in that would have been estimates at best. What we are now doing is working through systematically and identifying the range of services that will be within the hospital and the staffing requirements accordingly.

THE CHAIR: Is it possible for the committee to have a copy of that report, *The new north Canberra hospital*?

Mr Corbell: I am happy to take that on notice, Mr Smyth, and provide further advice to the committee.

THE CHAIR: How many beds did *The new North Canberra hospital* report say would be in the University of Canberra public hospital?

Mr Corbell: Again, without having that report in front of me, I would not want to

hazard a guess, so I will take the question on notice. I do not have that report before me at this time.

THE CHAIR: That is okay. What is the cost of a subacute bed to construct and to operate, and what is the cost of an acute bed to construct and operate?

Mr Corbell: There are quite a number of complex variables at play there, depending on whether it is overnight or day bed or day space capability. The key point to be made is that the key cost is actually the occasions of care that are provided. But I would be happy to seek some further advice on that. I do not know whether that can be provided today. If it cannot, I will take the question on notice. I think we will take it on notice, Mr Smyth.

THE CHAIR: That is fine. When will the full cost of the hospital be known?

Mr Corbell: Once the government has agreed to a preferred bidder and we have a detailed bid to agree with that bidder.

THE CHAIR: When will the government have to make its first payment on the hospital?

Mr Carmody: That will depend on the actual tender that comes in and the conditions that they put into their tender. I cannot be any more specific than that.

THE CHAIR: But if it is a design, construct, maintain does that mean we do not start paying anything until it becomes operational? Is it like a PPP in that regard and we pay an availability payment? With most construction firms, if they are building your house, the builder wants some up-front money.

Mr Corbell: I might ask Ms Feely to give you some context regarding how this operates.

Ms Feely: Chair, depending on the style of the contract, often builders want to have payments made at particular defined points throughout the contract. Once the building is completed you then have, as Mr Carmody pointed out, a period, usually of about 90 days, a defect rectification, settlement, discussion phase, and there is also a lump sum paid at that time. But it really will depend on what contracts come out as. It is not unusual to expect there will be a periodic payment being sought by the builder on reaching particular key milestones for the delivery of stages of the building.

THE CHAIR: In some cases builders would expect some up-front payments before they start?

Ms Feely: I have seen that happen before. Again, in relation to this case, it will depend on what the actual requirements as part of the tender back to us are seeking.

Mr Corbell: The government has made provision for this project in the budget. However, the exact detail of the payments regime in terms of timing will be determined at the conclusion of the bidding process and negotiations with the successful bidder.

THE CHAIR: Normally in this case, as we had explained to us on Monday, the provision is made for payments the government does not expect to make but it provides the provision so that you have transparency, apparently. In the 2015-16 capital works budget how much money have you allocated for initial payments for the University of Canberra hospital, given that that is what we are voting on in a month or two?

Mr Corbell: As the government has made clear previously, it is not for publication at this time.

THE CHAIR: No, I have not asked you for the full amount; I have asked you what allocation you have made just in this year.

Mr Corbell: They are not separate questions; they are interrelated matters. The fundamental driver for the territory is value for money. We will not seek to prejudice a competitive process which is designed to drive down the cost for ratepayers by disclosing in advance, ahead of the bidding process, what we are anticipating is a payment, either during construction or at completion. That remains the government's position.

THE CHAIR: You have said the government has made provision for this. On page 164 of budget paper 3 there actually are no infrastructure investment provisions in this year's budget. So if you can point to where the provision actually sits, I would be intrigued.

Mr Corbell: It is held centrally, Mr Smyth, not by the Health Directorate.

THE CHAIR: What line does that appear in, in the budget documents?

Mr Corbell: It is held centrally by the Treasury directorate. You would have to direct your question to them.

THE CHAIR: Are we appropriating any money for the University of Canberra public hospital in this budget?

Mr Corbell: There is provision in the budget and—

THE CHAIR: No, the provision line is zero, minister.

Mr Corbell: No, there is provision in the budget and it is held centrally by Chief Minister and Treasury directorate.

THE CHAIR: I am not asking for the full value. I am intrigued as to why we cannot know. You are asking me to vote on this. All the members here will have to vote on this in August, but we are not allowed to know how much you are going to spend on the project in this year.

Mr Foster: At this stage there would be no plan to spend any design, construct and maintain funding in 2015-16. Remaining in the ACT budget for 2015-16 is

$7.9 million of design funding from the original allocation. That will be expended in 2015-16. With the timing of the tenders being determined and the procurement process and planning, there would not be any expectation of any funding going out in the construction phase in 2015-16.

THE CHAIR: So if a builder in the contract that you signed wants a payment either to start or in 30 days, 60 days or 90 days, where will that money come from, given you are not appropriating any funds in this year?

Mr Foster: That would then be a matter for the Treasurer to deal with through a budget process during the 2015-16 financial year.

THE CHAIR: Mr Hanson has a supplementary.

MR HANSON: Minister, just following up on a previous comment you made that you were not counting hydrotherapy pools and you had not said that, there are two documents here. One is a document you tabled in the Assembly, which is advice that you provided through your office to the media where it says:

> …the number of overnight beds … was … adjusted … "People coming to a day service will be formally 'admitted' … Their program of treatment and therapy might be conducted in a gym, the hydrotherapy pool or consultation rooms …"

There is another document in this package that you provided to the Assembly and it talks about what is and what is not a bed. We have accounted for the 140 overnight beds. It then starts talking about spaces and:

> Their program of treatment and therapy might be conducted in a gym, the hydrotherapy pool or consultation rooms

I understand and can get my head around what the 140 overnight beds are but then there are 85 beds that you have been saying repeatedly are beds. I am again asking for an explanation of that. You have ruled out a bed being a hydrotherapy pool, you have ruled it out being a gym. What are these 85 beds? You have said they are beds.

Mr Corbell: Neither of those statements asserts that a gym or a hydrotherapy pool or anything else is a bed, and it is wrong to claim otherwise. Neither of those statements makes that claim as you have just quoted them.

MR HANSON: But you are counting them as beds.

Mr Corbell: As I have made clear, there is a mixture of overnight and day beds or day spaces and my answers are consistent and the government has been consistent. We said up to 200 beds, a mixture of overnight and day beds or day spaces, and that is exactly what has been delivered.

THE CHAIR: Members, there is a tea break at 11. We are still on output class 1.1, acute services, which will often crossover with the local hospital network. What we will do is have a final question before the tea break from Ms Fitzharris. When we come back we will spend a little more time on acute services and then move through the list. A question, Ms Fitzharris.

MS FITZHARRIS: I have a question about the Canberra Hospital emergency department expansion. Could we have an update on that and, in particular, the paediatric aspect of that? If you could give the committee an update, that would be great.

Mr Thompson: The planning for the expansion is effectively complete. Construction will commence shortly. What we are expecting overall with the new EDU expansion is the full works being completed in late 2016. The paediatric component of that is expected to be completed a few months earlier than that, to come on a little earlier than that.

The design there is about making a dedicated area if you are looking at caring for children within the emergency department. That has a sub-waiting area and is open so that the sub-waiting area and the treatment spaces are managed more as a whole, as opposed to the current separation where, as I am sure you are aware, in the emergency department there is a clear distinction between the waiting area and the main department. What that will enable staff within the area to do is coordinate the care for people who are still sitting in the waiting area and observe them more closely, as well as have a much more informal and child-friendly atmosphere for the area to reduce the anxiety that parents and children can experience in this space.

MS FITZHARRIS: I must say I have had experience at Royal North Shore where they have a separate area with a two-year-old and it made a very big difference to that experience of being in a separate area with a small child.

Mr Corbell: There is no doubt that an emergency department is a difficult environment at times. People are unwell, they are presenting unwell and they can be very distressed, kids particularly. So I think separating kids and their parents from other adult patients is very important to reduce the stress that can occur when you are in that environment and you are already unwell. I think that is very important.

I would also add that the other critical thing for me, apart from the improvements in overall bed capacity and layout at the ED—and it is over a 30 per cent increase in bed capacity at the ED through this project—is the improvements to the mental health area within the ED. We know that many people who are presenting to the ED have underlying or pre-existing mental health conditions and I have to say that the existing facilities at the ED for the accommodation of people with mental illness when they are in the ED are simply not what they should be. And so it is very important that we improve those, and this project does that.

Whilst there has certainly been a right and proper focus on the area for kids, a good, humane, well-designed space for people with mental illness who need to be cared for in the ED for a period is very important. We need to show respect for people with mental illness when they present to the ED, and this gives us that capacity and it is very important.

THE CHAIR: As a supplementary on that, where is the money coming from for the emergency department upgrade?

Mr Corbell: It was funded in last year's budget.

THE CHAIR: But a project was cancelled to allow this one to go ahead?

Mr Corbell: No, no projects have been cancelled. This is new funding provided by government in last year's budget. The cost is $40.17 million.

MR HANSON: I want to follow up on this. I go to media reports. There was a $23 million cash injection for the Canberra Hospital emergency department. I quote from the previous Chief Minister and Health Minister:

> We appropriated about $40 million to design the new hospital and then because of the pressures [on the emergency department], I've basically taken the decision that we've needed half of that money to build our emergency department …

We followed up with questions. What you have just said completely contradicts what the previous minister said, which was that there was $40 million appropriated. You will see that that was previously in the budget. That money was taken out and the previous Chief Minister said that that money was then rolled into this project. You cancelled the $40 million that was there for the redesign of the Canberra Hospital and that money is being used for this appropriation. That was what she was saying. One of you is not telling the truth.

THE CHAIR: Perhaps we will go to—

MR HANSON: I will go on:

> It won't hit the bottom line at all. It's not new money coming, it's money we've appropriated but we've finalised how to use it …

It was going to be used for one project. You stopped that and you are using it for another.

Mr Corbell: The funding that I am referring to was originally provided for the development of a proof of concept report and delivery of a preliminary sketch plan for the redevelopment of building 2/3. The government took the decision that further work was required before we could proceed with some of that work. So the funding was redirected to allow the expansion of the emergency department.

MR HANSON: As Mr Smyth said, it was money appropriated for a project that was stopped. That was cancelled, that was taken out of the budget. It was in the budget and taken out of the budget and now it is being used for this project. I believe that Dr Hall, head of ED, said that this is now a short-term solution. He described it as a bandaid solution. The $40 million has been taken out of the long-term planning to rebuild the tower block and put it into the ED, as the previous Chief Minister described, because of pressures in the emergency department.

Mr Corbell: No, that is not correct. The issues with redevelopment of building 2/3 are the most complex of all the capital works decisions we have had to make in ACT Health. We are talking about the development of an entire new tower block structure at the Canberra Hospital. It will be a fundamental and very disruptive change when it

occurs that will have to be managed very carefully and it will have long-term implications in terms of how service delivery operates at the Canberra Hospital for many decades to come.

The government is not going to rush into the redevelopment of building 2/3 until we are absolutely confident that we have the right model and that we understand fully the spaces and places required and how they should be delivered and financed. We are going to take the time to get that right. So I am not going to commit to a project that may ultimately cost our health system and our budget, I would anticipate, over $1 billion until we have done the appropriate scoping and analysis. And that is exactly what the former Chief Minister was saying.

MR HANSON: But that $40 million was specifically for that.

Mr Corbell: Let me finish, Mr Hanson.

MR HANSON: That was what it was there for.

Mr Corbell: We have determined that we will make an investment from a very small part of that money to increase the capacity of the ED and—

MR HANSON: $23 million.

Mr Corbell: I think that everyone—

MR HANSON: In terms of the $40 million, it is more than half.

Mr Corbell: Everyone in the community will welcome that expansion. The emergency physicians welcome the expansion. I know patients will welcome the expansion. The government has never said that that is the be-all and end-all for the ED. But I tell you what, it is needed and this government is getting on and delivering it.

THE CHAIR: We will finish there but we can return to that when we resume at 11.20.

Sitting suspended from 11.03 to 11.20 am.

THE CHAIR: We will recommence. Minister, you said you had some answers?

Mr Corbell: Yes, Mr Chairman. In the earlier session you asked a question about a variance in relation to staff numbers between the 2013-14 annual report and the 2013-14 budget paper. The variance between the two is 106 FTE. The variance is due to externally funded FTE which is available for some health-related positions—that is, commonwealth funding, McGrath breastscreen nurses, research positions and so on. The budget papers show the number of FTEs appropriated by the ACT budget, which is 5,873. The larger figure, 5,979 FTE, included in the annual report includes all staff regardless of how the position is funded. As a comparison, currently there are 163.96 FTE externally funded positions in the ACT.

THE CHAIR: Perhaps in the annual report there might be a little note that says "this

includes". Dr Bourke, a new question.

DR BOURKE: Continuing on acute services, could the minister expand on the $5.7 million allocated in the 2015 budget over the next four years for emergency specialists and what that is going to deliver?

Mr Corbell: Yes. This funding allows for the continuation of the employment of a number of emergency specialists that are currently in place in our emergency departments—three in total. I will ask Mr Thompson to give you some more detail.

Mr Thompson: This was originally funded though the national partnership agreement with the commonwealth on improving public hospital services. They had an amount of facilitation funding that was available to support a range of services. We used the funding to increase the number of emergency specialists we employed. That money has now run out and the territory has agreed to continue funding so that we can maintain the employment of those specialists.

DR BOURKE: Which targets will those specialists help you to meet?

Mr Thompson: The specialists provide senior leadership and critical capacity and skills across the emergency department. Obviously, having those specialists available assists us to improve the timeliness of care provided within the emergency department and the targets associated with that.

THE CHAIR: Ms Lawder, a new question.

MS LAWDER: I want to ask a question relating to page 21 of the budget paper. It is about changes to appropriation for capital injections. I have a couple of questions on the table on that page. Firstly, I have one about the revised funding profile for Calvary Public Hospital car park. Can you explain why some money has been moved from this year to next year?

Mr Foster: This part of the appropriation deals with reprofiling based on advice as to where we are at with projects and providing the cash to match the timing of the works. This page largely deals with reprofiling to have the cash available when it is most needed rather than when it was originally forecast.

MS LAWDER: When you profiled, if that is the right word, it would have been based on the tender and the contract about when payments were due, as we just talked about with the UCPH; is that correct?

Mr Foster: It would have been profiled in the first instance through a budget process. It comes before going through a tender process. So the profiling would have been done at the time about an expectation and when it could be achieved. When you go through the process, the variety of reasons and the progress of a job or the complications that emerge, in the case of the Calvary car park, there were some issues to do with planning around access to things and some subterranean issues, I believe, which initially delayed it. That would be a reason why you would have to revisit when the cash is going to be provided.

Mr Corbell: Obviously the key step, Ms Lawder, is that the government cannot proceed to procurement until funding is available and has been appropriated. So assumptions are made about when payments will occur but they are subject to change once procurement has occurred and the detail of the payments regime and the staging of works is locked in.

MS LAWDER: When did the procurement occur?

Mr Corbell: Following passage of the budget. In relation specifically to Calvary hospital car park?

MS LAWDER: Yes.

Mr Corbell: Capital appropriation was provided in 2014-15 and the contract was awarded in September 2014. Construction commenced in the same month and is due to be completed late this year.

MS LAWDER: So is everything on track?

Mr Carmody: Yes, it is on track for completion by the end of this year. There were some—

MS LAWDER: According to the project plan, there have been no delays; everything is on track according to the agreed project plan?

Mr Carmody: There were some delays initially with the contract starting off. As the minister mentioned, there were some in-ground issues—relocation of services, the need to avoid a couple of trees and there was also some contaminated ground that had to be repaired before we could start construction. But construction has now commenced and is well underway and is due for completion by the end of this year. I am not sure how far back the original completion date would be, but certainly for the last six, seven or 12 months that I have been involved, completion has been scheduled to be by the end of this calendar year.

Mr Corbell: That is unchanged from what the government anticipated.

MS LAWDER: Procurement occurred in September, the project started that same month and you are completely on track as per the project plan from there. Have there been any delays between September and now?

Mr Carmody: Yes.

MS LAWDER: When, and what time?

Mr Carmody: There were some delays in the December-January period. That was because of the in-ground issues that were encountered that had to be resolved. However, the contractor has taken steps to recover that time to maintain schedule. One of the initiatives that the contractor adopted was to erect a tower crane; people driving down Belconnen Way will see a tower crane there. That was not the original intention. The original intention was to use mobile cranes around the site. However, it

is a much more efficient way to use a central tower crane to speed up and save time.

Mr Corbell: Whilst there have been delays at particular stages, the overall completion time frame is maintained.

MS LAWDER: If people want to use that car park, it will still be available in the original time frame?

Mr Corbell: Yes.

MS LAWDER: Has the use of the tower crane been at any additional expense to the territory?

Mr Corbell: No.

MS LAWDER: I have two more questions from that same table. A bit further down we see project management continuation for health infrastructure. What is that about? Why has it changed from one year to the next? "Revised funding profile—health infrastructure program—project management continuation".

Mr Foster: This is the funding that provides the staffing for it to deliver on all of the projects. Funding was provided two years ago for two years. The expenditure has not been as great as envisaged at that time because there was some rollover available from the year before that dealt with some of the staff costs. This is the money that provides Paul and his team to be the link between the construction and all the work associated with developing and delivering the HIP projects.

MS LAWDER: Will there be any savings or will you still expend that?

Mr Foster: This money is for staff, and if we do not need to spend it all in a particular year, there will be a decision taken about whether we need to roll that over for another year or not. That is a decision of the budget process.

MS LAWDER: Finally, slightly further down it says, "Revised funding profile—secure mental health unit". Could you explain why that has moved from the 2014-15 year out?

Mr Carmody: Primarily, that is a bit like Mr Foster mentioned earlier. The original forecast expenditure in this year has been reprofiled to reflect the program that the contractor who has now been appointed will be following for the time frame for the delivery of the project.

MS LAWDER: When was the contractor appointed?

Mr Carmody: The contractor was appointed for that towards the end of last year, mid to late last year. I will check that, if you do not mind.

Mr Corbell: We may need to take that on notice, Ms Lawder.

MS LAWDER: From when they were appointed, is everything progressing to plan so

far?

Mr Carmody: Yes.

MS LAWDER: Thank you.

THE CHAIR: A new question, Mr Hanson.

MR HANSON: Thank you, Mr Chair. Can I go back to the issue of the TCH tower blocks. We talked about this a little earlier. I would like more detail in terms of where that project design and planning have got to and what sorts of time frames then are being considered for the completion or even starting that project. As we talked about earlier, $40 million was put aside to do some of that work and it was taken out. So is that work on ice, is it being done differently or what is happening?

Mr Corbell: No, that work is not on ice. Ongoing analysis and assessment of options is being undertaken by the government in relation to what should be the scope and scale of that work. In terms of the adjustment in the budget figure, I will ask Mr Foster to give you a brief summary of how those adjustments occurred and where they occurred in prospective budget processes.

Mr Foster: I thought it would be useful to understand that there was $40 million appropriated originally for building 3-2 design work. In the 2013-14 budget that project was removed and rebadged to deal with still building 3-2 work, but also to deal with a critical need to deal with short to medium-term infrastructure issues around emergency department, and at the same time paediatric ED was announced as well, with funding coming from the commonwealth.

I thought it would be useful to know that that went through a budget process in 2013-14 where we formally moved one project and then rebid for a new project, at a lesser amount, but still working on building 3-2 forward design and some concept work, and also money to deal with short to medium-term growth issues in ED.

MR HANSON: There was a lot of discussion, in estimates and annual reports hearings repeatedly, about the new tower block. It was then an $800 million project. There was some urgency, based on the state of tower block 1, the growth that we are seeing in acute services and so on. Two or three years ago this seemed to be the number one issue and the priority within ACT Health, and now it seems to have gone off the boil a bit. What is the time frame for this body of work? Is this something we will be seeing in the next two or three years, four or five, or in decades? What is the plan?

Mr Corbell: It is certainly not off the boil. For me it remains the single most significant priority in terms of health infrastructure that the government has to consider and make a substantive decision on.

I would anticipate that we would be in a position to do so heading into next year's budget. But as the new minister I have reviewed the work that has been undertaken to date. I have taken the matter to the cabinet on a number of occasions to allow cabinet to be briefed and to understand the scale and scope of the issues at play, in terms of

demand and in terms of the potential size of the project.

The cabinet has determined that there will be joint work undertaken between ACT Health and the Chief Minister, Treasury and Economic Development Directorate, through a dedicated task force in relation to this project to provide further advice and options to government on how to ensure that we are building a piece of infrastructure which meets demand and which takes account of changes in models of care, takes account of changes in methods of service delivery, changes in technology and opportunities to improve patient flows.

That is what we are very focused on. There is money already appropriated that will be expended to undertake that analysis and options work and allow the government to make a substantive decision on the future of this infrastructure heading into next year's budget.

THE CHAIR: Before I ask the next question, I would just like to say that I think everybody here knows I take issues of privilege and contempt of committees very, very seriously. I was very concerned this morning when our photo journalist friend wandered in with a Queensland football jumper on. I had occasion to speak to her about such behaviour. I have decided at this stage not to charge her with contempt of the committee—only because we might be embarrassed in the morning. Moving on from that, well done you and go the Blues!

Strategic objectives, minister, in the budget papers have declined over the years. In the 2011-12 budget, there were 28 objectives for health. In 2012-13 there were 23; in 2013-14 there were 21. Now in 2015-16 we are down to 18 strategic objectives. Why the decline?

Mr Corbell: Overall, as I have indicated previously in answers to earlier questions, strategic objectives and accountability indicators are adjusted over time to have regard to changing circumstances, changes in levels of performance in terms of improvement in levels of performance and adjusting them to make sure that they continue to drive further improvement. So this is an iterative process. Often we take feedback, particularly from the Auditor-General, particularly from committees of this place, around those strategic objectives to make sure that they are the most concise, accurate and effective they can be.

THE CHAIR: I refer in particular to strategic objective 7, the optimum occupancy rate for all overnight hospital beds. The target in 2014-15 was 90 per cent. The outcome was 85 per cent. But you have then gone back in 2015-16 to the same target at 90 per cent. If you have actually had an improvement, why would you then set yourself a lesser target?

Mr Corbell: Well, we still have not met that target figure, Mr Smyth, so we—

THE CHAIR: I am sorry; not a lesser—a higher target. If you are not achieving the 90 per cent as is?

Mr Corbell: I think it would be common sense to say: let us try to achieve that target before we increase it.

THE CHAIR: Why did you not get the 90 per cent target this year?

Mr Thompson: That is a measure of the occupancy across both public hospitals. What we have is a situation where the bed occupancy rates at Canberra Hospital are higher than the bed occupancy rates for Calvary hospital. There are a lot of factors that drive that for reasons that remain unclear to a degree. The presentations at the Canberra Hospital are increasing at a significantly greater rate. The Canberra Hospital emergency department at present has a more significant rate than Calvary. So what we have is a situation with more people coming to Canberra Hospital and the Canberra Hospital occupancy rate being a bit higher than the 90 per cent result—

THE CHAIR: I am sorry, Mr Thompson, you are very hard to hear.

Mr Thompson: I am sorry; my apologies. We have a situation where the Canberra Hospital occupancy rate is slightly higher than the 90 per cent rate and the Calvary hospital occupancy is a fair degree below that. We are looking in planning around elective surgery, for example, at approaches we can take to balance that, but that is currently a work in progress.

THE CHAIR: Is it possible to have those numbers split into Calvary and TCH?

Mr Corbell: Yes, we can do that. I will take it on notice, but that can be provided.

THE CHAIR: Thank you.

MR HANSON: I have a supplementary on bed occupancy. Are you comfortable that you are running above the 85 per cent level consistently? Have you come to a view that you agree with the AMA assessment that that is dangerous? I know that Dr Hall has said it is dangerous. Do you share that view or is there a different school of thought that you do want to run at a higher level? Have you got a view about what you actually want to be running at?

Mr Corbell: It is certainly not optimal to be above that figure. That is why we have that as a target to drive improvement. Issues of clinical safety, I think, should not be bandied about in general terms. I think it is important that when it comes to clinical safety it is based on the judgement of our clinical safety frameworks and processes. I rely on them to determine whether or not there are issues around clinical safety that have to be addressed. I have every confidence that the performance of the hospital is within the normal bounds when it comes to clinical safety.

MR HANSON: Because the nurses came out and raised a number of questions about the crowding in ED and the treatment there and that the plans to counter it lack intellectual rigour. We have got the AMA saying that the amount of bed occupancy above 85 per cent is dangerous, but we seem to be putting the expansion of the Canberra Hospital on ice and cutting beds at the University of Canberra hospital. What is the plan to address that?

Mr Corbell: Neither of those statements are true, Mr Chairman, for the reasons I have outlined in my earlier answers. We have increased bed capacity in our hospital system.

We now have over 1,000 hospital beds. When we came to office, there were 670. So that is this government's record when it comes to increasing—

MR HANSON: We have seen how you count hospital beds, minister.

Mr Corbell: That is this government's record when it comes to increasing bed capacity.

MR HANSON: If you get treated, it is a bed.

THE CHAIR: If the minister has finished, there is a supplementary from Ms Fitzharris and then a new question from Ms Fitzharris.

MS FITZHARRIS: Thank you. Mr Thompson, I go back to the difference with the Canberra and Calvary EDs. Are you able to assess whether that has anything to do with where people live?

Mr Thompson: It does to a degree but it is not fully explained by that. In other words, we have a number of people—a proportion of people—who come from the north side of Canberra to Canberra Hospital emergency department for services that could be treated at Calvary. We do not know quite why that is. We have speculated. We are working with Medicare Local to try and get a better sense of that and work out what the patterns are and what, if anything, can be done with them. But, of course, it is individual choice there and if people have confidence in Canberra Hospital and prefer to present there rather than Calvary hospital, then that is their choice.

MS FITZHARRIS: I have spoken to some people who think that maybe for paediatric care you cannot take children to Calvary, which is not at all my experience. Has that got anything to do with it, do you think?

Mr Thompson: The paediatrics is one aspect of it but it is not the sole factor. Within the Calvary emergency department they have the capacity to treat a wide range of paediatric conditions. They see a significant number of children there every year. Calvary does not have within its inpatient services specialist paediatricians; so if someone needs inpatient care under a specialist paediatrician, they do need to be transferred to the Canberra Hospital. But we have well-established processes to manage that should that be required.

MR HANSON: A supplementary?

MS FITZHARRIS: I have a substantive.

THE CHAIR: We will finish the supplementary and then we will go to the substantive.

MR HANSON: Just on the issue of choice of hospitals, there was a concern about using postcodes for maternity services. Do you recall that last year there was consideration within ACT Health that access to certain maternity services would be dictated based on where you lived? If you were north side, you went to Calvary and south side to Canberra. Has that been further explored?

Mr Corbell: These issues warrant consideration but no decision has been made in relation to them and nor would it be without engagement, discussion and consultation with the broader community. There is no determined proposal at this stage to look at that matter, to proceed with that approach. However, there is no doubt that our maternity services are under considerable pressure. There is a very significant number of births occurring at the Canberra Hospital. We have some excellent facilities at the Canberra Hospital in that respect. But we do have to have a look at the capacity of both of our public hospitals, both of which provide very high quality care when it comes to maternity services, and make sure that they are being utilised effectively.

At this point in time I have asked for further work to be done on understanding the best possible approaches to manage demand when it comes to maternity services but no decision has been taken on that matter and nor would it without a proper engagement and discussion with the community about it.

MR HANSON: To be very clear, you are not ruling out telling women who are expecting a baby that they cannot go to a particular hospital? You are not ruling that out?

Mr Corbell: I am not ruling out making sure that we use our maternity facilities in the most efficient way possible. It does not make sense to have underutilised capacity that is not being used in any part of the health system. That is the issue.

MR HANSON: No, the issue is that for mothers who are expecting who live in a particular area of Canberra, you are not ruling out cutting their access to the hospital of their choice, the public hospital of their choice. Will you rule that out—yes or no?

Mr Corbell: I am not ruling out any measure that denies us the capacity to properly utilise our health infrastructure. These are very expensive pieces of infrastructure and it makes no sense to me to exclude any measure that results in better utilisation and better access. That is exactly the issue at play when it comes to maternity services.

THE CHAIR: A new question from Ms Fitzharris.

MS FITZHARRIS: Could I move on to output 1.2?

THE CHAIR: Are there are any final questions for acute services, output 1.1? We probably should do the ACT local hospital network, otherwise those people are going to have to hang around all day. They are basically the same thing. Are there any further questions for acute services or the local hospital network? Then we will move on to mental health.

DR BOURKE: I have a general departmental question.

THE CHAIR: Or general departmental questions.

DR BOURKE: This is probably a good time to go with it.

THE CHAIR: Dr Bourke has got at least one. I think Mr Hanson indicated one and

Ms Lawder has one. Do you have a general question?

MS LAWDER: No.

THE CHAIR: Dr Bourke, a new question.

DR BOURKE: Thank you. Yesterday when we had the Head of Service in, I was asking questions about the targets for Aboriginal and Torres Strait Islander employment in the ACT public service. She said that she had set targets for particular directorates. What is the target for the Health Directorate?

Mr Corbell: The advice to me, Dr Bourke, on this question, is that as of March this year there are 85 employees in ACT Health who self-identified as Aboriginal or Torres Strait Islander. That is an increase from the previous figure of 78. We have a target of two per cent for people in the ACT public service as a whole who are of Aboriginal or Torres Strait Islander descent, and at the moment our workforce is at 1.1 per cent.

DR BOURKE: One of the key recommendations from the Standing Committee on Health, Ageing, Community and Social Services inquiry into this matter last year was that the ACT public service adopt the project management approach to dealing with this issue. What approach has Health adopted to promote Aboriginal and Torres Strait Islander employment in your directorate?

Ms Centenera: The strategies we have been undertaking in relation to Aboriginal and Torres Strait Islander employment have been at all levels of classification throughout ACT Health. We are partnering with Chief Minister, Treasury and Economic Development Directorate in relation to a traineeship program and their new employment pathways program. We have had our own traineeship program in the past, which we are continuing with also. And we intend to participate in intakes in relation to cadets when that tranche comes through, with Chief Minister, Treasury and Economic Development Directorate.

We have asked specifically for some identified positions in relation to the whole-of-government graduate program—as have other directorates, I understand. We have had a very heavy emphasis in relation to identifying that we want graduates with Aboriginal and Torres Strait Islander background amongst that cohort and that we would prefer over 50 per cent of that cohort to be from that group.

We have also got specific programs—I would need to hand over to my colleagues—in relation to nursing, in particular, around Aboriginal and Torres Strait Islander employment, which I believe have had a measure of success. We employ an inclusion manager specifically to look at this issue and also the employment of people with disability. We monitor our employment statistics. I think we are slightly ahead of CMTED's specific target. I could not give you the exact numbers; I would have to take that on notice. We are slightly ahead in relation to Aboriginal and Torres Strait Islander employment. We are a little behind in relation to people with disability employment.

We cannot rest on our laurels, obviously. It is a very competitive market for that

cohort, because it is small here in the ACT, so we monitor it regularly through our inclusions manager and look for other opportunities through the community providers and through Habitat and similar groups, in terms of opportunities for Aboriginal and Torres Strait Islander people to participate in ACT public sector employment, whether in terms of permanent positions or in terms of possible secondment opportunities, the other aspect that we are looking at.

DR BOURKE: Thank you for that very comprehensive answer. I would also ask about one of the other recommendations of the committee's report, to consider a focus on executive or senior positions. What efforts have ACT Health made around recruiting senior Indigenous health professionals to join your professional ranks?

Ms Centenera: With executive employment, given that that is very much closely handled by the Head of Service, the delegation does not extend down to the directors-general. She keeps it very close; that is her choice. Obviously, we do the recruitment down to the lower levels, and we have emphasised our interest in relation to recruitment of Aboriginal and Torres Strait Islander executives. We have not had very much executive recruitment in the last six months to a year, so the opportunities really have not arisen. In terms of future recruitment of executives when that comes around, we tend to structure and hire them in groups, if you like, if that opportunity should arise. Also, with single long-term appointments we will be having a focus on and recruiting from that field, using contacts within the community to see whether we can garner a good field for those positions.

DR BOURKE: My question was perhaps more focused on senior health professionals.

Ms Centenera: I would have to hand over to my colleagues in relation to that answer, because recruitment is handled by the business units—I suppose is the best way to put it—within ACT Health. It is not centralised in terms of control over who is recruited. That is a decision taken at the business unit level. We have had conversations with business units in relation to our desire to recruit Aboriginal and Torres Strait Islander people as well as people with disability, and they are aware. As I said nursing has had take-up, and we will continue to have those conversations around recruiting in those areas. I understand that at the moment the difficulty is finding a good field. We have to make more efforts in that regard, I think.

DR BOURKE: Would you see that that decentralised recruitment process makes a project management approach to this issue difficult?

Ms Centenera: It does, but also, I suppose, with 5,700 employees I think that we have pitched it correctly in terms of having our advisory role through our inclusions manager—and through, I suppose, the person who sits in this position. It is me at the moment, but it was Judi Childs prior to February. We have both been active in having those conversations around ensuring that people pay attention to the fact that we do have these targets. They are very important to us, because having an Aboriginal and Torres Strait Islander cohort within our ranks is very important in terms of the effective delivery of health services.

I think that for now it is the correct approach. As I said, we do monitor it very closely through our employment figures, and it is a continuing conversation. We may make a

change to more centralised project management of those particular positions at some point in the future, but given the successes we have had in nursing and given that our focus also is on field at the moment, I think we will probably continue with this approach for a while and then reassess, probably within the next six to 12 months.

THE CHAIR: Ms Lawder.

MS LAWDER: I am done; I will hand over to Mr Hanson.

MR HANSON: Thank you. In relation to non-elective surgery, there were some concerns raised by people in the community that they had turned up to have their non-elective surgery, often people with broken limbs or elderly patients, and been prepped for surgery and then sent home—and that happened two or three times. This seemed to be an issue that came out in the community. I note that the health committee annual report called for more information to be provided about that. At the moment there is nothing reported that tells us what the timeliness is for non-elective surgery or how many people are attending that. And there is no target set on it. What is the number of people that have received non-elective surgery? What are the time frames for that surgery? And what targets do you set internally for it?

Mr Corbell: I will ask Mr Thompson to give you some further detail on that, Mr Hanson. I simply preface his comments by saying that this is recognised by me and by my predecessor as an area for improvement. My predecessor announced a number of reforms to provide for a dedicated capability, separate from the elective surgery capability, so that we would see fewer interruptions for non-elective surgery. That program is now being implemented. I will ask Mr Thompson to talk about that and to talk about the specifics of the performance measuring that you asked about.

Mr Thompson: To start off, leading on from what the minister was talking about, we have got two primary changes that we have put in place in Canberra Hospital for managing emergency surgery. One is an acute surgical unit which has dedicated operating time every day and a dedicated roster of surgeons to enable them to review patients more quickly and to get the surgery undertaken more quickly. We also have what we term an "anaesthetist of the day", who is a senior medical specialist who is able to manage the workflow through the theatres to ensure that we are getting optimal use of the theatre capacity and that we are keeping track of the urgency of cases and whether people are being delayed.

In terms of performance indicators, we have not got them finalised. We are working through it with the data area, identifying theatre information and standardised reports that we can use to monitor the effectiveness of this, but that remains a work in progress.

MR HANSON: Is there any intention to set targets?

Mr Thompson: The first thing we are looking to do is get the report in, to understand where our key areas of focus will be. Once we understand that, we will review what the—

MR HANSON: For a major area of surgery within the Canberra Hospital—and

Calvary as well, I presume—how is it that you do not know this information already, that this is not being reported? It seems extraordinary to me that you would not have visibility on this and have that information to hand.

Mr Thompson: I have visibility. Twice daily I get a report on anyone who has had their surgery cancelled. We manage it at that level. It is a very dynamic situation, with new people coming in, people's conditions deteriorating and the overall flow through the theatres. That is what we are meant to be looking at. We could spend a lot of time and effort on generating reports, KPIs and the like without really contributing any additional benefit to the operation of the theatres beyond what is currently done in terms of monitoring cancellations and doing everything we can to avoid those cancellations.

MR HANSON: With the information you do receive in terms of cancellations, can you provide that to the committee over, let us say, the last two or three years—how many surgeries have been cancelled? And I presume that information comes with a reason why it was cancelled?

Mr Thompson: I do not ask for any reason why. The cancellation is the issue that matters.

MR HANSON: Surely, if you are trying to address problems in the system, you would need to know why it was cancelled—capacity issues, staffing issues or whatever it was. If you are simply getting a number, how do you understand how to fix the problem—if you are not understanding why the surgery was cancelled?

Mr Foster: It comes down to two factors. One is substitution for more urgent cases and a demand that exceeds our operating capacity. I get, globally, information about what our operating capacity is, and the volume of surgery and the estimated time it is going to take, as of a morning and of an evening. That deals with that side of it. Beyond that, the reason why people get cancelled is that there is a more urgent case that needs to be done.

MR HANSON: Given that you get that information twice a day, you have got that information. Could you provide that information to the committee over the last couple of years so that we can get an understanding of the number of people who have had their surgery cancelled?

Mr Corbell: I will take that on notice, Mr Hanson, and see whether we can present information in a form that is coherent and able to be collated in that way. I have no objection to—

MR HANSON: Mr Thompson just told us that he gets that information twice a day.

Mr Corbell: It is about the coherence and the presentation of it. I am happy to take it on notice. In relation to access more broadly, I make very clear that in relation to improving access in these key areas—surgery, both elective and emergency, and access into the ED, the two key priority areas for me when it comes to access—I have asked Ms Feely as the new D-G to put particular priority on this. There will be a body of work undertaken over the coming months to look at what our options are to further

improve access and, in particular, to improve our performance when it comes to the target times. I think that is very important. But in terms of emergency surgery, we are implementing change. Previously there has not been a clearly delineated separate stream between elective and emergency. Now there is. Dedicated resources are going into that, and certainly there is scope to allow the Assembly to have greater visibility around that performance as we implement those reforms.

THE CHAIR: Ms Lawder, a supplementary.

MS LAWDER: Following on from that, because you are perhaps not collecting that information how do you work out whether someone who has fallen over and broken their arm has been put off for several days in a row? Potentially they could be put off forever?

Mr Thompson: That was what I was saying earlier. This is one of the caveats about producing data. We need to produce it in a form that is not identifiable. I do not get patient names, but that is not the same as not identifiable. I get information, by individual patient, on who has been cancelled and how often they have been cancelled. The purpose of that is to avoid exactly the situation you are talking about.

MS LAWDER: For example, if several persons have diabetes and those delays are causing other issues for them—they still may be reasonably healthy—it is still a difficult situation for them. Do you take those factors into account as well?

Mr Thompson: Indeed. The way the process works is that there is an urgency categorisation given to people's surgery. Intuitively you will understand that a broken finger is less serious than a major trauma from a car accident. There is an urgency category. Within that there is a concept of whether or not someone is fit for surgery. A number of factors are associated with that. Their health status is one. Frequently, with fractures, for example, the site around the fracture will swell to the point that it is not possible to do the surgery until the swelling has gone down. The clinical staff monitor all those sorts of factors when it comes to assigning urgency and scheduling when it would be desirable for that surgery to be undertaken. So they take that into account.

THE CHAIR: I have a question on page 40 of budget paper C. The currency is the national weighted activity unit. We had national weighted activity units for 2014 and we are now moving to 2015. I see in the notes on page 40 that the 2015-16 target is, in fact, Canberra Hospital and Calvary Public Hospital combined. Is Calvary public not contained in the 2014-15 results?

Mr Foster: Yes, they are. This is the local hospital network. It deals with in-scope services funded through ADF, Calvary public, Canberra Hospital public—

THE CHAIR: What does "in-scope" mean?

Mr Foster: I think it is better to describe what is not in scope, I guess. Things that are not in scope are where you are funded by a different source—Department of Veterans' Affairs activity, private patient activity, NBS-funded activity for outpatient services. They are out of scope for receiving funding from the commonwealth through the national health reform agreement. That activity remains in the Health Directorate or in

Calvary hospital separately, which is funded not through this LHN.

THE CHAIR: If you are saying that in 2014-15 the Calvary public numbers are included, why does it say in the note that these measures combine the results?

Mr Foster: I suspect the person who wrote that was being helpful and thought they were not doing anything other than being helpful. Calvary has been in since day one.

THE CHAIR: Maybe I was reading it incorrectly. The last measure, (h), talks about contacting people with mental health issues who have been discharged. We seem to drop the target from 85 per cent of contact within seven days to 75 per cent. Why is that, minister?

Mr Corbell: I need some advice on that. Is someone able to answer that question?

Ms Bracher: The target was increased in 2013-14, I believe, based on our performance, with a particular definition of calculating our performance. In 2014-15, in keeping with the national reporting requirements that we have to the AIHW, we changed our calculation method but the target remained at 85 per cent based on our previous calculation method. For 2015-16 the target has been changed to align with the national calculation for this particular indicator.

THE CHAIR: What services are delivered in the Canberra Hospital precinct for mental health patients? There is the adult facility and ward 2N?

Ms Bracher: Ward 2N is on Calvary campus but it is a public mental health service.

THE CHAIR: The public ward at Calvary, that is right. I am aware of a case of a patient who had attempted suicide and who went to casualty. They preferred to put her into 2N but there was not a bed, so they put her in the adult facility. When a bed became available in 2N, rather than going there, the patient was attempted to be discharged because the staff at 2N apparently were not—this is what was told to me—able to help somebody with suicidal ideation. How do we discharge somebody home to a family that have no training to cope with somebody in that state when potentially they could have gone to 2N?

Ms Bracher: I cannot talk about a particular incident or a particular case. Staff at Calvary 2N are trained. They are mental health nurses, psychiatrists and registrars. They are trained to deal with people who, as part of their mental illness, have suicidal ideation. If the risk assessment for that person is such that the risk is so high, the involuntary provisions under the Mental Health Act are enacted. In the ACT people can only be admitted to the Canberra Hospital in those circumstances. It is the only gazetted facility for involuntary mental health care.

THE CHAIR: I have suggested to the family they might want to take up with management what happened. They were told this person could not go to 2N because of her state. Yet they were happy to discharge her home where most of the day she would have been on her own because people had to go out and work.

Ms Bracher: The transfers between two inpatient units are a challenge from a bed

flow perspective. They are a challenge not only in mental health but also across the board. Changing somebody between two treating teams, for an inpatient, is not ideal. We prefer to keep people in the adult mental health unit voluntarily, if that is possible, for a little longer than transferring them to Calvary for the end of their stay. We find their overall length of stay is longer if we have the episode of care across two units.

THE CHAIR: I will not labour the point. I have asked the family to contact—

Ms Bracher: And we are very happy to—

Mr Corbell: I certainly encourage them to.

THE CHAIR: The suggestion was that she needed more treatment but they did not think she was suitable for 2N. They were willing to send her home where there was nobody qualified to care for her.

Ms Bracher: Transfer back into the community is part of our model of care. We have extensive community-based services and a crisis team that provide that care and support to families at home. The clinical assessment about whether person A or person B is ready for that care is in the remit of the treating team. I would be very happy to look into any particular case—and we do.

THE CHAIR: I appreciate all the good work. I know it is not easy. Members, final questions for output class 1, acute care, or output class 1, ACT local hospital network?

MR HANSON: Yes.

THE CHAIR: A last question and then we will move to mental health.

MR HANSON: There have been a number of concerns raised about patient care, particularly in TCH. There were a number of elderly patients in particular—patients left lying in urine and not cared for properly. I know that the previous minister became aware of these concerns and said she was going to address this. What has been done to improve patient care, particularly at the Canberra Hospital?

Mr Corbell: I would assert, as I know my predecessor did, that the level of patient care at the Canberra Hospital overall is outstanding. I think that will be confirmed when we see the results of the latest accreditation for the hospital as a whole.

THE CHAIR: When is that due, minister?

Mr Corbell: The accreditation process has been completed. The inspections have been completed and the summation has been given, but the final report from the accrediting body takes a bit of time. Is someone able to say when the exact time frame is expected? Yes; it is imminent. As with any complex public hospital system, there are incidents of sub-optimal care. We have to make sure that when they occur they are investigated and appropriate action is taken to remedy those circumstances. That is what we do.

MR HANSON: A lot of this stems from nurses, in particular, being overworked and

under pressure. I note a number of comments from the ANF. There was a media article on 27 March which talked about staff in the emergency department being under a huge amount of stress. A letter that had been written to Mr Thompson referred to the plan "as of poor quality and lacking intellectual rigour". That is from the nurses union. They said that the plans were a temporary solution to systemic demand issues. They said, "By accommodating patients in hallways or other high-flow areas of wards, you are creating an environment where patient confidentiality and privacy will be breached." They were saying that the pressure was then being pushed onto busy wards from the ED. You will probably recall that article. Have you responded to the nursing federation about that issue? Do you accept some of that criticism?

Mr Corbell: I have ensured that my directorate has engaged further with the ANMF on these matters. We have not yet finalised arrangements in relation to overcapacity protocols because we are engaging seriously on these questions with stakeholders and testing all of our assumptions around those arrangements.

MR HANSON: I note that a number of doctors—it goes to a broader issue—are concerned as well in terms of a pay dispute. Where is the doctors pay dispute at at the moment?

Mr Corbell: The industrial action has ceased and we are awaiting the outcome of an application made by that small group of doctors to Fair Work Australia in relation to the scope and the structure of the agreement.

MR HANSON: You say "small". Can you give me a specific number?

Mr Corbell: At last count, if I recall correctly—someone will correct me if I am wrong—it is approximately 40 doctors out of almost 1,000 across both public hospitals.

THE CHAIR: It would seem that we have come to the end of output class 1.1.

MR HANSON: I have more on output class 1.1, if we are free to go?

THE CHAIR: We will move on.

MR HANSON: Maybe we can come back to it later if there is time.

THE CHAIR: I do not think there will be a chance to come back to it later. You might have to put them on notice. We have done output class 1.1, acute services and the ACT local hospital network. Any other questions for those two areas, members, will have to go on notice. I apologise. We have pushed back into the day, so we will move to output class 1.2, mental health, justice health and alcohol and drug services. A new question, Ms Fitzharris.

MS FITZHARRIS: Thank you. Minister, I want to ask about the enhanced mental health services and community services initiative in the budget, the $16.5 million over four years. Would you be able to explain generally where those services are going, and, in particular, what new services will be available at the Gungahlin Community Health Centre?

Mr Corbell: This will include funding to provide for growth in a range of services in relation to mental health care, with a particular focus on improving community services for mental health clients. There will be a new multidisciplinary team established at Gungahlin across medical, nursing, allied health and support services to establish a dedicated community mental health service for the Gungahlin region, with 6.4 full-time equivalent staff. Previously, the district of Gungahlin has been serviced out of Belconnen, but this will provide for a dedicated capability within the district itself. That is a very important investment.

There are a further 15 full-time equivalent staff across medical, nursing and allied health professions to implement a redesigned model of care for community adult mental health services with a particular focus on the delivery of clinical management, psychological therapies, better crisis care functions and clinic and home-based care. There is also funding to commission the secure mental health unit. This is in relation to coordinating recruitment to that program, so a dedicated team to undertake the recruitment of staff for that facility.

There are also 2.6 full-time equivalent staff to provide nursing and allied health care for the Common Ground facility, which opens shortly. There will be a dedicated nursing and allied health capability to assist people with chronic and severe mental health issues who will be residents of that facility. Again, that is obviously a capability in Gungahlin.

There will be additional staff to assist with psychogeriatric conditions living in residential care—an additional 2.6 full-time equivalents there—and an additional 1.5 full-time equivalents for people admitted into the general wards of Canberra Hospital who have mental health related issues. That will allow that service to operate after hours, seven days a week. There will be an expansion to the child and adolescent mental health services—an additional two staff there—to assist with early identification and treatment of children presenting with emerging mental illness. There will be an expansion of alcohol and drug services at the Canberra Hospital to a seven-day-a-week service—a number of other improvements there and also in the justice health sector.

Importantly, there is an expansion of the crisis assessment and treatment team—seven full-time equivalent staff—for further intensive in-home support. The CAT team is really important in terms of the acute episodes that people suffer. Some expanded capability there will be very welcome. Finally, there will be funding provided to the community sector to support people with serious mental illness who currently receive support who will not be eligible under NDIS. There will be funding to support people in those circumstances as well.

MS FITZHARRIS: The 6.4 FTE at the Gungahlin Community Health Centre—are the Common Ground staff in addition to those?

Mr Corbell: They are in addition.

MS FITZHARRIS: Will they be based in the Gungahlin Community Health Centre and work with Common Ground?

Ms Bracher: The 6.4 FTE is around a dedicated community mental health team that will replicate the teams in Belconnen, Tuggeranong and Phillip, at Woden. The 2.6 FTEs that the minister has referred to relate not only to the Common Ground but also to other supported accommodation across the ACT. It is 2.6 FTE to support people in Common Ground, absolutely, but across other supported accommodation facilities as well.

MS FITZHARRIS: Could you talk us through a day in the life of a mental health team at any of the community health facilities? Do they do a lot of work in the facility or out? Can you even characterise a day in the life, what it might be like?

Ms Bracher: No two days are the same. However, the teams usually start around 8 o'clock in the morning. Through our electronic clinical record, there are notifications of people who might have been in contact with either the emergency department or the after-hours services. The community mental health team will know that that has happened through the electronic record.

There is a multidisciplinary team meeting first up in the morning that incorporates all the clinical team, including the registrars and psychiatrists that are based in the health centres. Multidisciplinary reviews are done for complex clients that need a full team review, and any of the new referrals for that team are considered on that day. Then a game plan is made for that day.

Each of the individual clinicians then undertakes that follow-up. The majority of that follow-up is face to face, in-home care, in-school care, in-workplace care or sometimes in the community, if that is where the person wants to be seen. Some of the follow-up is around the organising of services for that person. That can be done from the office by phone.

Mr Corbell: In terms of overall levels of occasions of care or contact, it is important to note that this is an area where we are seeing our targets well and truly exceeded in terms of contacts by our community adult mental health program community services. The target for 2014-15 was 109,000 contacts. The estimated outcome was 112,000 contacts. These teams are reaching more people than we were anticipating, which is a really great outcome. We anticipate with this expansion in capability at Gungahlin that we will see the occasions of contact increase to 120,000. So an extra 8,000 contacts by our teams as a result of this expansion.

MS FITZHARRIS: You have the benefit in Gungahlin of being adjacent to the child and family centre. Are there ways the team will work with people who might be clients of the child and family centre in particular?

Ms Bracher: "Yes" is the short answer. It is more the child and adolescent mental health teams that work with the child and family centres, and they work very closely with each other.

MS FITZHARRIS: In terms of walk-ins, in that sense is there a capacity to deal with people who walk into the community health centre?

Ms Bracher: All of our teams will respond to people who walk in. We have a principle of no wrong door; so if somebody arrives, we care for them. That might not necessarily be a full-blown assessment at that point in time. It is really about supporting the person into the right place for them.

MS FITZHARRIS: Thank you.

Sitting suspended from 12.28 to 2 pm.

THE CHAIR: Ladies and gentlemen and members, we will recommence the hearing. We are back to output class 1.2, mental health, justice health, and alcohol and drug services. Dr Bourke has the call for a new question.

DR BOURKE: Thank you, chair. I will ask an exploratory. Minister, do you want to deal with alcohol violence now or do you want to deal with it as the AG? Or do you want to have a conversation with the AG about it?

Mr Corbell: They cross over both portfolios, Dr Bourke; so I will do my best.

DR BOURKE: Okay. Let us go then.

Mr Corbell: It is all in my head in some form or another.

DR BOURKE: As you will recall, last year I was calling for some changes in policy around management of alcohol violence and, in particular, drawing out the issue around alcohol-related domestic violence. The things I was calling for were better programs for perpetrators, questions around availability and supply, issues around alcohol pricing, which I appreciate is a federal issue, and also issues around marketing to young people.

This morning I was at the launch of the national framework for action to prevent alcohol-related family violence by the Foundation for Alcohol Research and Education with Rosie Batty launching it. I ask you: what changes have been implemented in the territory over the last 12 to 18 months to deal with alcohol violence?

Mr Corbell: There have been a broad range of responses, Dr Bourke, but I have to say in relation to that particular aspect that they largely relate to the Attorney-General portfolio. Whilst I could give you chapter and verse right now, I am cognisant that we are not dealing with the Justice and Community Safety Directorate today. Perhaps it may be better, given that those issues largely relate to regulation of alcohol, in terms of its availability and supply and the justice system in response to it, to leave it for me when I reappear in a couple of days time.

DR BOURKE: We can talk about it more then. Does the $1 million committed in the budget to drug-related treatment include treatment for alcohol-related issues?

Mr Corbell: I will ask Ms Bracher to speak to that one.

Ms Bracher: There are two aspects to the budget for alcohol and drug services. One

is an appropriation for, I believe it is, $800,000 that relates to funding for the community sector. We can go through the various bits within that if you wish. There is also some funding within the big mental health component, which is around some community-based enhanced services—specialist services. They relate to our addiction specialists and nurse practitioners providing specialist care in the community health centres.

DR BOURKE: Could you elaborate as you suggested, Ms Bracher?

Ms Bracher: I will have to find the brief.

Mr Corbell: There is some funding going towards a number of community-based organisations for specialist drug treatment and support. That would include alcohol addiction. There will be funding of approximately $95,000 to each of six non-government organisations to increase their capacity to treat patients and to reduce their waiting times. This includes Directions ACT, Karralika, Ted Noffs, Salvation Army, Toora Women and Gugan Gulwan Youth Aboriginal Corporation. Each of them will receive $95,000 in the coming year.

In addition, there is funding of just over $100,000 to CAHMA—Canberra Alliance for Harm Minimisation and Advocacy. That is largely to do with naloxone overdose management. That is on the drug side, not so much the alcohol side. Also, there is funding to ATODA, again in relation to crystal methamphetamine responses. Obviously, there is a strong level of overlap between certain types of drug abuse, substance abuse and alcohol abuse. So this funding obviously will have benefit in that area.

DR BOURKE: I understand that it is going to be reassessed in 2016. What figure is the government looking at to increase or decrease funding?

Mr Corbell: I think it is more about better understanding how this additional funding will help these services to better manage demand and taking their feedback on what we are seeing from this additional capability. Equally, it is about being cognisant of the fact that there is ongoing work, particularly in relation to drugs in concert with the commonwealth, particularly around crystal methamphetamine, and looking at how we position ourselves once some of that completed work with the commonwealth has occurred.

DR BOURKE: On page 88 of BP3, it says that the naloxone overdose management program is being evaluated in 2016. Can you tell me more about that program and what the nature of the evaluation is?

Mr Corbell: Yes, naloxone is an intervention to deal with overdose. It is to deal with overdose related to opiates—opiate-related products. So not crystal meth, but there is a correlation between crystal methamphetamine use and opiate use. One is often used to counter the effects of another. There is this poly drug use, is that right?

Mr Thompson: That is right.

Mr Corbell: So the naloxone treatment allows for workers to immediately respond to

the consequences of an overdose in relation to opiate substances. Ms Bracher can give some more detail around that.

Ms Bracher: The naloxone trial was run through CAHMA, which is the peak body for illicit drug users in the ACT. As the consumer group, they ran the trial. It was really quite clearly focused on the individuals themselves and their immediate family being trained to administer naloxone in the event of an overdose so that as well as an ambulance response, there was an immediate response from the people that were in the immediate family and friendship group of the person involved.

DR BOURKE: What data do you have on the use or effectiveness of that program?

Ms Bracher: That is part of the evaluation that is being done through the policy area in ACT Health. I do not believe that the evaluation is complete yet. It is underway.

DR BOURKE: So what is the ETA for the completion of the evaluation?

Ms Bracher: I would have to check that.

Mr Corbell: We will take that on notice, Dr Bourke.

MR HANSON: A supplementary on that, Mr Chair: the money that was provided for a response to drugs was put forward in a press release as a response to ice. How much of that is specifically targeted at ice and how much is for other programs? Do you have a breakdown of that $800,000?

Mr Corbell: The funding has been provided to these organisations as part of the government's response to provide further assistance in relation to ice addiction and abuse. However, it is worth making the observation that obviously these organisations deal with clients who have drug abuse but also often alcohol abuse. So they are dealing with the same person and a number of those behaviours can be present. Obviously, it is of assistance in that context. But yes, you are right, Mr Hanson; this was in relation to a response on ice.

MR HANSON: So for that $800,000 could you provide—perhaps on notice—a breakdown of where that money goes and what the objective of each of those portions of that money is?

Mr Corbell: Yes, as I have indicated it will go to six non-government organisations. There will be $95,000 each to six non-government organisations. Those are Directions ACT, Karralika, Ted Noffs, Salvation Army, Toora Women, and Gugan Gulwan. In addition, there will be $115,000 to CAHMA for the naloxone overdose management pilot program, and $115,000 to ATODA in relation to their responses to crystal methamphetamine matters as well.

MR HANSON: With that $95,000 that has been allocated to each of those organisations, does that come with strings attached? Is there a focus on ice or is it just simply a supplement to the funding for what they are already doing?

Mr Corbell: It is essentially a supplement to their funding because what they are

telling us is where their pressures are in relation to ice. We are supplementing their budget so that they can better respond to that problem.

MR HANSON: Thanks.

THE CHAIR: Ms Lawder, a new question.

MS LAWDER: Thank you, chair. I have a couple of questions about the accountability indicators for output 1.2. It is on page 16. I know that four of the indicators were exceeded. Good work! One was sort of met and three of the estimated outcomes were not achieved. Some of the ones that were achieved have got an increased or improved target for this coming year, which is also good to see. In respect of the ones that were not achieved, which I think were the ones relating to children and youth services, the Bimberi assessments and the alcohol and drug community contacts, could you explain a bit more about why the targets were not reached and what you are doing this coming year to reach them?

Mr Corbell: That is an estimated outcome. We are not at the end of the financial year. With that rider, perhaps we can give some more context.

MS LAWDER: With that rider, perhaps the ones that are exceeded should also be taken into—

Mr Corbell: Yes, that is why it is an estimate, yes.

Ms Bracher: The first one that you mentioned is the child and adolescent community contacts. That was underachieved by 2,000, which was, by our calculation, about a two per cent underachievement. We had some vacancies in our service in the third quarter of this reporting period. That does directly impact on our performance. We have recruited to those positions and we are now fully staffed in CAMHS. So our month-on-month achievement that is not reported in that detail in the budget papers is now achieving—delivering—a monthly target. That is the child and adolescent occasions of service.

The next one that you mentioned was the Bimberi one. The Bimberi indicator is for the assessment of children entering Bimberi within 24 hours of detention. That is a measure that is required through the Children and Young People Act. It is a legislative requirement that we see children; so we have an indicator around that. With very small numbers of children entering Bimberi now, fortunately, it only takes one or two children that we miss seeing within 24 hours to really knock that indicator down. We cannot bring that up to 100 per cent achievement. So that estimated outcome will, at the end of the financial year, be under.

I was briefed on the specific reasons for that underachievement. There were three young people to date that had missed technically being seen within 24 hours. But all three of them had been seen within 36 hours. So technically we have not achieved that indicator. However, from the perspective of our duty of care for understanding the health needs of young people entering detention, we have actually seen them.

MS LAWDER: So technically why are they not seen within 24 hours?

Ms Bracher: It depends on the time that they enter into detention. We have a service out there. Our nursing service runs until 5 o'clock in the evening and then there is a medical officer that is on call for Bimberi seven days a week. Sometimes the young people enter into detention at a time when it takes a while for our nurses. There were two occasions—two of those three—when our nurses actually were not notified that a young person had entered into care until it was too late for us to get to them.

MS LAWDER: Given that it is a legislative requirement, have you put some processes in place to avoid recurrence of those sorts of incidents?

Ms Bracher: Every time there is an incident like this we work with the management at Bimberi—it is through the Community Services Directorate—to understand the reason for missing that target and to try and do better next time; absolutely.

MS LAWDER: You said that there were perhaps two instances where you were not notified. Did those two people, children, come in together?

Ms Bracher: No.

MS LAWDER: Two separate incidents?

Ms Bracher: Yes.

MS LAWDER: Even though you worked with Bimberi staff after the first one, it occurred again a second time?

Ms Bracher: It did.

Mr Corbell: It was not a case of not being notified, but not being notified—

Ms Bracher: In a timely—

Mr Corbell: in time for the occasion of care to occur within that time frame.

MS LAWDER: Do you feel you have now, after the second instance, put the process in place to avoid another occasion?

Ms Bracher: To the best of our ability we have, yes.

MS LAWDER: Thank you. Then the third was the alcohol and drug services community contacts.

Ms Bracher: That is correct. We underachieved there by 3,000 occasions of service, which by our calculations is about a four per cent underachievement. That indicator measures our occasions of service against our opiate replacement program at building 7 but also our counselling and treatment service at 1 Moore Street and the community health centres.

We had some significant vacancies in social work and counselling staff through the

first two quarters of this reporting period. That is the reason for our underachievement. In the same way that we have picked up on the CAMHS monthly occasions of service, alcohol and drug services are tracking upwards on a monthly target as well.

MS LAWDER: If that is the case, was there an opportunity to increase the target for the coming year?

Ms Bracher: There was an opportunity. We were part of a process where we briefed. Given the changeover of staff and our difficulties in finding staff, my recommendation forward was not to increase that target until we are confident we have got our staffing permanently and consistently employed.

MS LAWDER: Because there is also additional funding for the coming year, I think.

Ms Bracher: That is correct.

MS LAWDER: So more reasons to achieve or exceed the target. Thank you.

MR HANSON: With regard to mental health staff, we have been advised that that is an area, particularly for mental health nurses, that is under pressure as we try and grow the workforce and that it is difficult to recruit and retain sufficient staff. Is that a concern?

Ms Bracher: Recruiting and retaining staff is a concern across all mental health services across the nation, and it is a concern across ACT Health too. Our retention rate is no different really from any of the other jurisdictions. We are working very actively with the University of Canberra nurse training school on undergraduates and graduates that enter our service, and we support student placements across all of the disciplines, not only nursing.

We have a postgraduate nursing program that we run through our division that is a conjoint placement with the University of Canberra. The academic component is through the University of Canberra. We train somewhere between eight and 12 postgraduate nurses every year and graduate that number of staff. They work in our service, and they go on to work in all sorts of places.

We have recently sought applications for a scholarship program specifically for forensic mental health care and that is not only related to nursing, but psychologists and social workers and other allied health disciplines would be eligible to apply for that. That is a workforce priming initiative for the staffing of a secure mental health unit, and there are 10 scholarships that we have offered in that space.

MR HANSON: Have you done any workforce modelling with just the normal growth and the growth expected because of the forensic unit, to identify what that growth is either in numbers or percentages and how you are actually going to fill those? It seems that this is a growth area. It is a good thing in terms of providing provisional services but it is one thing to allocate the funds if you have not got the bodies to fill the jobs. Do you know what that delta is in terms of the number of people you need to train or recruit to fill that gap?

Ms Bracher: We have projections that we need for this growth envelope and we have projections that we are working on for the establishment of the secure mental health unit and that is with the phasing of the beds there. This is the area that I consider the biggest corporate risk that we have to manage within our division. I have established a monthly committee, a steering committee, for workforce very specifically.

As it happens, yesterday was the meeting where I tabled our workforce plan across all those major projects, being this growth envelope and the two significant health infrastructure projects that we have that fall within my division, the secure unit and the University of Canberra public hospital project. And we have very good engagement from within our division, within the community sector organisations that are also represented and also from the people services and strategies.

MR HANSON: Are those plans available to this committee?

Ms Bracher: They are an internal plan that is being endorsed through our divisional government structure and it was my intention to table that through our health infrastructure program governance system up to the committee that Ms Feely chairs.

MR HANSON: And one of the issues raised with me is that one of the difficulties in retaining staff and probably recruiting as well is the difficult environment in which the staff work. I am aware that there have been a number of assaults. A provisional improvement notice was placed on the adult mental health unit. Has that issue been rectified and what is the situation with regard to the number of assaults and how that is being managed?

Ms Bracher: Unfortunately from time to time behaviours in a mental health unit do result in assaults on staff. We try very hard to reduce that and the best way of reducing assaults on staff is good clinical care to reduce the psychological distress that people have when they are in the mental health unit. Since the provisional improvement notice last year we have been very active in that unit. Our clinical director has taken on a lead role in the management of aggression and violence in our unit and we are developing a divisional-wide framework for management of aggression and violence which will not only be relevant for the adult mental health unit and the mental health assessment unit in the emergency department but will be the background framework for managing aggression and violence in our secure mental health unit as well.

MR HANSON: What is the status of that improvement notice now?

Ms Bracher: That was lifted or revoked—I think that is the language under the Workplace Safety Act—by the health safety officer but in the time frame that was required.

THE CHAIR: Where is the bush healing farm and when is it likely to open?

Mr Corbell: The bush healing farm is now under construction. Construction works have commenced. The lead contractor has been appointed. In terms of the time frame, the middle of next year, I am advised.

THE CHAIR: How long overdue is that?

Mr Corbell: I will ask Mr Carmody to come up.

Mr Carmody: Sorry, I missed that question.

THE CHAIR: When was it initially to be completed? How long overdue is it?

Mr Carmody: That was a good news story. When the tenders closed the successful tenderer came up with a very attractive construction program, as they all did actually—all the tenderers. We were expecting it was going to be finished early 2017. All the tenderers indicated they could have it finished by the middle of 2016. The contract that we have now entered into with St Hilliers Pty Ltd shows them completing it in mid 2016.

THE CHAIR: But when was it originally slated when the government first announced it? How many years overdue is it?

Mr Corbell: Obviously there have been protracted delays in the regulatory approval process which are beyond the control of ACT Health insofar as there have been objections raised through the territory plan rezoning process as well as during the development assessment process. That is what has contributed to delay, not the project management by ACT Health.

THE CHAIR: And what is happening with the cost?

Mr Carmody: The accepted contract sum is well within the approved budget and at the moment, subject to any unforeseen issues which we are not aware of, it will come in under budget.

THE CHAIR: So what is the contracted cost?

Mr Carmody: I am sorry, I do not have the actual dollars.

Mr Corbell: We will take that on notice.

Mr Carmody: If I could, it would be a bit more accurate.

THE CHAIR: Ms Fitzharris, a new question.

MS FITZHARRIS: I want to ask about the focus under this output class around engaging and liaising with community sector services, the role of ACT Health in the local network trial. What role is ACT Health playing in that particular initiative? I know there was funding in last year's budget and a small amount in this year's budget for the Community Services Directorate.

Mr Corbell: Are you referring to the human services blueprint?

MS FITZHARRIS: Yes I am, and the trial in west Belconnen that is currently underway.

Mr Corbell: If Ms Bracher could come back. Sorry, we are chopping and changing a little. It is about the involvement of your area, Katrina, in relation to the human services blueprint and the trial at west Belconnen.

Ms Bracher: Mental Health, Justice Health and Alcohol and Drug Services have been involved in the consultation process around the developing of the blueprint very actively as have a number of areas within ACT Health. With regard to the specific trial at west Belconnen, operationally we are not involved in that directly but indirectly. We still provide services there but are not directly involved in the trial.

Mr Corbell: If I could in relation to a question on notice I took from Dr Bourke earlier this afternoon about when the evaluation of a naloxone overdose management program was due to be completed, I am advised that it is due to be completed in July of this year.

DR BOURKE: This budget has got $212,000 for Aboriginal and Torres Strait Islander smoking cessation. What strategies will this money fund?

Mr Corbell: This is funding for a group in society that we know has a higher percentage of people smoking compared to the population as a whole. It is almost double if I recall correctly. Smoking in the Indigenous community is double the rate of that in the community as a whole. In the community as a whole it is around nine per cent, 10 per cent. In the Indigenous community it is at least double that. So there is a real need to reduce the level of tobacco use amongst that community and this is a targeted initiative to do that work. I ask Ms Bracher to speak on this.

Ms Bracher: The rate of smoking in the ACT, I believe, is just over 10 per cent for the population. This particular initiative on smoking cessation is to fund community organisations to work within the Aboriginal community. There are a number of strategies as part of this. There will be a social marketing campaign. There will be health promotion campaigns. There will be an evaluation of the program, the alcohol, tobacco control strategy for Aboriginal and Torres Strait Islander peoples. That will also be evaluated as part of this strategy.

Mr Corbell: Looking at those figures, the proportion of Aboriginal and Torres Strait Islander adults who smoke in the ACT is sitting at 29.8 per cent compared to the population as a whole figure, which is sitting at well under half of that. That is a really disproportionate level of tobacco use.

Smoking during pregnancy is also higher amongst Aboriginal and Torres Strait Islander women. The percentage of Indigenous women who reported smoking during pregnancy was much higher than the overall ACT percentage. Sixty-eight per cent of Aboriginal and Torres Strait Islander women aged less than 20 and 59 per cent of those aged 22 to 24 report they smoked during pregnancy. This is obviously a significant health issue for them and also for their unborn children. That is compared to 44 per cent for non-Aboriginal and Torres Strait Islander women aged less than 20 and only 28 per cent of those aged 22 to 24. There are much higher smoking rates, unfortunately, amongst the Indigenous community, and we all understand the impacts of smoking during pregnancy on the health of babies.

I was very keen to make sure that we kept a focus on this. It is not a large amount of money but it does not need to be. It is about driving better awareness and understanding of what is available and driving more people to take advantage of the programs that are already on offer around smoking cessation and helping people to kick the habit.

DR BOURKE: Evaluation was mentioned. What KPIs will the evaluation be covering to determine whether the spending has been successful?

Mr Corbell: We have a tobacco control strategy for Aboriginal and Torres Strait Islander people. That strategy formally expired at the end of last year and we are now evaluating that strategy. That will allow us to identify where we need to focus our efforts in a new strategy document.

DR BOURKE: Will spending continue if tangible decreases are seen in smoking rates or will the program be—

Mr Corbell: It would be fair to say that we are going to have to keep spending money in this area because the smoking rates are far too high. It is a question about where the area of emphasis is once the evaluation is complete.

MR HANSON: On smoking, can I have a supplementary?

MS LAWDER: Me too.

THE CHAIR: Certainly.

MR HANSON: After you; ladies first.

MS LAWDER: While we are talking about smoking, I want to take the opportunity to ask about the no smoking policy at the Canberra Hospital, minister. I drive past there every day and I find it quite disconcerting that there are smokers. There are chairs, milk crates and things on Yamba Drive. What can we do to not have this public display of smoking? I find it quite extraordinary.

Mr Corbell: Canberra Hospital has gone smoke free as a campus in its entirety. People have worked out where the perimeter of the campus is and they are choosing to go on to land which is not hospital land. It is separate territory-controlled land on the verge along Yamba Drive. You are quite right; it is unsightly. At the moment our powers to deal with that matter are limited. However, the government is currently finalising its options in relation to changes to relevant legislation to allow for declarations of smoke-free areas on public land and other public places around the ACT.

We do not have that legislative power in a more wide-ranging way. We have it for specific areas but not, for example, on a street verge somewhere. Potentially, once the government has resolved its response on those questions, I envisage that there will be legislative power proposed for endorsement by the Assembly that will allow us to deal with those issues and say, "Look, you cannot be smoking anywhere, whether it is—

MS LAWDER: I appreciate your intent.

Mr Corbell: This is a complex issue, but obviously the point behind banning smoking in particular areas is on public health grounds. There is real benefit in that it acts as an added incentive for people who are smoking to realise that there is some inconvenience in that and that it may be another spur for them to get help, to go to one of our smoking cessation programs and get some help to kick the habit.

MS LAWDER: It is also awkward seeing people in their pyjamas and stuff out there on the street.

Mr Corbell: Yes, I appreciate that. Obviously, people are choosing—

MS LAWDER: Would a designated small area not be a solution where they could go?

Mr Corbell: The position of the government is that smoking is not good for your health and it should not be happening anywhere on the hospital grounds.

THE CHAIR: Mr Hanson, a supplementary, then a question from Ms Lawder.

MR HANSON: I have a question on smoking and the issue of e-cigarettes. What are the government's policies and regulations with regard to e-cigarettes? Is there any clinical advice that has been provided to you or available with regard to that issue? I have certainly been approached by people on various sides of this debate regarding e-cigarettes. It is an area that seems to be somewhat ambiguous at the moment. I am wondering what the government's position is on e-cigarettes.

Mr Corbell: I will ask Dr Kelly, the Chief Health Officer, to come up. Whilst he does that, what I can advise you, Mr Hanson, is that I have agreed on a preferred response for the government to consider on e-cigarettes. The government has not yet considered my cabinet submission but they will in due course. The government will make a decision on that matter. We have undertaken a comprehensive public consultation in relation to options to deal with this question. This is a new and novel product and there are a variety of views around what the response should be and, indeed, whether or not the products are beneficial.

My general view is that I do not see a lot of evidence that they are beneficial or act as a way to help people stop smoking. I have serious concerns that they may help renormalise or socialise people to the idea that smoking, even an e-cigarette, is an okay thing to do and could actually help normalise, again, tobacco use when, of course, our whole public health push for the last couple of decades has been to say that it is not a healthy thing to do, that it is not something that should be taken as a given in society and that it is something we have to try and phase out.

That said, there are a range of options on how we regulate or not e-cigarettes. I am putting recommendations to the cabinet and the cabinet will determine the government's position in due course. Dr Kelly may be able to talk a little about that debate about the benefits or otherwise of e-cigarettes.

Dr Kelly: Thank you, minister. Thanks for the question, Mr Hanson. It is an issue which has arisen around the world. The e-cigarette, as the minister has pointed out, is a relatively new phenomenon. We use the term "e-cigarettes" to cover any of the devices that look like cigarettes, but some of these contain nicotine, others do not.

The debate, as you have quite rightly pointed out, is between whether this is a harm minimisation strategy potentially for people that might otherwise be smoking to have a product which is not as dangerous to their health. Other proponents say it is helpful for people to help them to stop smoking. The evidence for that is actually pretty scanty. Most places where they have looked at this and studies have shown that people that use e-cigarettes ostensibly to stop smoking continue to smoke. So the debate is really still out there as to whether that is an effective strategy for stopping smoking.

The point that the minister made about re-normalising smoking through these products, particularly for young people, is a major concern. I think for that reason we need to look very carefully at what we can do to stop that happening. As the minister has pointed out, ACT particularly can be very proud of our efforts in that regard, in decreasing teenage smoking to the lowest in the country and decreasing adult smoking to the lowest in the country over many years. We do not want that to slip backwards.

There are a range of regulatory options we could look at which, as the minister has said, have been put to him. In terms of the public consultation we had late last year, we had 242 replies to that consultation or submissions and there were a range of views expressed. Some from—well, we do not know who, or exactly their ages, but I suspect fairly young people, who said, "Hey dude! Don't interfere with my lifestyle," that sort of arrangement. So there certainly was—

MR HANSON: I think the word "dude" went out a while ago, which may indicate they may not be as young as you suspect.

Dr Kelly: Younger than me, anyway; that is the point. I am still young at heart, Mr Hanson. So that was one side. There were very strongly put views on the opposite side, from public health groups, other non-government organisations and from clinical groups such as the Australian Medical Association. They were very strongly putting the case that further regulation was required to stop what I have already talked about. There were a range of things—

MR HANSON: What is the situation at the moment, because it does seem a little ambiguous? Is there any regulation, are they outlawed or are they just sort of—it is silent.

Mr Corbell: It is an unregulated product.

MR HANSON: Yes.

Dr Kelly: There is some—

Mr Corbell: Except for anything around import control.

Dr Kelly: Yes, the one regulation that is there is for those that contain nicotine. Under the Medicines, Poisons and Therapeutic Goods Act here and also national laws, they are not regulated by the Therapeutic Goods Administration. Therefore they are illegal. For those that do not contain nicotine, there is no regulation of those at all, apparently.

Interestingly, there is a fairly strong and coherent national approach to this, at the national level through import restrictions and so forth being considered by the national government. Across the other states and jurisdictions, in WA they are essentially banned, to the point where they actually have prosecuted under their anti-smoking laws someone who has imported this product for sale in WA, through to Victoria which is not really looking at this in any great detail.

But most of the other states have similar views to what has been put to the minister, as mentioned, and what was put out to consultation, for there being some sort of restriction. New South Wales introduced legislation last month to restrict its use by minors. Essentially, as we do not allow cigarettes to be bought by people under the age of 18, it would be similar for e-cigarettes in New South Wales. That is the proposition.

MR HANSON: So a COAG response, in terms of being consistent across all the jurisdictions, is looking difficult to achieve, but being consistent with New South Wales, given our geography, is feasible, or is one of the options on the table, is it?

Mr Corbell: Without wanting to pre-empt cabinet's consideration of it, certainly it is my view that some form of regulation is required.

THE CHAIR: A new question from Ms Lawder and then potentially the last one from Mr Hanson on mental health. Then we will have to move on to public health services.

MS LAWDER: I have a question about reducing seclusion and restraint in the mental health inpatient settings. It is strategic indicator No 5 on page 5. I absolutely note, as it says in the note, "ACT Health is a national leader in reducing seclusion and restraint." Nevertheless the target was not met this year. What makes you think that this will not happen again? Is it a seasonal thing or—

Ms Bracher: We have, over the course of the last six or seven years, had a very rapid decline in our seclusion and restraint data, right down to less than three per cent, which is why our target sits at that point. That happened probably three or four years ago and we have been tracking along at the two to three per cent each year since then.

At the end of last year and the beginning of this year—Mr Hanson has already referred to some high levels of aggression and violence in our unit. Most jurisdictions will tell you that levels of aggression and violence and the rate of seclusion quite often track each other in terms of rising or declining. They are very closely intertwined. Late last year and early this year we had some peaks in our seclusion data. In the last two months we have had no episode of seclusion.

The National Seclusion Restraint Committee was on two weeks ago in Melbourne.

We sent a group of staff down very specifically to have their skills refreshed and to learn what other jurisdictions are doing. In fact the performance of some jurisdictions is actually headed beyond—in front of ours. We are certainly a national leader, but there is a jurisdiction in Victoria now that we are learning from who has not had an episode of seclusion in two years, and that is commendable. So we have now got a clinical target for us to deliver against. That group is challenged professionally by that and they are working very actively in that direction again.

Mr Corbell: This is an area where our performance is nationally reported. I am very pleased that we are the jurisdiction with the lowest level of seclusion use at a state or territory level of any jurisdiction in the country. That is a really good outcome but obviously it presents other challenges when it comes to some of the issues that we have been discussing earlier around violence and so on in secure facilities.

MS LAWDER: I will leave it there.

THE CHAIR: Mr Hanson, a final one on mental health.

MR HANSON: Thank you. Community mental health organisations deserve quite a bit of the government's outputs. How much is actually provided in total, who is it going to and for what objectives? You could provide some of this on notice: how much money in mental health funding goes to community organisations, for what purpose, how is it monitored and how is it controlled?

Ms Bracher: I do not have the data in front of me. Our policy and government relations area is responsible for the community organisation contracts and the proportion of grant money that is put through there. I am responsible for the public mental health services. I am sure we can provide the data.

Mr Corbell: There is growth in this budget. There is an extra $375,000 in the next financial year and that is indexed—it looks like a bit more than indexation to me, but it grows to about half a million in the outyears. So we are providing additional funding. That is in part recognition that there will be some people who need support in the mental health sector broadly—clients who will not be captured by the NDIS arrangements. They will need to make sure that their existing levels of support are sustained. Once transition to NDIS occurs, people who are found to be ineligible for NDIS will still need psychosocial support services and this is to provide for that.

MR HANSON: With the funding that goes to those community organisations, I am a little surprised that that is not coordinated by you. I would have thought you would want a seamless provision of mental health services, whether it was being provided by the directorate or by community organisations.

Mr Corbell: It is the difference between policy coordination and funding. Obviously, when it comes to policy and service delivery, that is very closely done with Ms Bracher's area, but the administration of contracts is dealt with through a different part of Health that manages grants to organisations outside the government.

MR HANSON: Does this mean, for those community organisations who have been receiving funding from ACT Health that, as a result of the NDIS, they will no longer

receive a funding stream from Health? Has that been reduced or what has happened there?

Ms Bracher: Very generally—the specifics might have to be taken on notice—the funding for many of the community organisations has been transferred into the NDIS. So the services for people to provide their care and support will be funded through the NDIS, rather than through the funding arrangements directly from the—

MR HANSON: Let us say ACT Health was providing an amount—I will say a million dollars, for the sake of argument. As that organisation now will be funded by NDIS, has the million dollars that you were previously providing to those community organisations been transferred from ACT Health to NDIS, or has that remained in ACT Health as a separate funding stream, federally or from wherever, for NDIS?

Mr Corbell: There is a break-up. Obviously funding provided by state and territory governments for services that are to be delivered through the NDIS is transferred as part of the NDIS arrangements in general terms.

Mr Foster: The principal is, yes. We retain the funds at the moment and pay that funding to the NDIS; then they enter into funding arrangements with individuals to be able to buy services and care plans.

Mr Corbell: We recognise that it is not going to be a uniform scenario for everyone. There will be people who need psychosocial support and services who will not fit within the criteria of the NDIS, and they will need to be supported directly by the government, or through grants to non-government organisations, on our behalf. That is what this funding is designed to address.

MR HANSON: Because it is a complex process would it be possible to get a snapshot of the community organisations that have been receiving funding from ACT Health, with a breakdown of who they are and how much they have been getting, and maybe that could be a little bit historical—pre-NDIS—and then where we land post-NDIS, so that we can see that organisation X was previously funded by ACT Health for an amount to do X; that has all been transferred to NDIS? Or with another organisation it could be in part—some is ACT Health, some is NDIS—and another one might be remaining entirely with ACT Health. I am trying to get a snapshot of who is doing what out there in the community, what the funding lines are and also to establish on this side of the equation, because we will have people here from the NDIS later—

Mr Corbell: I am happy to provide that detail on notice, Mr Hanson.

MR HANSON: where money has been essentially not provided then. There might be an organisation that was previously doing things for ACT Health; NDIS has picked it up, but that money has not followed. That might be entirely legitimate, but I want to find out why that might be and then what happened to that money that was previously going to that organisation.

Mr Corbell: I am happy to take that detail on notice.

MR HANSON: That would be great.

THE CHAIR: Just for clarity, in which output class do the officers that now administer the funding appear before the estimates committee?

Mr Corbell: It is corporate services, so wherever corporate services—

THE CHAIR: So it is in the corporate? Okay.

Mr Foster: I am sorry; what was your question?

THE CHAIR: For instance, where do the officers that now administer those grants appear in the output classes?

Mr Foster: They are an overhead.

THE CHAIR: They are an overhead? That is a bit sad, to describe them as just an overhead.

Mr Foster: Some of us are overheads!

THE CHAIR: Are you the head overhead?

Mr Foster: Yes. The policy and government relations area that does that is considered an overhead and they are spread across—

THE CHAIR: So they are in corporate?

MR HANSON: Surely the decision is made by Ms Bracher or through the sort of policy chain of command, isn't it? You are not the person making the decision?

Mr Foster: The decision to fund NDIS?

MR HANSON: Or to fund any particular organisation.

Mr Corbell: The decision is made by me, on advice—

MR HANSON: Yes ultimately, but through Ms Bracher, rather than through—

Mr Corbell: It is developed in a collegiate manner. No, it is not simply developed by policy and government relations in isolation.

Ms Bracher: In terms of developing the business case that went to cabinet and Treasury for 2015-16, we had a number of joint workshops between the operational area and the policy area, the corporate area, in order to develop those. So it was very collegiately done, in terms of what the population needs, in terms of both public mental health services and services that can be provided by community organisations. There was a joint briefing process up through the director-general into cabinet—minister to cabinet.

THE CHAIR: We might move from mental health to public health services. The first

question, minister, would be: where is the healthy weight initiative at, and what is happening as a consequence of this year's budget?

Mr Corbell: Healthy weight continues to be a whole-of-government priority. Healthy weight is considered a whole-of-government priority and is overall coordinated within Chief Minister and Treasury directorate, because it is a whole-of-government priority. However, ACT Health plays a critical and important role in that. There is funding in this year's budget to improve health promotion in a range of areas, including in relation to obesity prevention. For example, we continue to fund healthier work, which was established by WorkSafe ACT to support local businesses to create healthy environments in their workplace. That comes down to issues such as food choices that are available, convenience food that is available at worksites and so on.

We continue to support ride or walk to school. This is a very popular program amongst primary schools. We are supporting that in conjunction with the Education and Training Directorate. Kids at play is being implemented by a fantastic non-government organisation in conjunction with ACT Health. There is the fresh taste program, which is to increase children's access to knowledge and uptake of healthy food and drink choices and ensure that we are staying consistent in the implementation of the healthy food and drink policy in schools.

Those are some examples of what has been funded with that $370-odd thousand in last year's budget, and $396,000 in this year's budget ongoing. There is additional funding in the Chief Minister and Treasury directorate of $150,000 this year and $400,000 indexed over the outyears.

THE CHAIR: In regard to, for instance, the selling of food at checkouts, at the register, there was some consultation promised with business and the community. Where is that at?

Mr Corbell: The selling of less healthy food choices, yes. The government received some very valuable survey work undertaken by the Heart Foundation in relation to community attitudes and prevalence of advertising of energy-rich foods, particularly those foods that are targeted at children. We have taken that report, with thanks, from the Heart Foundation and policy options are currently being developed for the government's consideration in relation to the conclusions of that survey work.

THE CHAIR: Dr Kelly gave me a briefing on some of the activity and it was suggested there was to be a path forward involving direct consultation with business. I understood that was with you for decision. When is that likely to commence?

Mr Corbell: We are still in the policy formulation stage, but it is the case that there will need to be consultation with business before we reach any final position in relation to these matters.

THE CHAIR: When is that consultation likely to be?

Mr Corbell: Dr Kelly may be able to remind me what the time frames are in relation to this work.

Dr Kelly: Thank you for your question, Mr Smyth. As we discussed in your office a couple of weeks ago, a range of options have been looked at in terms of what we should do with this issue of what I would call the pester power of children and what role the government may have in that regard. That is part of the healthy weight initiative that you have already asked about that was announced by the previous Chief Minister and health minister a couple of years ago as being one of the things we would look at. The Heart Foundation audit that the minister has mentioned was part of the process of seeing what is out there and what we should be discussing. The plan is still to have consultation both with the community and with business. Minister, the decision about when that should happen is with you; it is imminent. The plan will be that we will, of course, have proper consultation, as I discussed with you.

THE CHAIR: How imminent is the decision, minister?

Dr Kelly: Sorry to flip that back.

Mr Corbell: Across all of my portfolios I am getting through all of my briefings pretty well at the moment, so imminently.

THE CHAIR: Which is faster or slower than a Ted Quinlan "soon"?

Mr Corbell: These are relative terms, Mr Smyth.

THE CHAIR: Indeed they are, minister. We look forward to the consultation.

MR HANSON: I have a supplementary on obesity issues.

MS FITZHARRIS: I also have a supplementary.

THE CHAIR: We will go to Ms Fitzharris first; and if those questions are asked, we will go to Mr Hanson.

MS FITZHARRIS: Being very familiar with the pester power of children, are you going to talk to children about how you might figure out a way to understand? Some of them are very young, but obviously some of them are a bit older. Is it worth having—

Mr Corbell: I think it would be a reasonable observation that if we are to engage the community in consultation on this issue, engaging young people needs to be part of that.

Dr Kelly: If I might add to that, minister?

Mr Corbell: Yes.

Dr Kelly: We have a good track record in that, in fact. In our ride and walk to school policy, for example, that is how we ended up with BMX bikes rather than what we would have suggested perhaps as adults. We had a very successful conversation with children. Also, with our it's your move program, which is at the high school level, again, the way we came across specific ways of dealing with obesity, nutrition and

physical activity for that age group has been almost like a citizens jury, with high school students and their teachers and parents. So it is a very collaborative approach. I think we need to look at ways we can do that in this process as well.

MS FITZHARRIS: Thanks.

THE CHAIR: A supplementary to my question, Mr Hanson.

MR HANSON: Yes, on obesity, the obesity clinic. My understanding is that there is a long waiting time involved for people. Can you advise what that waiting time is, what the situation is and what is going to be done about it?

Mr Corbell: I will ask Mr Thompson to speak on that.

Mr Thompson: I do not have the exact waiting times at hand, but there is a waiting list. The service is still in its establishment phase. The last piece of the establishment we have recently undertaken is finalising recruitment for senior medical staff to staff the clinic. That has been completed. We now have additional medical staff on deck, and that will assist us to reduce the waiting times. That is where it is. If you would like the exact waiting times, I can provide that on notice.

MR HANSON: Yes, thanks. Part of this, I assume, is the bariatric surgery that was put in place a couple of budgets ago, I think. How many surgeries have been completed? As part of that, I recall there was going to be a review or study to see how effective that was. Have we got any results from that on how many surgeries have been conducted to date, and is there a review of that?

Mr Thompson: The surgery has not commenced yet. We have funding in the budget this year for 13 cases that we expect to undertake. One of the principles we are operating under, and the staging process we have been looking at in relation to the service, is that access to bariatric surgery should follow other attempts at weight loss and should not be the first intervention. We are looking at a process whereby those clients who have gone through the obesity service who have reached the point where other options have not been successful will be referred on to potentially receiving bariatric surgery—should they be fit for it. That is another of the matters we need to be mindful of in this space: it is fairly significant surgery and frequently dealing with people who have co-morbidities and relatively poor health status. That is another factor we have to look at.

MR HANSON: Is that figure of 13 based on need or is that a random number based on funding?

Mr Thompson: Given the process I have just described, we do not have a clear sense of what the need might look like in this space. That is one of the things that, over time, we will get a better handle on. At this point, the number has been chosen around looking at the rates of bariatric surgery interstate, our population and what would be a reasonable number based on our expected population or a comparison on a population basis.

MR HANSON: That service has been up and running for a while. This has been

agreed to. I remember it came before the Assembly as well. I am a bit surprised that there is not a sense of how many individuals would be eligible for this surgery and whether that would exceed 13 or not.

Mr Corbell: I think, for the reasons Mr Thompson has outlined—this is a new service for the ACT—we can draw on what we know of the experience in other jurisdictions, but it is a complex area in terms of people's suitability for surgery. We have taken a relatively conservative approach for the first rollout of a new service. Once the service is operational and we have some experience, we will be able to better inform what our understanding of demand overall is.

THE CHAIR: Ms Fitzharris has a supplementary, as does Dr Bourke. We will then go back to a substantive with Ms Fitzharris.

MS FITZHARRIS: I want to ask a few questions around the evaluation aspect of the healthy weight initiative and your role in that. How will you go about collecting the data? In terms of the web-based platform that you are looking to develop, what stage is that at and when will that be live?

Dr Kelly: Thanks for the question, Ms Fitzharris. As the minister pointed out, the issue with the healthy weight initiative is that it is actually being led by Chief Minister's at the moment. The model we had envisaged a couple of years ago is that various directorates across the government would be in charge of certain aspects. You are quite right to say that evaluation is one of the ones still sitting in Health, under my area.

There are a range of actions within the plan—19 specific actions and six clusters of actions. I will deal with the evaluation side first, and remind me to come back to the web-based platform. With each of those, we have gone through a process with the people who are engaged with those projects within those 19 actions. The steering committee, which is chaired by Chief Minister, Treasury and Economic Development Directorate, has come up with a series of indicators. Some of those are process related, some of them are short or medium-term outcomes, and there is a long-term outcome, which is subtitled "The plan: zero growth for obesity". We have well-considered evaluations around obesity: physical activity, nutrition; specific elements within nutrition around vegetable and fruit consumption, for example; and decreasing sugary drink consumption. Those are the sorts of longer term issues we are dealing with across the board.

Another component of the evaluation is to look at the whole-of-government approach and how that works in this way, because it is a novel approach and we want to know what we can learn from those things. That is another arm. Then there are more specific things related to the particular actions.

Much of the data we have is routinely collected data or things we collect for the Chief Health Officer's report, for example, on a routine basis. For other figures we have had to be a bit more novel as to how we collect them—for example, active travel use and so on. That plan is there. We have collected or are in the process of collecting baseline data. That will be reported on on a regular basis as the plan goes forward.

In terms of the web-based platform, there are two elements. I am not quite sure which one you are referring to, but I can talk to both of them.

MS FITZHARRIS: I thought there was one. If there are more—

Dr Kelly: In the plan there was a web-based platform for health professionals so that as part of their preventive focus on obesity they would be able to recognise where people go, for example, for advice about nutrition or physical activity. There are a range of options there. That is in progress at the moment. We are doing very good collaborative work with the ACT Medicare Local—which is about to change its name, but that organisation.

The other web-based platform we are looking at is more about transparency of data. With the data we have and report on every two years in the Chief Health Officer's report, we are looking to make that more openly available. It goes with the whole-of-government approach to transparency and openness of data.

They are the two that are progressing at the moment.

MS FITZHARRIS: Is one of those available to the general community to use?

Dr Kelly: Yes. The second one about the data would be available broadly. One of the issues is to make sure it is confidential and all of that. But in general terms, that will be available to anyone. This is based on similar platforms we have observed in other parts of the world—and some in Australia.

The other one is more focused towards particularly GPs and other primary care practitioners, to be used as part of the preventive approach and to support their preventive approach.

Mr Hanson asked about the bariatric surgery and where the 13 number might have come from. I would like to remind the committee that we are dealing with an issue that is affecting 180,000 people in our jurisdiction—overweight and obesity. Not a lot of those would be eligible or would be wanting or looking to have bariatric surgery, but as an issue this is a major one and we need to look at prevention rather than cure as the main component.

MS FITZHARRIS: In terms of evaluation, is it fair to say that ultimately the measure of success is pretty simple—fewer people overweight? Or is there more to it than that in very simple terms?

Dr Kelly: In simple terms that is the main one. To get to that, as was said in the preamble of the plan, is a marathon, not a sprint. It has taken us a generation to get to where we are; it will take a generation to get back to where we should be in relation to healthy weight. There are a whole range of measures we can look at on the way. The evaluation plan is really based on that—what we can measure in the first year, the second year and so on.

MS FITZHARRIS: I know there are health checks for kindy kids across all schools. Is there a subsequent one later on as they get older?

Dr Kelly: Yes. The kindy screen you are referring to—as children come into their first year of school, there is a check—is not compulsory, but we have a very high uptake; over 90 per cent of kids go through that screen. It looks at a whole range of things, including weight. So there is that measure. We have surveys, which are not as comprehensive. At year 6 level, we have a survey—which is a survey, not a measurement. We ask kids at that time, or their parents, to report on their weight and height. There are other similar ones in our general health survey and other methods that are used; for example, the Australian Bureau of Statistics and AIHW both have their own surveys. We can gather all of that information and use it for ACT-specific purposes.

MS FITZHARRIS: What is the take-up of the year 6 survey?

Dr Kelly: I think it is around 1,000 kids across a number of schools. We go out in conjunction with the Education and Training Directorate and we get a list of schools and approach them for their agreement to do this survey. Kids in schools are surveyed a lot, so we have to be cognisant that this is not the only one. Through that, we get a list of schools, and then we sample from within those schools. That is how we get our data. It is about 1,000 kids per year—sometimes a bit more, sometimes a bit less.

THE CHAIR: A supplementary from Dr Bourke.

DR BOURKE: Thank you, chair. What treatment modalities are offered in the obesity clinic?

Prof Abhayaratna: I have helped out with the obesity clinic as a consultant. I would also like to address some of the questions previously asked, if you do not mind. At the moment the obesity management service has a waiting list, which is about 250 people. With the new staff, particularly the medical staff, it is likely that we will be able to get through that list and also meet demand within the next nine months. But the issue is a bit more complex. The referrals do not necessarily have to go through medical management. Indeed, most of the referrals require the multidisciplinary team to provide input and do not require further medical input.

Most of these staff that I am talking about are allied health staff—dieticians, physiotherapists and psychologists. Patients have been referred by primary care and medical specialists to the service and already have medical input. It is about getting the patients to reach a healthy weight or at least attempt to reach a healthy weight. We are talking about people who have BMIs of greater than 40—very large and overweight persons—people who sometimes do not have any comorbidities but who often do have very complex medical histories.

Therefore, the service provides input into patients who are complex, who are frequently readmitted to hospital and, therefore, who do not necessarily get access to allied health. And the value-add comes from allied health. There is a group of people who have very few comorbidities and who require a pathway into bariatric surgery. Those people are a very select group and have to be carefully chosen. There is the ability for those patients to have bariatric surgery in the private system. The initiatives that you have talked about, Mr Hanson, relate to the public access. Obviously, we will

not be able to completely meet the demand and we have to be very selective with screening. That is one of the purposes of the obesity management service.

MR HANSON: That is really useful information. When you said that it would not completely meet the demand, I was trying to get a quantum of that. Is the demand 14 people or is the demand 340 people? Is that 13 a drop in the ocean or is it satisfying the demand broadly?

Prof Abhayaratna: I go back to the response that Mr Thompson gave. What we have tried to do in the public sector is provide or initiate a service that can at least meet the demand for a similar proportion of patients for our population per capita. That is a start. What I have seen as a clinician as part of that team is that it is certainly not a pathway for all patients. I would not want, as Mr Thompson said, for this to be a pathway that patients go to in first instance. You have to select and also go through a series of pathways for screening.

MR HANSON: Agreed. I accept all those points. I suppose that ultimately, though, after people have gone through all those pathways, come to that point, the last option, perhaps, is surgery. How many people then are we finding not available for private surgery, for whatever reason, that would fit the requirement for bariatric surgery? The figure is 13. How close is that to meeting demand? I am not saying that there should be more.

Prof Abhayaratna: No, no.

MR HANSON: I am just trying to get some sort of sense of it.

Prof Abhayaratna: Sure. Unfortunately, I cannot give you a simple answer to that. What I would say is that there is a whole series of interventions; some of them related to dietary interventions, others related exercise, some of which staff have contributed to in the international literature. The outcomes that are achieved with those interventions are sometimes as good as bariatric surgery interventions. One has to remember also that there is a huge range of bariatric surgery offered that also has differing outcomes. We need to be careful about the surgery that is tailored for the patient's need. I am sorry I cannot give you a simple answer but there is no simple answer. I do not think anyone in the world would be able to provide you with that as a simple yes or no.

THE CHAIR: We might have to leave it there, and thank you for your answer. If Mr Hanson has more questions, perhaps he might ask for a briefing through the minister, but we need to move on. Members, if we could finish public health by 3.30 that would be good. Dr Bourke, a new question.

DR BOURKE: I had some more supplementaries.

THE CHAIR: Professor Abhayaratna, if you could please return, Dr Bourke would like to use his option to ask supplementaries.

DR BOURKE: I believe that Mr Hanson was asking about evaluation of the bariatric surgery that will be taking place in the obesity clinic, 13 cases a year. What sort of

value would you achieve from that evaluation, given that you have already got the NHMRC clinical guidelines for treatment of obesity and overweight?

Prof Abhayaratna: I think the evaluation for that sort of number—when a service is just starting, the most important evaluation will be safety. Internationally it has been recognised that bariatric surgery should be offered only if there is a very low mortality rate with that service, because we are talking about people who are—if I may remind everyone, the type of patients that are selected for bariatric surgery are the ones who are the very low comorbidities. They are otherwise relatively healthy from the list of medications and list of medical issues that they have got; there are very few medical issues. These are the people who are pre-diabetic and are at risk of having a whole lot of obesity-related issues. So they have a low mortality rate over the next five years. It is extremely important that we have a surgical pathway which results in very low death rates. That would be the one that I would be able to provide back.

DR BOURKE: What you are saying is that you are not so much evaluating the treatment as you are evaluating the team?

Prof Abhayaratna: Indeed, yes, and to some extent the process of filtering the right patients who could safely go through the procedure and benefit from outcomes. Interestingly, some of these outcomes are dramatic with the bariatric surgery. With people who are pre-diabetic or diabetic on medications, their sugar levels normalise overnight. It has an incredible paracrine effect. We can certainly look at all of those things but they are probably lower in terms of our need to evaluate safety, which is the most important thing, I think

DR BOURKE: You mentioned psychologists and dieticians as part of your allied health team. What about the social determinants of health and their impact upon obesity?

Prof Abhayaratna: Yes, this form of treatment and the obesity management service would really, hopefully, be something that in a generation's time would not be required, except for very unusual endocrine conditions. The preventative efforts that Dr Kelly has mentioned previously need to be very much implemented to prevent what is happening on the other side, where we see obesity-related illnesses in hospital.

DR BOURKE: What I am talking about is the linkages between poverty—

Prof Abhayaratna: Right.

DR BOURKE: lack of education, social exclusion and obesity and whether those are areas where your obesity clinic is actually using perhaps a whole-of-government approach to manage people?

Prof Abhayaratna: Certainly, our area is not doing that, but Dr Kelly's area and the intergovernmental collaborations are certainly addressing that. But, no, it is not something that the obesity management service is doing. It is not within its remit. It is getting patients referred to them and dealing with the individual patients.

THE CHAIR: Does anyone have a final question for the last four minutes?

MR HANSON: I have a quick one on breast screening.

THE CHAIR: Yes.

MR HANSON: We always seem to struggle to meet targets in the ACT. I am wondering where those results are at the moment and—

THE CHAIR: Is that more appropriate for cancer services, which we will get to after the break?

MR HANSON: Sorry, it is, yes.

THE CHAIR: Is there a last question on public health services?

MR HANSON: I was probably moving ahead.

MS FITZHARRIS: What other broad population health risks are we looking like facing over the next five years?

Mr Corbell: I think Dr Kelly might be able to give some of the detail. Overwhelmingly, I would simply say to you, Ms Fitzharris, that overweight and obesity, when you look at the sheer volume of people who are affected, has to be considered number one. There are a range of diseases like cancer and others that continue to have very high levels of morbidity and mortality, but they are often driven by lifestyle-related factors. Dr Kelly can give you a very quick synopsis.

Dr Kelly: In 2½ minutes; thank you again for the question. I think the Chief Health Officer's report that will be due again about this time next year, as it is every two years, will outline some of those issues. But from the last one, the things that came forward very clearly as risk factor/disease issues at the moment are obesity, as has been mentioned; smoking continues to be there, particularly in certain groups as we mentioned earlier—in Aboriginal and Torres Strait Islander people, particularly young women who are pregnant. Injury is another thing I think we need to start looking at, and to tease out what are the causes of injury, particularly how it affects the emergency departments. Mental health, and there is quite a lot of discussion that is happening about that. I suppose that they are some of the issues that we should be dealing with.

There are old diseases and old issues that are not going away, particularly the issues we have had with our preparedness for Ebola, for example, over the last few months and with the middle eastern respiratory syndrome which has now bobbed up in Korea quite dramatically in the last few weeks. We need that preparedness for infectious diseases to continue and we will continue to do work in that regard. There might be a new disease around the corner that we have not seen yet. We need to make sure that our hospital services and our public health services are ready for that eventuality. I have probably exhausted my two minutes.

THE CHAIR: With that, thank you Dr Kelly. We will finish the session there. Minister, we have now finished—I am not sure we have finished but we have used up

all our time for mental health, justice health, and alcohol and drugs health services as well as public health services. We will resume at 3.45 with cancer services, with Dr Bourke getting the call.

Sitting suspended from 3.28 to 3.45 pm.

THE CHAIR: We will resume this afternoon's hearing with output class 1.4, cancer services. Dr Bourke, you have the call.

DR BOURKE: The strategic priorities for cancer services in the budget include screening and early detection. The output reveals that in 2014-15 the estimated outcome of 15,000 breast screens was 500 short of the 2014-15 target. How will the additional funding help achieve the 2015-16 target?

Mr Thompson: There are two aspects to the issue of achieving the targets. The first is that the activity of breast screening is dependent on the take-up and we have had difficulties in the past attracting women, particularly in the eligible age group, to sign up for the breast screening. Towards the end of last year we had access to the electoral roll and we are now sending out routine letters to all women within the age group to remind them of their eligibility and the desirability of them attending for breast screening. We are seeking to increase the take-up that way. To date over 5,000 letters have gone out and we will continue that strategy.

We are also sending letters directly to lapsed attendees, people who have had screens in the past but have not attended for their routine follow-up, as well as trying to contact women directly by phone. That is one aspect of the issue in terms of meeting the demand.

The other aspect is looking at access and with the new Belconnen health centre we have the opportunity to set up another breast screening location there. Through the funding that is particularly being provided by the commonwealth to expand the target age group to include 70 to 74-year-old women we have been able to purchase an additional mammography machine and set up a space at the Belconnen community health centre to enable screening to be undertaken there. We think that will be attractive to women who live in the local area, as well as anyone who is concerned about getting into Civic and the logistics of that. Those are the two approaches that we are looking at to try to improve the screening rates.

DR BOURKE: This will encompass also those older women in the 50 to 69 age group who are more at risk of developing breast cancer?

Mr Thompson: Absolutely. The screening cohort is divided. It is a screening program, it is not a diagnostic mammography program and it is not targeted follow-up for people who have already been diagnosed or have been cleared of cancer and are at risk of relapse. But we have, within the cohort of women, women who have been identified for various reasons, frequently family history, to be at high risk and depending on their circumstances they will be on a more rapid recall—an annual recall instead of a two-yearly recall, as an example—to recognise their increased risk and to give them more active monitoring.

DR BOURKE: And what does the latest medical literature show about the effectiveness of breast screening and reducing mortality from cancer?

Mr Thompson: There is a lot of debate about this. In the ACT we follow very much the Australian national breast screening guidelines. It is a nationally funded program. While there have been some studies that have raised questions about the effectiveness of breast screening, that is not the position that is currently accepted within Australia and as long as the Australian position remains that it is of value and should be continued to be provided, we will do so.

DR BOURKE: Could you also update the committee on the operation of the Canberra Region Cancer Centre?

Mr Thompson: The Canberra Region Cancer Centre was established to provide a coordinated range of outpatient services for all people diagnosed with and needing treatment for cancer, drawing together services that had been more disparate prior to that, and as a regional service hub as well for people in the surrounding region. The feedback we get about that centre is very positive, from patients as well as staff. The centre is now fully operational. We are continuing to see a growth in cancer services, and that is one of the reasons of course that the government has provided additional resourcing to respond to that growth. Overall it is being received very positively and is functioning well.

DR BOURKE: Is the central intake service in place?

Mr Thompson: That is one of the initiatives we were looking at in this budget. Some of the other initiatives that we have put in place are a rapid assessment clinic to enable people to access that clinic as opposed to going to the emergency department—a streamlined service there. The overall multidisciplinary approach of the centre is another of the positives.

DR BOURKE: And when will more specialists be available at the cancer centre?

Mr Thompson: At the moment we are fully recruited for medical specialists. Yes, that is correct. We are fully recruited for medical specialists. With the growth, we are in the process of determining the right allocation of the growth funding and the distribution across different professional groups. We have not got a final answer as to the exact deployment but in line with the increased demand we would expect that we will be increasing medical staffing associated with that.

MR HANSON: Is the new mammography machine in Belconnen going to be operating full time, or is it limited hours of operation, or—

Mr Thompson: Three days a week.

MR HANSON: That is one staff member, is it, then, or how many staff operate the mammography machine?

Mr Thompson: To physically operate the machine, you need one staff member at a time but it needs to have a reception capacity as well. There will be more than one

staff member employed there.

MR HANSON: And that machine, you said, was funded jointly by the commonwealth and the ACT?

Mr Thompson: What we have signed up to with the commonwealth is increasing activity targets to accommodate the expansion of the target group to include women aged 70 to 74 years. There is an amount of funding that was provided for that, and within that we have already devoted some of the funding which can be used to establish a new machine. That is very consistent with the idea of expanding the services, and it has given us the opportunity that had not been available previously.

MR HANSON: How much do these machines cost?

Mr Thompson: This one costs about $400,000, I am told.

THE CHAIR: A new question, Ms Lawder.

MS LAWDER: Actually, it is a bit of a follow-up. I just wondered whether you were considering adopting the national target of 70 per cent for the breast screen.

Mr Thompson: That is the national target. Across the country, jurisdictions struggle to meet that target. As I explained earlier, we are looking at every avenue we can think of to increase take-up but have not seen, particularly with the electoral roll, the full impact of that. Until we understand whether or not that is going to be a successful means to increase people accessing the service we have decided to leave the target unchanged.

MS LAWDER: On the ACT Health website, under "our services", it is difficult to see where breast screening comes in. What area does it appear under?

Mr Thompson: Breast screening is within the cancer, ambulatory and community health services division of Canberra Hospital and health services.

MS LAWDER: It is just that on this particular page, where it has got "our services", under "cancer" it is not actually listed there. Unless you search—

Mr Corbell: I am sure if you searched "breast screening" you would find it.

MS LAWDER: I did. It also then had the address in Moore Street, I think, and said you could have it in the city or Phillip. But if you search for Phillip you cannot find an address in Phillip. Is it the central intake service ?

Mr Thompson: There is a single line to receive appointments, and appointments can be provided at both centres, Phillip and Civic currently, and soon Belconnen. We are not anticipating separate access points for all three, because we do not think that would be the most efficient way of doing it.

MS LAWDER: It is just that when you put it in the system, it does not say to go to or call the one in the city. If I look up BreastScreen ACT Phillip, there is no result.

Mr Corbell: We will have a look.

MR HANSON: Just to clarify there, you have got one machine in Civic, one in Phillip and one opening?

Mr Thompson: That is correct.

THE CHAIR: Mr Hanson, a new question?

MR HANSON: Yes, thanks. On the issue of paediatric oncology, at the moment there are not many services offered at all. Is there anything offered here or is it all by referral to Sydney?

Mr Thompson: I will ask Denise Lamb to talk in more detail. The general issue here is one of critical mass and maintenance of clinical skills. Where we are dealing with very low numbers, it is difficult for people who have those skills to maintain the skills in an isolated centre. There are difficult approaches typically taken to address this issue. One is that at times we organise visiting services, and that would be something we would look at. That is dependent on their availability to visit here. Where that is not possible, it is usually a matter of accessing services in Sydney. I am sure Denise can talk more about it.

Ms Lamb: As Mr Thompson identified, with paediatric oncology, there are very small numbers in the ACT. For safety of care, it is better to treat people in a centre of excellence. So children will go to Sydney for their initial treatment and ongoing treatment; then at times when they are able to come back to the ACT the paediatric service will provide ongoing monitoring and care. There is an age group, the 16 to 18-year-olds, that move between paediatrics and adult services. They can be treated within our cancer centre and cancer service, depending on their type of disease.

MR HANSON: I guess there are other cancers which are rarer; for things like prostate cancer or breast cancer unfortunately there is high demand and you can create a centre of excellence. For what other cancers are people then referred to Sydney or elsewhere to be managed?

Ms Lamb: Most cancers can be treated here in the ACT. There are some very rare gastric cancers that tend to get referred to Sydney—again because there are very small numbers and they are better off being treated in one central place. We are unsure of numbers because there is also a practice from the private sector that they at times will refer to Sydney from historical referral pathways.

MR HANSON: There was an issue a few years ago with radiotherapists; there was a lack of radiotherapists which meant that people were going to Sydney. Basically there was a shortfall in staff here. Has that been addressed, so that we do not have that issue anymore?

Ms Lamb: We are completely recruited in radiation therapists and radiation oncologists. So there is no referral to New South Wales at all for ACT patients.

MR HANSON: That is all I had in that area.

MS FITZHARRIS: I have a supplementary. On the paediatric oncology, for those families who do go to Sydney, I know that often the financial burden on them becomes very high. Is there anything specific in place in terms of ACT government support that is provided through Health that can support them while they are—

Mr Corbell: Yes.

MS FITZHARRIS: What sorts of things?

Ms Lamb: Certainly, the ACT government funds the Eden Monaro cancer support service. The role of that organisation is to support families, and in particular if they have to travel for any type of care.

MS FITZHARRIS: Can you tell us a little bit about what that involves?

Mr Thompson: Just before Denise goes into that, there is also the interstate patient travel assistance scheme that we administer. That provides reimbursement for some of the costs of travel as well.

MS FITZHARRIS: That information is provided; families do not have to seek that out?

Ms Lamb: Yes.

THE CHAIR: In terms of deaths from cancer, what are the cancers that cause the most death in the ACT? When we get Dr Kelly to answer that question, what do we have in place to address those? We have a big focus on breast screening, which is entirely appropriate, but what about cervical, ovarian and prostate?

Dr Kelly: The question was about mortality. The common cancers in the ACT are the same as they are in the rest of Australia—breast for women, prostate for men, lung for both and colorectal cancer for both. They are the main ones. Melanoma is another one that is of interest and is close to the top five. What was the other question?

THE CHAIR: Rightly so, we have a large focus on screening for breast cancer, but is there a strategy to make people aware of, for instance, how to have good prostate health, good lung health, good colorectal health? Are we seeing numbers of sufferers go down as a consequence of those programs or do we not have a coordinated overall strategy to address all cancers?

Dr Kelly: That is a good question; thanks, Mr Smyth. There are a couple of strands there. One, to feel like a bit of a broken record, is that obesity is a risk factor for multiple cancers, including all of the above mentioned other than lung. Lung, of course, is predominantly driven by smoking. So the general principles that we have talked about already in the other output classes in terms of prevention of obesity, good nutrition and antismoking messages all go into prevention. In terms of screening, we have talked about breast screening. The cervical screening program is another one. Cervical cancer is, luckily, a very rare cancer in the ACT but it is another component

of our program nationally. The national government also—

THE CHAIR: Is that because of urging women to have regular smears?

Dr Kelly: Pap smears at the moment. There are moves afoot to change the approach to that over the next couple of years, but there will continue to be a screening program. The ACT government's role in that is running the cancer registry. There are promotion messages to both women and practitioners to make sure they are following a similar process to what we have with breast screening, but with a slightly different age group. In terms of colorectal cancer, the other big component there is the screening program which is run at the national level. So there is a national screening program for that. Melanoma, which I also mentioned, is one of the skin cancers. "Slip, slop, slap" and other similar campaigns have been running for many years and continue to be run here.

THE CHAIR: Thank you. Ms Fitzharris.

MS FITZHARRIS: In terms of early detection, where does that most often happen? Is it most often at your GP surgery, at home?

Dr Kelly: Early detection of which particular cancer?

MS FITZHARRIS: Any, in general terms, and then the links between GPs and the cancer services and hospitals.

Dr Kelly: For the cancer services, I will need to do a quick swap again. In terms of primary care, I can talk to that. It is very dependent on the type of cancer. ACT Health and the population health area would encourage people to seek the advice of their general practitioner in the first instance. There are a range of measures that GPs can put in place, including referral for cancer services if that is required. I am not sure whether that answers your question.

MS FITZHARRIS: In terms of the output classes, a key strategic priority is early detection.

Dr Kelly: Yes.

MS FITZHARRIS: In general terms—this is certainly not a technical term—what about the assistance of Dr Google? Do you notice any impact from that in terms of public health?

Dr Kelly: Dr Google is an interesting one. It can be helpful. Self-diagnosis is certainly one of the ways that means they then go to primary carers or a referral pathway to the cancer services or other related matters. I suppose you could put it into two classes—possibly three including Dr Google. The first is the screening programs that are more formal and which is a regular screening for a particular thing—breast, cervical and colon cancer, for those three in particular. Then there would be general alerts that would go to people to self-diagnose in some way. That may include internet searches to assist people's concerns. The third one would be a regular check-up of some sort from their general practitioner.

THE CHAIR: We will move on to the next output class, which is rehabilitation, aged and community care. Dr Bourke, you are the next cab off the rank.

DR BOURKE: Let us talk about hospital in the home funding, minister. What is in this budget and what are we doing about it?

Mr Corbell: Hospital in the home is a very effective program that allows people to undertake a good part of their rehabilitation following surgery or other treatment in the home. Obviously the home environment is very conducive to people's recovery, as long as they are supported with the clinical care that they need. The hospital in the home service provides both medical and nursing support, as appropriate, in the home environment.

We are increasing the capacity of the hospital in the home program to see more people receive that care. The funding in this year's budget will allow for the expansion to see an additional two full-time equivalent nursing positions at Canberra Hospital. That is to expand hospital in the home by six bed equivalents across both public hospitals. That is a very important expansion of the hospital in the home service.

DR BOURKE: Does the service currently meet the demand for the service from the community?

Mr Thompson: Broadly speaking, yes, but like most of our services there is continuing growth and opportunity for expansion in the service. In terms of the question of demand, one of the objectives of hospital in the home is to reduce the pressure on beds within the hospital. We are not saying that these are not services that are currently being provided; all we are saying is there is an opportunity, in transferring them into a hospital in the home program, to reduce or even sometimes avoid a physical hospital admission, thereby freeing up the capacity within the hospital and the hospital beds for other activity.

DR BOURKE: Given that you are constructing a subacute hospital, how will it interact with the hospital in the home service?

Mr Thompson: It is a different cohort of clients, essentially, that we are talking about. We are not expecting the subacute hospital to have any direct impact on the hospital in the home service.

DR BOURKE: Or vice versa?

Mr Thompson: Yes.

MR HANSON: Can I have a supplementary, please?

THE CHAIR: Yes, Mr Hanson.

MR HANSON: The two nurses are six bed equivalents. Is there a formula for that? Generally speaking, is it a third of an FTE nurse for a bed? And then I assume that once you have a certain mass, you need a doctor or other staff as well. Is that the

case? What is the formula?

Mr Thompson: I will need to take the exact formula on notice, but it is essentially a measure of—

MR HANSON: The formula is an easy one.

Mr Thompson: Have you got the formula, Ms Croome?

Ms Croome: There is a formula for working out nursing FTEs. It is based on the number of hours of operation. If you were staffing a 24-hour a day seven-day a week service, you would have a formula based on those hours and a workload methodology that we use to determine FTE. In hospital in the home, the service does not run for 24 hours a day seven days a week, so you would adjust the formula, based on the number of bed equivalents and the number of hours you were running the service for. With six beds, for the time that those patients were being visited by a nursing staff member, which generally, in a hospital in the home service, would be on a morning shift and an evening shift, but not overnight, you would work out the FTE. While I have not done the exercise, two FTEs sounds about right for six beds.

MR HANSON: At what stage do you then say, "This service is not just nurses; there are other medical staff as well?" I am probably asking you the wrong question as the Chief Nurse, but is there a similar sort of ratio for doctors—one doctor for every 10 beds or something like that? What is the ratio there? Is there a doctor here who has the magic pudding for doctors?

Prof Abhayaratna: The model of care in hospital in the home is quite different. The medical staff exist in the various subspecialty units. They continue to care for the patient even though the patient is placed in the home. Those staff exist and there is no need to increase the number of those staff. What has happened since the 2012 initiatives to increase the services in hospital in the home is that we have been able to fund a medical registrar who can assess the patients in their home rather than getting them back into the hospital to be assessed. So we have had some increase in medical staffing.

MR HANSON: This takes us to a total number of hospital in the home beds. I do not know what that number is across Calvary and Canberra Hospital. Do you have that total number?

Prof Abhayaratna: It is again a bit more complicated, because some patients require more than one visit at home per day. It is a matter of occasions of service that we can cope with. At the moment it is about 180 occasions of service.

MR HANSON: Do 180 occasions of service equal 180 beds?

Prof Abhayaratna: No. So some patients may require up to three visits.

MR HANSON: But in terms of the classification of the number of hospital in the home beds, we have said it is six today. What is now the total number of hospital in the home beds? I appreciate that it is an aggregate, because some might get one

occasion of service and some might get four or something like that; I do not know. But what is the total number of hospital in the home beds? And then, for that, across Calvary and the Canberra Hospital, what is the total number of nurses and the total number of doctors? Maybe you can take that on notice?

Prof Abhayaratna: Yes, please.

MR HANSON: The total number of beds and then essentially the staff associated with that.

Prof Abhayaratna: Okay; we will take that on notice.

MR HANSON: That would be great. Thank you very much.

THE CHAIR: Have you finished?

DR BOURKE: No, not this area. Turning to strategic objective 13, minister, you managed to achieve a reduction in DMFT between year 6 and year 12. How have you got that?

Mr Thompson: Currently the rates are measured through the child dental health survey. The most recent rates we have in relation to the survey are for 2009. The 2013-14 survey has recently been conducted, but the national results are not yet available for publication. Within ACT Health, we have a dental health program that has a specific focus with staff specifically dedicated to look after the dental health of children. The activity in that service and the waiting time for that service have been reduced substantially over recent years, currently sitting, overall, at about six months. One part of it is provision of restorative dental services, but equally, within that, there are health promotion messages aimed at educating children about dental health and what they can do.

DR BOURKE: Can I suggest that the actual reason there is a difference is that the index at six years is little DMFT, which equates to deciduous teeth, not permanent teeth, which is the index at year 12. So perhaps you need to do some more correction to your papers there. A more interesting measure might be D versus M—that is, decay versus missing and filled. Is that data available?

Mr Thompson: I would need to take that on notice.

DR BOURKE: That would be a measure of the effectiveness of the intervention and actual treatment rather than the preventative treatment programs, primarily water fluoridation, which is probably the public health measure of the 20th century that is best known.

We might turn to strategic objective 2 on page 3 of your budget statement, "No waiting for access to emergency dental health services". What budget measures are the government taking to ensure the waiting time to access emergency dental services is less than 24 hours?

Mr Thompson: There is not a specific budget measure in this budget linked to that.

The most recent change in this area is the intergovernmental agreement from the commonwealth to support additional activity within dental services. The commonwealth has renewed that in the most recent budget, and that continues to be available to the ACT. We have within the dental health program a range of different interventions that are used—emergency, which this one is talking about, as well as restorative dentures et cetera. To identify and respond to the most urgent emergency persons, we have a triage process, which has now been in place for several years and has proved very successful at being able to identify clients who need the care most rapidly and those clients who, while they have an emergency, can wait for a bit longer. That is the primary intervention that we use to address this particular indicator.

DR BOURKE: How does that service operate on the weekend?

Mr Thompson: That service is available seven days a week and is available as triage.

DR BOURKE: So you are operating emergency dental services seven days a week?

Mr Thompson: In terms of the actual emergencies, we also provide emergency dental services through the emergency departments.

DR BOURKE: Thank you.

THE CHAIR: Ms Lawder, any questions?

MS LAWDER: Thanks. In previous years, there was a strategic objective "Maintaining the waiting times for in-hospital assessments by the aged care assessment team". That has been dropped. Can you talk about the reasons why that measure was dropped?

Mr Thompson: The aged care assessment program is a commonwealth-funded program, and the commonwealth establish the parameters around that program. They have recently changed some of the ways that program is measured in some of the priorities within that program, which means that there really is not a specific category that looks at in-hospital assessment. We have aligned our indicators to the commonwealth's expectation; accordingly, we do not report on that indicator.

MS LAWDER: So you have aligned your indicator to the commonwealth indicator. Is that reported in the year somewhere?

Mr Thompson: We do not have it as a specific strategic indicator, no.

MS LAWDER: Will it be available in the annual report somewhere?

Mr Thompson: The indicators that are in the budget papers are what we will be reporting in the annual report.

MS LAWDER: So it will not be in the annual report. Surely it does have a bit of an effect on the availability of beds et cetera in the hospital.

Mr Thompson: Aged care assessment is important; as I said, it is a commonwealth-

funded program with commonwealth expectations. The staff and the delivery of it are ours. We work very closely with the aged care assessment teams to ensure that we get timely assessment within hospital, within the priority categories the commonwealth has stipulated.

MS LAWDER: Is the commonwealth indicator two days, as this one used to be?

Mr Thompson: The commonwealth do not have the indicator for assessment within hospital. They have priority according to an assessment of client needs as opposed to the location that the client is in.

MS LAWDER: Thanks.

THE CHAIR: Mr Doszpot, welcome.

MR DOSZPOT: Thank you very much, Mr Chair; I accept your welcome. I ask a question, through the minister, with regard to the HAAS pilot program. I understand the HAAS pilot program is currently being trialled in some mainstream schools and it is jointly run by Health and education. Minister, can you confirm which is the lead directorate in this trial?

Mr Corbell: ACT Health is responsible for the employment and administration of the nursing service that is provided at the schools, and it is done in collaboration with the education directorate.

MR DOSZPOT: What is the time frame that has been set out for the pilot program?

Mr Thompson: The program is currently under review. We are expecting to complete that review and report back to the Assembly by the last sitting day in August.

MR DOSZPOT: Can you confirm for me which schools are taking part in this trial?

Mr Thompson: I do not have with me the full list of all schools that currently have students who have enrolled in the program. The program is available to all public schools should they have students who would be eligible and benefit from the program.

MR DOSZPOT: You are the lead directorate in this?

Mr Corbell: Yes. Your question relates to mainstream schools, as I understand it; is that correct?

MR DOSZPOT: Yes, it is.

Mr Corbell: As Mr Thompson indicates, it would depend on whether or not a student who needs those services has enrolled in a mainstream school. We can take that on notice and provide you with that detail, but obviously that is a changing picture in terms of enrolment in mainstream schools as opposed to special school settings.

MR DOSZPOT: Can you indicate to me how many schools are involved?

Mr Corbell: I have indicated to you, Mr Doszpot, that we will take it on notice.

MR DOSZPOT: I would appreciate the number of schools and the names of those schools.

Mr Corbell: Yes.

MR DOSZPOT: Was it Health or ETD that initiated this pilot?

Mr Corbell: It is the Health Directorate's service.

MR DOSZPOT: What evidence drove the decision to make changes to the previously existing arrangements?

Mr Thompson: This was based on the increasing demand and the need to look at the most effective way to provide for the increasing demand. We looked at services that had been successful in operating interstate and used that model to form the basis of the development of our program.

MR DOSZPOT: Were there any reasons based on the feedback from nurses that were employed in doing this particular task?

Mr Thompson: We have in the past had difficulties in maintaining staffing—those nurses that were specifically assigned to schools. That was one of the factors that we looked at when it came to the question of how we could maintain a sustainable service over time and respond to the demand.

MR DOSZPOT: There are a number of teachers who I understand are quite concerned about this proposed trial and aspects of it. How do you differentiate between the issues that are cropping up from a teaching point of view as opposed to a nursing point of view—in other words, the impact on the teachers? Do you handle those issues or do you get the education directorate to look at that?

Mr Thompson: I am not quite sure what you mean by issues for the teachers.

MR DOSZPOT: To do with what teachers are required to do under their duty arrangements as teachers.

Mr Thompson: With the HAAS program, each student who is referred to the program is assessed by a registered nurse, supported by a paediatrician. Following that assessment, a range of activities are identified that are needed to support the student to continue within the school. That range of duties will be able to be met by staff with different skill levels. For those duties that require a registered nurse to provide them, a registered nurse will provide them. For those duties that do not require a registered nurse to provide them, the approach has been to seek what we call volunteer HAAS workers within the schools who are interested in receiving training to undertake those duties. The training is provided by a registered nurse, and the registered nurse signs off when they believe the HAAS worker is competent to undertake those duties.

Within the HAAS care plan there are escalation processes about what to do if things do not go according to plan, and at times that will involve additional support from a nurse. At times that will involve the much more significant emergency response of calling an ambulance. The HAAS care plans do not specify a role for a teacher, unless a teacher has volunteered and been identified as the HAAS worker to provide that role.

MR DOSZPOT: Can you just confirm the starting date for this program?

Mr Thompson: The program commenced in 2014. Again, I do not have the exact date when the first child was assessed. I can take that on notice.

MR DOSZPOT: Can you indicate whether it was first term, second term, third term?

Mr Corbell: We can take that on notice, Mr Doszpot.

MR DOSZPOT: Thank you. I understand that you are currently conducting additional consultation with parents, teachers and nurses. Why was this consultation not done prior to starting the process?

Mr Thompson: Consultation was done prior to starting the process.

MR DOSZPOT: How come you are consulting again?

Mr Corbell: Because of the Assembly resolution, Mr Doszpot.

MR DOSZPOT: But the Assembly resolution was based on complaints, and those complaints should have been understood when the previous consultation was conducted.

Mr Corbell: Perhaps it would be helpful if Mr Thompson gave you some context around what occurred in the earlier consultation process. Just because you undertake consultation does not necessarily mean that there is 100 per cent agreement on the proposal. It is worth highlighting that there was a pilot undertaken in relation to HAAS in 2012 and there was subsequently consultation before the program was implemented in the school setting. Mr Thompson can give you some context around that consultation exercise.

THE CHAIR: Minister, just for the record, for *Hansard*, HAAS stands for?

Mr Corbell: Healthcare access at school program.

Mr Thompson: The first round of consultation commenced in 2012, as the minister said. Based on that consultation and review of evidence elsewhere, the proposed parameters of the program were drawn up. Further consultation took place in 2014 prior to the enrolment of any students and the implementation of the program in any schools. That involved consultation with the school community. It also involved consultation with parents. Each care plan is developed in consultation with parents and they sign off on the care plan, as well as the registered nurse and the paediatrician.

MR DOSZPOT: As I understand it, when the original HAAS program started—on whatever date it was that you will come back to us on—there were severe impacts on teachers and some nurses. Teachers were traumatised because they were being asked to do work that they should not have had to do in health terms. Surely those issues would have been understood a bit better before you started such a program?

Mr Thompson: The HAAS program involves, as I explained earlier, identification of a range of duties and who would conduct those duties, and training for people to conduct those duties. That is the process that has been involved in the care plan. The HAAS workers who have been based in schools were asked whether they were willing to take on these roles. It was a volunteer process; it was not required of anyone. That is the way the process has worked.

MR DOSZPOT: Are you on track to report back to the Assembly by the date that you have mentioned?

Mr Corbell: Yes.

MR DOSZPOT: So we can expect that on that date?

Mr Corbell: Yes.

THE CHAIR: Dr Bourke has a supplementary, as do I.

DR BOURKE: Thank you, chair. Mr Thompson, you mentioned some successful interstate services with this particular program. Which jurisdictions were you referring to?

Mr Thompson: Predominantly Queensland and South Australia.

DR BOURKE: Queensland and South Australia. Who performs these services for students when they are not at school?

Mr Thompson: For those that do not require a registered health professional, in most instances a registered nurse. It is usually the parents or guardians.

DR BOURKE: So it is parents or guardians when they are at home?

Mr Corbell: The point is well made, Dr Bourke, that in most instances, if it was outside the school setting, the care would be provided by the parent or their carer, their guardian.

THE CHAIR: You mentioned that you have had difficulty in keeping the nursing staff. Have you ascertained why it is difficult to keep the staff in these positions?

Mr Thompson: One of the significant points is that a large proportion of the activities that nurses had previously been engaged in within the schools were not technical nursing duties within the usual scope of practice for nurses. Nurses, like other registered health professionals, are required to maintain their skills and to have currency of practice. In circumstances where they are not using their nursing skills on

a full-time or regular basis it can create questions of professional satisfaction and challenge and also whether or not they can maintain currency of practice for registration purposes.

THE CHAIR: Mr Doszpot, are you finished?

MR DOSZPOT: I am for the time being. I would expect some of those questions to be taken on notice as soon as you can. Thank you.

THE CHAIR: Mr Hanson has a new question in this area.

MR HANSON: I have a question about the nurse-led walk-in centres. Is there an update on how they are progressing? The figures are probably broken down between the two of them. So I have a bit of a sense of how they are going in terms of how many patients have been treated. Can you give us a breakdown on what the treatments were and what we have been able to achieve in terms of treatment versus referrals on to EDs, GPs or elsewhere.

Mr Corbell: The implementation of nurse-led walk-in centres has been a very successful one. In terms of presentations, we are seeing more people than ever before presenting and taking advantage of this service. Obviously, there has been an expansion in the number of centres and that is partly driving the increase. Year to date we have seen an increase of 83 per cent in the number of people presenting. That is year to date—April this year—compared to the previous financial year. That is a really very, very strong—

MR HANSON: What is that as a figure? Are we talking about 1 July through to April?

Mr Corbell: The figures in my brief may not relate to that more recent figure.

MR HANSON: I am trying to get sense of it.

Mr Corbell: But I will give you what I have. They relate to that figure. In the financial year 2010-11, we had approximately 15,200 presentations. In 2011-12, we had 17,450 presentations. In the financial year 2012-13, we had 19,142 presentations. In the financial year 2013-14, we had 19,687 presentations. In the financial year to date, 2014-15, we have had 27,452 presentations. That is a very, very strong level of uptake. I am very pleased that more Canberrans than ever before are getting access to nurse-led care in these centres.

MR HANSON: Is that 27,000 figure split roughly even between Tuggeranong and Belconnen?

Mr Thompson: Slightly more at Tuggeranong than Belconnen, but the gap is closing.

MR HANSON: I remember in the early days there was an advertising campaign. I guess that people were turning up to the nurse-led walk-in centre for things that could not be treated. I guess that there was an education issue. I know that that was part of the learnings from England. Has that steadied now so that people understand what it is

that they can get treatment for in a nurse-led walk-in centre? What number of people are turning up that clearly need to go somewhere else or who are referred somewhere else?

Mr Corbell: While Mr Thompson is looking that up, I can provide you, Mr Hanson, with some assessment of what the top 10 presenting issues are that people coming to the walk-in centres are presenting with. They are upper respiratory tract infections, wounds and lacerations, wound dressings, muscular or skeletal complaints, sore throat, ear wax, skin conditions, gastro or diarrhoea-related conditions, other respiratory conditions, and ear, nose or throat conditions.

MR HANSON: What is the percentage—is that what Mr Thompson is looking for?—of people who are referred twice?

Mr Corbell: Yes, he is looking for it. We will endeavour to get you something.

MR HANSON: It might be a little anecdotal, but are the staff comforted now that the message has got out that people are turning up appropriately to the nurse-led centre? That was one of the concerns that I remember was raised. There might be confusion or something like that. But you are confident that that confusion is not apparent, that people are pretty clear in the community through your advertising campaign?

Mr Corbell: Based on the advice I have received, and the figure provided to me by Mr Thompson, 68.3 per cent of all people who have presented are fully treated in the walk-in centre. So that is a pretty strong figure that indicates that the majority of people who are presenting are presenting with conditions that are suitable for treatment in the centre.

MR HANSON: I do not know if it is as easy to classify as this, but would you classify them as priority 5s for an ED, or are they 4s and 5s? Is it that easy to classify?

Mr Thompson: It is not that easy. Probably I think the best way to explain why it is not that easy is that within triage category 4 and 5 patients in the emergency department there is a percentage of each that will be admitted to hospital. Accordingly, almost by definition, they are not the clients that we would be expecting to present to a walk-in centre. So it is more complicated.

MR HANSON: Part of the rationale behind the nurse-led walk-in centres, as you are aware, is that they were intended to reduce demand at the emergency departments. But what we have seen in the corresponding period since the nurse-led walk-in centres have been established is actually an unexplained and exponential growth in presentations to ED. I am not saying that that is related. I am not saying that the nurse-led walk-in centres have created that growth. There are some that have asserted that. I think that Professor Richardson and others have sort of identified that correlation. But if the intent was that walk-in centres would reduce demand at the ED, but at the same time growth at EDs is significantly beyond expectations, how do you explain that?

Mr Corbell: I will ask Ms Croome if she would like to come up, in that she has caught my attention; so that may be a lesson.

THE CHAIR: Because somebody was very quick at slipping back to her seat and avoiding your attention.

Mr Corbell: I will let our chief nurse collect her thoughts, but in general terms it certainly was a consideration that if there were more alternatives easily available for people in the community to attend than the ED that may assist. But obviously we are dealing with a new service. It is difficult to completely predict how the population will respond to the provision of that service.

What is clear is that there are a large number of conditions that can be managed by a nurse practitioner and a very large number of Canberrans are getting the care they need, and receiving it appropriately, through the development of these centres. The increase in demand in our EDs remains a significant concern, but whether or not that would have occurred in any event, with or without the nurse-led walk-in centres, I guess is a matter for speculation. But I will ask Ms Croome if she wants to talk a bit more about that issue in some more context.

Ms Croome: Thanks for the question, Mr Hanson. The minister is absolutely right. It is very difficult to work out whether or not the presentations to the walk-in centre would otherwise have impacted in a reduction in presentations to the emergency department, because it is very hard to work out exactly how many patients would have presented to the emergency department anyway. Certainly in terms of the types of presentations to the walk-in centre, sometimes they are conditions that people would otherwise sit at home and recover from anyway, but perhaps take longer to do so and perhaps take time off work in terms of recovery.

I think from that perspective that the role of the nurse practitioner and the advanced practice nurse in being able to manage these conditions for people who do present to the walk-in centre has been very effective. A lot of them are young people who work and who come to the walk-in centre as a means of having certain conditions treated that have been caused at work or that have stopped them from attending work.

I think that the role of the nurse practitioner and the advanced practice nurse has been very effective in treating those conditions. They are one-off conditions. They are not recurrent illnesses that perhaps would see somebody more appropriately managed by their general practitioner and they are not serious issues that would cause someone to go in preference to the emergency department.

MR HANSON: The other rationale when these were set up was the shortage of GPs. Is this taking people away from GP practices? When you think about the funding, all the costs of visiting a nurse-led walk-in centre are borne by the ACT taxpayer, whereas visiting GPs, depending whether you are bulk-billed or not, is borne by the commonwealth. Have we just transferred the liability from the commonwealth towards us if these are patients who would otherwise be going to a GP?

Ms Croome: The waiting time to see a general practitioner for one-off illnesses and injuries may be longer than the time that it takes for that matter to resolve. I think the timeliness of access to care in relation to the service that the walk-in centre provides has been one of its highlights. There are great referral processes in place between the walk-in centre and the GPs. In fact, some of the GPs are now referring patients to the

walk-in centre. So I think it is a good collaborative arrangement that is now in place.

THE CHAIR: If you could finish now, Dr Bourke has a question.

MR HANSON: I have one last question, which is to clarify the figure. The 32 per cent of people that are not being treated—

Mr Corbell: Fully treated.

MR HANSON: Fully treated. Are they are being referred, I assume, to somewhere else? Where is that referral to? Is that to ED or somewhere else? Is there a breakdown of that 32 per cent?

Ms Croome: I do not have the breakdown with me, but there would be a breakdown. It is to the GP, it is to the emergency department or it might be to a community nursing service.

MR HANSON: Can I get a breakdown of that, please?

Mr Corbell: Yes. We can take that on notice.

THE CHAIR: Dr Bourke has a supplementary and then Ms Fitzharris on this issue.

DR BOURKE: Are we are fully utilising the capabilities of our nurse practitioners? Are there are further things that they could be doing that could be claimed under the Medicare schedule?

Ms Croome: That is a very good question. We have a good healthy number per capita of nurse practitioners here in the ACT. We have them working both in the public hospital system as well as in private practice. One of the things that has occurred since changes to the role of the nurse practitioner, in terms of access to PBS and MBS, has seen nurse practitioners become quite valuable commodities within general practice. I think from last count that it is five or six nurse practitioners who are working in general practice, alongside GPs, who are able to access MBS and PBS entitlements.

Within the public hospital system, that is not the case because the federal government made a decision some time ago that only nurse practitioners working in community environments, in rural and remote areas and in private practice could access MBS and PBS. Nonetheless, the role of the nurse practitioner in the public hospital system has proved very beneficial in some of the areas where we have them placed. We have them, for example, in rehabilitation medicine. We have the only nurse practitioner in the country working in rehabilitation medicine. She is doing a fantastic job.

We also have them in the walk-in centre, clearly. We also have them in other areas like women's health and in the sexual health unit. They are invaluable roles in terms of the service that they provide. But there are limitations on the role of nurse practitioners, and nurse practitioners will never be everything and anything to client groups, but they are very specialised in their area of expertise.

DR BOURKE: But could we utilise them to do more things in walk-in centres?

Ms Croome: In the walk-in centres, we could. We have advertised for nurse practitioners in the walk-in centre and we have had a varied response. The role of the advanced practice nurse in the walk-in centre is equally as effective as the nurse practitioner. If we could employ more nurse practitioners, we would. Their role has proven to be quite effective.

DR BOURKE: There are no limitations to the scope of practice with nurse practitioners in our walk-in centres?

Ms Croome: There is a limitation to any nurse practitioner's scope of practice. Each nurse practitioner has a set of clinical practice guidelines that determine what they can and cannot do. Those clinical practice guidelines are formulated with an advisory group who signs off on the capabilities of the nurse practitioner to work to those clinical practice guidelines.

On that advisory group would be a consumer. There would be a pharmacist, a radiologist, a general practitioner and other personnel relevant to that nurse practitioner's role. If you took the example of a nurse working in the walk-in centre, their focus would be around primary care. But they would not be able to treat certain things that fell outside their scope of practice.

DR BOURKE: So that is an individual determination of a scope of practice?

Ms Croome: It is.

THE CHAIR: Ms Fitzharris, a supplementary?

MS FITZHARRIS: You mentioned the top 10 reasons for people presenting at nurse-led walk-in centres. Do you have any information on the demographics of people who are presenting? Is there any group that is more likely to come to a walk-in centre than others?

Mr Corbell: I think we may have to take that on notice, Ms Fitzharris, but I am sure we have some data on that. I am happy to look into that.

MS FITZHARRIS: Thank you. The other question was around the Healthdirect line. It has been my experience when calling them that they give you a few options. I presume they are fairly generic: wait a certain number of hours, call your GP tomorrow but they do specifically refer you on to CALMS. But I do not recall being specifically told about the nurse-led walk-in centres through Healthdirect. Is that something that you would be likely to be able to share with Healthdirect so they could refer Canberra-based—

Ms Croome: Yes, most definitely and we will address that.

MS FITZHARRIS: I might be wrong; it has been a few months since—

Ms Croome: No, I will follow that up and if that is not in place we will do that.

THE CHAIR: Do you have a substantive question, Ms Fitzharris?

MS FITZHARRIS: I do. I want to ask a question around aged care, just to try and get an understanding of the separation between the commonwealth's roles and responsibilities for funding and those of state and territory governments.

Mr Corbell: Ms Fitzharris, with your indulgence, I have just been provided with some further figures in relation to Mr Hanson's question on the redirection. I might deal with that now, if I may. Of the percentage that is redirected, 20.9 are redirected from the walk-in centre to their GP, 5.6 to the emergency department, and the other five per cent to other services, for example, medical imaging. Only a small number are sent to the ED. I beg your pardon, Ms Fitzharris; could you repeat the question?

MS FITZHARRIS: I would like to get an understanding of the distinction between what the commonwealth does in the aged-care sector and what it provides versus what the ACT government provides.

Mr Corbell: Aged-care services are the responsibility of the commonwealth government. That is in relation to residential aged care. Their responsibilities are in relation to residential aged-care services; obviously acute care services, hospital services and community health services are the responsibility of the territory.

MS FITZHARRIS: In terms of projecting demand for nursing homes in the ACT, where does that responsibility lie?

Mr Corbell: The commonwealth funds residential aged-care services. The extent to which they plan for and project demand I think is a matter of some significant debate because there is then an interaction between their assessment about demand and actual supply, which is dictated by private or community sector, not-for-profit sector decisions about whether or not they want to develop facilities, and its interaction with land supply and planning and development systems at a state or territory level.

MS FITZHARRIS: Ultimately, it is based on the funding available from the commonwealth as to whether or not there is, for example, a nursing home service provider in the territory as opposed to retirement living?

Mr Corbell: Yes, that is correct. The commonwealth provides for the former but not the latter.

MS FITZHARRIS: If the territory thought there was a need for a nursing home service that was not being provided, what avenues are there to litigate that with the commonwealth?

Mr Thompson: We have regular communication with the commonwealth about the aged-care planning rounds, which is the means through which the commonwealth identifies the number of places. However, the decisions are very strictly controlled within the commonwealth's Aged Care Act and are held at the commonwealth level. They make the ultimate decision according to planning ratios and expected number of beds by population. They have not in the past varied that for ACT purposes, to my knowledge. That is the way it works.

MS FITZHARRIS: Are you able to say whether you think demand is being met at the moment in the ACT?

Mr Thompson: I can say that, and it is not, I do not believe. The minister has already talked about some of the issues with having a planning ratio and a process of allocation of places not translating into places being available. The process of a community not-for-profit or for-profit provider then accepting those places, gaining the capital, undertaking development and so forth can take some time. The experience we have, particularly currently, in both public hospitals is that we have quite significant numbers of patients who are waiting for residential aged-care places and at times for quite extended periods. That is the primary piece of evidence to suggest there is a shortage.

Mr Corbell: I have made representations to my federal counterpart on this issue, as do other state and territory health ministers, where we see unacceptable periods of waiting for people who need residential aged care and who are forced to reside in a hospital bed when that is really not the setting they should be in, in any way, and the impact that obviously has on bed availability more broadly in our hospital system.

MS FITZHARRIS: Is there aged-care reform underway at the commonwealth level to address this?

Mr Corbell: I have not seen any specific proposals from the commonwealth, nor has it been raised recently with me. I am aware that there is some work being undertaken but I am not familiar with the detail of it.

MS LAWDER: I have a supplementary. I know there are quite a lot of transfers via either ambulance or some other kind of transfer ambulance from residential aged care and nursing homes to hospitals for check-ups. Does that come under the Health Directorate or directly under the Ambulance Service?

Mr Corbell: It is a mixture. Patient transfer services are predominantly delivered by ACT Ambulance Service, but there is a smaller capability that is delivered directly by ACT Health for patient transport. That would include people who are transported to or from their residence which is in an aged-care facility, but not exclusively so.

MS LAWDER: What is the demand like? Does the demand exceed availability for those transfers or vice versa?

Mr Corbell: Patient transfer services overall work well. That is my assessment of it. It is based on day-to-day requirements in terms of people needing to be transferred home following a procedure or, alternatively, needing to be transferred to hospital for a procedure.

MS LAWDER: Is the consumer charged for that service?

Mr Thompson: With the Ambulance Service, of course, there are fees unless it is covered by private health insurance. For more routine attendances—appointments or consultations—there are community transport providers as well. Some of them have a

charge.

MS LAWDER: Patient transfer vehicles: is there a charge for those?

Mr Corbell: Those are an ambulance service. I always take the opportunity to say that it costs very little to get basic private health insurance cover for ambulance, and it can save you hundreds of dollars. It is well and truly value for money. You probably pay less than $100 for an annual subscription.

MS LAWDER: But most of those residents in aged care would not have to pay an ambulance fee, would they?

Mr Corbell: In general terms, if you are using a service provided by the Ambulance Service, you will be billed for it after the event, or if you have private health cover, basic ambulance cover, the Ambulance Service will bill your private health provider.

MS LAWDER: So an age pensioner, a 90-year-old living in a nursing home, would be billed for those trips to and from the hospital?

Mr Corbell: Yes, if it was provided by the Ambulance Service. As Mr Thompson said, there are alternatives. You only need to use that ambulance service if you need it. It is different from being picked up by the community bus, for example, which is a service that the government provides without charge, and it is delivered by community service providers.

THE CHAIR: To close on rehab, aged and community care, what strategic objectives pertain strictly to output class 1.5?

Mr Corbell: I will take the question on notice.

THE CHAIR: That is good, because I cannot see any of it strictly or solely pertaining to rehab, aged and community care. I would have thought that if it is important enough to have an output to it, you might have had some strategic objectives for it. I look forward to your answer, minister.

Mr Corbell: All I would say on that is that strategic objectives are across the Health portfolio, whereas we have specific accountability measures in relation to each of the output classes. This one has a number that are outlined there.

THE CHAIR: There used to be some that were very much in this output class. I note that key strategic priority No 2 is improving discharge planning to minimise the likelihood of readmission. That strategic objective seems to have gone. It was one of the measures that we used to have. What was the readmission rate for this year and the previous year for both Calvary public and TCH?

Mr Corbell: Unplanned?

THE CHAIR: Yes.

Mr Corbell: We have one of the lowest unplanned readmission rates of any hospital

system in the country. In relation to the specific numbers, if you give me a moment I will obtain that figure for you. We have specific targets for the proportion of people separated from the public hospital system who are readmitted within 28 days of their separation due to complications—unplanned readmission. The target is less than two per cent for Canberra Hospital. The estimated outcome is 1.3 per cent. At Calvary hospital our target is one per cent; our estimated outcome is 0.7 of one per cent.

THE CHAIR: We will move on to output class 1.6, early intervention and prevention. Mr Hanson.

MR HANSON: We did a bit of this earlier, on smoking and so on. I note in the schedule the local hospital network. Can we broaden it out a bit, Mr Smyth, or am I limited to prevention?

THE CHAIR: You can try. We have let the local hospital network people go. We did that earlier.

MR HANSON: I want to follow up on a question I asked earlier when I got advice about hospital in the home and the nurse and doctor ratio for that—more broadly across hospital beds. I do not want to relitigate some of the stuff from earlier, but what is that ratio for acute beds and subacute beds?

Mr Corbell: It is not really early intervention or prevention, Mr Smyth.

THE CHAIR: No, it is not. I said he could try, but you might take it on notice and we will move on.

MR HANSON: Can I finish the question and you can take it on notice? That would be great. What I am after is the ratio for each category of bed—acute, subacute—and if you could break it down into ICU and so on within acute, that is fine. I want to find out the number of nurses per hospital bed, be it half FTE, a third FTE or one FTE, acute and subacute, and also the number of doctors for each hospital bed. If that could be taken on notice, that would be great. Just add it to the one earlier on the hospital in the home.

Mr Corbell: We will take it on notice.

THE CHAIR: Ms Lawder, a question on early intervention.

MR HANSON: I am happy to move to prevention as well.

THE CHAIR: Do you have a question on early intervention and prevention? If so, ask it quickly.

MR HANSON: I will go to that. I will ask about general practice, which is obviously a key part of providing prevention in the community. Where are we trending with GPs? It was certainly an issue in the community a number of years ago. It seems to be improving in terms of the number of GPs per capita. Do we have updated statistics? We were 140 short. Do you have an update on that?

Mr Corbell: Unfortunately, we do not have any per capita figures available at this time. I can provide that information to you on notice, Mr Hanson. Overall, in my discussions with Medicare Local and the AMA, it would be clear to me that the situation certainly has improved considerably. It has improved because of collaborative work between the ACT government and the primary healthcare sector, the GP sector and their representative organisations.

We have had some really innovative programs to assist in uptake. For example, we have provided a small grants program to allow practices to expand their facilities to accommodate additional GPs. Later this week I will be opening one of those facilities at a local practice here in Canberra which has taken advantage of a very modest ACT government grant, but it has allowed them to expand their physical premises to a degree. That means they have been able to bring in additional GPs and still make it economically viable. That has been a really good example of collaboration. Overall, I think the assessment is that the situation is significantly improved, but it is a matter we will need to continue to pay close attention to.

MR HANSON: I am sure you are aware there has been a change in the boundaries for GP training. It used to be that the training was done in the region, Queanbeyan and down to the coast, but that has been changed and those boundaries now have us training out west. So a doctor who is doing their training here at the ANU, rather than go to Queanbeyan, has to go out to Dubbo. Have you made representations to the federal minister on that? What action have you taken on that? Are you concerned by it, firstly? If so, what have you done about it?

Mr Corbell: I do not think it is ideal but it is not a factor that is within the government's control. It has been fairly clear to me that it is not a matter that is going to be revisited, either. I will ask Professor Bowden to assist me on that question.

Prof Bowden: In the first instance the Chief Minister has written to the federal government about this. There has also been some direct information from our professor of general practice, who has been very interested in this issue. So there have been a number of contacts. I think we all share the concerns. We have built up long-term relationships with the area; therefore it certainly has not been an ideal outcome as far as people here are concerned. As the minister said, we have been unable to change that.

MR HANSON: The correspondence—I appreciate it is not your call and maybe this is for the minister—from the Chief Minister and any response he has got, would that be available to this committee?

Mr Corbell: I would have to make inquiries about that, Mr Hanson.

MR HANSON: Perhaps follow it up in a bipartisan sense.

THE CHAIR: A new question, Ms Lawder.

MS LAWDER: Thanks. I have a question on page 18, which talks about immunisation rates and a target of 92 per cent with a possible estimated outcome of 93 per cent. Do you expect or anticipate any changes this year, given the federal

government's no jab, no play policy?

Mr Corbell: Changes to it?

MS LAWDER: Improvements in the rates of immunisation?

Mr Corbell: As a result of it? This is a vexed area, I think. Dr Kelly can give you some more advice on this. He has been engaged in discussions with his chief health officer counterparts.

Dr Kelly: Thank you, minister. Before I start, I will make an apology to the minister about an earlier remark I made in relation to your question, Mr Smyth, on the Heart Foundation audit. I have been advised that the minister has signed that brief and given it back to us.

Mr Corbell: I told you it was imminent.

Dr Kelly: He was extremely fast. It is with us to come up with a time line. It is related to work we are doing across the healthy weight initiative.

THE CHAIR: So when is it likely to happen, Dr Kelly?

Dr Kelly: Next week we are having a meeting of the committee, so after that. It is—what do we say?—imminent.

THE CHAIR: Now to the other matter.

Dr Kelly: In terms of immunisation, I have been involved with those national discussions, although the national initiative is a national initiative, which was announced by the federal minister without an enormous amount of consultation with jurisdictions. It is really related to issues of major concern and emerging concern in other parts of the country. There are pockets of increasingly low immunisation take-up, particularly in the northern rivers area of New South Wales and some inner city parts of other states. Luckily, we do not have that issue here so much in the ACT. We have some conscientious objectors to immunisation, but mostly the small proportion that do not take up immunisation is related to the busyness of being a mum or a dad looking after kids. Our efforts are to look at how we can facilitate immunisation uptake rather than the stick approach, if you like.

MS LAWDER: Is 92 per cent a national target?

Dr Kelly: We are regularly the best-performing jurisdiction. If we look through all of the cohorts—immunisation is looked at at three different cut points in child immunisation—we have exceeded all of the targets for a number of years. We are very proud of that achievement. We can always do better, and eternal vigilance is really important in this regard.

One of the particular strategic indicators is in relation to Aboriginal and Torres Strait Islander children. That is a particular area we put a lot of focus on, with our collaborators in general practice in that particular group of the community, with

Winnunga Nimmityjah, and also through other parts of ACT Health. We can always improve. Are we reaching the targets? Yes, usually, and usually exceeding them and being the best-performing jurisdiction.

MS LAWDER: Something I have not seen—I do not know if you have an indicator on it or whether it belongs in another portfolio—is newborn hearing screening. Is there a particular target?

Dr Kelly: That is not in my area. I am not sure who it is best to talk to about that.

THE CHAIR: CSD tomorrow at 9.30. Come back; it will be very exciting.

Dr Kelly: I do not have a comment on that.

MS FITZHARRIS: Could I have a quick supp on immunisation?

THE CHAIR: Before you go, Dr Kelly, we will have a quick supplementary on immunisation; then we will go to hearing.

MS FITZHARRIS: You mentioned before that the drop in immunisation rates has been in the northern rivers and some inner city areas. That is, I assume, quite a different demographic of people. Is it a different demographic of people now no longer taking up immunisation?

Dr Kelly: Immunisation is an interesting, vexed question as to how people make that decision. In some parts—let us take the northern rivers, for example—there are beliefs strongly held by many people in that area that immunisation is a bad thing for their particular child. There is a whole debate about how that can be worked through, but some of the issues are involved with the fact that the diseases we are trying to prevent by immunisation are exceedingly rare, and most individual mothers or fathers with small children have never seen these diseases and never seen the devastation they can cause.

We had a very well publicised death from pertussis earlier this year in Western Australia. That happens every year; there are deaths from pertussis in small children. The main way we can protect those small children is by having a high immunisation uptake in the rest of us. To take pertussis as an example, those kids that are at most risk cannot be protected by the vaccination. To take that a bit further, that is why we have introduced the antenatal pertussis vaccine this year, which the ACT government is funding. We are having good uptake with that through our antenatal clinics and general practice now.

THE CHAIR: Now the hearing answer, if there is a hearing answer.

Ms Chatham: I do not have the figures here today—I am able to get them to you and take them as a question on notice—but I can reassure you that we have a very high uptake in the ACT. The test is done in hospital. We have high participation. We have a process in place to follow up with women who for some reason do not have it in the hospital setting.

MS LAWDER: If you could take on notice the current national target, and how the ACT is going, which I suspect is quite well—

Ms Chatham: It is very well.

MS LAWDER: With those who perhaps miss out, is that because people are leaving hospital much sooner after the birth of the baby?

Ms Chatham: Anyone who leaves hospital early to go home, which is common here, we follow up. We invite them back and give them an appointment back in hospital; we follow them up.

MS LAWDER: I am interested in the take-up of the people coming back.

Ms Chatham: There is another group that are at risk of falling out of the process. They are the ones that go to Sydney or Melbourne for care immediately after birth.

MS LAWDER: What is the take-up with home births?

Ms Chatham: We do not have the stats around the take-up with that home birth population.

MS LAWDER: You have no way of knowing whether those babies born at home have a hearing test or not?

Ms Chatham: No, we do not.

Mr Corbell: The number is very small, though, in terms of home births. It is a handful of births every year.

MS LAWDER: You will take some of those questions on notice?

Ms Chatham: Yes, all of those.

THE CHAIR: Dr Bourke, a new question.

DR BOURKE: Thank you, chair. Minister, can we talk about the importance of the legislative amendments to allow for the deregulation of temporary non-profit community organisations that sell food?

THE CHAIR: An outstanding success.

Mr Corbell: These are matters that are the responsibility of Access Canberra. I refer you to the Chief Minister's directorate, which is responsible for Access Canberra.

DR BOURKE: Okay. Maybe I will talk about risky behaviours, then.

MR HANSON: Could I have a supp?

THE CHAIR: A supplementary question, Mr Hanson.

MR HANSON: Are you concerned about the cleanliness of barbecues, minister, and the handling of food at community events?

Mr Corbell: I think it is important that people are aware of basic food hygiene practices. Whilst we can make light of it, a gastro outbreak is nothing to laugh at. It can be quite serious for the people who are affected. I think raising awareness about basic food hygiene practices is important. There is a range of ways in which you can approach that. Certainly I support a strong educative approach to that type of issue.

MR HANSON: This legislation that you are repealing, with Access Canberra, is previous ACT Health legislation, isn't it? There is a strategic objective in the budget which is to repeal your own legislation.

Mr Corbell: The government has a strong red tape reduction agenda.

MR HANSON: But it is your own red tape, isn't it?

Mr Corbell: Regardless of who instigated it, if it is not demonstrated to be necessary or is no longer meeting its objectives, a sensible government looks at that and decides what steps should be taken about it.

MR HANSON: You do not see the irony of implementing red tape and then applauding yourself and putting it down as a great outcome when you then repeal it? You do not see the irony in that?

Mr Corbell: I think it is a bit of a silly question, with all due respect, Mr Chairman. You can implement legislation to achieve a particular end. That end may then be achieved and the legislation may no longer be required. Alternatively, it may not be operating in the manner that was originally envisaged, in which case you go back and revisit it.

MR HANSON: And then applaud yourself for scrapping it.

THE CHAIR: Ms Fitzharris, a new question.

MS FITZHARRIS: I want to ask some questions around measuring the success of prevention. When the Chief Minister and Head of Service were with us yesterday, the Head of Service talked in particular around whole-of-government approaches and how we are using data to inform further policymaking and funding decisions. In terms of prevention, what are some of the ways that is happening with very important health data being used with data from other directorates to inform decisions on preventative measures and whether they are achieving outcomes?

Mr Corbell: That is a fairly broad-ranging question, Ms Fitzharris. The point I would make is that, obviously, data collection is a very significant task in the Health portfolio. There is a lot of data that is collected and reported—reported within the ACT's own fora, such as this one, and in annual reports and so on; reported as part of national reporting regimes which are contingent on funding agreements; or reported more broadly for academic and research purposes. There is a whole range of data sets

that are drawn on in the ACT Health portfolio.

We are always looking at ways we can better utilise data and also at synergies with other data to improve our policymaking. Perhaps a good example, which is a collaborative approach across all jurisdictions, is access to MBS data, which is held by the commonwealth. This is Medicare data on what is being billed under the Medicare schedules and what types of conditions are sitting behind those incidents of billing.

Previously much of this data was not available for epidemiological purposes, and that has been a source of quite significant frustration for academic researchers, because they would like to see what are the trends over time nationally in terms of occasions of care, what is Medicare being billed for and what is going on behind those statistics in terms of illness and care. For the first time, it has been agreed by the commonwealth, in conjunction with the states and territories—it was a decision of the last health ministers meeting a month or so ago—that there would be a framework for the release of de-identified data so that researchers are able to look at that MBS data.

I think that is a good example of opening up very significant data sets. When you think about Medicare, which has been around in one form or another since the 1970s, you have got three or four decades of data around billing that you can rely on and draw upon. That will be a very powerful research tool. That will be of benefit for all jurisdictions, including the ACT.

MS FITZHARRIS: Thank you.

THE CHAIR: I will have the last question. Minister, in the description in the output class, it talks about reducing risky health behaviour such as alcohol consumption. Has the portfolio ever determined the cost of alcohol-related injury or diseases in the health budget in the ACT?

Mr Corbell: I do not think we have ever been able to quantify that directly. Since the passage of the changes to the liquor licensing laws back in 2010-11, there is now an improved reporting framework, including in our emergency departments, that allows us to identify occasions of service, if you like, occasions of treatment, where alcohol is a factor. And it is the same in the ambulance service. Previously we did not have a coherent and regular framework for reporting, if someone was cared for by ambulance and transported, whether it was due to alcohol in part or in whole. We are now strengthening that. There is more work to be done on that, but the changes to the legislation in 2010 have supported our capacity to improve that reporting.

But no, I do not think we have ever been able to quantify that. Of course, there has been some national assessment done of that, but I think if you were to speak to our ED physicians, they would certainly indicate that presentations where alcohol is a factor are not insignificant.

THE CHAIR: On the same line of questioning, reducing risky health behaviour such as smoking—have you ever attempted to quantify the impact of smoking? By impact, I mean the cost in dollars, in staff time, in facilities allocated to treating people with smoking-related injuries?

Mr Corbell: Again, I believe we would be able to extrapolate that from national research. There is certainly a significant body of analysis over time in relation to the cost of tobacco-related illness and mortality. Whether or not it has been done recently is something I would have to ask my directorate.

THE CHAIR: You will take that on notice?

Mr Corbell: Yes, I am happy to try and provide it.

THE CHAIR: Does any member want to try their hand at a last question in the last three minutes of the day? No.

MR HANSON: Now you have told everybody that you had the last, it would be very bold, wouldn't it?

THE CHAIR: It would be most inappropriate, Mr Hanson. As the chair is wont to do, his award today could have gone to himself for leaving his phone on after lunch, which was somewhat embarrassing—but, there you go; we are all fallible. However, I think the WIN photojournalist wins with her audacious attempt to influence the state of origin tonight by wearing her Queensland jumper, although Mr Thompson came close; he should review, when he was talking about screening, that he or the portfolio writes to women about their availability and desirability. One could take that out of context, but I would not do that. All your colleagues will now read the *Hansard* to see what you actually said.

Members, we are now one-third of the way through estimates. You can see that cabin fever is already setting in. We return in the morning at 9.30 with Mr Gentleman to discuss issues about youth in the ACT. Thank you all for your attendance today.

The committee adjourned at 5.26 pm.