LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2016-2017

(Reference: Appropriation Bill 2016-2017 and Appropriation (Office of the Legislative Assembly) Bill 2016-2017)

Members:

MR B SMYTH (Chair)
MR J HINDER (Deputy Chair)
MS J BURCH
MR S DOSZPOT

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 29 JUNE 2016

Secretary to the committee:
Ms K Harkins (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 9.31 am.

Appearances:

Fitzharris Ms Meegan, Minister for Higher Education, Training and Research, Minister for Transport and Municipal Services and Assistant Minister for Health

Health Directorate
- Feely, Ms Nicole, Director-General, ACT Health
- Strachan, Mr Shaun, Deputy Director-General, Policy, Planning and Innovation, System Innovation Group
- Thompson, Mr Ian, Deputy Director-General, Canberra Hospital and Health Services
- Kelly, Dr Paul, Chief Health Officer
- O'Donoughue, Mr Ross, Executive Director, Policy and Government Relations
- Croome, Ms Veronica, Chief Nurse, Canberra Hospital and Health Services
- Dykgraaf, Mr Mark, Executive Director, Critical Care, Canberra Hospital and Health Services
- Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Service, Canberra Hospital and Health Services
- Ghirardello, Mr Phil, Executive Director, Performance Information
- McDonnell, Mr Sean, Director, Employment Services, Strategy and Corporate
- Mooney, Mr Colm, Executive Director, Project Delivery, Health Infrastructure
- Donda, Mr Jean Paul, Senior Budget Development Officer, Financial Management Unit
- Richter, Mr Matthew, Senior Manager, Government Relations, Primary Health and Chronic Conditions Policy Unit
- Cook, Ms Sandra, Acting Clinical Systems Program Manager, E-Health and Clinical Records

THE CHAIR: Good morning and welcome to day nine of the public hearings of the Select Committee on Estimates 2016-2017.

Please be aware that proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed. On the table before you, Minister and officials, is the pink privilege statement. Could you confirm that you have read the statement and understand the implications of privilege?

Ms Fitzharris: Yes.

THE CHAIR: So acknowledged. The committee wishes to acknowledge the traditional custodians of the land we are meeting on, the Ngunnawal people. We wish to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

Minister, would you like to make a brief opening statement?

Ms Fitzharris: Good morning. Thank you, Mr Chairman and committee, for the opportunity to provide an opening statement this morning. I am very pleased today to

present to you a budget which clearly indicates the Labor government's continued commitment to the health of people living in the ACT and surrounding regions. The health of Canberrans will always be the ACT government's top priority and this budget invests further in our health system, investing a record $1.6 billion to provide more doctors, more nurses and better health services for Canberra.

This record investment in better health services for Canberrans is almost one-third of the entire ACT budget. It includes over $144 million for rehabilitation, aged and community care; $37 million in public health; and $94 million in early intervention and prevention services. This budget will also see more services provided in the community. There is $8.06 million over four years for drug services in the community sector, including measures for addressing family violence, and $2.7 million over four years for community services for hard-to-reach populations, sexual health and Aboriginal and Torres Strait Islander people. The budget also funds $4.2 million over four years to provide additional outpatient services for cancer services, respiratory, neurology and cardiac services.

A $2.1 million investment over the next four years will expand palliative care services in the ACT. Children and their families in need of palliative care in Canberra will now have access to a dedicated palliative care nurse. Palliative care is a significant and crucial service provided to those in our community requiring end of life care. Sadly this is not just for adult or older Canberrans but, tragically, too often children are in need of these services as well.

These are just some of the investments being made in health, and I know my colleague the Minister for Health, Simon Corbell, will discuss more of the detail of our record investment in health this afternoon.

As Assistant Minister for Health over the past five months supporting the Minister for Health, Simon Corbell, I have been responsible for community health services, population health and public health protection policy. It has been a privilege to be appointed to this role and already I have had first-hand experience of how essential these services are to maintaining and improving the health of our community and also protecting the health of Canberrans through speciality areas such as communicable disease and infection control, food safety, radiation safety and environmental health.

As assistant minister I have also seen how community health services and population health programs support the acute healthcare services that are provided within our public hospitals. I acknowledge the full spectrum of health needs our community has, right from hospital care, outpatient care, community health care, walk-in centres, and healthy lifestyle programs and activities.

Canberra has six wonderful community health centres and two nurse-led walk-in centres at Belconnen and Tuggeranong health centres. All provide a broad range of community-based services to the ACT and surrounding region and demonstrate how this government has made improving our healthcare system a priority. Community health centres offer a comprehensive range of services to local communities in an inviting physical and operational environment that promotes health literacy in terms of navigating the health system and self-managing one's own health. The consumer is the centre of care. They and their families are involved in decision-making and there

is a focus on connecting and integrating all aspects of a person's care and treatment.

The broad range of services includes a preventative, primary care focus through to specialist services and tertiary level reviews. These services are affordable and accessible so that they reach the people who need them most. Community-based services available in the ACT provide multidisciplinary care in health centres and people's homes and other community settings.

The first public nurse-led walk-in centre in Australia opened in Canberra Hospital in May 2010. The walk-in centre services provide free, one-off treatment for minor injuries and illnesses and were launched to improve access to primary health care. Perhaps the best gauge of the quality of services provided is from patient feedback. The overwhelming number of compliments attests to the responsiveness and effectiveness of the care provided in the community. The community sector is a vital partner to the ACT government in setting health policy and delivering positive health outcomes, not only by direct provision of health services but also by encouraging self-determination and empowerment.

ACT Health has strong community partnerships and service funding agreements with a number of NGOs who provide quality, innovative and much-needed health services to people in our community. They range from early intervention mental health services to the facilitation of National Sorry Day. In addition to improving the wellbeing of Canberrans, community health provides ACT residents with options for health and wellbeing services to reduce hospitalisation rates and help people stay in their homes and in their communities.

We have a great basis for good health in Canberra: a healthy environment to live in with clean air, clean drinking water, access to healthy and safe food, open spaces and parkland and many opportunities for healthy, active lifestyles. To build on this healthy environment, the ACT has a strong record for taking a proactive approach to health promotion, health protection and disease prevention activities, evidenced by us leading Australia in several areas in relation to the general health of the ACT population.

In October last year the government, through the health portfolio, delivered $2 million in grants to six organisations to combat the concerning rates of overweight and obesity, reduce alcohol and tobacco-related harm and promote healthy, active ageing in the ACT. In February this year we introduced new legislation for people who decide to donate their organs after they have passed away. This government has also introduced a number of legislative changes this year, including restrictions on e-cigarettes and a more streamlined process for declaring public places in the ACT smoke free.

Last month I launched the 2016 ACT Chief Health Officer's report, *Healthy Canberra*, marking the 20th anniversary of the report and offering the chance to reflect on some of the great progress we have made towards a healthier Canberra. Some of the highlights include Canberra being one of the most livable cities in the world with good air quality, clean water, high rates of employment and access to excellent social, community and health services. The report also shows that the ACT has the lowest smoking rate in Australia, and the proportion of secondary school students who have

never smoked has almost doubled between 1996 and 2014. The proportion of adults who are overweight or obese in the ACT has increased remarkably in the past 20 years but has remained relatively stable since 2007-08.

The report also promisingly shows that the number of children who consume sugar-sweetened drinks has decreased over the past five years down to 30 per cent in 2014 from almost 50 per cent in 2017. The report shows excellent results in our vaccination rates but also that we can do still more to get our kids more active and help them to stay active, with the report showing that 35 to 40 per cent of children actively participate in active travel to school.

While the *Healthy Canberra* report overall shows a positive result for the ACT, it outlines a number of areas that we need to focus on to improve as a community. There are a few pointers, but the simple message for me from the report was: we should all eat more veggies. The ACT government will continue to invest in our health system, promote healthy lifestyle choices, increase access to mental health services and expand existing health services and preventative programs in the ACT to address these concerns. Thank you, Mr Chair. We are ready to take your questions.

THE CHAIR: I will buy you a dictionary for the definition of "brief", but such is life. Minister, is junk food part of healthy weight tomorrow or will we deal with that today?

Ms Fitzharris: It can be. We have only half an hour tomorrow; I am in your hands, but probably most specifically tomorrow.

THE CHAIR: We will do it tomorrow. In the accountability indicators for output 1.3 on page 16, samples analysed went from 8,500 to 11,900 for the year. What is the reason for that increase?

Ms Fitzharris: The Health Protection Service analysing all samples and getting out amongst the community and talking to more businesses in particular about health protection activities. Dr Kelly will be able to talk in more detail about that.

Dr Kelly: That particular output, Mr Smyth, is related to the work done at the Health Protection Service, the component of that being the ACT Government Analytical Laboratory. In the laboratory we have different sections; all of them have been busier this last year than previously. The increase mainly, though, is due to our work in the forensics area which is on behalf of ACT Policing. Whenever there is a drug bust, a clandestine laboratory, or an increased blitz on roadside drug or alcohol testing that influences directly the number of analyses that take place in the laboratory. That is the major part of the growth.

We have also had an increase of 10.7 per cent on food samples, which relates to what the minister said about issues of food safety. We have also had an increase in asbestos samples relating to tradies finding issues when they are doing renovations and so on.

THE CHAIR: In regard to the asbestos, what happens there? Can somebody just say "I think I've found some asbestos" and bring in a sample?

Dr Kelly: They can, yes. This is a service we provide to the public, but it is mostly people in the trades area who are doing work on previous houses; this is not specifically related to the Mr Fluffy issue. That is not us; but if someone is doing a renovation of a bathroom in a house, if they find issues they are concerned about they will often routinely bring those samples in and we have a process of working through that and giving the information back to the person who has provided the sample at the cost of a fee.

THE CHAIR: On page 12 output class 1.3, table 20, the budget seems to have gone up some $2.4 million. Is that extension of services or doing more of the same or are there additional things included in that?

Ms Fitzharris: Mr Strachan might be able to answer, but I mention in regard to your previous question, Mr Chair, that there is funding in this budget for additional forensic chemistry capacity in recognition of the increased number of operations the Health Protection Service is working on, in particular with the AFP.

THE CHAIR: Is it possible to get a breakdown of that? I cannot imagine there have been so many drug busts that we have gone from 8,500 to 11,900, and what is the number for the roadside drug testing?

Dr Kelly: I have to take that on notice, Mr Smyth, but there has been a very large increase over the past few years and it is continuing. For example, in 2014-15 there were 8,500, so that 45 per cent increase from 2013-14 to 2015-16 is actually the increase. Most of that, as I say, is related to work with the AFP. When a drug bust happens, for example, samples need to be done. These figures are for each individual sample and not just a particular thing. There has been remarkable growth in that area, reflected, as the minister said, in increased funding. But I can bring more information.

THE CHAIR: A breakdown would be appreciated.

Ms Fitzharris: In relation to the specific costs, Mr Donda from the finance department will be able to answer your subsequent question.

Mr Donda: There is one specific new initiative in this budget for population health, which is the additional forensic chemistry capacity initiative of $249,000.

THE CHAIR: What is the other $2.1 million?

Mr Donda: That is indexation.

THE CHAIR: And what is the rate? Is that about six per cent?

Mr Donda: No, indexation is about three per cent. The output class increases by around four per cent in total cost.

THE CHAIR: Two million dollars on $34 million is about six per cent.

Mr Donda: Are we talking total expenses, total costs?

THE CHAIR: Yes, total costs.

Mr Donda: Thirty-six million dollars from $34 million is a four per cent increase, so three per cent of that is indexation and the other one per cent is the growth.

Ms Fitzharris: Some of the healthy weight initiative funding is allocated to the public health service—$0.9 million. We can bring you the breakdown of that tomorrow when we talk about the healthy weight initiative. We can provide the specific breakdown of that increase as a question on notice.

THE CHAIR: A new question, Mr Hinder.

MR HINDER: Minister, I want to ask a question about smoking rates. I know that we in the Assembly passed legislation this year in relation to e-cigarettes. I notice that this week the ACCC has taken action against two manufacturers because of inaccuracies in their description of products they are selling. Your legislation was well in advance of the curve, by the sound of it. Can you give us some information about what measures are put in place by that legislation or have been put in place by that legislation and how that will work to target this threat to public health particularly in terms of women who are pregnant?

Ms Fitzharris: Thank you for the question. There are two pieces of legislation that were introduced and passed in the first half of this year. Both go towards our overall tobacco reduction strategy. Our overall figures are really encouraging. We see a substantial reduction in the numbers of people smoking in general. It is no longer by any means the norm. My primary school aged kids are quite puzzled whenever they see anyone smoking. That certainly was not the case when I grew up.

What we do know is that there are still some pockets that we need to target and what we certainly want to do is to make sure that smoking is not re-normalised in any part of our community. The legislation around e-cigarettes, or personal vaporisers as they are classified in the legislation, was an attempt to stop any re-normalisation of smoking behaviours. A number of the vaporisers or e-cigarettes actually look like quite harmless products particularly for young people. For example, some of them look like lipstick and some of them look like pens.

There is no real evidence yet that they actually do assist people in stopping smoking for good. We think that it was a really important preventative measure because as a community as a whole we have made so much progress on stopping people smoking. But as the Chief Health Officer's report noted, although the number has fallen we still have a couple of areas that we really do need to target. You are right: particularly young women who are pregnant are a key focus for us. There are a number of programs funded through grants and working with particularly non-government organisations.

We will continue to work particularly with the Aboriginal and Torres Strait Islander community through Winnunga Nimmityjah health services in particular to do what we can to bring down rates of smoking, particularly in young pregnant women, and also to really send a message home to secondary school students as well.

Dr Kelly might like to add further some of the historical trends and some more of the work that we have got underway.

Dr Kelly: Thank you, minister. Mr Hinder, thank you for your question. The issue of e-cigarettes is a controversial issue globally in public health around the balance between harm minimisation and the re-normalisation of smoking—and there are strong proponents on each side—but we looked at this in relation to the evidence and did some community consultation a year or so ago now. That is where we landed with the legislative amendments which, essentially, treat e-cigarettes like cigarettes. Wherever cigarettes are unable to be smoked, the same will apply for e-cigarettes. The restriction on advertising is the same for e-cigarettes. Restriction on who can purchase them is the same for cigarettes.

Adults still have a choice if they want to go down that path, particularly if they feel that that is one of the things that might be able to help them to decrease their smoking. It is a safer option but it is not an entirely safe option, and it can be extremely dangerous for children.

Some work that has been done in New South Wales in recent times has demonstrated that even though e-cigarettes may say "does not contain nicotine" they often contain potentially lethal amounts of nicotine for children. We thought this was a safety issue and the re-normalisation component was part of that. That was why we went down that path.

In terms of our smoking reforms, as the minister has said, there are some particular targeted populations that we need to really do more work on, and are doing more work on. There was money in last year's budget for work on smoking in pregnancy, for example, targeting young women, and also work that has been going on for some years and is being expanded in the Aboriginal and Torres Strait Islander population, another group of the population which has higher rates than we would like.

MR HINDER: I have a supplementary on that. It is smoking related. I drove past the Canberra Hospital the other day, and there was a swarm of folk out on the footpath there smoking. I know it is a dilemma. I know it is a health facility and zero smoking is the position—and I understand that—but you have got the staff and then you have got the patients. The patients do not have the choice, I would suggest. I know that you could describe that as an opportunity for them to give up smoking, but a question coming out of this would be: is this the national position on smoking within hospital premises? Or is it like Singapore airport where there is a little glass box you can go into and smoke away?

Ms Fitzharris: That is particularly unpleasant, I have to say.

MR HINDER: It is a difficult scenario for everyone.

Ms Fitzharris: Yes.

MR HINDER: People in hospital are already in a bad way, by definition. I assume that we do not want to make their stay any harder than it already is.

Ms Fitzharris: That is right. I think my officials would be well aware of this, having worked on this for many years and had this question over a number of years. Certainly the campus itself is smoke free, and the smoke-free public places legislation that we brought in and was passed by the Assembly earlier this year provides us with a much simpler mechanism to declare smoke-free places. It still has to be notified by the relevant ministers, at this stage the Chief Minister and me, after some community consultation.

Yes it is a question that gets raised. I think Mr Thompson would be able to answer in more detail questions on this. I do know that there is certainly plenty of signage around the campus, and there are also programs offered within the hospital, I think, both to staff in particular and obviously with patients, about supporting people who want to stop smoking. I will hand over to Mr Thompson on that particular question.

Mr Thompson: The minister is correct. The policy that we have put in followed a period of time where we had had designated smoking areas on the campus. What we found was that the designated smoking areas on the campus encouraged a continuation of smoking and that what happened was people would sort of spill out of those areas. Smoking continued to be sort of observed and normalised to a degree on the campus. The approach that we have put in place is that there is no smoking on the campus at all.

In terms of the approach we take around the policy, we have specific programs for staff and for patients and we provide our nicotine replacement therapy, particularly for patients over relatively short periods of time, to support quitting. Frequently it is an opportunistic point of intervention where we can work with patients and assist them to consider quitting and start quitting if they are interested in that. Otherwise we provide nicotine replacement therapy for them.

THE CHAIR: Ms Burch, a new question.

MS BURCH: I am looking at early intervention and prevention with a focus on—and there is a budget line in here—primary care for hard-to-reach populations. There is another line here around supporting Aboriginal and Torres Strait Islander people who are in that situation. What does that look like and what are the strategies? Often those hard-to-reach ones are the ones with the worst health outcomes.

Ms Fitzharris: That is exactly right. The primary health care for hard-to-reach populations is funding provided to—probably the best way to think of it is—the sorts of services that are provided at the moment at the early morning centre in Civic. What we are looking to do now that this funding has been identified in the budget is to work with relevant community sector partners to identify how and where a similar service can best be provided and/or expanded with a complimentary service somewhere, quite possibly in the city centre, for those people who are, as you say, particularly hard to reach.

We know that the early morning centre provides a range of effectively wrap-around services. Primary health care for these vulnerable groups is particularly important. The funding for Aboriginal and Torres Strait Islander people is funding in particular to continue our already very strong partnership with Winnunga Nimmityjah. It will build on and support the activities that were identified in the new Aboriginal and Torres Strait Islander health plan's priorities for the next five years, which Dr Bourke and I consulted on earlier this year.

We will be working in particular with Winnunga about how those services will be delivered. What those services will do is enable Winnunga to provide more specialist services and have an expanded outreach model. While they provide very good holistic primary health care, their capacity to deliver specialist services is limited at the moment. This funding will enable them to do more. It may include areas such as paediatrics, dental health, mental health and suicide prevention, cardiac care, continued drug and alcohol support, correctional health services, young people's sexual health services and midwifery support as well.

MS BURCH: Is that building capacity within Winnunga or facilitating connection to other mainstream services?

Ms Fitzharris: A bit of both; and it will be a very collaborative process for Winnunga.

MS BURCH: Both of these groups are starting from such an unhealthy base. And is this additional—

Ms Fitzharris: Additional funding?

MS BURCH: Additional investment?

Ms Fitzharris: Yes. Mr O'Donoughue can talk more specifically about the Aboriginal and Torres Strait Islander package but within the primary health care for hard-to-reach populations we are looking at how that is best delivered. There is also funding in there to support the Orange Sky Laundry which was launched in Canberra a couple of months ago.

MS BURCH: I was going to ask about that.

Ms Fitzharris: I am sure committee members are familiar with the two young guys from Brisbane who established a mobile laundry service for homeless people. They came to Canberra a couple of months ago. There is funding in this budget to further support their efforts here. It is an almost entirely volunteer-based organisation. The two young guys who established it were the winners of the Young Australian of the Year at the Australian of the Year Awards this year.

MS BURCH: Is that what that funding is going to in totality, or it is just a small part?

Ms Fitzharris: No, just a component, $50,000 this year. The primary healthcare portion of it is over four years of the forward estimates.

MS BURCH: So $50,000 to the laundry service?

Ms Fitzharris: Orange Sky Laundry, yes.

MS BURCH: And $30,000 to primary health care services? Is that right?

Ms Fitzharris: Thirty thousand dollars for the hard to reach, yes.

Mr O'Donoughue: The minister is correct. We are looking to build on the successful program of primary care that has already been happening at the early morning centre on Northbourne and establishing a similar service at another location. Obviously we have not actually found that location as yet or the configuration of services that we will deliver there. The laundry service is a sort of supplement to that. In other jurisdictions what the laundry service has been able to do is use a second service as an opportunity for training homeless people to deliver a commercial laundry service from the van. They train up participants in the program and then use the van to go around and provide a laundry service on a commercial basis to other locations. We are thinking that is one potential for the second van in the territory.

In respect of the Aboriginal initiative, there has already been a quite successful program of outreach specialist services from TCH to Winnunga, including liver clinics, ophthalmology clinics and diabetes clinics. We see the potential for extending those and or building more capacity in Winnunga itself. There are also probably other opportunities, for example at the AMC, maybe to do more outreach services there. We are interested in exploring other partnerships as well as Winnunga.

MS BURCH: Is there a connection to get the client base that might get support services through Gugan as well?

Mr O'Donoughue: Yes, potentially. Gugan has quite a specific focus on younger kids and young women but there is also that potential as well to have outreach services to them.

MS BURCH: On page 17 under output 1.6 there is reference to the proportion of clients attending the Well Women's Clinic and the percentage from culturally diverse backgrounds. I know this is a bit of a leap from the hard to reach. Is this just representative of our community? We have a multicultural community. Is 40 per cent reflective of our community or is an element of that again going into our CALD community, making sure that they access services?

Ms Fitzharris: It is also a reflection that this group in our community is particularly vulnerable and may have difficult not so much accessing mainstream services but may not be as familiar as others. It is a marker of the people that we want to reach in the community. Those people, as you say, are not quite as hard to reach as the target group with the primary healthcare initiative but certainly the health of these women from multicultural backgrounds is particularly important for us. We need to reach them in their early stages. As an indicator, it is important.

MS BURCH: What strategies sit underneath that to grow it or to get these women in?

Ms Fitzharris: What I have learnt, as I am sure you will know, is the collaboration across a number of different directorates as well. There is a lot of collaboration, particularly with the Community Services Directorate and the Office of Multicultural Affairs as well, in terms of identifying these groups of women and working with them to identify their needs.

Mr Thompson: Building on what the minister said, the purpose of the program is to target vulnerable sections in the community. The percentage of women from culturally and linguistically diverse backgrounds is reflective of that, very much along the lines of what has already been discussed. The service itself has very strong links with similar health service providers and government organisations. That is the primary way, as well as working with referrals, for generating the referrals to reach the target population.

MS BURCH: And given that one in five, 20 per cent of our community, could be described as from a culturally diverse background and, given what you have said, what are you doing to grow that number then?

Mr Thompson: The target is not proposed to change, around 40 per cent. That number is a reflection that, if you look at the overall percentage of the population, there is an overrepresentation of people who are within the vulnerable target group of the service. The target has been set higher, in fact double the percentage of the population, to reflect that.

MR HANSON: A supplementary before I go to my question, if I could, Mr Chair.

THE CHAIR: Certainly.

MR HANSON: On primary health care, how are we tracking with GPs and the issue of the number of people, which I think is the highest in Australia, deferring going to a GP because of cost and also the lowest rates of bulk-billing in Australia? Are you monitoring that situation and what impact it is having on early intervention and prevention?

Ms Fitzharris: I am sure, Mr Hanson, that the figure that you refer to of the highest number of people deferring because of cost—I do not know where that is from. Where is that from?

MR HANSON: Probably AIHW, I would imagine.

Ms Fitzharris: Right.

MR HANSON: It is regularly recorded. It would be an AIHW figure, I imagine.

Ms Fitzharris: We might take that on notice. Minister Corbell might also be able to answer that. If the issue is cost, we know that if the cost is going to go up, that is going to prevent more people from accessing services. A freeze on certain aspects of the Medicare payments certainly—

MR HANSON: This is about what has been happening now in this jurisdiction for

well over a decade, if not longer, with the lowest rates of bulk-billing in Australia and also, as I said, the highest rates of deferral. It is a pretty significant issue that impacts on prevention and early intervention. As minister, what are you going to do to address that?

Ms Fitzharris: The walk-in centres, the community health centres, as I mentioned in my opening statement, are an essential part of providing accessible no-cost, in most cases, services to people throughout the community, closer to where they live. The walk-in centres we see are particularly successful. People are accessing them at higher rates each year for the right types of services. Understanding in the community is building on the accessibility of community health services, and also the community health centres aim to improve health literacy among the community so that they know the right service to access at the right time for them. These were in direct response to being able to provide accessible primary healthcare services to Canberrans and also to take the pressure off hospitals and emergency departments.

MR HANSON: But since the walk-in centres began—I think it is six years since the first one was introduced—how are we trending in terms of ED presentations? I believe they have gone up significantly. And access to primary health care: has that improved or not?

Ms Fitzharris: Yes, it has, and Minister Corbell will be able to talk about ED rates later on this afternoon.

MR HANSON: Sure, but access to primary health, does that come under you or does that come under Mr Corbell?

Ms Fitzharris: It is a bit of both. The community health centres and the walk-in centres are with me but, more broadly, the relationship with GPs, and people accessing GPs is very much shared between Minister Corbell and me.

MR HANSON: Is access to GPs improving, or is it static or declining? What is the trend?

Ms Fitzharris: The trend is that there are more GPs in Canberra, that there are more GPs in the growing parts of the city where previously there were difficulties accessing GPs.

Ms Feely: As a general way of addressing your question, we are working very closely with the former LHN, now Capital Health Network. Together with them, we are looking at things such as discharge planning from the hospital. We are working also to look at better engagement with the GP community across the board into places such as back into the nursing homes. It is looking at a different way that we can try to encourage care in situ rather than having people either come to a GP, travelling, or, from my immediate perspective, come straight into the ED if they are concerned. I have also commenced discussions with some of the nursing home providers to talk about what they require with their ageing communities to make sure that they have proper access to GPs.

The focus, from my perspective, rather than being on increasing GP access, is about

how we make sure that the communication flows between the acute and subacute community sector are flowing better back out into the GP communities. But it is also looking at different models of care to try to make sure that people can access a GP. We even had very preliminary discussions with other groups, such as the ambulance people, to work out what we can do to maybe keep people more in their current place of residence rather than requiring the dash in an ambulance into the hospital, for example.

I am not answering your question directly; I appreciate that. But there is a lot of project work that is happening about diversionary—that is one word you use; I prefer to call it making sure we are caring for people appropriately in their home, as much as possible—rather than the automatic trip into hospital which can then result in a stay that maybe could have been avoided if we could have treated them, for example, with drips, antibiotics or something at home.

Everyone is looking at me as though I have obviously got something to say. May I bring up Matt Richter, who has responsibility. We can probably talk to you in a more detailed way about the after-hours care and the coordinated care for those with chronic conditions that we are working on with the Capital Health Network, in relation to your question about GP access.

Mr Richter: Thank you for the question. This is a difficult area because it crosses the state and territory and commonwealth divide, so we all have joint responsibility. It is an important area because a strong primary health system leads to a strong health system overall. We are very focused on working in the area.

The first question was around what is happening in the GP space. One of the things to look at in Canberra, which has been really positive over the past few years, is that there are different models of care and operation in Canberra now than there were, say, five years ago, with things like the after-hours doctor service, Healthdirect playing a different role and more community co-ops opening around here. There are different access points now through different models, which is really good.

This is leading us to do more work with the Capital Health Network around what models we should work on together in future to try and promote coordinated care of general practice focused on areas around different disease groups where we might need to work together, like heart failure, diabetes or distribution of the new drugs for hepatitis C.

So it is more targeting general practice who have a special interest in a certain area rather than the sector more broadly. It is working with the Capital Health Network on initiatives like trying to work up how we coordinate care better across the system. That is with the commonwealth and us coming to the table saying, "Okay, we have a primary healthcare system. We have an acute system. It is unreasonable for us both to be sitting here and saying, 'This is our game, and that is your game there,'" and just leaving the poor patient till they get lost in the middle. It is saying, "How can we both work better together to coordinate care across there?"

We are starting to frame up projects around that and look at who can help in assisting that and broadening our view more than we ever have before. It is not just considering

NGOs and community sector organisations—public health organisations—but also looking at private insurers, private hospitals and those kinds of players in the market that are interested in participating and helping the patient journey. Different models, as Nicole said, are one of the key things that are happening in the market here, which is a good thing.

MR HANSON: Is there any substantive change between the Capital Health Network and its predecessors? Has there been a known change? Has there been a significant role change and expansion or contraction?

Ms Fitzharris: Yes, a significant change.

Mr Richter: Yes, sure. There has been a fundamental change in the purpose and the function of the organisation. They have been charged with becoming a planning and commissioning organisation, which means looking at the needs of the community in which they have been appointed and using commonwealth funding and working with us, hopefully, and the community, identifying what solutions are needed to address those needs and purchasing services, if you like, or putting services in place. They are not so much going to be the service deliverer anymore; they are going to be more planners and purchasers of services. That is good because it enables them to come to the table with us in a much more robust way, to sit down, plan, identify needs in the market and go, "How can we address those needs? How can we frame up a service to respond to those needs?"

MR HANSON: So you think this new model is a good one?

Mr Richter: I think it is moving in the right direction. It is a vastly improved model. The relationship has improved markedly between us and the Capital Health Network, because we are able to functionally work better together to deal with common interests.

MR HANSON: All right.

THE CHAIR: Before we go to the substantive, Mr Hinder has a supplementary on the original, and I have a supplementary on your supplementary. Then we will go to your substantive question.

MR HINDER: Minister, my question is around bulk-billing and the National Health Co-op, formerly known as West Belconnen Health Co-op. I recall that a few years ago Ms Burch was instrumental in securing $300,000 from the ACT government department or the great institution Bendigo Bank to provide a health co-op in Chisholm in Ms Burch's electorate.

MS BURCH: A grand day.

MR HINDER: And Ochre Health, I understand, has one going in in Calwell shopping centre and also won the contract to provide bulk-billing GP services out at the UC hub in my electorate of Ginninderra. Is it those kinds of expansions of those 100 per cent bulk-billing services that government has been engaged with? Can you give us an indication of the expansion, perhaps, of the National Health Co-op, the West

Belconnen Health Co-op, in the term of this government?

Mr Richter: You are exactly right; those are good examples of different models where government has played a role in creating a market environment. It was some years ago, through Ms Burch, I think, that there were a couple of hundred thousand dollars to help get the original co-op off the ground.

MR HINDER: Three hundred, I think.

Mr Richter: That has been incredibly successful. We now have a number of different sites across the jurisdiction. It is important to remember in primary care that we are talking about the private market. We do not have the ability to tell anyone to bill at a certain rate or to bulk-bill or not bulk-bill. But we can work with the different providers and on different models. That has been a good example of something that we worked with at the start to get something happening, and now it has seen great success.

MR HINDER: And the GP co-payment? What sort of threat would that be to a business model like National Health Co-op?

Mr Richter: I would let them talk about that rather than us. From our perspective, it is important that GPs and the primary care industry as a whole are appropriately resourced to do their job because when it is not we see the effects in the acute system.

THE CHAIR: Just to go back to Mr Hanson's supplementary, what is the rate? What do we normally measure the number of GPs by? Is it GPs per 1,000, per 10,000, per 100,000?

Mr Richter: There are a couple of measures. One of the common ones is FTEs per 100,000 head of population.

THE CHAIR: How many did we have last year and the year before and how many have we got this year?

Mr Richter: We can take that on notice and get those numbers to you. They have improved substantially over recent years.

Ms Fitzharris: In terms of the many things that we can do to improve access to primary health care, there was the regulatory change we made earlier this year to enable pharmacists to deliver flu vaccinations. The *Canberra Times* reported this morning that significant numbers of people have taken up this option in pharmacies. Nearly 3,500 people already have had their flu shot in a local pharmacy. Pharmacists view themselves very much as primary healthcare providers and are providing broader access in many locations across the city to important primary healthcare services and advice and helping their customers navigate the health system of which they are one key professional group.

They are aiming to reach, I believe, 4,000 flu shots before the end of the year. Some of the anecdotal evidence coming back from pharmacists is that many people whom they are giving flu shots to are telling them this is the first time they have ever had a

flu shot. Of course, we still encourage people who have particular needs to visit their GP or their primary healthcare provider. This goes to the government really making every effort to open up access at as many different points as possible for people to access primary healthcare services.

THE CHAIR: Ms Burch has a string of supplementaries and then we will go to Mr Hanson with a new question.

MS BURCH: It is just on GP FTEs. Over time, the co-ops in particular are increasingly getting an allied health or primary care team within them. Gone are the days when it was only a GP in a GP clinic and, therefore, the place would have been taken by a GP. Now it is an OT or a physio or a practice nurse. Are you able to collect that data? Rather than GPs, it is about the increase in a primary care team within a GP setting. That might give some depth to the number.

Ms Fitzharris: We will see what we can provide on that. We will take that one on notice too.

THE CHAIR: Mr Hanson, a new question.

MR HANSON: I want to talk about increased rates of HIV. The Chief Health Officer's report this year showed that there was an increase from previous years. What is the reason for this increase and what are you looking to do to try to increase public awareness to bring that number down?

Ms Fitzharris: Dr Kelly can talk in more detail about that. There is a budget initiative specifically to provide additional funding to help implement the statement of priorities which I released just a couple of weeks ago. Certainly those HIV statistics are a cause for concern. The funding specifically addresses it and has a focus on HIV rates amongst particular target groups. It also has a rapid testing component which was sought by the AIDS Action Council in their budget submission. I believe they have welcomed this funding. Dr Kelly can provide more detail.

MR HANSON: I am just interested in whether that is an increase with regard to sexually transmitted infection or whether it is intravenous drug use or something else.

Dr Kelly: Thank you for your question, Mr Hanson. The rise in HIV rates here in the ACT reflects national and indeed international trends. I guess you could think of it as the unintended consequence of the improvements in treatment for that particular disease over the past few years. The evidence internationally—as far as we can tell, it is similar to here—is that we are losing the safe sex message for younger people overall but, particularly in relation to HIV, it is men who have sex with men. That is the broad issue. They are not seeing this as a death sentence anymore because actually it is not. HIV has become more of a chronic disease and can be controlled but not cured.

It is time for us to start looking at different strategies other than what we have had since the start of the epidemic in the 1980s in relation to some new things that we have available. For example, we are looking at different ways of getting testing done. Last year we had our second year of the November testing month for sexual health.

That was a great success. Many more people were coming in and having tests, sometimes for the first time, not only for HIV but also other sexually transmitted infections and blood-borne viruses, in fact. That is one thing we can do, and we are looking at different ways that we can offer that testing, including point-of-care testing. Some of the funding in this budget goes toward that type of approach.

It is also about thinking of other ways of preventing infection with the strong medications that we now have available to us. There is a term called pre-exposure prophylaxis: the use of medication as well as the strong safe sex message and condom use for some parts of the community that may find that more attractive. So these are some of the things.

As to your specific question around whether this is sexual transmission or through intravenous drug usage, luckily, early on in the epidemic there was a very strong harm minimisation strategy of providing safe needles and syringes so we have never really had that issue strongly throughout Australia, including here in the ACT, around HIV being transmitted through needles. This is primarily a sexual health issue.

MR HANSON: What about hep C? Has that increased, decreased or—

Dr Kelly: Hepatitis C was also highlighted in the Chief Health Officer's report. We certainly recognise that hepatitis C is an issue. Hepatitis C can be sexually transmitted. It can be transmitted through intravenous drug use as well as other practices where blood-borne viruses can be transmitted. There are two ways that we look at hepatitis C. The most important one from our point of view in terms of seeing whether there is an increased transmission is where there are new cases of hepatitis C, where someone may have had a test before and it was negative and is now positive, or there are other reasons for us to believe that this is a new infection. Those rates have remained quite steady over the past three years. We had 16 new cases in 2013, 11 in 2014 and 14 in 2015. Across the five-year average through that period it is 13 new cases per year. Hepatitis C is a chronic disease. It lasts for a lifetime, once you have it, unless you are treated.

The other way of looking at it is any positive tests; this may have been there for some time. Again, that is a fairly stable number: 167 in 2013, 162 in 2014 and 170 in 2015. But even that probably underestimates the issue throughout the community. We are in exciting times around hepatitis C in terms of treatment. New treatment has been put onto the PBS and is now affordable for people. We really need to look to increase and improve access to particularly hard-to-reach populations where hepatitis C tends to be more common.

MR HANSON: How successful are those treatments proving?

Dr Kelly: Very successful and very safe. This is brand new stuff which is very important for us to be involved with and which we are involved in. We are working with Hepatitis ACT, for example, to look at ways that we can improve and increase access to that treatment which is funded by the federal government.

MR HANSON: One of the major arguments being put forward for providing needles or syringes in the jail was because of hep C infection, but you are saying there are now some very encouraging cures. Does that alter your thinking on that issue?

Ms Fitzharris: On the program itself? That issue remains under consideration. Following the establishment of a new consultative committee within the AMC in particular there is advice being worked up to be provided to ministers around this issue. I do not know if there was any other—

MR HANSON: It probably comes under corrections health a bit later, doesn't it? I am not trying to duplicate it.

Mr O'Donoughue: Thanks for the question, Mr Hanson. I guess, despite the exciting development of these new drugs, which are very effective and very efficacious, they are also very expensive and the risk of reinfection remains a problem. It would be most unfortunate if people did not have the means of prevention to avoid reinfection in a setting like a closed institution such as a prison. There would be no point in treating someone only to have them become reinfected because they did not have access to the means of prevention.

MR HANSON: All right.

Mr O'Donoughue: May I just supplement the answers that have already been given by the Chief Health Officer. In the budget there is an initiative to encourage more testing and screening for hepatitis C, hepatitis B and HIV. That is partly structured around the idea that with the availability of these new treatments, as the Chief Health Officer has said, it is very important to get the risk populations tested and to ascertain whether they can take up those new treatments and possibly end the hepatitis C epidemic.

MR HANSON: Good.

THE CHAIR: Ms Burch has a sup on the question, as do I.

MS BURCH: You made mention that perhaps the HIV numbers are going up because people are not so worried about the safe sex message. Do you see those increases across all the sexually transmitted diseases? Is there a need to perhaps recalibrate the safe sex message across any of the STDs?

Dr Kelly: Thank you for your question, Ms Burch. It is definitely an issue across the board. HIV numbers of new infections in the ACT are actually fairly small per year, so even an increase of the proportion that we have seen over the past few years is only a few people. Our major concern in sexual health remains chlamydia in young women in terms of numbers. Of course, this is a curable disease if diagnosed properly but, unfortunately, particularly for women, it is not necessarily associated with symptoms. They may not actually understand that they have got that problem.

I think the sexual health issue at the moment really is around that safe sex message and making sure that we redouble our efforts to get that message out and in ways that are accessible and believable by the community, particularly those at high risk; so

young women particularly for chlamydia. Gonorrhoea and syphilis have varied through the years but they have nationally increased. In some parts of Australia, for example, we are still seeing congenital syphilis as an issue. It has been transmitted from the mother to the baby; not here in the ACT but in other parts of Australia. This is a national tragedy which we need to work through. Again, that is particularly in the hard to reach populations. So there are some targeted messages that need to be put out there in relation to specific risk groups but overall it is reiterating the importance of that safe sex message.

THE CHAIR: Just on the HIV infection rates, you mentioned pre-infection prophylaxis. What is that exactly and how is that accessed?

Dr Kelly: There was an announcement recently. At the moment pre-exposure prophylaxis is being used in different parts of the world. There is a clinical trial that is going on through the Kirby Institute in Sydney called EPIC. I cannot remember what it stands for but that is the name of the trial. They have now enrolled over 1,000 people who believe themselves to be at risk of HIV and then go through a process of becoming part of that clinical trial.

These drugs are the same as those used for treatment for HIV. It is one of the combination treatments that has been used for more than 20 years—those particular drugs. They have been found to be safe. But what this clinical trial is about actually is: how does that work in a larger community setting and population-based approach? Is it safe? Is it useful? Does it work in that sort of larger group? The ACT has been invited to join that. Some of the funding from the budget will support that process.

THE CHAIR: How would somebody in the ACT access that? Is the only way through the trial?

Dr Kelly: At the moment, yes, but that is through the sexual health clinic at the Canberra Hospital.

THE CHAIR: Are there other drugs that you can currently access if you suspect that you might have been exposed?

Dr Kelly: Yes, post-exposure prophylaxis—pre-exposure would be before, post-exposure afterwards—has been available for some years. That is available through the sexual health clinic and I believe other sources in the community as well—GPs that have a particular accreditation.

THE CHAIR: Is that available 24-7 or do you have to make an appointment to go and see the doctor later?

Dr Kelly: I am not able to answer that question but there is a window period; so it does not have to be absolutely immediately.

Ms Fitzharris: We can take that on notice.

THE CHAIR: Because concerns were raised that there were delays in being able to access post-exposure prophylaxis. People were concerned that because of the delays they increased their risk of contracting the disease. How is it funded? Is that PBS or is that—

Dr Kelly: I am not sure. We will take that one on notice as well.

Ms Fitzharris: We will take that on notice.

THE CHAIR: I have a new question. Is the Canberra Clinical Genomic Service in this area or is that somewhere else?

Ms Fitzharris: No, with Minister Corbell.

THE CHAIR: Under prevention, rehabilitation, aged care and community care, what is the wait time now for older people to get an appropriate assessment from the ACAT?

Ms Fitzharris: I will have to get the right person to answer that question. We will take that on notice, Mr Chair.

THE CHAIR: It is part of the key strategic priorities. Is there not anyone here who can answer that question? Because the accountability indicators for output class 1.5 are just down to the number of nursing occasions of service and the number of allied health regional services. But your key strategic priority is ensuring that older people in hospitals wait an appropriate time for access to proper assessment. How do you know you are achieving that if you are not measuring it?

Ms Fitzharris: When Minister Corbell appears this afternoon for inpatient service he will be able to provide that answer to you.

THE CHAIR: I thought this was in your output classes.

Ms Fitzharris: The output classes do not specifically necessarily reflect all the services that are split between ministerial portfolios. Some output classes, as you will appreciate, have a combination of services that are delivered under the output class; so they have been—

THE CHAIR: We were told that this was in your responsibility. In output class 1.5 what are you responsible for; which part of rehabilitation, aged and community care?

Ms Fitzharris: In output class 1.5, the locations of service are under my responsibility but necessarily the service delivery itself may be within an area that is under the acute part of the Health Directorate. So we can answer your question. We can either take it on notice or Minister Corbell can answer it.

MR HANSON: I have a supplementary, Mr Chair. I am trying to delineate what is your responsibility and what is Mr Corbell's. Under rehab, what do you do and what does he do?

Ms Fitzharris: I have a responsibility for the community health centres and for the full range of services provided under the Chief Health Officer's part of the portfolio as well. Under the different output classes there may be a number of services, a number of programs, that are delivered that may have a split. They may not be easily categorised under the budget statements themselves because they obviously summarise a very broad range of services and programs that are delivered, either through the hospital itself or in community settings, for example, in the community settings where mental health services are delivered in the community health centre settings or in other community health settings. But I do not have responsibility for the mental health—

MR HANSON: Essentially anything that is on the campuses of TCH and Calvary is Mr Corbell and anything external to that is you?

Ms Fitzharris: Yes, plus mental health even where that may be delivered in a community health setting.

MR HANSON: Is who?

Ms Fitzharris: Minister Corbell.

THE CHAIR: It sounds like the third dot point in output class 1.5 is yours: community-based nursing and allied health services.

Ms Fitzharris: Yes, to a large extent but not all of it, depending on your question. Your questions will be answered. What was your question specifically?

THE CHAIR: Again, in that output class what is "timely based community nursing and allied health services"? How are you measuring that, given that there is no time-based measure in the accountability indicators?

Ms Fitzharris: Which page are you on?

THE CHAIR: Page 13.

Mr Thompson: It is correct that there is no time-based measure. What we measure is occasions of service as the best indicator of the activity of the program and, by implication, access to the services.

THE CHAIR: Your key strategic priority—third dot point—for rehab, aged and community care is, "Ensuring that access is consistent and is timely." How do we know if it is timely?

Mr Thompson: As I said, we measure the volume of services. The volume of services that we are providing is increasing. They are increasing at a rate that is proportionate to the way the population is increasing. As I said, by implication we believe the timeliness has been maintained.

THE CHAIR: So what is timely?

Mr Thompson: Appropriate to people's needs.

THE CHAIR: And how do you measure that?

Mr Thompson: I have answered that question.

THE CHAIR: No, I do not think you have.

Mr Thompson: It says—

THE CHAIR: You said you provide a lot of services. I get the growth and the service. We get the growth in population. We get the population is ageing but just saying, "We have provided a service" does not ensure that is provided in a timely way, as we know from the elective surgery waiting lists. The service is eventually provided but most of it is not timely. So how, in this case, given that you have listed this as a key strategic priority, minister, do you confirm for your interest that the department is delivering this in a timely manner?

Ms Fitzharris: I take your point, Mr Chair. We will most definitely review this in terms of timeliness based on the service itself. It will have different measures but we will certainly take that as a good point and improve the indicators around that for the next set of budget statements. If there is any information we can provide to you in the next five days we will certainly get that to you.

THE CHAIR: Mr Hinder and Ms Burch, supplementaries, and then Mr Hinder, a new question.

MR HINDER: I agree with the chair. The accountability indicators are not reflective of that stated aim but I assume you track these sorts of statistics within the directorate so that you know that you are delivering in a timely way consistent with clinical needs? That was the question.

Ms Fitzharris: Yes, and that is the work that we will do and provide to you what we can in the next couple of days.

MR HANSON: Sorry, you do track it?

Ms Fitzharris: Yes.

MR HANSON: Can you provide it to us, then?

Ms Fitzharris: That is what I indicated; we will be providing what we can in the next five days.

MR HANSON: Who made that decision to drop that indicator?

MR HINDER: Ms Burch had the next supplementary.

MR HANSON: Sorry, Mr Chair.

Ms Fitzharris: To drop the accountability indicator?

MR HANSON: Yes, there was an indicator for the ACAT assessments, wasn't there, for timeliness?

Ms Fitzharris: I do not believe it was dropped.

MR HANSON: Is that one still there?

Ms Fitzharris: I am not aware of it being dropped. Whether I can answer right now the question on the timeliness, but I do not believe, and I will double-check, that any indicators have been dropped bar one because one was fully achieved.

I am advised it has been gone for two years. It was in the 2014-15 budget. I will—

MR HANSON: Before your time.

Ms Fitzharris: And also—

THE CHAIR: I think we asked these questions last year as well.

Ms Fitzharris: Yes.

MR HANSON: It used to be there; we have been around this buoy before.

Ms Fitzharris: Okay.

MR HANSON: It always used to be an assessment that was recorded. I have got data going back to 2008-09. It was dropped.

Ms Fitzharris: I will find out the answer to that question, Mr Hanson. It is a reasonable question and we will find out the answer for you, yes.

THE CHAIR: Ms Burch has a supplementary and then a new question from Mr Hinder.

MS BURCH: I think it goes to the thread we are on. Just to be clear: you will come back with the waiting list for access to clinic and community-based nursing based on the third dot point there, Mr Thompson?

Mr Thompson: Correct.

MS BURCH: I think it is an important indicator.

Mr Thompson: We will provide what information we can.

THE CHAIR: Mr Hinder, a new question.

MR HINDER: Minister, in your opening statement you touched on the tragic need for palliative care for children. Can you give the committee some information about how that initiative came into being and what it consists of?

Ms Fitzharris: Certainly it was a need identified within Health itself, but I had also been advocating for this having been made aware of a number of families that had been through, obviously, a very difficult time with their own children in palliative care. I would like to recognise two families that I had been working with. One in particular would be well known to many members of the Canberra community—the Anthoney family, whose daughter Dainere passed away three years ago when she was 15. She was named posthumously as the ACT Young Citizen of the Year with her brother Jarrett in 2014 after she had passed away. Her family has since been fundraising and advocating for awareness, particularly around brain cancer, which Dainere suffered from, in conjunction with a number of other families but, in particular, the Wills family, who lost their son Benny when he was just four years old nearly eight years ago.

In meeting with them—they are local constituents of mine—and talking to them about the work that they did and the experiences they had, they felt that they really wanted to continue to advocate on behalf of the children they had lost and on behalf of other families they had met, and sadly continue to meet, who have children suffering in a similar way. In Benny Wills's case, this particular tumour is generally prevalent amongst young children only and in every case is 100 per cent fatal, and often within 12 months of diagnosis. They knew on the day he was diagnosed that he would pass away, most likely within 12 months, so they knew straightaway that they would need access to palliative care.

For me, this is a special initiative to be funded in the budget and it is particularly special for both of these families. I originally met the Anthoneys while I was doorknocking in 2012 when Dainere was still alive. I know that she also received support from a former member of the Assembly, now Senator Seselja, who has continued to stay in touch with the family as well. They have since, as I say, been strong advocates.

I would like to make special mention of Dr Jeff Fletcher from paediatrics at Canberra Hospital. Just recently he hosted the Anthoney family on a tour around the new hospital to show them how much services have improved. I know from talking to them since their relatively recent experience—it was only three years ago—that they are aware of how much the new centenary hospital means for families. Jeff Fletcher was able to take the Anthoneys on a tour through the hospital. They found some artwork on the wall that Dainere had done when she had been a patient there that they were unaware was on the wall.

Dr Fletcher spoke at the annual dinner that the Anthoney family attended just a couple of weeks ago. He spoke about this initiative. He also spoke about another family he is currently working with who have a one-year-old child who has been in palliative care since he was four months old and what this initiative will mean for them. This is a particularly special one. It is a small investment. A dedicated paediatric palliative care nurse, I think, will make a really big difference to families going through a particularly difficult time.

MR HANSON: A supplementary. With palliative care, do you have responsibility for all palliative care or is that split between community based and Clare Holland House?

Ms Fitzharris: It is split between community based and Clare Holland House.

MR HANSON: So you take the community based?

Ms Fitzharris: That is right, and Clare Holland House falls under the local health network.

MR HANSON: How many palliative care nurses do we have at the moment?

Ms Fitzharris: How many all-up? I could take that on notice. I know that this will add one and I know that there is not a dedicated child nurse. This new initiative provides two additional nurses—two additional positions in the palliative care team—as well as increased education and awareness for palliative care provision as a whole across the territory.

MR HANSON: Have you had any meetings or engagement with the palliative care society?

Ms Fitzharris: My office has been in touch with them, yes.

MR HANSON: You have not personally?

Ms Fitzharris: No, I have not had the opportunity yet, but my office has been in touch with them. I have been in touch with some palliative care nurses directly as well.

MR HANSON: With the evolution of palliative care, some reports were done a few years ago. The intention, as I understand it, is to try to increase the amount of palliative care that happens in people's homes. What have you done to try to, I guess, develop and enhance that?

Ms Fitzharris: That is an important part of this initiative as well. Some of the feedback that I had received was that many people increasingly seek palliative care services in their own home in community-based settings and may indeed move between settings as well. Under this initiative, with two FTEs and investment in that, we will continue to work to improve services. Ms Feely might be able to provide more information on the model of care.

Ms Feely: That is a very good question. It will be part of the model of care review we are about to commence to look at what the needs and the developing trends are and to make sure that across the ACT in every element of the service delivery span we are providing the best care we can. Palliative care more within hospital and back into the community in the home and also using Clare Holland House will be a key consideration that we need to look at.

When I was the chief executive of St Vincent's we trialled an education process with all the clinicians in the tertiary setting about the role of palliative care in a tertiary

setting. It was an incredible change in approach. We then set aside a floor where we were able to move patients to an appropriate palliative care setting and it was very well received. That was in the tertiary sector. I want to take that sort of different thinking and look at what is happening across the world and across Australia to make sure that we can provide first-rate palliative care wherever the patient needs it as soon as possible.

MR HANSON: Providers and Palliative Care ACT and so on work between Clare Holland House and the community and there is a sort of movement between the two. Delineating that you have responsibility for people externally, you are splitting it between two ministers, when it should be a cohesive, coordinated, connected service looking at palliative care as a system. Are we not better off having a single minister looking at palliative care substantively so that you can actually look at it holistically, rather than one minister looking at this segment and another minister looking at the other?

Ms Fitzharris: You are absolutely right that this is the system. The directorate will be working very much across the system as a whole, as all of our government agencies do. This will involve the community sector, and questions around the provision of health services in the AMC involve the Minister for Corrections. It is our responsibility as ministers to make sure that we very much indicate to the directorates that this is system-wide. From my point of view, I will consistently say that, whichever model of care directorates are looking at, they need to look at this as a system. I will work with Minister Corbell and other ministers as it might touch on their specific ministerial responsibilities. Certainly my strong preference and the government's strong preference is that the care that is provided to individuals and families in the community will be the driver. We will figure out our responsibilities and our directorate structures so that it works for the people that we are delivering services to.

MR HANSON: What is the logic behind having two ministers for palliative care?

Ms Fitzharris: I would not say that there are. There are two ministers who have a strong interest in and a responsibility for palliative care. I think that is a good thing. As is the case across a range of health services that we provide, as the discussion has obviously indicated, we want to make sure that the services that are provided to people are delivered cohesively. We will do everything we can to make sure that we—

MR HANSON: But in mental health you indicated that that has been taken on by a single minister. So there is a cohesive look, I suppose, regarding both community and people who are in a mental health facility. Why the difference in palliative care and some other health services?

Ms Fitzharris: There is not a difference. ACT Health is delivering these services in collaboration with a range of partners. There are two ministers who have an interest. I have had a personal connection to a number of families as their local member and then as assistant minister for health. On this particular one I have taken a strong interest.

THE CHAIR: We will leave the supplementary there. Ms Burch, a new question?

MS BURCH: I go back to output 1.5 on page 117—the number of occasions of service. There is a growth of 6,000 and 5,000 across nursing and allied health. Is that growth in any particular area? Are the nurse walk-in clinics counted in those numbers?

Ms Fitzharris: Yes, they are. Mr Thompson can specifically answer that.

Mr Thompson: These numbers are separate from the walk-in centre numbers specifically.

MS BURCH: They are separate?

Mr Thompson: Yes.

MS BURCH: Where are those numbers then?

Mr Thompson: We do not have specific indicators in the budget papers around the walk-in centres.

MS BURCH: Does your annual report track them?

Mr Thompson: We track them on a monthly basis through our internal performance reporting but Health does not have a specific indicator.

MS BURCH: There is no public reporting on the increase in—

Mr Thompson: No, we also provide information in the quarterly performance reports that ACT Health provides.

MS BURCH: That is tracked somewhere?

Mr Thompson: It is available.

MS BURCH: These are just clinics. What is a clinic-based service and what is a home-based service?

Mr Thompson: Accountability 1.5a covers both clinic-based services, in other words, where inpatients come in to receive care within a clinic setting, as the name implies, and home-based.

MS BURCH: But not a nurse-led clinic?

Mr Thompson: These are at times nurse-led clinics but it is not the walk-in centres. The walk-in centres are a distinct service. They have a very different focus and client group. These services provide both home-based and clinic-based care. In terms of the increase in service, that is in response to improved staffing levels from ACT government funding in the 2015-2016 financial year in the budget. That has enabled additional staffing to be provided and an expansion of services.

MS BURCH: It builds a little on what Mr Hanson was saying and what is spoken about increasingly, whether it is palliative care, aged care, dementia care, a whole range of nursing or clinical supports preferred in a home-based environment. Does this accommodate that? Is there a particular area where you are focusing on to increase that to get a patient out of a tertiary setting of a hospital and into home?

Mr Thompson: One important component of this service is, in fact, to provide care post-discharge so that people are able to be discharged from hospital sooner than others. Otherwise, we also provide education sessions around self-management of chronic conditions to enable people to continue to maintain their health and to prevent unnecessary hospitalisations. We have wound care specialist nurses involved in this home therapy and generally community nursing. These are examples of what is provided.

MS BURCH: Can you break that up and give us a sense of whether there is a particular clinical discipline that those 90,000 occasions of care are split over? Are there four or five key areas that you are investing in?

Mr Thompson: Yes, I will see what we can do; it operates as a program as a whole but I will see what I can in terms of breaking it down.

MS BURCH: Are the allied regional health services in-home services or is that done through your community health centres?

Mr Thompson: It provides home visits. Again, it provides home visits and clinic visits. The sorts of disciplines covered are physiotherapy, occupational therapy, social work, podiatry and nutrition.

MS BURCH: Again, is that linked to the hospital? I am trying to get a sense of how the home-based care is split up. Is it driven on discharge planning or is to supplement your ACAT and home-based aged care services? I am trying to work out what it looks like.

Mr Thompson: It is in part about discharge from hospital and supporting people post discharged from both a nursing an allied health point of view. But equally there are some aspects of chronic disease management and continuing care that we provide to maintain people, to maintain their health in the community as well.

MS BURCH: On podiatrists, do you train up therapy assistants for foot care in home-based care? A podiatrist is an expensive component of health care.

Ms Fitzharris: Could we go back to the original question about focus in nursing and I was wanting—

THE CHAIR: Are you asking us to focus on the original question?

Ms Fitzharris: Yes, the nursing question and then we can break it down. Then we can break it down further in the allied health services as well.

THE CHAIR: Quickly; we have fifteen minutes before this session ends. I know how much you like answering questions.

Ms Croome: Can I have the question again please?

MS BURCH: What I am trying to get a sense of, across allied health and nursing—I am interested in home-based care. What does it look like? What elements of that service make up the 90,000 occasions? Collectively, there are 120,000 occasions of service. I am trying to get a sense of what that actually looks like.

Ms Croome: I would have to take that on notice but in terms of how patients are referred into the community service, it is through the discharge liaison nursing service. Last time we counted I think we had about 11 FTE of discharge planners who see complex patients in the wards and plan for the discharge. They will refer them to a community-based program for follow up.

As Mr Thompson was saying, we having a very well established chronic care program and many patients are seen on a regular basis through that program. There are actual hospital avoidance strategies within the chronic care team to prevent patients from being admitted back into hospital. It is all well coordinated through a central approach, which are the discharge liaison nurses. But I will break that down for you.

MS BURCH: Yes, home-based care is fabulous. I am just trying to get a sense of what are those key areas.

Ms Fitzharris: Equally with the allied health services, as well.

THE CHAIR: Mr Hanson had a supplementary.

MR HANSON: Yes, there was some—

Ms Fitzharris: Sorry, Mr Thompson was going to add to that.

Mr Thompson: On the podiatry assistants, yes, I can confirm that we do have podiatry assistants working with the podiatrists.

MR HANSON: Mr Thompson, you referred to the quarterly performance reports. When was the last report released publicly?

Ms Feely: December quarter.

MR HANSON: December, okay. Where is the March report?

Ms Feely: On its way to me.

MR HANSON: On its way to you? Why is it that a report that is meant to provide information to the public and the community, that is useful for the estimates committee and so on, has not been released when we are just at the end of the next quarter? The one before has not been released. If you are not going to publish them in a timely way, why are you bothering? It serves no purpose, does it?

Ms Feely: No—

MR HANSON: If we do not get information until, sort of, two or three quarters after the fact.

Ms Feely: The March one—as I understand it, and I will look over to my friend over here—there is no set date when this report needs to be released. But I agree that it would have been preferable had it been released prior to these hearings, for a number of reasons. But it has been completed over the weekend, as I understand it, and it is ready for my review ASAP. I have not actually—

MR HANSON: Sure, but given—

Ms Feely: But, no, your point is valid.

MR HANSON: that the next quarterly report is due in two days time, I am surprised that that is not the one that is coming to you as opposed to the one before.

Ms Feely: It is a good point.

Ms Fitzharris: That is a good point, Mr Hanson, and we will certainly take that on board for this current past quarter.

Ms Feely: I can bring Mr Ghirardello up—he is responsible for the information contained in the report—to add anything further. But your point is valid.

MR HANSON: The problem is that we do not have the report to prosecute the information. I am relying on press releases that you have put out—by the health minister this morning half an hour before the commencement of the committee—that do not even reference the quarterly report and some random information that has been put out. Meanwhile, we do not have a quarterly report that was due months ago.

Ms Fitzharris: I am sure Minister Corbell can provide further information but in the meantime—

MR HANSON: Sure, but I suppose my point would be that if you are going to be answering questions referring to quarterly reports, it is best to release those quarterly reports if you are going to be talking about them. Otherwise the members of the committee are sitting here blind about a quarterly report that has information that we are oblivious to and that the community is oblivious to. We are now six months on since any quarterly has been released. I note that the December quarterly report was late as well. Can you take that on board?

Ms Fitzharris: Yes, certainly.

THE CHAIR: Is it possible to have the report after the tea break or after the lunch break?

Ms Fitzharris: I do not imagine that would be the case if the director-general has not

yet had an opportunity to have a look at it.

THE CHAIR: But what is the purpose of the review? I am assuming you do not change the information in it.

Ms Feely: I read it very—

MR HANSON: Don't be so sure.

Ms Fitzharris: Oh, Mr Hanson!

THE CHAIR: You receive it and then it is released?

MR HANSON: Don't be so sure.

Ms Fitzharris: Oh, Mr Hanson!

Ms Feely: No, Mr Hanson, I can assure you—

MR HANSON: Well, I have been assured many times of that.

Ms Feely: I do not play with the statistics.

MR HANSON: I have been assured of that before.

Ms Feely: What I do is I read it. I read it to make sure it makes consistent—

THE CHAIR: That is okay; we accept your guarantee that you do not change the statistics. What is the difficulty in bringing it back for—

Ms Feely: I like to actually take the time to read it, have a look and make sure it looks consistent, make sure that I cannot see any errors in the report, as well. That is something I have read in great detail. I take my time to look at it. It is not a case of me changing statistics or anything like that. Sometimes when you read them through you do pick up things that are obvious issues that need further discussion.

THE CHAIR: When is it likely to be released?

MR HANSON: They do not always get picked up.

Ms Fitzharris: Mr Chair, I am sure you will appreciate that for accountability purposes, the director-general is accountable to the minister. It is entirely within the director-general's—in fact, it is a responsibility of the director-general to receive the report and to provide it to the minister, in this case, Mr Corbell. I am sure, given these questions, that the director-general and the minister will want to have this information made public, because you are right; it is important and—

THE CHAIR: But you do agree it would have been useful to have it today?

Ms Fitzharris: I do agree, yes. We have the December figures but, yes, I agree. They

are obviously not available the day after the quarter ends.

THE CHAIR: Yes, sure.

Ms Fitzharris: But as soon as possible afterwards; we do take that.

MR HANSON: Six months.

THE CHAIR: Three months after the end of the March one.

Ms Fitzharris: Three months—it is not six months since—

MR HANSON: Six months since the last report.

Ms Fitzharris: But it is not six months since the end of the quarter.

THE CHAIR: Yes, but it is three months since the end of the March quarter.

Ms Fitzharris: That is right, yes.

THE CHAIR: Mr Ghirardello, could you enlighten us.

Mr Ghirardello: The quarterly report generally comes out two to three months after the end of each quarter. There is a huge amount of information that we need to collect and capture. There are also large amounts of data validation that occurs to check that we have got the full amount of information for an activity that occurred in that quarter. That process does take some time. There are also double and triple checking of the information before it is then put up through the organisation, through to the director-general. We did an additional process for this quarter based on some areas that were in the previous quarterly report, which extended the time frame for another week or two.

THE CHAIR: We will perhaps take that up with the other minister.

MR HANSON: We might follow this up when we have got the other minister.

THE CHAIR: That was a supplementary from Ms Burch. Now it is a substantive question from Mr Hanson.

MR HANSON: I go to the issue of alcohol use. The government has put out a liquor white paper. Have you had involvement in developing that? This is the issue of alcohol licensing.

Ms Fitzharris: That is with the Attorney General.

MR HANSON: It is, yes. Obviously, part of the intent is alcohol consumption, I imagine.

Ms Fitzharris: Yes, that is right.

MR HANSON: Have you had any involvement in that at all?

Ms Fitzharris: In preliminary discussions, yes, in the cabinet process and I will continue to be engaged in that process as it continues to be developed within government.

MR HANSON: Beyond that in terms of alcohol consumption in the community, have you looked at any trends, good or bad?

Ms Fitzharris: Yes and, certainly, as you will know from the Chief Health Officer's report, I have also met with some of the stakeholders in this area as well. Obviously, the white paper will indicate—there will be discussions within government about the approach that we take with regards to licensing in particular. But certainly we do know from the Chief Health Officer's report that there remains a concern in the community.

We know that there continue to be people who drink alcohol at a risky level. We have a range of different programs, services, both to prevent and to educate people, particularly younger people, about alcohol consumption. But we also provide funding to alcohol and other drug service providers at the other end of the spectrum to work with people who may have already had problems with drinking behaviours.

MR HANSON: Who has responsibility for the Bush Healing Farm? Is that you or Minister Corbell?

Ms Fitzharris: Minister Corbell.

MR HANSON: What about any other rehab services? Do you have responsibility for those or do they lie under Minister Corbell?

Ms Fitzharris: Largely under Minister Corbell, yes.

MR HANSON: Largely?

Ms Fitzharris: Yes, again some of the stakeholders will seek to meet with both Minister Corbell and me. We will work together in terms of the relationships of those stakeholders. To the extent that there are obviously broader community health aspects, there will be a range of programs that will be funded that will be under my responsibility, yes.

MR HANSON: Which programs are you running under your responsibility?

Ms Fitzharris: Under the health prevention, under the health promotion grants, there will be a proportion of grants provided to alcohol programs. I can provide the specific of those grants.

MR HANSON: Have you got a breakdown of all the grants that have been provided? That might be a useful thing. Where is that contained?

Ms Fitzharris: In fact, we recently launched a report on the grants that had been

provided to a range of different NGOs over the past three years, from memory. I will find my brief and remind myself of the details. I can certainly provide that on notice in terms of the breakdown of the grants. That is in the annual report as well.

MR HANSON: Yes, that would be useful I think rather than going through them now.

Ms Fitzharris: Yes, sure.

MR HANSON: Thanks.

THE CHAIR: I refer to output class 1.6, early intervention and prevention. Is the breast screening program covered in this output class?

Ms Fitzharris: Is it in this output class? I believe breast screening is in 1.4. Yes, under 1.4.

THE CHAIR: Yes, it is with cancer services. There is an increase in this budget line. How much of that is going to advertising?

Ms Fitzharris: In which budget line?

THE CHAIR: Output class 1.6.

Ms Fitzharris: How much of it is going to education?

THE CHAIR: Education at the broad and advertising in particular.

Ms Fitzharris: I might have to take that one on notice, Mr Smyth.

THE CHAIR: What advertising is undertaken under this output class?

Ms Fitzharris: Under the whole output class?

THE CHAIR: Yes.

Ms Fitzharris: Again, I will take that on notice.

THE CHAIR: Mr Hinder, a new question?

MR HINDER: Thank you, chair. Minister, you spoke about the community health services when responding to various questions this morning. Can you give us a rundown of the services available out of the community health centres? Why are they important to the community?

Ms Fitzharris: Certainly, there are six community health centres located across the city. You will know well both the Belconnen and Gungahlin ones. Certainly, Belconnen and Tuggeranong also have the walk-in centres that are provided and collocated. There is also the Phillip Health Centre, the Gungahlin health centre, as I mentioned, the City health centre and our smallest health centre in Dickson.

As Ms Burch was alluding to, they provide a range of allied health services and, depending on the centre, might have specific specialities provided at each service. I am working with the directorate on a communications exercise to better inform the community about the services available to them in their local area and when they are provided.

But there is an enormous range of services that can be provided at our community health centres, including community health, both for adults and adolescents, nursing, a lot of dental programs—particularly for younger people—physiotherapy, podiatry and some pathology services. The project that we are working on to better communicate this will take a real patient focus and allow patients to understand fully what services are available in their local community health centre. That just goes further to increasing access and increasing awareness of the health services that we are providing for people.

MR HINDER: Do the community health services provide things like breast feeding training for new mothers and those kinds of—

Ms Fitzharris: The maternal and child health services are provided and, having used them myself, are a very vital part of the community health services. They provide access to new mothers—fairly immediate contact with new mothers once they have given birth—to provide them follow up services. They certainly do provide great assistance for weighing new babies to make sure that they are feeding well, providing breast feeding support if that is needed and a range of other services to new mums, particularly first time new mothers. They can then provide connections to other services that they may need, particularly in those early days, weeks and months of a new baby.

MS BURCH: I have a very quick one. A number of the community health centres are collocated. Tuggeranong, for example, is right next to the child and family centre. Do you consider them one of your key stakeholders? That clinical care goes on from breast feeding to parenting to broader parenting. So you are referring to the other agency as well.

Ms Fitzharris: That is right, yes, and the collocation is wonderful, particularly, as I know, the collocation in Gungahlin. Although not collocated with the Belconnen Community Health Centre, the West Belconnen Child and Family Centre is a really important part. I belief there might be some health services provided out of the child and family centre in Kippax as well. We want to provide services closer to where people live and closer to where they want to access services and locations that they know and trust.

Certainly, I know that the work that is underway through the local services network trial in west Belconnen, in particular, ACT Health are very engaged with, as are other directorates, together with community sector organisations as well businesses in the area, including pharmacists. Every effort is being made to break down silos to make sure that those services are delivered to people at the right time at the right location, when and where they need them. The community health centres are becoming hubs for new parents. I think where they are located, with child and family centres, just adds to the value of the services that we provide.

THE CHAIR: We will finish there. I think that finishes your time with us as the Assistant Minister for Health. We thank you for that. Members, we will resume at 11.30 with Minister Corbell as Minister for the Health. We will start with the local hospital network and acute services.

Sitting suspended from 11.16 to 11.34 am.

Appearances:

Corbell, Mr Simon, Deputy Chief Minister, Attorney-General, Minister for Capital Metro, Minister for Health, Minister for Police and Emergency Services and Minister for the Environment and Climate Change

Health Directorate
- Feely, Ms Nicole, Director-General, ACT Health
- Strachan, Mr Shaun, Deputy Director-General, Policy, Planning and Innovation, System Innovation Group
- Thompson, Mr Ian, Deputy Director-General, Canberra Hospital and Health Services
- Kelly, Dr Paul, Chief Health Officer
- O'Donoughue, Mr Ross, Executive Director, Policy and Government Relations
- Croome, Ms Veronica, Chief Nurse, Canberra Hospital and Health Services
- Dykgraaf, Mr Mark, Executive Director, Critical Care, Canberra Hospital and Health Services
- Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Service, Canberra Hospital and Health Services
- Ghirardello, Mr Phil, Executive Director, Performance Information
- McDonnell, Mr Sean, Director, Employment Services, Strategy and Corporate
- Mooney, Mr Colm, Executive Director, Project Delivery, Health Infrastructure
- Donda, Mr Jean Paul, Senior Budget Development Officer, Financial Management Unit
- Richter, Mr Matthew, Senior Manager, Government Relations, Primary Health and Chronic Conditions Policy Unit
- Cook, Ms Sandra, Acting Clinical Systems Program Manager, E-Health and Clinical Records

THE CHAIR: Welcome back, ladies and gentleman, with the Minister for Health to look at the rest of the health portfolio. Minister, would you like to make a brief opening statement?

Mr Corbell: Thank you, Mr Chairman. I am pleased to appear before the committee this morning and to speak about the continued investment of this Labor government in the area of health services and the importance of it. This year's budget invests a record $1.6 billion to provide more health professionals for our community, including more doctors, nurses, allied health professionals and overall better health performance.

Before I explain further this record investment in health, I will take a moment to reflect on some key achievements of the Health portfolio over the past 12 months, including in the emergency department at the Canberra Hospital. This year we have seen the opening of two key areas of the $23 million emergency department expansion. The $10 million first phase, which was opened in January this year, includes the new mental health short stay unit, which has six new private patient bedrooms with staff nearby and an overall increase of two beds. The second area of the ED expansion saw the ACT's first dedicated paediatric streaming and waiting area at the Canberra Hospital. This new space is improving how we care for younger patients and their families by providing a separate area in the ED with six patient beds,

two consulting rooms and a private sub-waiting area.

This week the third phase of the rebuilding program of the ED opened. This includes the new streamed B area which will now have 10 bed spaces and three procedure rooms. This area immediately behind the main reception and with its own dedicated waiting area will be utilised to treat patients with less acute conditions and will be instrumental in continuing to see improvement in timeliness in the emergency department.

The second area opening in the ED this week is the emergency medicine unit, or the EMU. This is a 12-bed purpose-built unit that will provide care to patients who require care for less than 24 hours. This represents an increase of an additional three beds in this important service. When the ED expansion is complete, the Canberra Hospital ED will receive an extra 1,000 square metres of floor space and a 30 per cent increase in patient treatment areas.

I am pleased to say these improvements are already making a difference in improving access to timely care. Today I can announce that the average wait time in the Canberra Hospital emergency department has improved by 14 per cent, and the average treatment time has dropped by 34 minutes over the past four months when compared with the same period last year. Between March and the end of June this year, the average wait time has reduced to 57 minutes compared to 66 minutes in the same period in 2015, and the average treatment time has dropped to 140 minutes from 175 minutes.

The average daily presentation rate continues to grow, with 222 people seen each day over the same four months compared with 203 each day in 2015. At a time when presentations to our emergency department continue to grow by a rate of approximately 10 per cent, access and timeliness is significantly improving. I expect hospital performance will continue to improve through the hard work undertaken by our doctors, nurses, hospital administrators and others through the ED reform agenda. The fact that this is being complemented by a $29 million commitment in this year's budget for additional nurses, doctors and allied health staff in the ED means we are well underway to very significant improvements in timeliness.

Finally, I would simply like to highlight the good work that is also occurring in relation to elective surgery. In November last year I announced that ACT Health would undertake an $11.8 million elective surgery blitz to greatly reduce the number of long-wait patients in the ACT. The blitz has delivered the highest number of elective surgery procedures ever performed, with close to 13,400 surgeries performed overall, almost 1,500 more than that provided for in the previous financial year. This increase in activity has reduced the number of people waiting too long for their surgery from 1,335 when we started the blitz to just 409 as of 27 June—a 69 per cent improvement. This means there are 926 fewer people on the waiting list who have been waiting for longer than their recommended time, a 69 per cent improvement compared to the previous period.

Again, I acknowledge the very hard work of our surgical teams, surgical specialists, nurses, doctors and also hospital administrators over the past six to nine months to put these reforms in place and to improve access and timeliness.

As I have said very clearly since I was appointed as health minister, Mr Chairman, my primary focus in the time I have available is on improving access and timeliness to care, particularly when it comes to acute care. I can say to you today that we are well and truly on track. Whilst there is a lot more work to be done, I am very pleased with the efforts of ACT Health to date. We are very happy to answer your questions, Mr Chairman.

THE CHAIR: Page 2 of budget statement C looks at the staffing. The estimated outcome for this year is about 80 higher than was expected. What is the explanation for that? Can you give us the detail on what is driving the growth between 16,415 as the outcome and 16,572 as the target for next year?

Mr Corbell: I will ask Mr McDonnell to answer your question, Mr Smyth.

Mr McDonnell: Can I have the question again, Mr Smyth, please?

THE CHAIR: The FTE in the estimated outcome for 2015-16 is 81, according to the notes, more than was predicted. What has caused that?

Mr McDonnell: I will take that on notice, Mr Smyth.

MR HINDER: It is in note 1.

THE CHAIR: No, that just tells you a higher FTE cap. You cannot tell me what the extra 80 staff have gone to?

Mr McDonnell: Not off the top of my head. I need to take that on notice.

Mr Corbell: We will take the question on notice, Mr Smyth.

THE CHAIR: And the extra 157 from the estimated outcome to 2016-17 budget, what is driving that?

Mr Corbell: Again, I will have to take that question on notice.

THE CHAIR: How can you not be prepared for what the staff are doing?

Mr Corbell: You are asking for specific movements in a workforce of nearly 4,000, Mr Smyth, so—

THE CHAIR: So is it just increased growth? Is it new programs?

Mr Corbell: I think—

THE CHAIR: Surely you know that. I mean, that is—

Mr Corbell: If I can provide you with an answer during this hearing, I will. Otherwise I will take it on notice.

THE CHAIR: Does somebody know? Ms Feely clearly feels somebody else knows.

Mr Donda: That increase of 150-odd is directly related to new initiatives in 2016-17, and we can provide a list by initiative.

THE CHAIR: If you could, that would be great.

Mr Corbell: Please.

Mr Donda: Now?

Mr Corbell: Yes, please.

Mr Donda: Going through the initiatives: expansion of the neo-natal intensive care, 8.2 FTE; expanding the intensive care unit, 8.5 FTE; emergency department expansion, 39.3; trauma service, 6.5; stroke service, four; improved and expanded community mental health, 3.4; secure mental health, 59.6; adult mental health unit, 3.8; enhanced rehabilitation and co-op services, 4.9; increased services for Alexander Maconochie Centre, three; more outpatient services, 9.5; palliative care, two; forensic chemistry capacity, two; and healthy weight, 0.7.

THE CHAIR: The secure mental health facility at 59, is that the expected—

Mr Donda: 59.6.

THE CHAIR: Is that the expected total staffing for that new facility, or will further be required?

Mr Corbell: For the next financial year, yes.

THE CHAIR: When is that meant to open?

Mr Corbell: Next financial year.

THE CHAIR: Is there a projected date in the next financial year for it to open?

Mr Corbell: There is a projected date. I defer to the department on that.

Ms Feely: At this stage, the building works are all on track. Assuming everything from a building capacity continues on track, we are probably looking for the building to be handed over in about November this year. That will also, however, include a testing period. We have to make sure all the IT systems, all those things, flow through. We often give ourselves a 12-week phase. We are looking to have patients admitted probably November-ish this year. With all the caveats attached to that, that is how we are planning to move forward.

THE CHAIR: We have opened some buildings a bit early in the past and the systems were not in place, so I am sure we will avoid that this time. The emergency department of 39.3, is that just for expanded capacity?

Mr Corbell: Yes. That is the staffing component to meet the expansion in physical capacity the government is currently undertaking through the ED reform program, which I outlined in my opening statement.

THE CHAIR: Thank you, minister. Mr Hinder, a new question.

MR HINDER: Minister, you touched on elective surgery wait times in your opening address. I understand that you said it was a 69 per cent reduction from the previous period. It appears from your strategic objective 1 on page 3 that you have smashed your target by 1,000 there or, if a few of the press releases are correct, closer to 1,500 by today's date. How is it you have achieved these sorts of numbers, and what are you doing to address that continued demand long term?

Mr Corbell: The elements of the reform agenda in relation to elective surgery are twofold. The first obviously is an immediate boost to overall capacity to perform procedures, to see a significant reduction in the number of people waiting longer than clinically indicated for their surgery. We have invested additional funding, around $11 million additional capacity, to see more procedures undertaken, and that has led to that significant reduction in long waits that I mentioned of over 900 fewer people on that long-wait list out of a total of around 1,300.

We have done that through better theatre utilisation in the public hospital system, and that has been driven by reforms around booking procedures and a review of people who are on the long-wait list, amongst others, about their readiness for surgery. It has also been driven by improvements in our utilisation of non-public theatres, the significant surgery theatre capacity in the private sector. And we have been able to negotiate good arrangements for access and utilisation of theatres in private hospitals in the ACT for the same cost as it would for us to perform them in the public system but in a way that means that we are able to utilise more operating theatre space. That is meaning more surgeries are able to be performed.

I would like to commend the directorate and the DG for the work she has undertaken and continues to undertake in exploring these partnerships with the private sector because at the end of the day I think it is very clear that the community expects all of our hospital infrastructure to be used as efficiently as possible to actually meet demand, to meet the need in the community. We have had great cooperation from the private hospital sector who are willing to make their theatres available because they are not as heavily utilised as the public theatres are.

The other key point to make is that these reforms are designed to be enduring. Yes we have put some additional capacity in, but the changes we have made around procedure and management of the list mean that we have a high level of confidence that we will be able to sustain a much stronger level of performance when it comes to people getting their surgery on time. Better management of the list, better management of the utilisation, better booking arrangements and coordination of the utilisation of theatre time all mean that more people can get their surgery. That is a very good outcome and has been one of the key priorities I have set as minister.

MR HINDER: So you are confident going forward that there will be no requirement for a further blitz, that procedures are now in place to make sure that the backlog—

Mr Corbell: The objective is to make sure that removals from the long-wait list are enduring and that we are able to meet our time frames so that we do not end up with large numbers of people on the long-wait list, and that is exactly what we have to try to achieve. We have to keep the long-wait list as small as possible if not eliminate it completely.

MR HINDER: Has there been any resistance from any of the stakeholders? Some have vested interests in keeping demand high, I would assume, from a profitability point of view?

Mr Corbell: No. Far from it. I think it would be unfair to characterise motivations of our health professionals in that respect. I think it is important that we recognise that we have only been able to do this with the strong support of the surgical professions themselves, the specialists who undertake the surgery, and the teams that support them in the operating theatres, in the hospital as a whole both at an administrative level and at a clinical level. It has been very important that we reform procedure, that we reform the processes that provide for booking and allocation of theatre space, that we have a clear and robust mechanism around review of readiness for surgery which is, very important. Keeping your waiting list up to date and making sure that the people who are on the list are genuinely ready for their surgery, are needing it and are genuinely ready for it are all issues that mean we have a more efficient and a more timely arrangement to provide surgery to people. We have not been able to do this without the support of a strong surgical task force across the different surgical craft groups and we are certainly very grateful for their support.

THE CHAIR: A supplementary, Mr Hanson, then a new question, Ms Burch.

MR HANSON: How many people in total are on the waiting list for elective surgery?

Mr Corbell: The long-wait list or elective surgery overall?

MR HANSON: Overall.

Mr Thompson: I will need to take that precise number on notice but it is about 4,200.

MR HANSON: So 4,273 as at 6 June, is that right?

Mr Thompson: It is around that. The exact number right now I will need to take on notice but it is of that order.

MR HANSON: Why has that blown out over the past four years? On 20 June 2012 over the same period in the lead-up to the last election—

Mr Corbell: Could you indicate what you are referring to?

MR HANSON: Page 3.

Mr Corbell: Of?

MR HANSON: Paper C. I am referring back to previous budgets now, which you probably do not have before you, but 3,996 was the total number of people on the waiting list in 2012. In 2013 it was below 4,000. Why is it that we have seen over the past four years a significant growth in the number of people on the waiting list if your blitz has been so successful? And why are there more people waiting today for elective surgery than there were four years, three years ago and two years ago?

Mr Corbell: The key indicator of performance when it comes to elective surgery is whether or not people are getting their surgery on time. If we have only 400-odd people waiting longer than necessary to get their surgery compared to over 1,300 last November, then that is a strong indicator that the rest of the people waiting for their surgery are being seen within the clinically indicated time frames.

MR HANSON: What has basically happened then is that—

Mr Corbell: That is the function of the elective surgery list. There are different categorisations, as you know. There are different priorities according to different classes of patient. The measure of underperformance or delay is the long-wait list.

MR HANSON: There are more people waiting for surgery—

Mr Corbell: I am not quite sure what you are suggesting. The measure of failure to be seen on time is the long-wait list and if the long-wait list is being reduced then other people waiting to get their elective surgery are being seen on time.

MR HANSON: Not necessarily because there are three categories. You have got categories 1, 2 and 3.

Mr Corbell: They are either in the long wait or they are not. This is the point to be made.

MR HANSON: You are talking about the category, the long waits, which is potentially category 3 for people over—

Mr Corbell: No it is all categories.

MR HANSON: So you are saying that you have been trying to trim the bottom of the lists of people in category 1 and category 2 now, have you, or the people that have blown out over their waiting time?

Mr Corbell: We have been targeting everyone who has been waiting longer than clinically indicated for their surgery. That is what the long-wait list is. Regardless of—

MR HANSON: And as a result there are more people waiting for surgery than ever?

Mr Corbell: You need to substantiate that claim because—

MR HANSON: I can substantiate it; 3,996 in 2012 and 4,273 this year.

Mr Corbell: What are you referring to?

MR HANSON: I am referring to the budget papers from 2012 and the budget papers from 2016.

Mr Corbell: Which budget paper and which part of the budget paper?

MR HANSON: Mr Thompson gave us the figure, did he not, that it is 4,200?

Mr Corbell: That is the number of people on the elective surgery list.

MR HANSON: It has increased.

Mr Corbell: But that is not a measure of whether or not they are being seen on time. That is the measure of the number of people waiting for their surgery.

MR HANSON: That is right.

Mr Corbell: Whether or not they are seen on time is the key issue. There will always be people placed on a list for surgery. Our task is to ensure that they are seen on time and the measure of whether or not they are being seen on time is the number of people who are on the long-wait list. That is why the government has focused on the long wait list, because if you are not on the long-wait list you are being seen on time.

MR HANSON: Is there any reason why you let the long-wait list blow out since the last election and waited until the election year before throwing a lot of money at the private systems to try to get that number down? Is that just coincidental?

Mr Corbell: I became health minister just over 12 months ago, 12 to 18 months ago now, and since becoming health minister I have been very clear about what my priorities are. They are improving access and timeliness to elective surgery and in the emergency department. Those have been my highest order priorities. I would have thought that, given the amount of attention that you as the shadow minister pay to these matters and the priority that you have made of it, you would welcome the fact that there has been a reduction in the number of people waiting for their elective surgery and there has been quicker and there has been—

MR HANSON: In the long waits maybe, but there has not been a reduction. There has been an increase.

Mr Corbell: So we are discounting the long waits now, are we?

MR HANSON: No. You said there has been a reduction in the number of people waiting and there has not been.

Mr Corbell: This just shows the political opportunism of your position and the fact that you are not genuinely interested in seeing people get their treatment on time.

MR HANSON: I am very interested.

Mr Corbell: You are just interested in making a political point. The fact is that there are fewer people waiting longer than clinically indicated today for their surgery than there has been for a very long time.

MR HANSON: Let us go to political points then.

Mr Corbell: There have been nearly 1,000 people removed from a long-wait list of over 1,300. That is a mammoth effort to get our system back on track and to get people to the surgery they need when they need it in the time frames that are clinically indicated. And at the same time the number of people being seen on time in the emergency department is going up. I would have thought, given your criticisms of the government on this issue, you would be welcoming that rather than nitpicking on it.

MR HANSON: Can we go to the press release you put out today? Where did that data come from, because we are still waiting for the March quarterly report and we are told that—

Mr Corbell: It comes from the data that is collected on a day-by-day basis by the emergency department for reporting on all measures of performance.

MR HANSON: You can get that information day by day, but for the quarterly report, we still have not seen it since March. Why is that you can get information that you are happy to put out in the press release of today's date but the rest of the community is still waiting for this information, and Ms Feely says she has not even seen it?

Mr Corbell: I receive daily reports on performance in the emergency department. I do that so that I get a good understanding of what is occurring in terms of trends in the emergency department and the timeliness of service provided. I get that every morning. Mr Ghirardello, I think, has already provided an explanation as to the slight delay in the finalisation of the latest quarterly report. It is a quality assurance measure to ensure that the relatively minor errors identified in the previous quarterly report are not repeated and that it is presented in an accurate form.

MR HANSON: Previously you had been putting out press releases stating there had been improvements in emergency department results, but that was based on data that was not correct. You have stated that you have accepted the data was not correct. I have been in correspondence with the Auditor-General about this matter, and I know she has also been in correspondence with ACT Health. She has asked a series of questions of ACT Health. Have you provided her with a response?

Mr Corbell: Yes, ACT Health Directorate has provided a response, and I would be very happy to table this morning the answers we have provided to the Auditor-General.

MR HANSON: Good. That would be great.

Mr Corbell: Can I add further in relation to that matter: yes, there were errors in that report. As you know, and as I think other members of this committee know, the errors in that report actually made the performance of the ED look worse than it was. Any suggestion that those errors were some sort of deliberate act to make the performance

of the ED look better simply cannot be substantiated because the reported figures were worse than the actual figures and—

MR HANSON: But is it not the case that the—

Mr Corbell: If I could complete my answer.

THE CHAIR: Let him finish, please.

MR HANSON: I thought he had; my apologies.

Mr Corbell: Therefore, any suggestion that there was some malign intent in relation to reporting these simply cannot be substantiated. Further, it is clearly not in anyone's interests for any of those figures to be incorrect. I have expressed to the directorate my significant disappointment about this error. It should not have occurred, and that is why I have asked for additional quality assurance to be in place for future quarterly reports. That is why the directorate is taking the time it is taking to finalise the quarterly report. When it is issued I want to have every confidence that it is accurate. Even though the errors in the last quarter were on the downside rather than on the upside, it is, nevertheless, the fact that they should be an accurate picture.

MR HANSON: Is it not the case, minister, that the figures that were made to look worse were for previous years, which then led to you on two occasions to state that ED performance was improving when that was not the case? I accept that it was made to look worse but, by virtue of the fact it was for the previous year, that directly led to you making statements in the media, in the Assembly and in press releases that ED performance was improving when, for the two occasions you referred to, in one case the performance had worsened and the other was, I think, static.

Mr Corbell: Well, that is a—

MR HANSON: That is inherently true.

Mr Corbell: Let me answer your question.

MR HANSON: That is true.

Mr Corbell: Let me answer your question. I think that is a very long bow to draw. It suggests to me you are reading too much Machiavelli or something, Mr Hanson. It reflects an extraordinary level of prescience and the need for some sort of convoluted conspiracy theory to justify your position.

MR HANSON: It is not Machiavelli I have been reading; it is the previous two Auditor-General's reports into deliberately fabricated data in the emergency department, where she found that it was deliberately manipulated to improve overall performance information. You may have read those.

Mr Corbell: Yes, and those are very—

MR HANSON: That is not Machiavelli; that is the Auditor-General.

Mr Corbell: Those are very different. That is ancient history, Mr Hanson.

MR HANSON: It is not ancient history.

Mr Corbell: That has been litigated to death. Everyone understands what occurred there and why it occurred. There is no suggestion that that has occurred on this occasion. It was an error. One of them was a typo; it was one digit rather than another. It is just a silly suggestion. I am very happy—

MR HANSON: Most fabrication is one digit rather than another, is it not?

Mr Corbell: To prove how comprehensively my directorate is dealing with these matters, I am very happy to table for the information of the committee all of the answers we have provided to the Auditor-General in relation to the matters that have been raised by you with her. I understand as a result of the answers we have provided to the Auditor-General that she will be determining how she will proceed from here.

MR HANSON: From here my understanding is that it depends on the answers and further discussions as to whether there will be a full performance audit similar to the previous audit, any public interest disclosures or involvement by the AFP if there is any indication of deliberate manipulation. But the first question I have with regard to this is: was there any deliberate manipulation of the data as occurred in 2012 to make performance look better, or was this incompetence?

Mr Corbell: It was an error, and there was no deliberate intent at all. As to the steps taken by the Auditor-General into the future, that is a matter for the Auditor-General. It is not a matter I can comment on.

MR HANSON: Given that this data set was the subject of extensive review, as you have discussed, including the 2012 committee and two auditor-general's reports, and that we received a number of assurances at the time that this was going to be rectified and steps were being taken, why is it that again ED data—which is clearly sensitive and has great community interest—has been shown to be inaccurate and false and again a Labor minister has made statements in the public domain about improvements in the ED that were based on false data? How has that happened again?

Mr Corbell: You need to be not so loose with your language, Mr Hanson, because it is not false data; the data is accurate. There is no suggestion that the base data that was reported in the latest quarterly report was somehow incorrectly entered into the data set in the first place. It was not. What occurred was that the wrong figure was inserted into a number of tables that was not consistent with what was in the data set. We have gone back to make sure that what is in the data set is what was reported, not some other figure.

What occurred a number of years ago was something completely different—it was false data entry. It was a completely different set of circumstances. That is not what has occurred on this occasion. For you to suggest that is simply something you are doing for your own base political advantage.

MR HANSON: I am trying to establish what happened—

Mr Corbell: In relation to the matters before us today and why this has occurred, I have just provided to this committee a three-page detailed list of answers to all the questions that have been asked by the Auditor-General. I encourage you to review those and look at the detail provided in them. If you have anything further, I am very happy to explore that further with you. But I think you can see very clearly the transparency and the openness with which my directorate is approaching this matter, which is fundamentally a small number of human errors in the preparation of the final report.

MR HANSON: Have you identified who made the error, minister?

Mr Corbell: I have indicated to the directorate that those responsible for the errors need to be made aware of the consequences of those actions and the fact that it causes problems and lack of confidence in the community in reporting, and that is not acceptable. The directorate is taking appropriate action and has, in particular, changed the governance overseeing the preparation of these reports.

THE CHAIR: The last question, Mr Hanson.

MR HANSON: So you have changed the governance in response to this. If this was simply a typo, what governance changes have you made and what actions have been taken against an individual or individuals involved in this?

Mr Corbell: Issues around performance are matters for the director-general and her other executives under the Public Sector Management Act. It is not for me to venture into those areas. The governance changes that have been made are around improved quality assurance, so additional levels of review to ensure that accuracy is maintained.

THE CHAIR: I have a supplementary and then I will have a new question. On the press release, the data is on non-standard time frames. Who collated this data? Did the department collate this data for you or was it done in your office?

Mr Corbell: No. The directorate and, in particular, the relevant service area of the hospital report on their performance on a daily basis in any event. It is the same data that is collected for the purposes of the annual report and other reporting frameworks, including quarterly reporting frameworks. It is the same data that is reported on a day-by-day basis around performance by which we measure the overall performance of each element of our hospital system.

THE CHAIR: The collection of this data and then it coming through the director-general to you, has that not displaced the effort that could have gone into finalising the quarterly report and then we could have standard points to compare time on time?

Mr Corbell: No, because it is the same data. It is not being entered twice. It is the same data being provided each year.

THE CHAIR: If it is the same data, can we have the quarterly report, please?

Mr Corbell: I have explained to you that the quarterly report is more than just performance on the ED. The quarterly report is performance across the hospital system as a whole. It relates to a number of areas of key service delivery and I have explained the reasons why it has been slightly delayed.

THE CHAIR: Because we have been doing a non-standard time period?

Mr Corbell: No. I should add that the reason it is a non-standard time period is that the reform agenda in place inside the ED only commenced in January this year. I was very clear at the time that we were going to be reporting against that and that we were going to be advising the community on how we were going in improving the performance of the emergency department. As it commenced in January, we now have six months, effectively, of data and it is a good opportunity to give the community an update on how we are going. Again, I am yet to hear a single word from you or from Mr Hanson actually saying, "Well, that's great. More people are being seen on time." That is the lived experience of people who are going to the ED; more people are being seen on time. I would have thought you would be welcoming that rather than scoring political points on it.

THE CHAIR: If, as you say, you have got six months of data, why have you chosen the period from 1 March to 27 June, and can we have the data for 1 January, when it commenced, to the end of February?

Mr Corbell: It is because it was the beginning of March when the ED navigators came into play and were appointed in the ED. It is really from that point that the substantive effects were able to take effect because of the changes in staffing and additional positions in the ED. I will ask Mr Dykgraaf to provide some further advice on that. I might ask him to outline further what has been occurring over the past six months and the timing around when those specific measures have been put in place.

Ms Feely: Minister, may I just jump in? With respect, I just advised the minister the navigators were there in March. That was incorrect. Apparently they were there in February. Is that right?

Mr Dykgraaf: That is right.

Ms Feely: I apologise, minister.

Mr Corbell: Thank you.

Mr Dykgraaf: The minister has correctly said that the reform agenda in the ED commenced in January. Clearly there was planning and work that went into that. The navigators actually went in in the last week of January and the team-based medical care went in on 1 March. The reason we have reported the figures in the manner in which we have is that those were the two key initiatives—two key interventions inside the emergency department—and we wished to reflect those two interventions in the data that has been reported.

THE CHAIR: The question still stands: can we have the data for January and

February?

Mr Dykgraaf: Certainly.

Mr Corbell: Yes. We are happy to take that on notice.

THE CHAIR: Mr Hinder has a supplementary and then a quick supplementary from Mr Hanson.

MR HINDER: If I can just go back to the numbers around the surgical wait list. Just to get it straight in my head, the number quoted is 4,200 or 4,270, if Mr Hanson is correct. That is not a wait list, is it? That is just a surgical list. That is an elective surgical list. Unless I go into hospital via emergency and I immediately need surgery, I am always going to be on a list, aren't I?

Mr Thompson: Yes. What that measures is the number of people who have been assessed by a surgeon as requiring surgery and a request for admission form has been submitted to a hospital for that surgery to be done.

MR HINDER: That other number you quoted of around 400 still on the long-wait list you would just deduct from that 4,270, which would then indicate that 3,870 people are getting seen within the time frame recommended by the medical professionals?

Mr Thompson: As it stands at the moment, that number is not the number. We cannot definitely say those 3,800—

MR HINDER: It is a rolling number. I assume there was surgery this morning and other people were put on the list today.

Mr Thompson: Exactly; it is a rolling number. Taking a step back, what the long-waits represent is that for each of the three categorisations for surgery—

MR HINDER: I understand what the long-wait list is.

Mr Thompson: Okay.

MR HINDER: Some people do not.

THE CHAIR: Well, if you understand, I am not sure why you asked that question.

MR HINDER: I have just got the answer to my question.

MR HANSON: So now you understand.

THE CHAIR: Mr Hanson, a final supplementary and then we will go to my new question.

MR HANSON: What are the days waited at the 50th percentile and the 90^{th} percentile? They are standard measures of reporting nationally. Nationally, at this stage we have the longest, as far as I am aware. What are the days waited at the

50th percentile at the moment?

Mr Corbell: At this time? As of today?

MR HANSON: As at the latest time that you can verify your numbers without getting into trouble, yes.

Mr Corbell: I would have to take that on notice, I think, but I would be happy to provide you with it.

MR HANSON: Super. Again, for ED, the press release is a bit of a cherry pick of results. There is not a comprehensive review of the sort of information that would be released in a quarterly report, an annual report or the budget. Have you got this information in a more substantive way? Can you go through, for each category of the emergency department, what the wait time is for Canberra Hospital and Calvary?

Mr Corbell: With the reporting we can. The reform agenda is focused on the Canberra Hospital ED because the Canberra Hospital is the hospital administered by ACT Health. Obviously, performance at Calvary is a matter for Calvary, albeit delivered under a contract—

MR HANSON: Yes, but you would have those—

Mr Corbell: ACT Health does not manage—

MR HANSON: But surely you would have the data?

Mr Corbell: Hang on. Let me be clear. ACT Health does not manage the day-to-day operations of Calvary Public Hospital. We are not able to run the sorts of interventions that we are running at the Canberra Hospital ED because we do not have direct management control. That is a matter for the Little Company of Mary and Calvary Health Care. In relation to measures of performance against each individual clinical category in the ED, we can provide that data, and I would be very happy to do so.

MR HANSON: Are we doing that now or later?

Mr Corbell: It is a large data set, so I cannot provide it to you verbally. I can take it on notice and provide it in an answer to you.

MR HANSON: It is five numbers. It is not that large a set, is it? By category at the Canberra Hospital there are five categories, and there are did-not-waits as well. That is five numbers. Have you got those here?

Mr Corbell: I do not have it immediately in front of me, but I can provide it to you as soon as possible.

MR HANSON: Okay.

THE CHAIR: Apparently it is Ms Burch's turn for a new question.

MS BURCH: Yes. Referring to page 13—and the committee touched on it with your colleague—it is around rehab, aged care and community care, hospital waits for appropriate time to access ACAT and discharge planning. It was deferred to you, Mr Corbell. It is in your output, but there is no actual indicator about how you measure access to services. Is that linked or will there be a budget line around improvement in stroke and Parkinson's services? Will that factor in any way into aged care, discharge planning and access to appropriate services?

Mr Corbell: I am sorry, Ms Burch, could you just clarify what the question is exactly?

MS BURCH: On page 18, under output 1.5—ensuring older persons in hospitals wait an appropriate time to access ACAT assessment—what is the indicator and is that line being met? Improving discharge planning to minimise readmissions—how do you measure that, and is that met?

Mr Corbell: You are saying page 18?

MS BURCH: Page 13, I do apologise.

Mr Corbell: Page 13.

MS BURCH: Yes, the first two dot points.

Mr Corbell: Yes, and what about them?

MS BURCH: What is the appropriate wait time, given that we are talking about wait, and are older folk in our community getting appropriate access to ACAT services and discharge planning?

Mr Corbell: I am advised there is no wait time at this present point in time for ACAT assessments in the ACT.

MS BURCH: And similarly with discharge planning, how do you measure any reduction in readmission linked to support—

Mr Corbell: Readmission is measured at a whole hospital level through our annual reporting framework.

MS BURCH: Is there a measure on that?

Mr Corbell: Yes, there is a percentage rate which is reported on an annual basis which indicates unplanned readmissions to the hospital acute care centre.

MS BURCH: So you are not able to take it down into this particular line?

Mr Corbell: We do not report on it by different category, no. We report it in terms of an unplanned readmission rate at a whole-of-hospital level. We have targets in relation to unplanned readmission. For Canberra Hospital, less than two per cent of

people seen is the target. The exact measure is LHN strategic indicator 3.2:

> The proportion of people separated from ACT public hospitals who are re-admitted to hospital within 28 Days of their separation due to complications of their condition (where the re-admission was unforeseen at the time of separation)

The target is less than two per cent. The estimated outcome for 2015-16 is 1.2 per cent.

MS BURCH: What page are you reading from there?

Mr Corbell: This is budget statement C, page 40.

MS BURCH: Okay. The discharge planning attached to ACAT—this morning we had a discussion about this area as well—

Mr Corbell: Sorry, what is your question in relation to discharge planning?

MS BURCH: You have as a statement under 1.5—improving discharge planning to minimise readmission or inadequate support for independent living—but the only measure you have for that is in the global readmission rate rather than being able to track how older folk are supported in appropriate systems and home care that is put in place, it would seem.

Mr Corbell: That is right. We measure readmission at a whole-of-hospital level; that is correct.

MS BURCH: Right. Within 28 days. But there is no internal measure to see how you actually meet those two dot points?

Mr Corbell: There is. In relation to the first one, we can advise that there is no—

MS BURCH: There is no waiting.

Mr Corbell: waiting and no delay.

MS BURCH: There is no waiting time.

Mr Corbell: In relation to the second one, the readmission figures overall give us indications of whether or not we are seeing an unacceptable rate of readmission at a whole-of-hospital cohort level. Clearly that data would be available to individual service delivery areas to make assessments about what is occurring in a sub-area on a speciality by speciality basis. But no, it is not reported beyond a whole-of-hospital level.

MS BURCH: Under the aged care and rehab area in budget paper 3, on page 107, the budget line around Parkinson's disease, while quite separate, will that be integrated within the aged care and rehab unit, or is it more focused in the acute area where this budget line will be done?

Mr Thompson: The budget initiative is specifically about deep brain stimulation

surgery for people with Parkinson's disease and for those people for whom the standard treatments are not effective. The initiative is around the provision of that surgery. The surgery has been demonstrated to show for select people extremely good effectiveness. What it enables, following the surgical episode, is discharge to a more independent level of living, depending upon the level of progression of the disease.

MS BURCH: So that is a new offering through this budget line?

Mr Thompson: Yes.

MS BURCH: You have not been doing it before?

Mr Thompson: Not in the ACT, no.

MS BURCH: Have we been sending patients out of town, or is this a capacity you are building up now through this budget line?

Mr Thompson: This is the capacity we are building up.

MS BURCH: How many do you do?

Mr Thompson: In the first year we are expecting to do five, growing to 10 in subsequent years. You will see in the budget initiatives that the funding increases in subsequent years.

THE CHAIR: Supplementary, Mr Hinder.

MR HINDER: I notice on page 18 there is a budget line which reflects a doubling of funding for Parkinson's in the 2018-19 outyear. The supplementary to Ms Burch's question relates to the item two lines below that. It is about better health services, improved stroke services, an additional $1.2 million, increasing slightly in the outyears each year. What is that additional funding going to deliver?

Mr Corbell: The improved stroke services are a very important improvement in service delivery for people who suffer a stroke. We know that there are significant advantages in early intervention, in the immediate 12 to 24 hours following a stroke, where if an appropriate intervention can be achieved the prospects of a patient having a very good recovery from stroke are dramatically improved.

At the moment in the ACT, and indeed in most places across the country, it is very hit and miss whether or not you receive this treatment, particularly if the stroke occurs, as they often do, whilst you are asleep or in the early hours of the morning. By the time you are seen in the hospital and an intervention is arranged it might be too late to provide for a good intervention.

This new initiative was designed to provide a standing capability in terms of our screening technicians, first of all, doing the necessary scans on a person's brain to understand where the damage has occurred in the brain as a result of the stroke, and doing it in a timely manner; secondly if it is feasible to intervene, to have that intervention in terms of clot removal from the brain so that recovery from the stroke is

able to be improved. This will see four additional full-time equivalents across medical, nursing and support staff, and it will be, we estimate, for around 10 to 15 per cent of the patients presenting with acute ischaemic stroke. What this means is that the clot retrieval technology will be able to be used, and that will mean more people have a better prospect of recovery from a stroke.

We know how debilitating a stroke can be. The fact is that at the moment really it depends on when you have your stroke whether or not you get this intervention. With this change there will be a standing capability available to provide this intervention if you are suitable for it, which, as is estimated by the neurologists, is around 10 to 15 per cent of all patients. But that is still a very significant improvement for stroke recovery and has been strongly welcomed by consumer groups such as the Stroke Foundation.

MR HINDER: A 24/7 stroke busters capability?

Mr Corbell: Effectively.

MS BURCH: With regard to the aged care assessment team, part of the ongoing care is dependent on the commonwealth's community aged care packages. How do you manage that interface and are there enough commonwealth funds? You often hear there is not enough community aged care commonwealth funding. How do we, as a jurisdiction, as a health system, accommodate or backfill that gap?

Mr Thompson: Working alongside the ACAT team, we have, in particular, the residential aged care liaison nurse who works with residential aged care and we have our discharge planners and social workers there who focus on the community-based options. In terms of the availability and the greatest impact on the system, we generally find it easier to access the community packages. The problem arises with the limited level of support that is available through the community packages.

Many people require residential care and it is the residential care and access to residential care in the ACT that is a challenge for us and does result in having people stay in hospital longer than is desirable from their perspective and from ours. When we compare ourselves to other jurisdictions, the availability of residential places in the ACT is lower than in other jurisdictions per capita.

MS BURCH: We just do not have enough providers and enough aged care residential beds?

Mr Thompson: It is the aged care residential beds. The commonwealth has an approval process. There is the commonwealth approval process that allocates the places to providers who then need to construct and operate the facilities and it is in the actual approval process that the mix in the ACT is different between residential and community. We believe that the residential side needs to be bolstered more than the community side does.

MS BURCH: We have enough providers to satisfy home-based community care—whatever it is called now, CAPS? A lot of folk, as we have said, want to be treated at home, stay at home for as long as possible. We have enough providers either through

HACC or through the commonwealth-funded—

Mr Thompson: There is always pressure on that. I am talking relativities here. I will not say that we would not benefit from greater provision of those services. It is just that the impact on our system we feel most directly, and the impact on individuals is frequently greater around residential care.

MS BURCH: And then that impacts on people staying in hospital longer.

Mr Thompson: Yes.

THE CHAIR: Mr Hanson, a new question.

MR HANSON: If you go to the MyHospitals website and look at our hospital and you do the comparison with other hospitals, you see that the Canberra Hospital has an average cost care that is in the top 10 per cent of the major metropolitan peer group and that therefore it could be seen as less efficient. If you go to the National Health Performance Authority comparison by peer group of the metro hospitals, of the 47 of the metro hospitals you see that the Canberra Hospital is the most expensive for occasion of service—by some measure, I would have to say—then followed by Calvary. Superannuation cost is part of the reason that is given on occasion. I note that for health staff it is only about six per cent of the budget. Why is it that our hospitals are described as least efficient and we come out as the most expensive per occasion of service for treatment in any hospital in Australia?

Mr Corbell: It is the case, as you have identified, that there are a number of historical factors that influence the base costs for delivery of health care, particularly around personnel costs—wages and conditions such as superannuation—and those are largely factors that are going to remain constant at least for an extended period of time. The key factor, therefore, is effective utilisation of resource. If we are able to increase activity and improve utilisation of existing capacity, then the overall unit cost—if you like, cost per patient—goes down. If we are utilising beds more efficiently for example, if we are seeing more people move through the emergency department in a timely way, then we are seeing more people with the same base capacity and therefore efficiency is improved and average cost goes down.

From my perspective, that is why reforms such as the ED reform and the associated reforms around better bed management are so important. They actually help us to reduce our overall cost per patient because we are seeing more people with the same resource and therefore the average cost goes down.

In this debate, as health minister, I must say I find it sometimes a little frustrating when people assert that we are expensive—and we are—but then people assert we need more beds or we need more doctors and nurses. We will always need some of those things. But it is not just about buying more beds or buying more doctors or nurses. It is also about making sure that with the resources we have—the beds and the highly trained doctors and nurses and so on—we are able to see more people in a more efficient way because that reduces our cost per patient. That is very important. Better utilisation of hospital infrastructure and services is critically important in terms of managing the cost issue.

At the same time the government will be moving towards the implementation of activity-based funding so that we measure our funding based on activity. That will be particularly important reform as well in driving efficiency and making sure that we move away from our current position in terms of the costs of providing hospital services. That is important for the long-term sustainability of health financing.

MR HANSON: What you are saying there sounds reasonable but after 15 years the reality is that under successive Labor health ministers we have reached this point where it is quite clear that the utilisation of beds and of staff, as you have just described, is anything but efficient. Why have we reached a point, after 15 years, where this government is administering the least efficient hospital in Australia?

Mr Corbell: These are political debating points. I am focused on implementing the reforms to improve efficiency and to improve timeliness and access of care. That is what I am accountable for in this place and that is why I am here today, to talk about where the budget is being spent and how it is going to be allocated to improve timeliness and access to care.

I think we have set out very clearly the reforms that we are making, the improvements that are being achieved on the ground, the fact that more people are being seen on time in our emergency department, the fact that more people are getting their elective surgery and that fewer people are waiting longer than is clinically indicated. These are the outcomes that we need to achieve to address the issue around efficiency and the cost of providing hospital services.

MR HANSON: With regard to costs, how many patients are admitted to or treated as private patients at the Canberra Hospital?

Mr Corbell: My advice is approximately 14 per cent.

MR HANSON: Is the 14 per cent based on cost, is it based on overnight admissions? Where does that figure derive from? Is it a dollar cost?

Mr Corbell: It is just 14 per cent of the total volume of patients seen.

MR HANSON: How does that work then? You either admit them as a private patient or you subsequently, once they have already been admitted, get them to then become a private patient through transition to private patient?

Mr Corbell: Yes.

MR HANSON: A portion of that cost gets paid for by their private health insurer?

Mr Corbell: That is correct.

MR HANSON: What is that 14 per cent? What does that represent in a dollar value?

Mr Corbell: I do not think we could provide that to you today. I would have to take some advice on that but I am happy to take the question on notice. It is the case that

the ACT has one of the highest levels of private health insurance cover, as a population, of any jurisdiction in the country but we do have one of the lowest levels of private health insurance utilisation. That is despite significant efforts to encourage people to choose to use their private cover when they are admitted to public hospital.

Ultimately this is a voluntary choice on the part of people and if people choose not to utilise their private cover they know that they are covered by the Medicare arrangements. People make rational choices about that when it comes to admission to hospital.

MR HANSON: Surely you have the information here today about how much revenue ACT Health received from private health insurance companies? I find it inconceivable that you would not have that information.

Mr Corbell: I think one of my officials is trying to get that now. If you can give me a minute or two, we will see what we can do.

MR HANSON: I can move on. We will wait for that. I will give you a minute. On average, how many beds, then, at the Canberra Hospital are occupied by private patients at any one time? I know that that would be a figure that fluctuates. How many beds are there now at the Canberra Hospital?

Mr Corbell: Ian, can you answer that question please.

Mr Thompson: Bed number questions are always controversial ones.

MR HANSON: They can be.

Mr Thompson: It depends on how it is counted but in terms of the overnight beds that we are talking about we typically have about 650. Obviously, 14 per cent means around about 90 of those beds—with my off-the-top-of-the-head maths—would be occupied by private patients.

MR HANSON: Have you looked at this? Have you done analysis of it? Is this a planned figure or is it ad hoc? Is this just based on how many patients you can convince to use their private health insurance or are you aiming for a target? Are you trying to increase that number? Are you trying to decrease it? Is there a plan around this or is it just a sort of ad hoc measure?

Ms Feely: Do you want to answer the question about what happens when someone comes in?

Mr Thompson: Yes. In terms of people coming in, it depends on the pathway, of course, that they come in. We have planned and unplanned admissions. In terms of planned admissions, the process is discussing, in the process of planning the admission, what the benefits are of private health insurance and whether or not they want to use it. In terms of unplanned admissions, a similar discussion happens. It can happen, depending on how well the patient is, in the emergency department or if that is not appropriate it can be once they are admitted to a ward area. What happens is the ward clerks would approach the patients at that point and discuss, again, the option of

electing to be private patients.

MR HANSON: If you have got a longer stay patient who has transitioned from public to private or got admitted as private, do you at some stage try to or consider moving them to a private hospital so that you can free up a public bed? Does that happen?

Mr Thompson: It is not restricted solely to long-stay patients. We have arrangements with the private hospitals where we do transfer patients backwards and forwards. That can happen at any point in the admission, again at the choice of the patients themselves and of course with the acceptance of a treating doctor and the private hospital itself.

MR HANSON: Back to my question: is this a planned number? You talked through the process, but are you thinking that this is a good thing, this is a bad thing, you are trying to increase that number, you are trying to decrease it? Is there a strategy around this?

Mr Corbell: The advice to me is that 14 per cent is a reasonable level of utilisation of private health cover in our public hospital system and compares reasonably consistently with the experience in other state jurisdictions.

MR HANSON: Did we get the total number?

THE CHAIR: We might leave it there. The gentleman who is searching for the data has taken his laptop and is searching outside. We will return at 2 o'clock and we might come back to that point and hopefully you can provide that data.

Mr Corbell: We will come back to that other point.

Sitting suspended from 12.45 to 2.02 pm.

THE CHAIR: Members, we are quorate and the minister is with us. I think Mr Hanson asked a question as we concluded, to which I think the answer was that 14 per cent of hospital patients are private. We were going to get a number on what that was worth as a monetary value. Is that available?

Mr Corbell: I do not have that available at this time but I do have answers available in relation to another question on notice, Mr Smyth. It relates to emergency department performance. I was asked this morning whether advice could be provided on the performance of the emergency department in the period 1 January to 29 February this year.

The figures are as follows: average daily presentations for the period 1 January 2016 to 29 February 2016 were 209. The average waiting time was 69 minutes and the average treatment time was 166 minutes. By way of comparison, the average waiting times for the same period in 2015 were as follows: average daily presentations, 198; average waiting time, 66 minutes; average treatment time, 176 minutes.

I was also asked for ED performance for the period March 2016 to June 2016 by category. I can advise that average emergency department waiting time performance

by clinical category for the period 1 March 2016 to 27 June 2016 was as follows: category 1, zero minutes; category 2, eight minutes; category 3, 58 minutes; category 4, 69 minutes; category 5, 60 minutes.

By way of comparison, average emergency department waiting time performance for the same period in 2015—that is March to the end of June 2015—was as follows: category 1, zero minutes, category 2, eight minutes; category 3, 66 minutes; category 4, 83 minutes; category 5, 67 minutes.

When you look at performance by category for the period March to June this year compared to March to June last year, you will see that there are some very significant improvements. Whilst category 1 and category 2 continue to perform at a very high standard of zero minutes and eight minutes respectively for each of those years, in 2015 category 3 patients we were seen on average in 66 minutes, whereas this year they were seen on average within 58 minutes.

Category 4 patients last year were seen on average in 83 minutes whereas this year they were seen on average in 69 minutes and category 5 patients were seen on average in 2015 in 67 minutes, whereas this year they were seen on average within 60 minutes. This highlights again I think, Mr Chairman, the very significant improvements we are starting to see as a result of the ED reform agenda. Whilst there is still much more work to be done, the figures are very encouraging and highlight improved access and timeliness in our emergency department.

MR HANSON: A supplementary on that, please.

THE CHAIR: Thanks for that. Minister, could you refresh for the committee on what the standard is for each of those five categories?

Mr Corbell: That is the—

THE CHAIR: Zeros are meant to be seen immediately.

Mr Corbell: Immediately, resuscitation.

THE CHAIR: Category 2 is meant to be seen within—

MR HANSON: Ten minutes.

THE CHAIR: Category 3?

MR HANSON: Thirty.

THE CHAIR: Category 4.

Mr Corbell: Three hours.

MR HANSON: Sixty.

Mr Corbell: Sixty. I beg your pardon.

THE CHAIR: And category 5.

MR HANSON: 120 minutes.

THE CHAIR: Yes. That gives us the context. A single supplementary, Mr Hanson, and then you can ask more questions when we come back that way.

MR HANSON: That data is normally presented in percentage of patients seen on time rather than the time taken to see a patient. Have you got that information in the format that we normally expect within a quarterly report or within an annual report? That is not the way that that information is normally presented. I am trying to get it from a consistency point of view so I am comparing apples with apples.

Mr Corbell: Yes, I am happy to provide it. Again, if you give my officials a little bit of time we will come back and provide the figure to you.

MR HANSON: Yes, that is great. That can be on notice.

Mr Corbell: Yes.

MR HANSON: Are they the same figures that are in the quarterly report, given that the quarterly report finished—this is the March quarterly report that we were talking about before. Have you got the figures here that will be in that quarterly report?

Mr Corbell: These figures span the period of two quarterly reporting periods. Obviously they are a year apart as well, but this is from the period March to June.

MR HANSON: Yes.

Mr Corbell: They cross over quarterly reporting periods, but they will be reported accordingly within their respective quarters.

THE CHAIR: Minister, there is a budget initiative for the Canberra clinical genomic service shown page 160, budget paper 3. What does that do and what does the new funding do?

Mr Corbell: There are two elements to this funding. The Canberra clinical genomic service is designed to take advantage of the advances that are occurring in relation to genomic science and our understanding of the human genome and what that means for the development of what is known as personalised medicine. Personalised medicine is about using our understanding of a person's individual genome to target the treatment of particular illnesses using particular specific drugs and other treatments to deliver the best possible clinical outcome for the patient.

The development of routine personalised medicine practice will provide a new pathway for the treatment of what are particularly quite difficult and complex diseases and conditions. We are very fortunate here in the ACT to have the ANU, the John Curtin School of Medical Research, which is undertaking leading research into the establishment of clinical genomic services.

The funding will provide for both the maintenance of that research capability—help the maintenance of that research capability at the John Curtin School of Medical Research. It will also provide for next generation genome sequencing-based information for specific patients, for the provision of it to clinicians to improve diagnosis and treatment in routine clinical practice.

This is a medical industry that is still in its infancy. As yet there are no large-scale routine clinical genomic services existing in Australia. We estimate that the demand for the service in the ACT is around 200 or more samples per annum based on the clinician feedback. It is anticipate that this number will grow in parallel with the availability of the service and the types of health outcomes that are being achieved.

Additional funding in the forward years will support growth in sampling numbers—you will see that in the expenses line—to support that growth and also to provide for the associated consumables and reagent supply costs. This is a very exciting initiative, particularly for very difficult and intractable diseases. Understanding how our specific genomic sequence preconditions us to be either more or less vulnerable to particular disease types and treatments will assist clinicians to match treatment to the specific circumstances of the individual patient.

THE CHAIR: Where will the clinic be?

Mr Corbell: The sampling will occur with the equipment used by the John Curtin School of Medical Research at the John Curtin medical school. But the clinicians involved in the delivery of the service also hold clinical positions at the Canberra Hospital. They will be practicing in the Canberra Hospital and using the sampling and testing technology available at the John Curtin medical school.

THE CHAIR: Will the funding provided for the sampling and the understanding be conducted by existing staff or is there staff tied up in this stuff?

Mr Corbell: The key component of cost is the sampling cost. That is obviously sampling of the individual genomic sequences from the individual patients for better treatment delivery. There are a number of other costs. There are some administration and staffing costs; there is NATA accreditation; there is a service agreement with the John Curtin medical school as well. But a number of these clinicians already have teaching and practising privileges at the Canberra Hospital too. It is led by the professor of medicine from the medical school.

THE CHAIR: It is on referral. It is not something somebody can go and have done?

Mr Corbell: No, it is very much very targeted sampling for specific conditions and circumstances. It is not broad range at this time. As I say, the initial sampling we estimate at only about 200 in the first year, which is very small in terms of the total number of people seen in a clinical environment.

THE CHAIR: What is that—about $45,000 a sample?

Mr Corbell: I do not know the per sample cost but it is certainly—

THE CHAIR: $4,500.

Mr Corbell: I would be happy to give you a more precise figure if that would be of assistance.

THE CHAIR: On notice is fine. Mr Hinder, a new question.

MR HINDER: Thank you, chair. Minister, we spoke earlier about the handover date for the secure mental health unit. Can you give us some information about the secure mental health unit? I understand that is about November this year if all goes to plan.

Ms Feely: All things being equal, in November we will be able to admit some of the first patients.

MR HINDER: What sorts of new services or capability will that facility deliver?

Ms Feely: I will invite Katrina Bracher, who is the head of mental health and who has main responsibility for this part of the organisation, to come to the table.

Ms Bracher: Good afternoon. The secure mental health unit has been in planning for a good four years—the design and the planning and the construction. The building will be handed over, all things going according to plan, in September this year. We will have approximately an eight week commissioning period and then first patients will be in, we are anticipating, in mid to end of November.

MR HINDER: What sort of services or capabilities will that provide that are not available at the moment?

Ms Bracher: The secure mental health unit is a 25-bed unit. There will be 10 acute beds and 15 rehabilitation beds. In the first instance we are opening the 10 acute beds. The model of care requires that everybody who comes through into the mental health unit actually goes through the acute beds to have a very detailed assessment of their forensic, their criminogenic and their mental health needs in that space.

The cohort of people that will be seen in this unit are people that either have come in contact, or are at risk of coming into contact, with the criminal justice system that need inpatient care. If people are in the AMC, for example, and need psychiatric care or mental health care, they can receive a level of care in the prison. But if they need inpatient care, their transfer would happen to the secure mental health unit.

MR HINDER: Minister, are there any other initiatives in the budget for mental health or allied drug services?

Mr Corbell: We are also providing some additional capacity, Mr Hinder, in relation to the adult mental health unit. The AMHU continues to experience growth in demand. We will be increasing the number of inpatient beds in the adult mental health unit from 35 to 37 to improve access to acute mental health services. AMHU has a very high occupancy rate. An additional bed capacity is warranted to ensure that we provide as much capacity as possible. This increase will see more people able to be

admitted, when needed, into the AMHU.

There is also expansion to community mental health services in terms of total service delivery. I think my colleague Ms Fitzharris may have mentioned that this morning. There is also enhance rehabilitation and follow up services. For example, the territory is providing funding of approximately $500,000 in 2016 with growth in the outyears for an assertive outreach service focused at providing intensive intervention to young people who are significantly challenged with mental health issues.

These include severe anxiety, depression and early psychosis. These young people are often at risk of poor social and economic outcomes. They are at high risk of being disengaged from mainstream services. Therefore, this service is designed to provide improved care to young people who are at high risk of developing not just serious but potentially lifelong mental illness. There needs to be more active detection and active engagement with them.

This is going to help reduce the risk of development of comorbidities and it is going to strengthen after-hours support to these young people. This will provide for an additional 4.9 FTE for dedicated outreach to young people with signs of developing serious mental illness. That is just a number of examples, Mr Hinder. I will not go through the whole list.

THE CHAIR: Mrs Jones has a supplementary and then a new question from Ms Burch.

MRS JONES: Regarding the secure mental health unit that we have touched on before, on page 22 of budget statement C, $8.2 million has been rolled over into the 2016-17 year. Is that regarding the build of the facility or is that something else?

Ms Bracher: That is the current budget to operate the building.

MRS JONES: The reason it has been rolled over is because it has not been opened yet?

Ms Bracher: Excuse me, sorry. No, that must be capital.

MRS JONES: Page 22 under "Revised funding profile, secure mental health unit", $8.21 million.

Mr Corbell: Yes, that is the capital provision that reflects the estimated completion time.

MRS JONES: Because the completion time has gone out a little further?

Mr Corbell: No, the completion time is unchanged, but when invoices fall due can vary during a build. You make an estimate about what your provision should be in each financial year but the actual payments may not fall due until the later financial year.

MRS JONES: On page 23, table 33, there is $19.3 million funding for the unit. How

does that relate to the overall cost of the start of the unit of $43 million that I believe we have been told in the past?

Mr Corbell: Sorry, direct me to which item?

MRS JONES: It is about the fifth last line on page 23, "Secure mental health unit", $19,334,000.

Mr Corbell: Again, that is a capital figure.

MRS JONES: The $43 million that we have been referred to in the past for the cost of getting this unit up and going, that is capital plus staffing, is it?

Ms Bracher: No. That is capital.

Mr Corbell: No, that is the capital cost.

MRS JONES: This is ongoing capital that has not yet been expended?

Mr Corbell: Capital is not ongoing; capital is one off. But it has not yet been expended, that is correct.

MRS JONES: The $19.3 million has not yet been expended?

Mr Corbell: Yes. The $43 million you are referring to, I think, Mrs Jones, relates to the cumulative operational costs of running the secure mental health unit over a four-year period.

MRS JONES: So we can assume that the $19.3 million plus the $8.2 million is the rest of the build and the rest of the $43 million will have been spent either in planning or in staffing?

Mr Corbell: No, the $43 million is separate from the capital.

MRS JONES: Finally, the recruitment process for staffing the SMH, is that underway and how is that going?

Mr Corbell: Initial recruitment processes have commenced. Obviously the government has made a very significant funding commitment in this year's budget to provide for the salaries and other costs associated with that significant staffing complement. I will ask Ms Bracher to give you some indication of what that recruitment process entails.

Ms Bracher: We are actually interviewing this week about 86-odd people through a whole range of staff—nursing, allied health, assistants in allied health, assistants in nursing and administrative staff. We will have a second round of interviews probably in about a month's time to fill in some gaps that there might be. We already have our clinical director in place for the unit. We have an allied health therapy manager in place, and we are currently recruiting the nursing services manager for the unit. That is a targeted recruitment. We had somebody who then withdrew so given it is close to

opening we have decided to do an executive search for that position. That is the clinical staff. With regard to the security staff and the non-clinical staff, a process is in place currently to source a security company to do that security contract.

MRS JONES: That is perimeter security?

Ms Bracher: Yes. That is correct. The non-clinical support functions—the people who deliver the meals and linen in the facility and that sort of thing—that process is also underway to increase the contracts that run through the Canberra Hospital to fulfil that staff quota.

MRS JONES: Finally, Brian Hennessy house, I understand there may be some people coming across from that. Is there a closure date for that which corresponds?

Mr Corbell: Brian Hennessy is for a different category of patient. The people who are resident at Brian Hennessy are not by and large in the secure mental health cohort at all.

MRS JONES: The closure of Brian Hennessy is not related to the—

Mr Corbell: It is not related to the secure mental health unit; it is related to the construction of the University of Canberra public hospital as a subacute facility. The UCPH will involve an element of subacute mental health treatment service, and some clients of Brian Hennessy will utilise from time to time the subacute, longer stay as well as shorter stay services at UCPH.

The key issue is that Brian Hennessy has evolved as a service for which it was not actually designed or built. I am aware there are reservations amongst the family of some of the longer term residents of Brian Hennessy about the future accommodation options for their adult children.

MRS JONES: Very stressful.

Mr Corbell: I understand that is very stressful, and I have met with a number of the parents who have those concerns over the past six to twelve months. What I have said to them and what I am very willing to say again today is that we will have a clear pathway forward for each resident at Brian Hennessy. In this budget there is funding for the specific investigation of options for alternative residential services for the people who live currently at Brian Hennessy.

We are specifically funding work to find those alternatives and to build the business case for the development of those alternatives for those residents, recognising, of course, that, for many of them, Brian Hennessy has provided a stable environment and has meant they are not engaged with the criminal justice system and are living stable and relatively healthy lives, and that is something we need to sustain.

I want to make very clear that I feel very strongly that the lives of those people who are resident at Brian Hennessy should see as little disruption as possible as we go through this change and that they and, in particular, their parents or carers have a high level of confidence about the alternative they will be moving to. That work is

underway and we will be keeping them informed throughout.

THE CHAIR: Mr Hanson has a supplementary and then a new question from Ms Burch.

MR HANSON: On the secure mental health unit, the original promise from your government was for a 25-bed facility costing $11 million to be opened five years ago. We are now in 2016 and the facility is due to be opened in November. When you look at the almost quadrupling of the price, the reduction in the number of beds and the six-year delay, has anyone sat down at looked at what has gone so very badly wrong with this project?

Mr Corbell: I am not here to litigate a political argument with you over this matter, Mr Hanson; that has been done extensively in the chamber and elsewhere over the past six to eight years and, indeed, longer. What is important is we have had to resolve a range of very complex matters involving the delivery of the secure mental health unit, including the model of care, the appropriate sizing of the facility, and, as you would be aware, the real challenges in moving through the planning process to get approval for a facility which is sensitive and which we know an element of the nearby residential population were very concerned about and opposed to. At the end of the day, this Assembly made some decisions about authorising the construction and development of this site because it meets a basic and fundamental gap in mental health care for people engaged in the criminal justice system. It needs to be done and I am pleased we are getting it done.

MR HANSON: But there is no formal process of review when you complete a project for lessons learned. There are things that go well; there are things that do not. But in this case it has been particularly complex. Given the budget increase and the delays, for whatever reasons, are you going to have a formal process of review to learn from this to make sure we do not have a situation like this happening again? It has been recognised by all sides of politics that this has been a hole in our system for a long time. Have you commissioned any review of this process?

Mr Corbell: We will undertake a normal review six months after commissioning in terms of post-occupancy review and the operation of the facility.

THE CHAIR: When is the official opening planned?

Mr Corbell: There is no scheduled official opening at this time.

THE CHAIR: Ms Burch with a new question.

MRS JONES: September.

MR HANSON: I thought he said November.

MRS JONES: No. September opening, November—

MS BURCH: Thank you—

MR HANSON: Is it really September opening?

Mr Corbell: Let us be clear: the building will be physically complete and handed over to Health in September, but it will not be—

THE CHAIR: In September. And patients will arrive—

MR HANSON: It is the AMC revisited!

Mr Corbell: No. Look, you clearly have not been listening to the answers that have been provided earlier today. There will be a handover of the physical building because it will be complete in September. Then there will be approximately an eight-week commissioning period during which systems and procedures will be bedded in before people start to be admitted to the facility. That evidence was given to you before lunch.

THE CHAIR: And you are saying there will be no official opening?

Mr Corbell: That has not been determined, and it is not a matter that has been brought to my attention at this time.

THE CHAIR: Ms Burch, a new question.

MS BURCH: Budget statement C has a series of indicators for mental health. On page 5, strategic objectives 5 and 6 talk about usage of seclusion and patients returned to acute mental health. The measures seem to be consistent over a couple of years. How does that compare to other services in the country?

Ms Bracher: The seclusion strategic indicator is a national best. That has been that way for five or six years. We continue to monitor it; there are minor ups and downs over the course of time, but we continue to monitor it because it is such a significant restrictive practice within mental health care.

MS BURCH: But we sit in the good space of being measured against other services?

Ms Bracher: Absolutely. We hosted the national seclusion restraint conference last year, and the Chief Psychiatrist presented our data at that conference as the jurisdiction with the best performance in that space.

MS BURCH: I am going to be looking at pages 5, 15 and 41, if people want to get ahead of me. Strategic objective 6 again has a consistent benchmark of 10 per cent. These are proportions of clients who return within 28 days of discharge with acute psychiatric presentations. Again, that is within a national benchmark of return?

Ms Bracher: That is a local indicator. Nationally, indicators are measured with slightly different definitions, so this is our local indicator. However, nationally the unplanned readmission rates are in the order of 14 to 15 per cent. Our figure of an estimated outcome of eight per cent for this year is well and truly under the national average.

MS BURCH: With some of these clients, if they are having an acute psychiatric episode, regardless of the best care and then discharge, things happen. They have another episode and they are readmitted. Is that what is in that 10 per cent?

Ms Bracher: That is right.

MS BURCH: Page 15, strategic indicators b. and c. talk about children and youth mental health program community service contacts and mental health rehab and speciality services. There is steady growth on indicator b. and that reflects an increase in service provision, some held within this budget, is that right?

Ms Bracher: The performance in 2015-16 was twofold: we had some additional budget that supported additional services. But we also changed our intake model during that time to what we call the CAPA model: the choice and partnership assessment model. We no longer keep people on a wait list; we book an appointment for everybody who contacts the service. That contact time is around 18 to 20 days now. So everybody receives a first contact, and from that choice appointment some of those young people and families enter into our child and adolescent system and some of those children and families move back into primary care or into another community sector organisation for their ongoing management.

MS BURCH: On indicator c., mental health rehabilitation and speciality services, 106,000 to 110,000 and back to 80,000. There is a footnote, but can you explain what that is?

Ms Bracher: For the 2016-17 financial year we have changed our reporting indicators slightly to reflect the organisation within our division around our service provision. Output indicator 1.2.c., rehab and speciality services, covers Brian Hennessy Rehabilitation Centre, our crisis team, our Aboriginal liaison team, our older persons team, our day service, neuropsychology services and various others.

This indicator has increased significantly against the 2015-16 target because the crisis and treatment team had some additional funding in the growth envelope last year and have been able to provide a lot more community contacts in that space.

MS BURCH: The drop back to 80,000 is accommodated and reflected in other indicators elsewhere?

Ms Bracher: Yes.

MS BURCH: The final question relates to page 41, table 9, indicators g. and h., the percentage of mental health clients with outcome measures completed and those contacted within seven days. Again, the targets are consistent. How does that stack up against other services, and have you thought about stretching?

Ms Bracher: The outcome indicators are a proportion of the total client group we see through our division. They are done every three months. If somebody is there for a short-term episode of care we do not do the outcome indicators for that cohort. There are a reasonable number of people for which it is not a valid assessment process to undertake. Where do we sit nationally? We report that data into the national data set,

and I think we sit fairly comfortably with our peers in that space.

With regard to the seven-day follow-up, we are above the national average in that. We have a very good post-discharge follow-up within seven days. I cannot remember whether it was two or three years ago, but in the growth envelope at that time we had funding for an additional four transition clinicians that we positioned in each of the community mental health teams. Their function was and continues to be to follow up people immediately post-discharge from the two acute hospitals, both Canberra Hospital and Calvary.

MS BURCH: Then that feeds into that first indicator about reducing the number who are readmitted within 28 days as well?

Ms Bracher: That is right.

MS BURCH: Follow up in that first week and make sure everything is settled?

Ms Bracher: That is correct.

MRS JONES: I have got a substantive question. Regarding the AMHU, obviously a little while back there was the issue with regards to the PIN and the slight increase in the nursing staff facility. Can you report back to us what the status of workplace incidents is, the number of assaults over the past 12 months as compared to the 12 months prior of staff members or from patient to patient?

Ms Bracher: I have not got the data for the past year, and we can provide that data out of our incident reporting system, if that would be useful for the committee.

MRS JONES: Yes, if you could take that on notice, that would be great.

Mr Corbell: We will take that on notice.

Ms Bracher: We will take that on notice, yes.

MRS JONES: With regard to staff in that facility, what is the current breakdown of permanent, casual, agency and skilled migrant visa staff, and is that how they are broken down? Or what are your measures on how you determine where your staff are coming from and what the permanency of your staff is?

Ms Bracher: We look at our data monthly in our scorecard across the whole division, and that is broken down into permanent, temporary and casual employees. We have an expenditure line item in our budget reporting that is around agency staff. That is data that we do look at monthly. Breaking it down to people on visas and further, that would be a manual task. We do not actually do that.

MRS JONES: Can you perhaps take on notice the three categories that you do recognise—permanent, casual and agency, is that right?

Ms Bracher: Permanent, temporary and casual.

MRS JONES: Are you able to give me that report for the past six months, month by month?

Ms Bracher: We can.

Mr Corbell: We will take that on notice.

THE CHAIR: Mr Hanson; and then we will work our way down this way. Ms Burch you will be next.

MR HANSON: On the issue of staff culture, there have been a couple of substantive issues over the last little while. There is the KPMG report and there is also the AMA doctors in training ACT survey. Both found extensive incidents of bullying within the Canberra Hospital and Calvary as well, I believe. Stats show 76 per cent of respondents observed bullying, discrimination, harassment and so on.

There were seven recommendations, I believe, from the KPMG reports, and a clinical culture committee was established. Can you give me a bit of an outline on how you are going with the implementation of the seven recommendations from the KPMG report and whether there are any issues from the AMA doctors in training survey that you are responding to?

Mr Corbell: I will ask Ms Feely in a moment to give you some more detail as I have asked her to help lead our response on these issues. Obviously the first thing to restate is that the issue of poor behaviour between senior and junior doctors is one which is, regrettably, historical across the training environment in the medical profession and has been for a very long period of time. It is not unique perhaps to the Canberra Hospital. It occurs at the Canberra Hospital but equally it occurs in every other training hospital in the country, to some degree.

Nationally the Royal Australasian College of Surgeons have indicated that they believe this is a culture that needs to change; that it is unacceptable. They have been taking a key leadership role in working with the members of their college in providing improved training and understanding of the issues around respectful behaviours in the training environment, both for their senior members and also for junior doctors.

Locally I have met with the ACT representatives of the Royal Australasian College of Surgeons and they have indicated to me in a number of meetings now their ongoing commitment to working with ACT Health Directorate in responding to these issues, working with the management of the hospital and sustaining an ongoing program of respectful behaviour training and development within the hospital environment.

To that end the college has commenced running as part of its own professional development offer to their members, which is of course a compulsory professional development framework, respectful behaviours training as a key element of their PDT and that is a very welcome outcome. The college is saying, "If you want to maintain accreditation with us, as a member of the college you need to engage in specific training around respectful workplace behaviours." That is a very encouraging outcome.

Obviously there is a range of other actions being followed through as well. I will ask Ms Feely to add what she can around programs.

MR HANSON: Just before you do, I pick up on a point that you made about a cultural issue between doctors. If you read the KPMG review it makes very clear that there is a management problem here as well. I notice one of the dot points in the summary refers to legislation and policies that govern work place behaviour not being well understood or complied with consistently; that there were perceptions of ineffective and untimely actions to resolve issues raised relating to inappropriate behaviour and conduct; that staff were fearful of speaking up and so on.

Mr Corbell: Yes that is all accepted, and that is why the clinical culture committee has been established. There are issues around ACT Health's administration, particularly of the complaints-handling framework, that need to be further strengthened. The KPMG review concluded that overall the actual framework itself was adequate. But it was its implementation and administration that were wanting in certain respects.

Obviously this is a complex interaction, particularly where the leader of a particular clinical unit may be a senior doctor but also a paid staff specialist, and obviously there are interactions there between their peers, between the people they are training themselves and their role as, effectively, a paid public servant of the ACT public service. These are complex interactions. Nevertheless they are issues that we are addressing.

I am going to ask Ms Feely to respond directly to the issues you raised around complaints handling and so on because that is accepted as an important area of improvement.

Ms Feely: The clinical cultural committee—I chair it on a monthly basis—has as members a combination of junior doctors, representatives from Calvary and, for example, the chair of surgery and a group, basically, across all elements of the clinical fraternity at TCH. It has been a fascinating process watching the leadership step up and talk about culture and I do not think it has been something that has happened universally across the organisation.

There is no doubt that we are at pains to reinforce that when we talk about a poor culture across TCH it is not in every element of the health service. There are some subdivisions which require more remedial assistance than others but we have also got some good examples of how you should behave across the board. Probably it is the first important point that we have been reinforcing through the clinical cultural committee. As a result of our meetings we communicate what we are talking about. But as the minister has said, one of the most difficult issues has been how we handle complaints that have been made in relation to bullying and harassment or whatever.

The biggest problem that faces me, as the director-general, is the balancing of the need for the complaint to be handled in an appropriate and swift manner with the rights of the individual against whom the complaint has been made, that we do not broadcast in a manner that could be potentially slanderous or libellous without having a formal investigation. We talk a lot at these meetings about Dr X has had a complaint

made against them. We will discuss how that is being handled. My focus to date has been on making sure that those who have made a complaint feel that they have been heard, that the issues have been resolved and that we have put in a plan with the individual concerned or sent someone out to counselling. We monitor their performance on an ongoing basis.

That is probably the key issue causing some of the angst if there is any angst left. It is about people not knowing exactly what is happening with doctors B, C, D and E. But you have got to find that balance between the carrot and stick and hitting someone over the back of the head, for whatever it is.

The first thing that we are looking at, though, in relation to the KPMG outcomes—and we have got a plan for each of them—and that we are now working on is what we call the statement of desired culture, which is the first initiative that I really want to focus on. To do that we are meeting with all of the units and we are going through to reinforce the fundamental ways of ACT Health but also to put them in the context of a clinical environment and see whether they need to be changed.

We want to get agreement across the hospital that there is an appropriate way to behave and that we all agree to that across the board. Of course, we also have to look at nursing and administration because we cannot leave those other two key areas out.

I have to say that to date I am very grateful for the engagement of the senior clinicians. I think the junior clinicians have been very good. They have been speaking up and talking about things that we need to address in their areas. I think the committee, in its infancy, is working well.

Mr Corbell: Just to add and to put some quantum on the level of activity that is occurring, a respect at work training program for doctors in ACT Health has been developed and has commenced its delivery. Its initial audience is DDGs, clinical directors, unit medical directors and senior doctors, before being rolled out to all doctors in ACT Health. As of 17 May 135 doctors have participated in this training. In addition a doctor leadership program has been procured and will commence on 30 August this year. All clinical directors and unit directors will attend this program.

In addition, we continue to work as a directorate in embedding the respect, equity and diversity framework—or RED, as it is known—to support prevention and management of bullying and harassment and embed key organisational values. To the end of May this year 4,649 staff and 836 managers had attended this training. We have also strengthened the RED contact officer network and as of the middle of May there were 125 RED contact officers in place.

I think this highlights that we are getting some good movement on key issues around changing culture and embedding appropriate workplace values. It is an ongoing task but I am pleased with progress to date.

MR HANSON: The AMA were a little sceptical. I refer to their comments in this quote from the president of the AMA locally, "We have serious concerns that the recommended internal ACT Health processes will almost inevitably fail to resolve the issues." Have you met with the AMA or are they involved in this process? What

participation are they having?

Ms Feely: I have a one-on-one meeting with the AMA every month. They have made very clear to me their views about not being involved in the actual committee. To that end, I took their desire to be a member of the committee back to the actual clinicians on the committee. We had two votes. It was unanimous. They were of the view that committee membership should only be the clinicians at the hospital and that we should not involve unions or any outsiders in the discussions, not only because they felt that they were the ones who had to take control of the agenda and they were the ones who had to be held accountable for delivery but also because the nature of some of the things that we discuss in those meetings was not appropriate for anyone who is not a senior clinician or a member of the committee to discuss. I meet with them on a monthly basis. We do agree to disagree but I am keeping them informed of what is happening on the committee and I think we have reached an understanding.

Also, if we allow the AMA to come in there would be questions about not having a VMO representative, a member of ASMOF and then it just continues to go on. The clinicians were very strongly of the view that they own this as an issue and they needed to be the ones to solve the issues.

MR HANSON: With regard to, I guess, the outcomes of the work that you have put into place, at what stage are you having, or are you intending to have, a subsequent independent review to then say, "We have been doing this for 12 months"—or 24 months or whatever the period is—"where are we at? Has this made a difference, has it not?" to assess independently whether the recommendations that were made are being implemented successfully.

Ms Feely: We actually discussed that at our last meeting and the general view was—and it was quite a detailed discussion with a lot of those who put a lot of store in having correct statistical data and it was agreed around the table that we know what the problem is—within 12 months we would like to get it externally reviewed and then probably again 12 months after that. It was also stressed that this is not just a 12-month program; we need to be in it for the long run. The issues have been around for many years and were not going to be solved automatically in 12 months. That was also agreed.

MR HANSON: Are you still doing the staff culture surveys?

Ms Feely: We do, yes.

MR HANSON: And how often are they done, annually?

Ms Feely: No. Every three years.

MR HANSON: Every three years?

Ms Feely: Yes, on average.

MR HANSON: When is the next one due?

Ms Feely: The last one was in November last year. I have not got a firm view on this yet but it depends on what happens with the clinical culture committee whether or not that needs to be done earlier. Generally it has been three years, and a pretty consistent cycle.

MR HANSON: How did you go last November with the results of the staff culture survey?

Ms Feely: It is a bit hard to answer that because every department is looked at. Across the board there were similar issues raised, I think it would be fair to say. Again, department by department, some were worse than others. I think there has been stalling of the culture over the last three years.

MR HANSON: A what, sorry?

Ms Feely: What I call a stalling of the culture. We had not continued the climb towards a culture of success. That is something that we again, as part of what we are looking at as a team, will look at—how we communicate better and make sure that we are delivering back on all the elements of the culture survey to show that we are actually listening. Most importantly though, the culture survey—a general, wide one—has the same issues about pockets of the organisation that have a culture that requires remediation. We are looking at that on a department-by-department basis.

MR HANSON: And talking particularly about pockets, obviously obstetrics has been an issue of concern with accreditation and culture. Do you have an update on accreditation?

Mr Corbell: Yes I do, and I have to preface it by saying that I am very pleased with progress that is being made in relation to the RANZCOG accreditation for obstetrics and gynaecology at the Canberra Hospital. This is in relation to the training program for doctors in that service. The Royal Australian College of Obstetricians and Gynaecologists returned for a visit on 30 October last year to assess the unit against the recommendations made in 2014. The overall results from the review were very positive. The survey team noted that several significant positive changes had been made in the past 12 months and commended the O&G unit on the progress made against the conditions noted.

The O&G unit has worked consistently during the last year to address the issues outlined in the college's 2014 report. As a result of the work undertaken to address the conditions suggested by the college, there is now more structure in the training program, regular review of the components of the program and a focus on the benefits of a positive, collaborative workplace culture.

All senior and junior medical staff in O&G and many senior nursing staff have completed their respective work training. This training is now a regular and ongoing part of the unit's education program.

The O&G unit has also made an application to RANZCOG to be accredited for sub-speciality training in maternal foetal medicine and this accreditation has been granted. The survey team has recommended to the RANZCOG board that the

Canberra Hospital O&G unit be granted two years provisional accreditation until October 2017 and a site visit will be conducted by the college in October 2016. The accreditation is classed as provisional as the college visit in 2015 looked only at the progress on recommendations. This will also be the case for the next visit scheduled in October 2016. The full accreditation process against the college standards will occur in the latter half of 2017.

That indicates that we are well and truly on a good path. Substantive steps are being undertaken to strengthen and improve the training environment for junior doctors. The college is complimentary of the steps in place and we continue to work towards that graduated process of full accreditation next year.

MR HANSON: That is good news. In terms of other areas—I think neurology was another area of concern—are there other areas that are struggling with accreditation, that are going for accreditation, that you are aware of?

Mr Corbell: No, none that I am aware of.

THE CHAIR: Just before I go to Ms Burch, were there any public interest disclosures in the past 12 months?

Mr Corbell: Not that I am advised.

THE CHAIR: On the statistics that are kept on bullying, how many cases of bullying have been reported?

Mr Corbell: I will have to take it on notice. We will provide you an answer.

THE CHAIR: Thank you. Ms Burch, a new question.

MS BURCH: BP3, two lines—if you could provide some more information? One is on page 108 and it is more about the outpatient services. There is over $4 million over the four years. It talks about neurology, cardiology and sleep services. Is that new services or expanded services to meet demand? The other line is about the feasibility of the pancreatic cancer services. Is that because there is demand that we are not meeting currently?

Mr Corbell: In relation to outpatient services, that is an expansion of existing capacity to meet demand in each of those respective areas. In relation to the pancreatic item—

Ms Feely: There has been a view put to us that there are some new surgical and other treatments that are becoming more worthy of consideration in relation to the treatment of pancreatic cancer. Given it is such a huge killer—unfortunately, if you are diagnosed with pancreatic cancer the outcomes are not often very good—we have put aside some money, given the surgical capacity we have on the site, to look at whether or not we should be investing further in new pancreatic cancer treatments. Hence there is some money set aside for us to pull together some advice and get ready if we make a decision to send it back through government for further funding.

MS BURCH: So that is new procedures as in new contemporary procedures—

Ms Feely: Yes.

MS BURCH: or it is just that we are not doing what other states are doing?

Ms Feely: No, there are a few. Westmead are starting to do some work. There is further work; I think two centres are doing it. I am sorry; I do not have it in my head at the moment. It is a new, revolutionary treatment of pancreatic cancer. It also involves new modalities of imaging. Again, quite often people come and say, "This is the new thing," but we want to take the time to do a full business case on it and make a decision on whether or not it is something that the ACT should be investing in, or whether we need to work in conjunction with some hospitals, maybe in New South Wales, to make sure that those who are diagnosed can get the appropriate treatment.

MS BURCH: Do we have high numbers of locals that are going to New South Wales? Is that a bit of the driver about delivering a new service locally?

Ms Feely: I do not know who is going where at the moment. All I know is that for people with pancreatic cancer, because of the new modalities that are coming into the system, we are trying to bring some innovation back into ACT Health. We just want to look at it to make sure we are on the tip of the wave rather than behind it in relation to that type of cancer in particular. Similarly, what we are doing with stroke services: we stood back and looked at what was happening in stroke and Parkinson's disease.

MS BURCH: This is now creating a new stroke service?

Ms Feely: It is extending the service that we are currently offering.

MS BURCH: Going back to the outpatients—and this is an enhancement—is there any particular clinical stream in there that has a stronger demand than others in the outpatients area? Do we need more sleep services? Is Canberra sleeping well or not sleeping well?

Mr Thompson: We do need more sleep services. The areas that we have highlighted are areas where we are seeing growth in demand. In each of those areas we have demand that we are now reaching the limits to respond to and this gives us the ability to supplement that capacity.

MS BURCH: These figures will be bringing in allied health professionals or doctors?

Mr Thompson: It will be a mix. It will be different in different areas. Some of it will be additional capacity for medical staff. Others will be allied health and nursing depending on what is appropriate for the particular clinics.

MS BURCH: Are these all in the hospital at Woden? Is this Canberra or are they through your community health centres as well?

Mr Thompson: We are actually looking at using the community centres in addition to the hospital. Part of the planning here will be about what is the most appropriate

location.

MS BURCH: You have put renal dialysis into the community centres to make that more convenient and accessible.

Ms Feely: We have talked about the model of care review. Again, we are trying to work out what we can deliver more out in the community as distinct from centralised. That is exactly the type of thinking we are trying to look at.

Mr Corbell: Mr Chairman, if I may—just coming back to the pancreatic cancer services—give some further figures. In 2014-15, there were 1,741 presentations to the ED specifically related to pancreatic conditions. Of these, 92 per cent were admitted. The total number of bed days across Canberra Hospital and the health service in Calvary public was 4,357 at a total cost of $8.74 million. So you can see it is a significant level of chronic disease that is high cost and very intensive for the patients.

MS BURCH: As is often the case with other specialist services, it is about critical mass—whether you invest in it here as opposed to good secondary level support and specialists being supported elsewhere. We are almost at that point of investing here, if this business case shows it is the smart thing to do.

Ms Feely: With these numbers, that is why we are trying to look at it in a different way. We are looking at the business as a whole and saying, "Is there another solution? What do we need to do with these numbers?" We have to make sure we are treating people in the best way possible, in the most cost-effective way, but also make sure that clinical care is at the right level.

MS BURCH: Yes. In many ways it goes back to the very early conversation around how do you manage hep C with the different new treatments coming in. Each year clinical responses will change.

THE CHAIR: Mr Hinder, a new question?

MR HINDER: My question relates to the $5.3 million indicated in the budget papers at page 18 of BSC for standard trauma services at the Canberra Hospital. It is 1.1 out to about 1.4 over the four years. What are those services, minister, and how will they improve the capabilities of the trauma unit?

Mr Corbell: Trauma is obviously a key element of service delivery at the Canberra Hospital, being the major trauma centre for the region. But we have not to date actually delivered the level of trauma service that the College of Surgeons has been particularly keen to see delivered. Our focus on trauma delivery has been by body-specific part or organ speciality rather than a fully coordinated level of trauma care.

When it has come to trauma care, if you have had an injury to one specific organ or part of your body, the relevant medical speciality has looked after that part of you, and if there have been other injuries, the other relevant medical speciality has looked after that part of you—and they have done that very well—but it has not necessarily been joined up and coordinated in terms of overall trauma care. This new trauma service is

designed to bring that level of coordination together and strengthen the capacity that is already being delivered by those individual organ or body-specific specialities.

It will provide for two specific trauma surgeons, three emergency department anaesthetic ICU capability, one trauma fellow and one trauma nurse practitioner, so 6½ additional FTE altogether. The outcomes we want to see from this are: reduced time to operating theatre for trauma patients; reduced returns to operating theatres due to complications; a reduced length of stay in the ICU; and a reduced length of inpatient stay.

Providing a holistic level of trauma care rather than site-specific treatment as and when the issue is identified, bringing it all together and saying, "What are the problems and specific traumas suffered by this patient? How do we deal with all of those together?"—rather than a site-by-site process—really will improve outcomes for patients.

This is a proposal that was put to the directorate, to the DG and then ultimately to me by the college. They said, very clearly, "We think we can do trauma better. We would like your support to do trauma better." I am very pleased that the government has been able to provide them with this resourcing because that demonstrates to our specialists that if they have got a good idea and can put together a strong case, they are going to get support from the government to deliver better health care.

This is a measure that does that. It delivers better health care. It should achieve a reduced length of stay in ICU and that is obviously good in terms of the efficient use of our resources. It is better for the patient, of course. This is a really important initiative and it is going to strengthen the capability of the hospital as a centre for trauma care in the city and the region.

MR HINDER: Thank you.

THE CHAIR: Thanks, minister. I turn to a couple of the capital works issues. Where is the University of Canberra public hospital at?

Mr Corbell: The project is under construction in terms of the build timetable. I will defer to my officials in terms of where we are at on the build timetable. I will ask Mr Mooney to answer your question.

Mr Mooney: Could you repeat the question, please?

THE CHAIR: Where is the University of Canberra public hospital construction at? I think when it was initially announced it was to be opened in 2017. Is it on time? What is the scope and what is the budget?

Mr Mooney: The DCM contract—the DCM delivery model—was entered into on 20 November of last year with Brookfield Multiplex as the construction D&C contract party and their partner company Brookfield Global Integrated Solutions as their—

THE CHAIR: You are very soft, Mr Mooney.

Mr Mooney: Sorry, I will try to speak a little louder. Brookfield Multiplex, the D&C partner, have been progressing with the design. The final sketch plan has been approved and construction has been working in parallel at site. If you go out to the actual Ginninderra-Aikman Drive site you will see a lot of the groundwork has all been completed. The tower crane has been installed and the initial concrete pours have been done. They are on track to program. We are expecting the actual completion of construction, including our own contingency, to be early 2018.

THE CHAIR: That has fallen back a year?

Mr Mooney: No, I am allowing in that contingency in terms of such things as wet weather delays and things like that. The actual overall hospital is planned to be opened in mid-2018.

THE CHAIR: What are the projected costs now?

Mr Mooney: The overall budget is $212 million. That is the total budget for the actual project. In terms of the construction element, we entered into a contract for just under $139 million.

THE CHAIR: So $212 million; on page 24 of budget paper C it lists $187 million as the four-year investment.

Mr Mooney: Yes, of the $212 million there is a number; it is not just construction-related. That is the total appropriation that has been allocated for the complete UCPH, the University of Canberra public hospital.

THE CHAIR: It has only got 187 on page 24. On page 22 it actually has $200 million listed against the project. What is the additional $12 million and when did that—

Mr Mooney: The original appropriations amounted in total to about $12.252 million. They were for early planning and design work. Then the $200 million was an additional appropriation to top it up to $212 million.

THE CHAIR: It is 212 all up. How many beds will it be?

Mr Corbell: There will be 140 overnight inpatient beds and 75 day spaces or day beds.

THE CHAIR: We are not going to get it up to 200 overnight beds?

Mr Corbell: It is over 200 treatment spaces in total.

THE CHAIR: Two hundred treatment spaces.

MR HANSON: I have a supplementary on the hospital, if I may?

THE CHAIR: Yes, Mr Hanson.

MR HANSON: The services to be delivered and the staff profile; has that work been completed?

Mr Thompson: Both the model of care and the final workforce profiles are still to be completed. We are expecting to have them completed within the next six months or so.

MR HANSON: In your preliminary work that you have done, have you got a view of how many staff will be employed at that site?

Mr Thompson: We have got some preliminary views, yes, but that is subject to confirmation.

MR HANSON: Without holding you to it, and I am happy not to be holding anyone to anything, what is the range—between X and Y?

Mr Corbell: The government is yet to receive final advice on those matters. I would be reluctant to venture a figure without that final body of work being complete.

MR HANSON: Can you give an update on the model of care that is going to be provided? Is that possible?

Mr Thompson: Yes, are you looking for a description now?

MR HANSON: Yes.

Mr Thompson: There are four components to the hospital, operating obviously within an integrated whole. We have got the mental health subacute services. As we have already talked about, and as Ms Bracher was talking about earlier, that is looking at a rehabilitation focus for people with mental illness, some of whom will be transferring out of Brian Hennessy Rehabilitation Centre, as well as providing subacute adjunct further rehabilitation to people who are experiencing an acute episode.

We have within the rehabilitation and aged care area predominantly a rehabilitation model of care. The intent of that model of care is to provide within a purpose-built, dedicated space rehabilitation services for people who are coming from acute hospitals and again maximising the therapeutic nature of it, maximising their ability to return to full functioning prior to going home after an acute episode.

In a similar vein we have within the day places a mix of mental health day program spaces as well as rehabilitation and aged care day program spaces. They have a similar focus but what they provide for is for people who do not require overnight inpatient care to receive the therapeutic services on a day basis and return home.

The fourth component of it is outpatient services. There will be a range of clinic, allied health, medical and nursing services that provide that assessment and therapy for people. It is integrated with the University of Canberra in that the hospital will be dedicated to the university's health faculty to enable them to be located within the hospital and to work very closely with us around teaching, training and research activities.

MR HANSON: I imagine that you are not going to be able to operate at full capacity on day one, due to the nature of recruiting staff and so on. Have you looked at a sort of scaling up: that you start with a certain capacity on day one and build up over a three or four-year period? How will that work?

Mr Thompson: Just so you know and we are clear about what we are talking about here, the hospital will be fully functional from the day it opens. It will not be full. In other words, we are not building a hospital that will be automatically filled and therefore we will not have the capacity to expand. That is exactly what we are working through at the moment in terms of the staffing model and the overall graduated expansion of the services.

MR HANSON: Yes. Is there a sort of model that you would work to on hospitals where it takes, for example, four years for it to become fully operational or two years? Is there a template so you build towards your capacity?

Mr Thompson: That varies according to the type of service you are talking about and the trajectory of the growth in demand. We have undertaken projections for the demand for the services that will be operating out of the hospital. We have identified what we think that demand will be at the point of opening and how that demand will increase over subsequent years.

MR HANSON: Again, it might be difficult to predict but do you think the initial demand is at 50 per cent of full capacity? Is it higher or is it lower?

Mr Thompson: I would not—

Mr Corbell: It will vary across the different specialty services that are provided.

MR HANSON: Of the 140 overnight beds: do you anticipate how many of those would be filled? That would drive the staffing model, wouldn't it?

Mr Thompson: Yes, absolutely, and we are doing that in parallel with the staffing. That is one of the reasons why we have not got a definitive position yet because we have not settled that definitive number.

MR HANSON: With the staffing, because you are transitioning some services from TCH and other areas, I assume that the staff sort of migrate across. So it is not a matter of having to recruit all new staff. My understanding from when we first talked about the model is that you will be able to move not the physical bed but the delivery that would be in that bed, the staff. That then frees up space for that to be acute services at TCH. Is that still the plan?

Mr Thompson: Yes, the bulk of the services at opening will be transfers from both Canberra Hospital and Calvary hospital. In terms of the physical space, yes, there will be physical space that could be used.

MR HANSON: How much physical space does that throw up at TCH and Calvary for acute services? Is it the full 140? Is it a portion of that?

Mr Thompson: It is a portion of that. Again, that is tied up with the demand projections that I was talking about earlier. Until we have got that settled, we cannot give a definitive number.

MR HANSON: But once it is mature, once you get to the final end state of that 140 overnight beds, how many are sort of relocated that then provide extra capacity at TCH and Calvary?

Mr Corbell: I think it is important to stress that it is not just TCH and Calvary. It is other facilities as well, so Brian Hennessy as well is part of that equation. It will vary in terms of the existing care setting and the new care setting.

MR HANSON: Yes, but I suppose in—

Mr Corbell: It is not just strictly in the acute space.

MR HANSON: the bulk of those positions or spaces.

Ms Feely: If I may jump in here, this is an efficiency argument too. One of things we have to take into consideration as we open the new facility is closing those beds behind. Otherwise we are going to just replicate what we have got. So we need to close the beds that we move and transfer across. Then we will be making a decision as to what type of beds—what is needed to be reopened. It is a very important thing. We cannot move people out of rehab beds on a TCH site, put them in Bruce and then just refill them behind. That is not the plan. So we will be closing those beds behind us and making an assessment as what needs to be opened if there is further capacity required.

THE CHAIR: What is the ratio of staff to a bed?

Mr Corbell: The answer is: it depends.

THE CHAIR: I turn to budget paper C, page 25. Your employee expenses in 2018-19 when the hospital opens go up about $17 million or three per cent, which I am assuming is just average growth in employee expenses. What is your projected allocation for 2018-19 and 2019-20 in terms of staffing the new hospital?

Mr Corbell: As Mr Thompson has indicated, the government is yet to receive a final concluded advice in relation to the initial staffing complement. The question you ask would obviously flow from that work that is yet to be completed.

THE CHAIR: When will that be available?

Mr Thompson: We expect to be providing advice to government within about six months. Obviously that needs to flow into a budget cycle for final confirmation.

MR HANSON: So there is no money allocated in the budget at this stage for staff even though that is going to be operational during the forward years.

Mr Corbell: That is not entirely correct. That is not correct insofar as existing staff already on the books will transfer. The issues will be the matters around balance there. That is yet to be determined.

THE CHAIR: So the 2018-19 or the 2019-20 budgets will grow appreciably depending on what services are offered at UC and then what is backfilled from existing facilities?

Mr Corbell: Again, as Ms Feely has indicated, this is about providing for subacute care in a dedicated facility. That includes a broader range of existing subacute activities that are already budget funded but which will change their physical location to the new facility. Obviously at the moment there is a range of different types of subacute care that, some of which will be provided at the new campus, some of which will be provided in other settings. The final model, as Mr Thompson has indicated, is subject to finalisation over the next six months.

THE CHAIR: Ms Burch has a supplementary on this issue and I have got some more capital works issues, but we may have to return to those after the break.

MS BURCH: You mentioned in your answer that the benefit of University of Canberra hospital is the collocation with the health training facilities at UC. Can you expand on that? Have you factored in growing your own, training your own and the benefits that that will have in the health service?

Mr Corbell: I think in general terms it is worth emphasising obviously that UC is the key training facility in the city and the region for nursing and allied health professions. This really strengthens their capacity as that key training centre. Clearly the government is very keen to strengthen and grow UC as a tertiary education research and training institution. This collocation gives a fantastic opportunity to the school of nursing and the allied health school there to have their students trained and build their skills in situ in an everyday health care environment.

That is a very positive and significant investment. There will be a range of different professions where students will be able to learn skills. I am not sure whether Mr Thompson can elaborate on that at all but I might ask him if he can add anything further.

Mr Thompson: Obviously nursing is a key one, as is physiotherapy, which is integral to rehabilitation care. Also we are looking at the provision of capacity for psychology as well as other allied health professions, some of which are not currently provided—do not have courses operating at the University of Canberra. One of the things we are going to be talking to the university about is whether or not this provides an opportunity to expand the range of courses that are available.

MS BURCH: That was probably going to be a follow-on question. Would this facilitate new offerings through UC or more numbers in their existing offerings? The chief nurse may recognise that there is a tsunami of retiring nurses, I have been told. Have we got to get the next generation in?

Ms Croome: There is, Ms Burch, you are absolutely right. But have you looked at

your superannuation lately, as a lot of nurses are doing? I think they are hanging on a bit longer. The universities around about three or four years ago made the decision to increase the numbers of students quite dramatically to brace themselves for the tsunami of retirements. In fact, now we have many nurses graduating from the universities who actually cannot get jobs. We are in that hiatus where we actually have too many nurses for the positions on offer. The trick is to keep those nurses engaged so that when those large numbers of retirements do come about we have got those nurses that we have invested in being available to come back into the system.

That is one of the reasons why across ACT Health we changed the recruitment pattern for newly graduated nurses. We are now offering them 12-month contracts rather than ongoing employment. That was a really important strategic move because it meant that we continued to flow new graduate nurses through ACT Health offering them 12 months' worth of supported education and on-the-job learning while they were getting that transition to practise occurring.

They are going off elsewhere to find jobs after that 12 months of experience with ACT Health but we have offered them a very positive experience. They will come back, hopefully, when the time comes. But we are taking probably around 150 to 160 new graduate nurses each year into the system to try to cope with those increased numbers.

MS BURCH: The different models of service delivery—community health, outreach and all that—is then of deeper interest to the nurse graduates so they do not just have to come into a ward environment to work. They have got different avenues of employment.

Ms Croome: Absolutely. At the undergraduate level, which is really where we felt the pinch in terms of being able to offer clinical experience opportunities, we have explored all sorts of areas out in the community. We place students now in general practice to work alongside practice nurses. We are placing them on night duty. We are offering them all sorts of really valuable experience. That is making a big difference I think to the level of interest that they have in the types of areas that you have mentioned. So we are getting a greater uptake in primary health areas in community nursing settings in general practice as well.

MS BURCH: Do you find that many of those who have had 12 months experience go elsewhere? Are we long enough into this to see a return to permanent?

Ms Croome: We are long enough into that cycle. In February this year we had our first lot of nurses who had been on a 12-month contract seeking re-employment at Canberra Hospital, for example. Forty-seven of the 53 who wished to return to Canberra Hospital were able to secure jobs.

MS BURCH: Would the same apply across the OT offerings as well because we always need OTs, physios and speech therapists.

Ms Croome: Absolutely. The pressures in the allied health area are not as great as they are in nursing but we are managing student clinical placements across all our life health disciplines. We are having quite successful recruitment in allied health. So I

think it all looks positive for the future but there is still a lot of work to do.

THE CHAIR: Mr Hanson, a supplementary and then we will have a break.

MR HANSON: I am happy to come back after the break with my supplementary. I do not want to be the person coming between the committee and afternoon tea.

THE CHAIR: We will suspend. We will resume at 3.45. I also have some capital works questions but we have still got to cover cancer services and rehabilitation, age and community care as well this afternoon. We will suspend there for 15 minutes.

Sitting suspended from 3.29 to 3.52 pm.

THE CHAIR: Ladies and gentleman, we will start the last session for today, which will finish at 5.30. We will return to some capital works. Mr Hanson had a follow-up question to Ms Burch's supplementary to my question.

Mr Corbell: Mr Chairman, before you throw to your colleagues, I have some further information on a question that I took on notice in the last session. In the last session I was asked if there could be a breakup of the number of patients seen on time in emergency departments by clinical category. I am able to provide that now. This is for the same period that the government has been reporting today in relation to March to June 2016 and for comparison performance in relation to 2015.

In relation to the Canberra Hospital ED, the percentage of patients seen on time by clinical category for the year 2015, March to June, is: category 1, 100 per cent; category 2, 78 per cent; category 3, 40 per cent; category 4, 46 per cent; category 5, 83 per cent. That is a total of 52 per cent of patients seen on time.

MR HANSON: Thanks.

Mr Corbell: That is for 2015. For 2016, Canberra Hospital, March to June 2016: category 1, 100 per cent; category 2, 76 per cent; category 3, 41 per cent; category 4, 55 per cent; category 5, 88 per cent. Total seen on time, 56 per cent.

MR HANSON: Thanks.

THE CHAIR: Thank you for that, minister. Back to you, Mr Hanson, then I will continue with a couple more capital works questions and then Mr Hinder.

MR HANSON: Before the break we had some discussion about staff recruitment and numbers and an excess of nurses and how that was being dealt with. But I am aware that there have been some areas in which it has been more difficult to recruit and retain staff. I think mental health nurses or staff more generally, for example, was one area. I suppose what I am looking at is particular areas of growth, for example, ED staff. In respect of both doctors and nurses, are there any challenges there? With the growth that has been anticipated, are there problems with getting additional staff or any suitable specialities?

Mr Corbell: There are some areas of staff pressure, certainly in terms of finding

sufficient candidates to fill positions. There are two most pressing areas that I am advised of: the first is in relation to registrars in the ED, so junior doctor positions in the ED. There is a challenge in recruiting and finding sufficient applicants for registrar positions in the ED. That is an issue we continue to work very strongly on.

The other is nurses in adult mental health facilities. That is a particularly challenging area of nursing because of the complex range of behaviours that have to be managed. But we continue to work very hard in both of these areas in terms of recruitment. I am also advised that there are some challenges in relation to plastic surgery and also nursing in ICU. There is a range of pressures and these are not unusual to the Canberra Hospital. They exist nationally in terms of recruiting.

MR HANSON: With the medical school and the graduates coming through from there, do you then see that that problem dissipates over time? Has that staff modelling been done?

Mr Corbell: The medical school has been operational for well over a decade now. There is certainly no doubt that we are seeing more Canberra-trained doctors staying in Canberra or returning to Canberra as a result of the medical school being located here. We give priority to students who train in Canberra to get positions in Canberra as part of our allocation. We never have any challenges in terms of making that provision.

We will continue to work closely with the medical school but these challenges really are a result of trends that are occurring nationally. Obviously all the states and territories have their own medical training facilities now, with the exception I think of NT. Ms Feely has some further information and I will ask her to speak on that.

Ms Feely: There has been a gap in the surgical training program in relation to the third year, which is PGY3. Through the surgical task force that meets monthly—all the surgeons come together and raise their issues—we are putting in place a new training program which will be led by Bryan Ashman, who is head of surgery, to offer places to students who do year 1, year 2. Then if there was nothing good in year 3, they left. Then years 4, 5, 6 et cetera are the college sort of years.

We are actively trying to retain as many of our surgical staff as possible. For those who do not get into an accredited training program, try to use this PGY year 3 to set them up to see whether they can actually get into an accredited training course. That would be a big thing to retaining our junior cohort as they make decisions about where they want to have their career.

MR HANSON: Okay.

Ms Feely: But the issue of whether someone is a plastics or not is really a college-driven issue. All we can do is keep talking to the colleges about opening up numbers. But in the absence of that happening, we just have to try to recruit from the membership pool of people that is available. I do not believe Canberra is any more the issue that it was many years ago—about not wanting to come to work in Canberra long term. I do not think they are as strong as they were, say, 10 years ago. It is much more attractive to come here as a city and a health service.

THE CHAIR: Back to the capital works; on page 23 of BSC there is reference to the city health centre feasibility study. When do you have to vacate the building that has just been sold? Where are you looking to take the centre?

Mr Strachan: Mr Shaun Strachan, Deputy Director-General.

THE CHAIR: It took a long time, but you got here.

Mr Strachan: I was trying hard. In terms of 1 Moore Street, the issue at the moment is that we have an option to take it for a further two years. What we are doing at the moment is just reviewing that. You are absolutely right. There is a feasibility review required. We will be undertaking that feasibility review over the next six months and looking at options associated with the appropriate clinical care model within the city limits. Then we are also looking at the broader issues; we are actually currently looking at the broader issue at the moment in relation to administrative staff, with the considerations for Woden.

THE CHAIR: Sorry—"considerations for Woden"?

Mr Strachan: For Woden, for the broader Woden—

THE CHAIR: How many administrative staff in 1 Moore Street?

Mr Strachan: I will have to take that on notice. I can give you a number. I think it is about 123 but I will have to take it on notice.

THE CHAIR: For the city health centre itself, is it looking at an expanded facility or just comparable services and size?

Mr Corbell: Part of the feasibility work is to look at the preferred model of care to be delivered into the future in a new facility.

THE CHAIR: Supporting good mental health—support for people with mental health issues to recover and live in the community as the step up facility. What likely location are you looking at and what time frames on delivery?

Mr Thompson: There are two components to this: one is a step up, step down facility. We are looking to locate that on the south side of Canberra. We have got a facility currently on the north side; so we are looking to provide something more convenient and closer to home for people on the south side. The timing of that is contingent on us identifying a property, but we are looking to get that commencing next financial year.

The other part of it is a broader feasibility study looking at the longer-term care options for people who require a level of continuing support and accommodation. The step up, step down is an up to three-month period of time but for the other facility it is for people who may need accommodation indefinitely, to identify what the most appropriate accommodation options are for them and to have them in place prior to the closure of Brian Hennessy.

THE CHAIR: Is this a construct or is it an acquire?

Mr Corbell: This is feasibility at this—

THE CHAIR: What; $2.3 million on a feasibility study?

Mr Corbell: I beg your pardon. It is feasibility and design and construct. It is all three.

THE CHAIR: How many beds are we talking?

Mr Corbell: That will be determined in the initial feasibility stage, but we know the cohort and the size of the cohort of people we are seeking to support. As Mr Thompson said, there is a small group of long-term residents in Brian Hennessey Rehabilitation Centre. I made reference to this work in my answer to Mrs Jones earlier. It is approximately 10 to 15 people who are long-term residents of Brian Hennessy. They will need alternative residential options when that centre closes in 2018. These are obviously clients who are unable to live independently due to the range of their mental health conditions.

There is also a further cohort of people who need suitable step down type accommodation once they exit the secure mental health unit. There will need to be options available for that smaller cohort as well. This will also take account of the work that is happening. One of the reasons we cannot put a definitive number on the total number of people at this stage is understanding that number of people who will be supported in the community through NDIS, whose accommodation options will be funded by NDIS, and those that will remain outside of the NDIS and needing support from the territory directly.

THE CHAIR: Whatever the answer from that work is, the answer is $2.3 million.

Mr Corbell: Yes. That is our best estimate of the costs at this time, that is correct.

THE CHAIR: The descriptor on page 146 of budget paper 3 says that this is for mental health patients for up to three months. How is it that the long-term residents of Brian Hennessy house will be living here? Is it a step up, step down facility? Is it a substitute for Hennessy House?

Mr Corbell: It is both. It is incorporating two elements: the longer-term residents and the short-term residents.

THE CHAIR: That is not what it says.

Mr Corbell: All I can say is that is an abridged description of the full initiative.

THE CHAIR: I find it hard to believe—it describes it as a step up, step down but you are now saying that is a long-term facility.

Mr Corbell: It is both. It incorporates both elements.

THE CHAIR: The last project there is—sorry, is there more information?

Mr Corbell: Just to clarify, the construction money is for the step up, step down facility. Then there is also a smaller amount of money for feasibility around Brian Hennessey. That is the break up.

THE CHAIR: It just sounded like you were saying they were going from Brian Hennessey to the step up, step down.

Mr Corbell: No, that is not what I meant, but my apologies if it was construed that way.

THE CHAIR: Under "Better health services—upgrading and maintaining ACT Health assets" $95 million is allocated over the four years. What is that specifically for? Does this include either a new tower or a revamp of the existing tower at TCH?

Mr Corbell: The government has made a very significant commitment to upgrade a range of assets and infrastructure at the existing TCH campus. This has followed a very detailed assessment of requirements for building upgrades and maintenance of facilities to make sure that we can fully utilise the operational life of those assets. I will ask Mr Strachan to elaborate a bit on what that entails.

Mr Strachan: In terms of the program over the next four years, as the minister has said it is in relation to sustaining our key infrastructure investment across all the ACT Health sites. The bulk of the investment is in relation to Canberra public hospital. It also extends to a minor extent to Calvary. The key issues in terms of the extreme and the high risk largely relate to the electrical systems and the main switchboard of the hospital. That is currently going through a request for tender process at the moment.

As you will appreciate, in order to allow the assets to perform, there is a requirement over the next five to seven years to ensure that we are absolutely confident that at the end of the day the infrastructure is there to support the front-line clinical services. The program has had a very keen focus in relation to looking over the short to medium term. We had in a consultant by the name of AECOM who provided a comprehensive risk assessment associated with performance.

This amount of money is also running concurrently with regards to the CUP funding and some other minor works funding that is in the recurrent envelope within Health. But it is subject to a very comprehensive and focused plan in relation to sustaining performance of the assets.

THE CHAIR: You did not mention the tower once in that. There was money allocated by the government for a new tower. Half of that was taken and spent on the extensions of the ED. Is there a new tower coming or not?

Mr Corbell: Decision-making in relation to that infrastructure is a number of years away at this time. The government has focused on ensuring that we achieve optimum utilisation of existing infrastructure in the short term. This funding gives us the capacity to ensure that that infrastructure is able to be sustained and deliver the

outcomes we need over the short to medium term. Certainly the assessment is that over the next five to 10 years utilisation of the existing infrastructure, with a modest level of improvement, will actually give us the capacity we need to meet demand over that period.

THE CHAIR: Is there a tower coming or not? Is there a new tower?

Mr Corbell: As I have indicated to you, we believe that through the level of investment indicated in the budget we can utilise our existing infrastructure to meet demand over the next five to 10 years without that new build at this time.

THE CHAIR: The work in the announcement Ms Gallagher made when she was the health minister has now gone out the window?

Mr Corbell: What I am saying is that the detailed assessment that has been undertaken by the Health Directorate over the past 12 months has identified that with the $95 million worth of investment in existing infrastructure, we are able to sustain and, indeed, provide all the capacity we need for anticipated growth and patient numbers over the next five to 10 years.

THE CHAIR: There was an expose here some budgets ago; who was the officer; Megan Cahill, I think? She gave us a long run through the strategic asset management plan that had been developed. Is that still the existent plan? I noticed that we will now develop a strategic assessment management framework.

MR HANSON: Capital asset development plan was the name of thing.

THE CHAIR: Asset development plan; so is that now gone? Is all that work now gone? Are you going to start again with a strategic asset management framework?

Mr Corbell: I will ask Mr Strachan to give you some more detail.

Mr Strachan: Chair, in terms of the focus of the AECOM report, as I mentioned, it focuses on the extreme and higher risks. We have a funding envelope created as a consequence of the $95 million. Running concurrently with that is also a capital asset life cycle maintenance program that will be developed. We are currently in the process at the moment of working through that framework with an external consultant. That process will further inform discussions with government in relation to what is required, leading through to the medium and longer term. In terms of any other issues associated with the infrastructure, either at Canberra Hospital or elsewhere, that process will bring those two issues together.

Mr Corbell: I will ask Ms Feely to add to this in terms of the strategic decision-making that has been occurring in relation to these matters.

Ms Feely: Mr Smyth, in coming here as Director-General last June, the first thing I did was to sit back and look at all the planning work that has been done and all the requirements and the talk about this tower block. It was the big discussion. However, I have made a recommendation to government that until we have completed the clinical services framework and the clinical services planning model that needs to follow from

the CSF and then a detailed infrastructure plan for the whole ACT—looking at how we can run the services across the entire ACT with appropriate understanding of population trends and all the financials that run with that—I was not in a position to recommend that we build a new tower block to the tune of $1 billion on the Garran campus.

I think it is very critical that we take a step back and make sure that we are planning services to deliver across the ACT. We are taking all different models of care into account. Then I will be making a recommendation to government as to where I believe we should be spending infrastructure money across the board.

Critical and germane to all that is also taking into account all the private hospital infrastructure that exists and looking at that approach from the community perspective about moving care closer to home. I am not saying that in two or three years we will not be making a recommendation to government in relation to the Garran site, because we still do need probably to do some more work on the ICU. We will need probably to upgrade theatres. But this concept of spending $1 billion on that site without the detailed planning work being done behind I thought was premature. I made that recommendation to government last—I do not know when it was now but—

Mr Corbell: Late last year.

Ms Feely: Late last year; so I am very comfortable with it. I think now we are putting in place a new team in Health. We are taking a different approach and a very strategic approach to the delivery of health care, putting the patient back at the centre. I need to be assured that the models of care are actually focused on all the elements, such as patient-centred care, delivery closer to home, those sorts of things. I think it is premature at this stage to commit that sort of funding to just a centre in Garran.

THE CHAIR: Are you saying that that work was not done before the announcement some years ago of the $1 billion upgrade to Canberra Hospital?

Ms Feely: Look, I was not here. This is just what I have taken on myself to look at across the board. I think we may have a different way of looking at it. We have now done what we call the population demand work. We have cut it right back to where I think the detail needs to be looked at. I think we do need to update the CSF and make sure that we have reviewed every single model of care across the health system. The extent to which that work is done, I think it required further work.

MR HANSON: I have a supplementary on that.

THE CHAIR: Could you tell the committee—you might have to take it on notice—how much was spent on the development of the previous set of plans for the—

Mr Corbell: We can see if we can make a figure available to you, yes.

THE CHAIR: The $95 million, what is the split between new works and maintenance?

Mr Strachan: I will have to take that on notice.

THE CHAIR: Mr Hanson with a supplementary, then Mr Hinder with a new question.

MR HANSON: With the approach that you are saying that building everything at the Woden campus is problematic, I assume—

Ms Feely: No, not problematic; I am not sure that it will properly meet the needs of a growing community across the ACT and its regions.

MR HANSON: So you think a more decentralised model—

Ms Feely: We have to have those discussions, and I need to have it with the clinicians. For example, delivery of a stroke service is not just about TCH; it is about what we do for that cohort of patients who come to us from the ACT and our wider regions and other elements of the service that need to be delivered back in the community and the nursing homes. This multiplicity of discussions we need to have over the next 12 months.

The first thing we are doing now is a review of the clinical services framework, which is the document that sets the level: what sort of ICU we have got, what sort of theatre capacity, those fundamental, big-picture discussions. Then we are going to roll out a very extensive consultation process with NGOs, advocacy groups and members of the community. Again, an example, if we are going to have a paediatric service, let us put all the requirements on the table and work out from a government perspective the best way to deliver that sort of service across the community.

You cannot assume that everything should be built just on a tertiary site. It is a mistake to talk about more and more on the tertiary site without us doing this work. Without sounding perverse, if that is what we end back at in three or five years' time, so be it. But right now I think it is a premature decision to make because I do not think my team and I have done sufficient work to get to that decision.

Mr Corbell: The government have accepted this recommendation and we recognise that, for example, a range of functions will need to be continued at the tertiary site, specifically ED services, other tertiary treatment services around trauma, surgery and so on. These are clearly functions that have to be delivered at a tertiary site. But when it comes to some of those community-based services—for example, we have already done this in areas like renal services where they are increasingly being provided in decentralised community settings—there is an opportunity to look at other options around that.

Fundamentally for me as minister, I need to be satisfied that the planning framework is robust enough to make a decision on what is a very significant health business investment into a big piece of infrastructure like a new tower block. The advice from the DG is clear; the advice from her executive team is clear. The government has agreed with that advice and has instead adopted an approach that will ensure that existing capability is augmented and upgraded to the extent required to deliver very significant additional capacity in terms of utilisation of that infrastructure without the need for a new build.

This comes back to the point we were discussing earlier about the cost of health services in the community and the fact that we are one of the more expensive jurisdictions when it comes to delivery of tertiary hospital services. If we are not utilising our existing infrastructure well and just keep building new things without achieving good utilisation, we will remain one of the most expensive health systems in the country.

If that is a concern—and I know it is a concern for you, Mr Hanson, and you, Mr Smyth, and it is a concern for me as well—we have to utilise existing infrastructure better because that actually means the unit cost goes down, the cost of delivering health services goes down and we then start to stop being the most expensive hospital system in the country. That is a key issue.

MR HANSON: But that cost—the 6,100—I do not think is the capital. That is the operational cost; it is the capital cost, which is the expense.

Mr Corbell: Yes, but the point is if you are not utilising your operational capacity to its proper extent and keep adding new stuff and then not utilise that to its proper extent either, then you are just adding to the cost of running a health service. Whereas if you are looking at what you have got and what you can do to utilise it more efficiently to see more patients through those beds, through those wards, through those theatres, through those other treatment spaces, if you are getting more people through that existing capacity, you are helping meet demand and you are driving down cost. That is why the government has adopted the approach it has adopted.

MR HANSON: We have been told in this committee countless times previously that there was an urgency, there was a need to build a new tower block, and we were presented with the plans. I have been briefed on the plans—there was a decanting of building three and a new tower block at building three, then a decanting of building two. We have seen the whole plan and been briefed on it. There were design studies; money was allocated; we were told it was urgent.

Numerous statements were made by ministers that an $800 million tower block was coming. It seems all of a sudden there is no $800 million tower block and we have got a new tram. You can appreciate why people would be a bit cynical that all of a sudden money is ripped out of health infrastructure—

Mr Corbell: I am sure if the weather is bad for the next three months it will be the tram's fault as well, Mr Hanson. The fact is that we have to come back to the core issues around the delivery of health services in our city. You, your colleagues, the public more generally and the media are rightly concerned about the costs of delivering health care in this city. Whenever the report from the AIHW comes out and tells us we are the most expensive hospital system in the country, there is criticism; and I accept that criticism.

But to address that issue, it comes down to how many people are seen using our existing capability and only adding extra capability when we are using our existing capability to the most efficient degree possible. If you just keep building new capability without improving the utilisation of your existing capability, you are only making your hospital system even more expensive. It is all about unit cost; it is all

about the cost of individual activity. The approach must be around improving utilisation of the existing bed stock.

The analysis that has been provided demonstrates very clearly that we can effectively deliver somewhere in the order of up to 100 additional beds of equivalent capacity just by better utilisation—simply by better bed utilisation. If we are already paying for those beds and the nurses and the doctors to staff them and to support the patients in them, let us make sure that capacity is being delivered. That is what this $95 million is about, making sure that changes and adjustments are made to the physical fabric of the buildings, that the capacity and the reliability of the buildings is up to scratch so that we utilise that capacity better. By doing that and making what is still a very significant investment—nearly $100 million worth of capital investment—we are improving utilisation. That means more patients are going to be treated and it means the cost of delivery of hospital services will become more efficient.

MR HANSON: There was $41 million for the redesign of the campus at Woden and the tower block, and $23 million was allocated to ED. I remember Dr Hall at that stage—I do not want to misquote him—said it was only short term and essentially was a band-aid solution. Are you not concerned that what we are doing here is a series of band-aid solutions to a long-term problem?

Mr Corbell: Let me point you to the outcomes the government has announced today around improved timeliness and access in the ED. Yes, we are building capacity in the ED, and that certainly helps in terms of workflows. But the real things that are making a difference in timeliness in accessing the ED are changes to work practice, changes in the way patients move through the building through that department of the hospital, changes in the way triage occurs, changes in the way patients are moved through to the treatment spaces, and changes in the way the teams of senior doctors, junior doctors and nursing staff work together to deliver care within the time frames.

The fact that we have seen very significant improvements just in the past four to five months in waiting and treatment times in the ED points to the fact that the key challenge in our health system is running it more efficiently so more people are seen on time and the infrastructure is utilised to the greatest extent possible. We are showing it is possible. We are showing that in the ED; we are showing that in the elective surgery long-wait list. The same reform agenda needs to occur across the hospital. Ms Feely and her team are driving that across the hospital to make sure the amount of money we spend on hospital services—$1.6 billion annually—meets demand and also improves efficiency. I do not think anyone can really argue with that.

MR HANSON: The 56 per cent figure that you quoted for ED still represents the lowest result in Australia based on the statistics I have—waiting time statistics from the AHIW. I accept we have had a four per cent improvement, but it is a long way from being at the target, which is, I think, 75 per cent. It was 80 per cent but it was switched to 75 per cent. We are still a long way off that, and it still represents the lowest figure in Australia based on what I can see. You have quoted 56 per cent, and the latest figures I have are New South Wales, 81 per cent; Victoria, 75 per cent; Queensland, 71 per cent. We are still a long way off, are we not?

Mr Corbell: We are now starting to hit on-time performance day by day of up to

80 per cent in the ED. It has not been sustained yet; it is not a trend that is locked in yet, but we are starting to see that level of day-by-day performance. And that is in the middle of an environment where we are rebuilding the ED: the physical building is being refurbished around the doctors and nurses as they work. This demonstrates that we can make significant improvements. I accept there is still a lot of work to be done, and the ED team and hospital administration recognise that as well. But every day we are focused on this reform. Every day we are working with our doctors and nurses in ED to improve outcomes.

Let me give you another example of where we are seeing a workplace reform agenda delivering results—it is in the area of medical imaging. The wait list at the end of November for a range of medical imaging services was very high: MRI, over 1,000 people waiting for images; CAT scan, over 550; ultrasound, over 1,100. The wait list as of earlier this week was: MRI, 315 people; CAT scan, nil; ultrasound, 500 people.

We have not put in any specific extra money or extra imaging capability, but we have changed the work practice in that unit. By changing the work practice—working with the clinicians, working with the allied health staff, working with the nursing staff—we have delivered major improvements in access to a key part of the hospital. If you do not get imaging right, everything else slows down because everyone relies on imaging for so much of their work.

This is another example of how we improve performance and utilisation and help meet demand by changing work practice in the hospital. That is the key part of my agenda as minister and of the DG's agenda as head of the directorate.

THE CHAIR: A supplementary on capital from Ms Burch and then a new question from Mr Hinder.

MS BURCH: On capital, you talk about a new way of doing business and modernising systems and processes. On page 24 of the budget paper it talks about ICT, so information and communications technology. There is over $13 million across a range of e-health and other ICT initiatives. How are they progressing, and are they part of that overall system redevelopment that you have just spoken about?

Ms Feely: At the moment we are in the process of trying to recruit a new head of information technology. One of the priorities of the new individual coming in will be to establish an ICT strategy for ACT Health over the next two, five and 10-year time frame. That is something that is still lacking. In relation to the e-health agenda, Sandra will speak to you.

Ms Cook: The government had given quite a substantial investment of $90 million in the e-health program.

MS BURCH: How much?

Ms Cook: Ninety million dollars.

MS BURCH: Ninety million dollars?

Ms Cook: Yes.

MS BURCH: There is only $12 million in here.

Ms Cook: We have actually expensed; we have delivered a lot of key components for ICT.

Mr Corbell: So it is over past years as well.

Ms Cook: Yes, it is over past years.

Mr Corbell: Previous budgets.

Ms Cook: Yes. We have delivered a lot of upgrades to medical grade networks. We have delivered a lot of underlying capabilities in our patient master index and a number of other clinical systems. We currently have $13 million allocated for next financial year to complete the clinical information systems required across Canberra Hospital and Health Services, community and the Calvary hospital. At the moment the program is on track for delivery of all of the key components we were expecting. We have another $3 million worth of rollover for EMM at Calvary hospital. That is our electronic medication management solution. We will commence with Canberra Hospital and Health Services campus and then move that on to the Calvary hospital campus.

MS BURCH: The e-healthy future—what is that? What will the investment of $12 million do?

Ms Cook: There were components within the clinical information system, so that was to improve. With the $13 million that we have left, we will be completing the electronic medication management at Canberra Hospital and Health Services campus. We will be completing electronic pathology ordering, which we have just put into production in the last week. We have got our first two pilot wards utilising that now and we will be rolling that out across the campus. We will be working to complete some additional pieces with the electronic health record. Our discharge summaries at Calvary hospital will go up to the my health record as part of that. We will also be progressing with a clinical records information system replacement, as well as working towards the mental health, justice health and alcohol and drug service electronic clinical record that we will be working with.

MS BURCH: A clinical record allows access across the different systems; the hospital campus, community health and others. No? So after all of this we will not have an e-patient record?

Ms Cook: We currently have a clinical portal. The existing electronic clinical records strategy is to try to pull together all of the systems that we have through that clinical portal. As Ms Feely has stated, when we have an ongoing chief information officer we will be reviewing the ICT strategy behind that to move ahead.

Ms Feely: Shaun, do you want to jump in?

Mr Strachan: Ms Burch, just to reflect on the e-health program: it was really in four key parts. One was in relation to the clinical systems program, which had a number of sub-elements, the support services program and then the digital health and supporting infrastructure. As Sandra has said, in relation to the program at the moment in terms of its current appropriation, we have spent to the end of April this year $69.09 million. There is money, obviously, coming through for 2016-17 and a final component for the following year. At this stage we are doing a number of things in the ICT space, apart from, obviously, the focus on the delivery of the program. Nicole has requested that we undertake an ICT long-term strategic plan. We intend to move that into the open market probably within about three-odd months.

Reflecting on the fact that we are doing a lot of work at the moment within the clinical services framework and the fact that we will be doing detailed work at a clinical services planning level, that will be supported and informed further by a master plan on the infrastructure side and also supported by a comprehensive ICT services plan. As you would probably be aware, New South Wales have just completed one. They have taken a long-term view in terms of the electronic medical record issue and a range of other issues.

MS BURCH: Are you able to provide the expenditure to date, the $60 million? Can you take it on notice and provide it?

Mr Strachan: I have it in front of me.

MS BURCH: If you can? How does that match up? Perhaps Mr Thompson can comment? What plan was that up against? Given that you are now talking about a long-term plan, you would have spent $60 million against that plan. It is just so that we can reconcile where you started out from and how you matched up what you wanted to do.

Mr Strachan: I am happy to table this report. I think it covers all of those issues in terms of what the plans started out to achieve two or three years ago and where it is obviously jettisoned to finish. As I mentioned before, the key issue moving forward is that we need a comprehensive ICT strategy for ACT Health. That will inform the next five to 10 years in terms of what I consider the next three generations of the ICT plan.

MS BURCH: Regarding primary care, is there an idea about linking our e-health systems?

Ms Feely: It is critical that we do that. There is not a massive formulated plan at the moment, but we must link our community sector, GP sector, ideally, all into the one database.

MS BURCH: That goes to that bigger picture plan that Mr Strachan was talking about?

Ms Feely: Yes.

MR HINDER: A supplementary.

THE CHAIR: A supplementary and then a new question from Mr Hinder.

MR HINDER: Talking about electronic records, I understand the federal government has had an initiative in place which has had a reasonably poor uptake for a range of reasons. Assuming we have a federal government at some stage in the near future that is capable of delivering a national electronic database, will our services be ready to integrate with something like that in the future given this level of expenditure?

Ms Cook: Yes. We are already submitting our discharge summaries and some other documentation up to the national electronic clinical record. We were the first public hospital to do that. Certainly at the national level the federal government is trialling an opt-out solution for the my health record. Previously it was an opt-in solution. I think that was contributing to the poor uptake of that use, as well as the amount of infrastructure and integration required for all health services to be able to submit their information up to that level. There is probably a critical mass point where there is information that needs to get into it for it to be valuable for people to want to uptake into that. So that is the challenge from a national perspective.

THE CHAIR: A new question, Mr Hinder.

Mr Strachan: Chair, in terms of the report I have just tabled here, could I just have it noted that it is not for wider circulation?

MS BURCH: It is just for the information of committee?

Mr Strachan: If we can have that noted? Thank you.

MS BURCH: Yes, that is fine.

THE CHAIR: What does that mean, that committee members—

Mr Strachan: It is an internal report in terms of the way that we are obviously communicating at the moment. I have tabled the report in terms of reconciliation for the e-health program.

THE CHAIR: All right. We will discuss that. I appreciate the not-for-distribution classification, but normally once something is given to a committee it becomes the property of the committee and it makes that decision. Perhaps you might want to review whether a—

Mr Corbell: Let me take that question on notice, Mr Smyth.

THE CHAIR: Yes, you might come back to us.

Mr Corbell: I will seek some further advice from the directorate and provide you with what the position is on that.

MR HINDER: So is he taking it back?

THE CHAIR: No. Once you hand it over, it is here. We might have a discussion.

Mr Corbell: We cannot give you documents with conditions without your agreement. I will take some advice on that.

THE CHAIR: A new question, Mr Hinder.

MR HINDER: Minister, my question relates to the delivery of health services to hard-to-reach populations, which I did not quite understand when I first saw the description, given I thought about geography and that is probably not what we are trying to address there. Can you give us a rundown on how it is that we are delivering services or what parts of the community are in the category of hard to reach? We touched earlier in passing, gently, on a contribution to the Orange Sky Laundry for delivery of laundry services to homeless people. What other groups are we reaching out to and how are we getting to them more effectively?

Mr Corbell: Hard-to-reach populations include those populations who suffer social or economic isolation in the community and therefore find it difficult to access conventional mainstream health services. Amongst this group would be people who are suffering from homelessness. They may have mental illness. There may be drug and alcohol addiction and trauma in their background. All of these are factors that can hinder—

THE CHAIR: "Can hinder"?

MR HINDER: That is an unfortunate word.

THE CHAIR: Yes. You are featuring in the answers now.

Mr Corbell: a person's capacity to interpret and find their way through the health service. A health service can sometimes be not an entirely legible thing to navigate. If you are suffering other things—if you are trying to cope day to day with serious mental illness or a particular form of addiction, or simply just trying to work out where you are going to be sleeping that night—often you just do not have the capacity to work through and understand where you can get care in the hospital and health system.

This is designed to provide a part-time in-reach primary health service, similar to an early morning centre, which would provide for MBS and PBS funding GP services. We will be looking at opportunities to provide this capability utilising existing service providers. Some locations under consideration include Directions ACT, Ainslie Village, mental health day services and other sites that may be frequented by these vulnerable population groups. It is about basing those GP-style MBS and PBS services in settings which are easily accessible for these vulnerable groups.

I think it is a very useful initiative. It is not a high cost service by any means. As you can see from the budget information—$80,000 in one year; $31,000 indexed for the outyears—it is a very reasonable cost, but it does make a very significant difference in terms of the health and the early intervention available for these hard-to-reach groups.

MR HINDER: Are there any indicators around how many people or how many services might be delivered through that funding at this stage? I know it is a new—

Mr Corbell: It is difficult to assess that at this point. Nationally, NATSEM modelling has highlighted that if we were achieving a greater level of health equity, that is, access to health services nationally, we would be avoiding more than 500,000 individual hospital separations. That is nationally, with an average length of stay of around 2½ days. That means the equivalent of 144 million fewer patient days spent in hospital or the equivalent of $2.3 billion in health expenditure avoided, just through better access to early intervention for these hard-to-reach groups alone.

That is at a national level. Extrapolate that down to an ACT level; obviously it is a much smaller figure but nevertheless a genuine level of need that needs to be addressed. This funding will allow us to plan with confidence the final model and enter into arrangements potentially with non-government providers and settings to delivery.

MR HINDER: I assume these new ways of thinking about delivering services out there rather than in here adds to your further contemplation about whether or not spending money on bricks and mortar is the best way to spend our health dollar.

Mr Corbell: Certainly outreach is important for certain types of services. There are always services that must be delivered in a centralised tertiary setting for clinical safety reasons. That is largely to do with volume and the availability of personnel and equipment. But when it comes to community health arrangements, there is real value. In 2014 there was a trial of primary healthcare services at the early morning centre at UnitingCare in the city. That was at a cost of just over $30,000, but it provided the equivalent of a GP home service to people who were attending that early morning centre. They would go and get some breakfast, particularly on a cold day.

That is a really valuable service. I guess that is the equivalent of what we are doing, for example, in the legal services sector, where we have a street law program that provides, as you would know, primary legal advice services again to people who are vulnerable in a setting which they can easily access and frequent. It is about putting a GP-type service into that environment as well.

MR HINDER: Thank you.

THE CHAIR: Ms Burch, a new question.

MS BURCH: I am looking at budget paper 3, two lines around drug and alcohol services, and I appreciate that we are free ranging this afternoon.

THE CHAIR: The page number?

MS BURCH: It is page 106 on better health care—expanding drug services—but then on page 109 it is part of safer families—referral to drug and support services. Between the two, we have close on over $8 million. Is that a new way of doing business and enhancing existing services? How will the safer families element of that, in particular, fit into the overarching safer families framework?

Mr Corbell: Thank you, Ms Burch. I will make some comments and then Mr O'Donoughue might be able to assist. The government has made a very significant commitment to expanding funding for drug services and this has been very well received by the drug and alcohol sector in the ACT—just over $6 million over four years in increased funding. It is about providing additional capacity for support and treatment both in terms of residential programs and day programs.

There is significant demand for rehabilitation places and we need to increase our capacity in those. This is particularly an issue, obviously, with the increased prevalence of crystalline methamphetamine in our community—ice, as it is known. The feedback from service providers is that they are having to change their model, particularly around the amount of time they need to provide for care in the rehabilitation setting. For example, service providers are indicating that the detox period for ice is much longer than it is, say, for other drugs.

That means people have to stay in rehabilitation longer to go through detox, let alone start rehabilitation. That is putting additional demand on the sector. This funding is designed to provide that support and also post-treatment rehabilitation, maintenance of and expansion of Naloxone and better training for drug treatment and support workers. It is, I think, a very welcome and important initiative in that space. In relation to the safer families element, I might ask Mr O'Donoughue if he can elaborate on that.

Mr O'Donoughue: Thank you, minister. In addition to that welcome expansion of funding for the drug and alcohol sector to cope with the extra demands on them from ice and other things, they are clearly also services that see people who are vulnerable to and suffer domestic violence. In fact, there was a study done in 2015—a project called "enhancing supports for women affected by harmful alcohol and other drug use and domestic and family violence"—which was funded by a small ACT women's grant and in-kind contributions from the Alcohol Tobacco and Other Drug Association of the ACT, the University of New South Wales and the ANU.

That project looked at key barriers to integrated service provision for women experiencing difficulty as a result of alcohol and other drug use and domestic and family violence, key facilitators to developing integrated service provision and how the alcohol and drug and domestic family violence service provider sector could better engage in the development of the integrated services models.

The intention is to use that evidence and the lessons identified there and deploy that for this recurrent funding of $500,000 in each of the outyears. We have proposed to conduct a procurement process and take expressions of interest and find service providers who can look to build the skill and capacity of the alcohol and drug and family violence sector to respond to this issue and to also implement regular alcohol and drug training and networking between the alcohol and drug sector and the domestic and family violence sector.

MS BURCH: A couple of questions fall out from that. What split of the money is community sector as opposed to territory health services? It is all community?

Mr O'Donoughue: It is all community sector.

MS BURCH: You made mention of going out to a procurement process to get a provider in. Is that to bring a new provider in or because it is new money you are bound to go out rather than use existing providers?

Mr O'Donoughue: It is because it is new money and because we are looking for ideas from the sector about good ways, innovative ways, to deploy these funds.

MS BRUCH: The evidence is about concentration on the victims of family violence, the perpetrators of family violence, or across?

Mr O'Donoughue: It is that intersection between, obviously, families who have drug and alcohol issues and are victims of family violence. The study was around: what are the facilitators and barriers to providing better service delivery for that vulnerable group given that there is alcohol and drug expertise and also family violence expertise? How do we bring those two things together in a more integrated way?

MS BURCH: Say a young person presents with a drug and alcohol problem. That is the trigger for going, "We have got to get back into the family." But the family have not come forward, through police or anything else. There is just this presentation of a family member with a problem. Is there an expectation the wraparound services may go back to the core problem?

Mr O'Donoughue: I think it is a question that there is already growing awareness in the sectors to develop further awareness around being sensitive to those potential issues as they may emerge or may yet emerge, and then making the links and the networks to provide effective services when they are identified.

MS BURCH: Is there a transition period or is the money—

Mr O'Donoughue: Because it is a relatively small amount of money in a given financial year we would be confident we can manage a procurement process and allocate most of the funds within the first financial year.

MS BURCH: Because you are building on existing services it is a full funding effect straight off because the services are already there?

Mr O'Donoughue: Yes.

THE CHAIR: Mr Hanson, a new question.

MR HANSON: The women's and children's hospital, the centenary hospital—there have been a number of reports of issues where there have been capacity constraints or women who have had to leave sooner than is perhaps desirable. Could you give me an update on what is happening there in terms of demand and whether there is a need for additional capacity? What are the issues? You are aware of some of the issues that have been reported in the media, I am sure.

Mr Corbell: Overall, we are continuing to see a very high level of demand for

maternity services. That is a function of a growing population and a world-class maternity hospital in place. There are no instances where we are seeing discharge where it is not clinically appropriate. Discharge is only occurring if it is clinically appropriate and in the best interests of the mother and child. The issue around demand is one the government continues to keep a close watch on, but at this point in time the government is comfortable with how the situation is being managed.

In addition, there is funding in this year's budget for additional neonatal intensive care capability. This is an area where we are seeing significant pressure and it is why we are increasing capacity. As we are with trauma, when it comes to neonatal intensive care we are the referral centre for the city and the region. When we see significant surges in need in the region when it comes to neonatal intensive care, we need to accommodate those cases. We need to do that whilst at the same time trying to make sure that for everyone in the ACT who has a neonatal intensive care need, that need is also met. Some additional capacity will be welcome. I can give you some exact numbers on that funding. Perhaps Mr Thompson can assist.

Mr Thompson: Within our neonatal intensive care area we have two levels of capacity—the intensive care level and the special care nursery level. What we are experiencing at the moment is that access to special care nursery care beds, which is the step down level, is where the demand is tightest. So we are looking to provide, with the support of the budget funding, two additional special care nursery beds which will enable the babies who are appropriate to be transferred down or transferred out of the more intensive places to be cared for with that, freeing up the intensive care capacity. The funding itself is for the staffing. These services require a high level of nursing staff, particularly in terms of their capacity. The total amount of money is $1.267 million for 2016-17, growing to $1.385 in 2019-20.

MR HANSON: Have you done any modelling in terms of demand to see whether you are going to have capacity at the current site and how long that remains?

Mr Thompson: We have. This picks up on a number of the comments that Ms Feely has made. At the women's and children's hospital we have seen a growth in demand that has outstripped demand elsewhere in both Calvary public as well as the private sector in the ACT. We still have additional physical expansion capacity at the women's and children's hospital, if necessary, but we are trying to look at a model of care that distributes the services more evenly across the territory. Part of that is talking to Calvary about increasing the number of beds that they provide for the next financial year as a way of providing care that will be closer to home for a number of people who are currently coming to the women's and children's hospital but also distributing the demand more evenly, and also working to upgrade the Calvary facilities.

THE CHAIR: Strategic objective No 4 on page 4 of budget statement C seems to have moved very little over the years. What is the dilemma there?

Mr Thompson: The dilemma there is attracting people to attend appointments. In this instance I have just been corrected. I can actually be gender specific.

THE CHAIR: No. Breast cancer affects two per cent of men.

Mr Thompson: Breast screening, though, does not. Breast screening is specifically for women. We have seen a slight increase over recent years in terms of the participation rate. We have, however, seen an increase in the number of screens done but that is, at the moment, only keeping pace with the growth. It is always just exceeding the growth in the target population. We have undertaken a number of strategies. We have opened a breast screening service in the Belconnen Community Health Centre to try to distribute the service across Canberra with a view that it would be more accessible to some people.

We have also undertaken a very active recruitment program involving reminder letters to women who have previously used breast screening but have not come back for their scheduled appointments. We have been using the electoral roll data to actually write to all women within the targeted age group and working very closely with community organisations and GPs. That has, as I said, seen a very small relative increase in the participation. The basic issue is that we have the capacity and we are doing everything we can think of to attract women to use the service, but until more women choose to use the service the participation rate is not going to increase dramatically.

THE CHAIR: Is there a jurisdiction in the country doing better than we are, and what are they doing differently?

Mr O'Donoughue: The rates across the country do not vary markedly from the ACT rate. We are above the national average on the most recently available figures, or slightly above the national average, and ahead of some of the bigger jurisdictions. But the range is still, from memory, within the 50s in terms of participation rates of pretty much every jurisdiction.

THE CHAIR: Is there a jurisdiction internationally that does this and does it better?

Mr O'Donoughue: I cannot answer that, but I am happy to take that one on notice.

THE CHAIR: Mr Hinder, a new question.

MR HINDER: A question about Indigenous health generally and specifically about the fact that Winnunga delivers the broadest range of health services to Indigenous people in the ACT and further afield, I understand. Is there any further funding for Winnunga in the budget? What is the commitment of the government towards those services going forward?

Mr Corbell: There is additional money in the budget for supporting Aboriginal and Torres Strait Islander people's health. I will ask Mr O'Donoughue to assist me here.

Mr O'Donoughue: I think I mentioned before the $300,000 funding that has been allocated to increase outreach services. They are primarily going to be in partnership with Winnunga, although not exclusively. It is an extension of the kind of specialist outreach clinics that have already been provided in Winnunga previously and other settings like the AMC. It is one key piece of funding that will enable Winnunga to provide more services at their site.

Mr Corbell: In addition to that, Mr Hinder, I have had a number of discussions and

the DG has had a number of discussions with the Winnunga board and CEO about the future of Winnunga health service generally. They are exploring very closely issues around their existing accommodation, its suitability and whether they need new premises. I and the DG have each given our agreement to look at the utilisation of some existing funding that had been announced for Winnunga and redirecting that into a detailed assessment of options for future accommodation needs to help inform a future decision on whether there needs to be funding for new accommodation for Winnunga. That is in the order of about $300,000 from an existing allocation to them that we have collectively agreed will be reallocated to look at that issue.

It is really important to stress that Winnunga is one of the most strongly community-controlled Aboriginal health services in the city. It has a very strong reputation and record of achievement in reaching vulnerable groups. Obviously the Indigenous community is their primary group, but they also reach non-Indigenous vulnerable people. The government recognises the significant contribution they make, and we are committed to continuing to work with them to make sure their service remains sustainable and builds on the success that has been achieved over the past decade or so.

MR HINDER: I saw a figure somewhere that said there was $8 million of funding. I am not sure how much of that is the territory's and how much is the commonwealth's. The document I saw suggested we were getting $40 million worth of value out of the services they provide. It seems to me like a pretty efficient way of spending health dollars.

Mr Corbell: I am not familiar with those figures, but there is no doubt that Winnunga provide a critically important primary health service to that population.

THE CHAIR: Ms Burch, a new question then Mr Hanson.

MS BURCH: There are two dental health indicators on page 3. There is no waiting time to access emergency dental health services. I do not know how you can improve on 100 per cent, but I will come back to that. That links with strategic objective 13, which gives a fairly positive indication around dental decay and general dental health. In the emergency clients seen within 24 hours, what sorts of numbers are we looking at? Are they seen in accident and emergency or are they referred to the dental clinics within the community health centres? How is that managed?

Ms Feely: I need to take the first part in relation to the numbers. We discussed the very issue of the 24-hour turnaround at length yesterday but I did not ask the exact numbers. I will take that on notice. Mr Thompson can speak to the second part.

Mr Thompson: The provision of emergency dental care, within the dental program we have a triage process for the community health centre provisions. While those services are available, people can contact them and they are assessed according to the severity of the condition and the urgency of their needs. As the indicator says, if it is emergency they are seen within 24 hours. At times when those clinics are not available we have dental services available at the emergency department so people can present. For example, if on a Saturday afternoon Tom gets a tooth knocked out playing football, we have dentists available on call to the emergency department to

assist as required.

MS BURCH: How does that differ from going to the hospital or being better off going to your local GP? Do you assess whether someone should wait until the next day and see their dentist, or do you see anyone who comes through?

Mr Thompson: From the emergency department point of view an assessment is made and an appropriate management plan is put in place depending, again, on urgency.

MS BURCH: Because if you have lost your tooth you have only a limited time about putting it back in and hoping for the best.

Mr Thompson: Yes.

MS BURCH: Strategic objective 13, it says the source is a child dental health survey. That is a national data set. Do you go back to your community health services, particularly child dental services, and match this with what you are seeing?

Mr Thompson: This is a national survey undertaken periodically. The data we report against is the 2009 survey published in 2013. Another survey was conducted in 2013-14 for which national data is not available yet. Given the infrequency of the survey, we use it as a benchmarking touch point as opposed to an active management source of information when it comes to the management of the program overall. But we refer to it and it is used to assess whether the dental health of the population is higher in the ACT or otherwise.

MS BURCH: The child dental health service covers a child I think up to the age of 13 within community health? What is the age?

Mr Thompson: It is an all-ages service with different eligibility criteria for children and adults. There are restrictions on access depending on whether—

MS BURCH: In managing your service and planning your service, how useful is data from 2009?

Mr Thompson: As I said, this is not used as an active, day-to-day management tool. It is the demand information and the waiting times that we look at much more actively. We have a target of a waiting time of less than six months, which compares very favourably with public dental programs in other jurisdictions. That is the main indicator we use, keeping it under six months, which it is currently now.

MS BURCH: And you are meeting those indicators?

Mr Thompson: Yes, it is under six months.

THE CHAIR: Mr Hanson, a new question.

MR HANSON: The initial nurse-led walk-in clinic was opened I think six years ago at Woden. We now have one in Tuggeranong and one in Belconnen. In terms of presentations—I know sometimes patients are referred on—how many people have

presented?

Mr Thompson: I do not have those figures, but I am happy to take it on notice and provide to you the breakdown.

MR HANSON: We do not have anyone that has those?

Ms Feely: I am just looking.

MR HANSON: While we are digging I will keep talking about some other stuff. I will be interested to see the total number of presentations and the breakdown between Tuggeranong and Belconnen. I have seen this information presented somewhere before—

Ms Feely: Yes, I certainly have, too.

MR HANSON: I am trying to think where it would be.

Ms Feely: It was the annual report last year. There were figures—

MR HANSON: Possibly. What was the nature of the presentations and where were people were referred? I know some are treated, some are then referred to ED, some are referred to GPs and so on. Can I have a breakdown of where that is? Has that service been expanding, has it been static? Is there more demand than we can cope with?

Mr Thompson: I can answer some of those questions without having the specific numbers. Tuggeranong over time has had more presentations than Belconnen, but the gap is closing. Overall the presentation numbers to the walk-in centres are tending to stabilise at the moment. Based on information like patient satisfaction and waiting times, they are well within the capacity for the walk-in centres to continue to cope. Overall the demand is stabilising. In terms of the most frequent presentations, upper respiratory tract infections remain the most common reason for presentation, but we can give you a breakdown of the others as well.

MR HANSON: If you could, so I can get a sense of how many people are presenting, how many people are being treated, how many people have then been referred on to another service, whatever that may be. Can you also give me a breakdown of the staff at each of the centres in terms of FTE? Are the operating hours still 7.00 till 11.00, or something like that?

Mr Thompson: We moved back to 10.00 pm close for the community health centres. Based on information about the number of presentations that were happening after 10.00 o'clock it really was not worth keeping them open.

MR HANSON: In terms of the maturity of that service—I know when it was initially set up there were concerns that people might go there when they should have been going to ED, for example—have people adjusted to what you go to that sort of service for?

Mr Thompson: Yes, we have not had significant incidents, for want of a better way of putting it, of people presenting with a condition that is unsafe for them to attend. Obviously there still is a percentage—which we will get for you shortly—of people who present where the walk-in centres say, "You're out of scope; you need to be referred on to another service." But overall the clear majority of people who present get their treatment at the walk-in centre.

MR HANSON: Do you have waiting times recorded at that service?

Mr Thompson: Yes.

MR HANSON: Right. Do you have that information?

Mr Thompson: Yes. I do not have it to hand. We can provide that as well. They are fairly stable and reasonably short as well.

MR HANSON: There were concerns that, if you introduced a service that was aimed at trying to relieve some of the pressure on both GPs and EDs, as the number of GPs increased you would essentially be impacting the market and preventing GPs from seeing people. Is that the case, or is it simply that people are referred on to GPs?

Mr Thompson: We consulted widely with GPs, both in the initial establishment of the walk-in centre and then with the plans to move them to the health centres. I am not aware of any significant concerns being raised by GPs. I have not been contacted for quite some time by any GPs raising concerns about an impact on their business.

MR HANSON: With the model in Belconnen and Tuggeranong, is there any consideration to expanding the service to Woden or Gungahlin or other sites?

Mr Thompson: We do not have any specific plans at the moment, but with the clinical services framework and the service planning we will be looking at it.

MR HANSON: It is part of that work you are doing to see where the need is. If you can get that information, that would be good.

THE CHAIR: Specifically what was taken on notice?

MR HANSON: How many in total presenting—

Mr Corbell: Different issues around numbers, waiting times and so on.

MR HANSON: How many presenting; what they are presenting with—broken down for each clinic—where they were referred, waiting times, number of staff. I think that was it – something like that. And anything else that might be interesting, I suppose.

Mr Corbell: You wish.

MR HANSON: Come on, minister; you have got 15 minutes left in estimates hearings for Health.

THE CHAIR: No, we have the minister back on Friday afternoon.

MR HANSON: For Health.

Mr Corbell: Yes, it is my last fifteen minutes as Minister for Health. I am counting every second.

THE CHAIR: There is at least one more brief introductory speech from the minister.

MR HANSON: On the big countdown.

Mr Corbell: That is right.

THE CHAIR: I will be quite brief. In regard to cancer services, the Chief Health Officer's report for 2016 identified a growth in the number of deaths from cancer from 21 to 29 per cent over the past 20 years. We do screening for breast cancer. Are lung, colorectal, prostate and pancreatic cancers able to be screened and are they worthy of such screening programs as we do for breast cancer?

Mr Corbell: That is one for the chief officer, I think.

Dr Kelly: Thank you, minister, and thank you for the question, Mr Smyth. There is a range of cancers that can be screened for and in fact are screened for. Breast has been discussed already and that is the main one as a service which is provided by ACT Health and the ACT government.

Cervical screening is the other one which is a highly successful program that has been running for many years. That is mainly done through general practice but our role there, in ACT Health, is to provide the register, reminders and so forth for women as they come due. There are quite a few changes in the wind for that, in fact, over the next few years in terms of the commonwealth government taking over responsibility for running the registers and also the way that cancer of the cervix is screened for. It is actually looking more at screening for the wart virus, HPV, which leads to the majority of cancers rather than the traditional pap smear. That is running at the moment.

The other one which is run also by the federal government and through general practice mainly is bowel cancer screening. The role of the ACT government in relation to that is, apart from reporting to the cancer registry the positive screens that lead to cancer, what happens once that initial screening is done, which is a reminder in the mail to send a specimen for that blood test in the faeces in relation to colonoscopy and so forth—the next level of testing that needs to be done.

As far as the other main cancers that were in the Chief Health Officer's report and that were outlined as the major concerns, there are no actual screening programs for those at the moment. Lung cancer would be the next on the list. There is an opportunity for melanoma to be looked at in terms of skin checks through general practice but that is not a cancer screening program as such. For some of these other rarer and important diseases—one that has been discussed today is pancreatic cancer, an emerging issue—

there is no really good screening program.

The final one I would mention for men is the prostate screening. Again the National Health and Medical Research Council has done good work on this in relation to whether that should be an official screening program. In general terms, the answer is no but many men are screened through general practice in relation to prostate.

THE CHAIR: On page 16, the accountability indicator in table 27 is confined to breast screening. Is there scope for other cancers that can be screened and registers kept for them to be included in the accountability indicators?

Mr Corbell: I think, as Dr Kelly has indicated, the only screening program that is administered by ACT Health is the breast screening program. That is the service we are delivering and that is why it has its accountability measures. The other screening measures are measures that are undertaken outside ACT Health services directly.

THE CHAIR: But given all the great work that is done by those who work in the cancer services, and bless them all for what they do, are there some other measures that could be considered?

Mr Corbell: It is difficult for us to have accountability indicators for services that we are not delivering. Whilst it is desirable—

THE CHAIR: I accept your answer on the registers. But are there other measures that show the success rates, for instance, that we have in screening cancer that might be measured?

Mr Corbell: I would have to get some advice on that. I just do not have any advice to hand on that but obviously it would vary from cancer to cancer in terms of the measures. But it is not something I can really answer without further advice.

Dr Kelly: Minister, if I may, there is another accountability indicator. I do not have the book in front of me at the moment but on the cervical screening recall rate we do actually have an accountability indicator for that as well.

THE CHAIR: Is that in the strategic indicators?

Dr Kelly: It may be in the strategic, yes.

THE CHAIR: It is not. There is only one listed. Table 27 only has the four that refer to breast cancer.

Dr Kelly: I think it is a strategic indicator.

THE CHAIR: Mr Hinder with a new question.

MR HINDER: My question is also related to cancer services and palliative care. In the media today there was a report suggesting a national figure of up to 30 per cent of chemo services are being delivered in the last six weeks of life. The suggestion is that they had no therapeutic value and in fact may well have decreased the comfort of the

patients and detracted from their expectation of—I think it described it as—a comfortable death. Do we, in this jurisdiction, have checks and balances in the palliative care area to ensure that we do not contribute to those figures or statistics?

Ms Feely: Whilst Mr Thompson is looking through statistics, I am delighted to say that we have two intensive care specialists who are actually looking at this entire concept of end of life as a key deliverable and we hope to be leading the way in that shortly. I lost both my parents to cancer. Both of them went through the palliative care service in Melbourne, at St Vincent's. I am very keen to make sure that we deal with end-of-life issues as best we can.

I am not answering the question directly but we have picked it up already as a key issue. It is again part of this model of care—how we actually treat patients in the health service—and it is about redirecting them to the appropriate levels of care. But end-of-life plans, all those issues, are already taken into account at TCH across the board.

Mr Thompson: The other thing I would add to that is that part of what we are looking at in the palliative care services budget initiative is the capacity to increase education and medical specialist support within hospitals for palliative care to assist with that decision-making both from the patients' point of view in terms of working with the patients around the choice to enter into palliative care and also working with the other medical specialists because that is frequently where a lot of the impetus for the care comes from, working with the other medical specialists to support the transition to palliative care as well.

MR HINDER: Just anecdotally as chair of the health policy committee of the Labor Party for the past two or three years we spent by far the largest amount of our time talking about end-of-life management and self-determination combined with medicinal marijuana and all of those issues. It by far took up the majority of our time. They are the sorts of issues the community are talking about.

Ms Feely: We have to have those discussions. We have to have those discussions and we need to have frank and open discussions and get people more accustomed to confronting these issues. I think the more planning that can be done, the better the end-of-life decisions that will be made.

THE CHAIR: A supplementary from Ms Burch and a quick final question from Mr Hanson and we will call it a day.

MS BURCH: With palliative care and end-of-life decisions, it is not only the clinical aspects; it is around preparation for end of life and decisions on enduring guardianship and others. Are your palliative care team in tune with that and are they making sure that those areas are covered? It is not just drugs and pain management.

Mr Thompson: We have what is called the respecting patient choices program. It is actually run out of our healthcare improvement division at the Canberra Hospital and Health Services. It is entirely focused on that. Ideally it is about getting out into the community. It is preferable for advanced care planning to happen with people when there is time to have the conversation, time to understand the implications, and that is

frequently more effective working with general practice or people in their homes than waiting for a hospital admission, in particular a hospital admission where they are really quite sick. Our program is one that is definitely looking at increasing advanced care planning within the hospital itself but also outreach and engagement with other public providers and the community to enhance that as well.

MS BURCH: Very quickly, how do you transfer the skill and knowledge you have in your palliative care team in terms of end-of-life stages? You can be aged and still need to also prepare for end of life but you may not have a diagnosis of cancer or something. Do you take that learning into your aged care area as well?

Mr Thompson: Yes. This program is not specific to palliative care at all. It is quite separate organisationally and quite separate in focus. It is really intended to be as broad based as we can.

THE CHAIR: A quick question from Mr Hanson.

MR HANSON: You probably will want to take this on notice. In line with the sorts of questions I was asking earlier with regard to presentations at both emergency departments—it seems that is increasing now—what are the number of presentations at both TCH and Calvary? I was just looking on your little app to see where they are. Obviously TCH is busier with presentation. What is that by category? There are a total number of presentations but what do they end up being? How many were ones, twos, threes or fives? By category as well, how many patients in each hospital are then actually admitted as opposed to being treated and discharged? I imagine you have that information. If you could provide that, that would be great.

Mr Corbell: Yes. We will take that on notice.

THE CHAIR: With that we will call an end to day nine. Members, we are now 81 per cent of the way through estimates. On behalf of the committee I would like to thank the Minister for Health, the Assistant Minister for Health and all the witnesses and officials who have appeared today and made our day so enjoyable. If you have taken any questions on notice could we please have answers to those to the committee secretary within five working days, the first working day being tomorrow. The secretary will provide a copy of the proof transcript of today's hearing when it is available. We are open to suggestions for corrections or the provision of other information and, with that, the committee's hearing for today is now adjourned. Members, we have a short private meeting.

The committee adjourned at 5.29 pm.