LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING, COMMUNITY AND SOCIAL SERVICES

(Reference: Annual and financial reports 2011-2012)

Members:

DR C BOURKE (Chair)
MR J HANSON (Deputy Chair)
MR A WALL
MR Y BERRY

TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 15 MARCH 2013

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

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 9 August 2011

The committee met at 9.31 pm.

Appearances:

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

Health Directorate
- Brown, Dr Peggy, Director-General
- Thompson, Mr Ian, Deputy Director-General, Canberra Hospital and Health Services
- Kelly, Dr Paul, Chief Health Officer, Population Health Division
- Bowden, Prof Frank, Acting Executive Director, Medical Services
- Carey-Ide, Mr Grant, Executive Director, Service and Capital Planning
- O'Donoughue, Mr Ross, Executive Director, Policy and Government Relations
- Redmond, Ms Judy, Chief Information Officer, E-health and Clinical Records
- Kohlhagen, Ms Linda, Executive Director, Division of Rehabilitation, Aged and Community Care
- Bracher, Ms Katrina, Executive Director, Division of Mental Health, Justice Health and Alcohol and Drug Services
- Chatham, Ms Elizabeth, Executive Director, Division of Women, Youth and Children
- Woollard, Mr John, Director, Health Protection Services, Population Health Division

THE CHAIR: Good morning, everyone. Welcome to this public hearing of the Standing Committee on Health, Ageing, Community and Social Services. The committee is inquiring into annual and financial reports for 2011-12. Today the committee will be examining the annual report of the ACT Health Directorate. We will commence with acute health services and break for morning tea at approximately 11 am. Could I also confirm that you have read the privilege card lying on the table before you? Do you understand the privilege implications of the statement?

Ms Gallagher: Thank you, chair.

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

Ms Gallagher: I will make a few brief comments. I think the annual report in many ways speaks for itself. I think you can see from the content of the information before you just how large the work of the Health Directorate actually is. Whilst we always spend a lot of time on probably two areas of hospital activity when discussing the health system, we rarely drill down into other important areas of the health system, which often operate outside the hospital or within the hospital in areas that do not get much coverage. I think this report gives justice to the work that the Health Directorate staff do.

You can see from all the strategic indicators and from the output classes the level of demand that is confronting the health system across almost every area. You can also see, I think, the attempts to meet that demand and to have in place a very strong

workforce strategy to continue to build up the health services across the ACT.

You will also see quite large reports on the health infrastructure program. The Health Directorate is rolling out the largest infrastructure program that the health system in Canberra has ever seen, and that continues I think to deliver high quality infrastructure in order to allow health staff to deliver modern health services in an appropriate environment.

In terms of our election commitments that we made in the election last year, they will continue to build, really, on the capacity of the health system to meet increasing demand. There will be some effort put into, of course, health promotion and preventing people becoming unwell. But we have not been able to, I think, deal with—we cannot put the effort into that that we would like whilst we are seeing the demand walking through the door that we are seeing. You can see that in demand for elective surgery, for cancer, for aged care and rehab, for community health services and, of course, for the emergency department.

We welcome the opportunity, as you can see. We have brought 50 of my closest friends and colleagues, or more, to answer the committee's questions today. But we certainly stand here ready and able to assist the committee.

THE CHAIR: Thank you, minister. On page 157 under the Calvary network agreement, an achievement is listed as taking a lead role in the development of the Bruce precinct master plan, which will set the framework for integrated and collaborative health and hospital services on and around the Calvary Bruce campus. Could you tell me more about the master plan and give me some examples of what will change in the precinct?

Ms Gallagher: Yes, this is part of the agreements that we have reached with Calvary over providing essentially a network of hospital services across the two public hospitals. The master plan, and getting agreement on the master plan, is like all master planning processes. You get an understanding of what Calvary Health Care are thinking in terms of their land and also how that works in with what we need for public health services. Of course, as part of that master plan, they will be considering their own capacity for private hospital services or private health services. So that work is underway. But before we can really map out what we are going to do with public health services there, apart from some of the immediate work we can do within the existing buildings for better capacity, we need to agree on the master plan for that site.

THE CHAIR: Again, regarding the Calvary network agreement on page 157, issues and challenges, could you tell me how many public beds might open up under the foreshadowed expansion of public hospital capacity at Bruce involving the repatriation within five years of beds currently co-located in Calvary Private Hospital?

Dr Brown: I think it is fair to say that there is not a definitive number as yet. We have the clinical services plan. That has been looking at essentially the allocation of services across Canberra Hospital, Calvary hospital and the new University of Canberra public hospital as well, and also looking at what is delivered in the community rather than in the inpatient setting. So that is an ongoing piece of work in terms of the actual bed distribution across those different campuses.

THE CHAIR: When do you think you will have an answer on numbers?

Dr Brown: I might ask Mr Carey-Ide to speak to the time line in terms of that bed allocation process.

Mr Carey-Ide: The master plan for the Calvary campus is currently in its final draft form and is being considered in the coming month by both the Health Directorate and the Little Company of Mary board who, of course, administer Calvary Public Hospital on our behalf.

The projections are currently being worked through and revised, mindful of the work being done to inform the services to be located within the University of Canberra public hospital as well. That, of course, has some effect on the number of beds at both the Canberra Hospital and the Calvary hospital.

MS BERRY: Minister, could you outline for the committee how Australia's first walk-in centre performed over the financial year 2011-12 and what plans the ACT government has for additional walk-in centres in Canberra?

Ms Gallagher: In terms of presentations to the walk-in centre, that is going well. As with all areas of health services, you open it and people use it. The feedback we have got, certainly from consumer feedback, is that it is meeting their needs. It is going to exactly the areas that we wanted people to present with—minor illnesses and ailments. Over the 2011-12 year 17,450 clients presented to the WIC for treatment. The median time for treatment was 22 minutes, which is down from 26 minutes.

We are very pleased with it. The next question is how we open them up in the community, the model we use. There has been a review of the walk-in centre, or an evaluation that was undertaken. We need to make some decisions about whether they are nurse practitioner walk-in centres or advanced practice nurse walk-in centres. We have to make some decisions about the scope of practice as well. That is all interrelated in a sense.

If we want it to be nurse practitioners then they are going to have an increased scope of practice. Nurse practitioners can do more in other areas than they will—as highly trained professionals they will seek that level of work that is commensurate with their skills. But increased scope of practice will mean consultations with the medical workforce as well.

There is some work to be done about the model that rolls out to the community and how we also structure the delivery of that service, and we are still considering that.

MS BERRY: And the second part of my question—additional walk-in centres?

Ms Gallagher: In a sense that is what I am saying. We have the opportunity to put walk-in centres in the Tuggeranong health centre and the Belconnen health centre. The Belconnen health centre will be finished later this year and the Tuggeranong health centre in 2014. The work has just started there. So within that time, and when funding becomes available, because we need increased funding through the budget

process to open the walk-in centres, we need to be working out those other issues. So the commitment is to do it but I am saying that it might not be exactly the model we are running at the moment, or, if it is exactly the model we are running at the moment, it will not necessarily be a nurse practitioner-led model.

MR HANSON: We talked quite a bit about the TCH site and the problems with it being located there—the reason being that you had difficulty in siting it in the community in the first step because of concerns raised by the medical fraternity. Is your intention to close down the site at TCH once you put it into the community? What is the plan? There have been a variety of statements about what your desire is versus perhaps what is possible.

Ms Gallagher: At some point the walk-in centre at Canberra Hospital will not be able to remain there because it is right in the middle of a redevelopment. So it is currently occupying space that in a few years time will be a construction site. So that is one of the issues we have to consider.

It was only some parts of the medical community that wanted it at the hospital. It was primarily the AMA and the Division of General Practice at the time that wanted it at the hospital under the clinical governance of the hospital. The medical staff at the hospital did not want it at the hospital, so there were mixed views then, and I think there are probably mixed views now.

Some of those decisions about the future of the Canberra Hospital walk-in centre will be made once we have made some decisions about the model of care, the staffing requirements and the timetable for redevelopment at the Canberra Hospital site.

MR HANSON: In terms of the model, have you got a number of different proposals you are looking at? Can you give a bit more guidance on what those models of care might look like? Are you talking about integration with GPs? What are you actually talking about?

Ms Gallagher: The evaluation report that was done 18 months ago said there would not necessarily be a GP working in the walk-in centre but having liaison with local GPs and connections with them. I think that is the question in the community. For example, if you are going down to Tuggeranong and we have Dr Rashmi Sharma operating a general practice in Isabella Plains, the opportunity is there. There needs to be clinical governance of the model, just as there is at Canberra Hospital. The evaluation recommended some clinical governance structure which involved a GP. I have certainly had some discussions with Rashmi in relation to that.

MR HANSON: You would remember from the election campaign that we had a model which was the urgent care clinic.

Ms Gallagher: Yes.

MR HANSON: They have rolled out in other locations in Australia and also overseas, and particularly in New Zealand. Has anyone had a look at that model to see whether that or a variance of that would be effective?

Ms Gallagher: From what I could understand of your urgent care clinics, they were essentially walk-in clinics that had a doctor in them. So it was doctors and nurses working together in a walk-in centre, basically. But it was named "urgent care clinic"—other than you had some sort of resuscitation capacity, which we would not be looking at doing.

MR HANSON: You are not necessarily looking at that?

Ms Gallagher: No. If you need resuscitating, you need to be in an ambulance going to the major hospital. That is where you need to be.

MR HANSON: It is an interim resus facility to provide that. I will not get into my policy. I was just wondering if you had looked at it as a model.

Ms Gallagher: I looked at it to the extent that I looked at it in the election campaign and there were elements of it that we would not be considering. We do want this to be nurse led. That is the model. But the evaluation did look at and examine the opportunities of strengthening general practice connections with the model. That would not necessarily mean having a general practitioner sitting in there and working with the nurses, but certainly being available as a mentor, as a guide, in terms of training. Also, if we are going to the community, there is the matter of how we connect with the existing general practices that are working in that region of Canberra. As I said, I have had some early discussions with Dr Sharma about how that could work, in her role as the chair of the Medicare Local, not in her role as a GP in Isabella Plains.

MR HANSON: What is the cost per occasion of service at the walk-in centre?

Ms Gallagher: It is between $116 and $196. It is a lot cheaper than an emergency department presentation.

MR HANSON: Yes, but are these all people that would otherwise have gone to the ED or are these people that would otherwise perhaps go to general practice? If they would have gone to general practice, there is really no cost to the ACT. But if—

Ms Gallagher: But they were not going to general practice. These are—

MR HANSON: Do we know that?

Ms Gallagher: General practice was an option before. We are dealing with 17½ thousand people who are choosing not to go to general practice who may have ended up in the emergency department or, even worse, not actually have sought treatment. So yes, there is a cost to the ACT government; we are aware of that. It is not a space that we necessarily want to be in, but it is the reality of delivering healthcare services, particularly when some people struggle to meet the costs of healthcare services. It is meeting a gap for those members of the community.

MR HANSON: Thanks.

THE CHAIR: Minister, I will take some supplementaries as well. Do you have any

other statistics on walk-in centres? You have already talked about cost per occasion of service.

Ms Gallagher: I think I have covered most of it—the median time for treatment, the number of clients seen. Some 67 per cent were fully treated by the nurse. That has maintained what we have seen from the beginning of the walk-in centres, although it has improved slightly. Six per cent were referred to a GP; just under five per cent were redirected to the emergency department; four per cent were referred to medical imaging for limb X-rays. That is remaining fairly stable now.

THE CHAIR: You talked about scope of practice earlier. Could you be more specific about what that is in detail?

Ms Gallagher: When we opened the walk-in centre, there were very strict operating procedures and a relatively limited scope of practice in terms of what was allowable to be seen and what was not allowable to be seen. In time, we realised that that has had limitations for highly skilled staff like nurse practitioners who have completed a master's through further study on top of their bachelor of applied science and all the rest of it. The model has not necessarily met with their capabilities. There are two questions. Do you increase the scope of practice to allow it to be a nurse practitioner model—that is, allow them to do more than they are currently allowed to do at the moment—or do you accept that the model we have created, the model that 17½ thousand people have used, is an advanced practice nurse model? That is what you base the walk-in centres on. They are some of the decisions that need to be taken.

THE CHAIR: Thank you. A substantive question, Mr Hanson?

MR HANSON: Thanks. Minister, in your opening remarks you talked about the infrastructure program that you have got. I would like to go through that in some detail, if we could. I do not know if Mr Carey-Ide needs to reappear. I have looked through the 2012-13 budget review and there are quite a few projects which are subject to delay, reprofiling and so on. I would just like to go through them if I could. With each of the projects—I will just go through them as we go—I am really interested in what is now envisaged to be delivered, when we anticipate that being delivered, what the cost is and any reason for delay, reprofiling or increase in budget. I am trying to get across exactly where we are with our infrastructure program. I will just go through a list of the ones that I am particularly interested in, if that is all right. The adult secure mental health facility—if you could give me an update on that.

Ms Gallagher: I can, to begin with. The adult secure mental health facility is going to proceed on the site of the former Quamby building. As you know, the history of this project is that it was due to be co-located at the Canberra Hospital site with the adult mental health unit. When it was clear from consumer concerns that that should not be the case, we started to look for another site. We have found the site. By the time we found the site, the budget available, from memory, was about $11 million. That was clearly not going to be enough for a stand-alone facility: where it had been co-located, there were going to be some shared facilities.

I took that money back from the budget, returned it to the budget, whilst we underwent some reviews of the facility. Those reviews have been completed now.

Grant can perhaps go through some of the detail, but it has looked at the experience of other services, other small services of this type. We have also looked at and had a review done by New South Wales Health Infrastructure over the cost, about delivering this type of service, which was a 15-bed high secure unit. We have also looked at it in the context of the Calvary master plan—and some of the issues at Brian Hennessy house and some of the work that needs to be done to that significantly ageing infrastructure. We are pulling that together for this year's budget for funding.

MR HANSON: When do you anticipate that the facility—

Ms Gallagher: It has got to be designed.

MR HANSON: But this has been a promise since 2006.

Ms Gallagher: Yes, and I have just gone through the history of it. It is not an easy project to deliver. Do what you want with it, Jeremy, but the reality is that I am not going to build a secure unit for this city until I am absolutely convinced it is the right one for the long-term interests of this city. You are the first one to squeal when budgets go over. The budget was way over with this, so I have pulled it back and I have said that it is not acceptable. We need to go back to taws and have a look at how we deliver this project within the money that is available, knowing what we know now with the AMC being operational, knowing what we know now with extra capacity in the adult mental health unit and understanding a bit more about the difficulties of running a 15-bed unit for clients of this type. We are pulling all of that together, but this is going to be built for the long term; it is not going to be built for the short term.

MR HANSON: What is the need at the moment? You said 15 beds. If we were to imagine that this was operational now, what sort of capacity would we see? What is the demand? Is it five people, is it 10 people or is it too difficult to predict that?

Dr Brown: That was part of the work that we did—go back and actually look at what would be the likely demand, given that we now had the AMC operational and that New South Wales, for example, had built some additional secure facilities during that time. I do not have the precise figures in front of me, but I think the current bed demand is somewhere in the order of between five and 10 beds at any one point in time in terms of medium or high secure requirements. Of course, in addition to that, we have the low secure capacity at Brian Hennessy.

MR HANSON: Yes. I assume, then, that people that have a need are currently going to New South Wales and are in facilities in New South Wales. Is that right?

Dr Brown: I do not believe that we have a very large number, if any, in New South Wales at the moment. We are managing the demand through a combination of the secure beds at Brian Hennessy, the adult mental health unit and the forensic mental health service at the Alexander Maconochie Centre.

MR HANSON: And we anticipate that the cost is going to be about $11 million? Or is that too difficult to predict?

Ms Gallagher: No, it will not be $11 million. You will remember that when I cancelled the project it was in the order of $35 million, I think.

MR HANSON: I do. So it is going to be above—

Ms Gallagher: The work from New South Wales—Peggy might be able to remind me, or Grant—indicated that it was more than they would pay for a facility of that type. Was it about 20 per cent?

Dr Brown: Twenty to 25 per cent.

Ms Gallagher: Twenty to 25 per cent more than they would think was a reasonable cost. We are using that work to inform decisions that will be taken in budget cabinet.

MR HANSON: It is a pretty niche facility for the ACT, because there is always a point at which these things are viable or not.

Ms Gallagher: Yes, that is one of the problems.

MR HANSON: We are managing the demand at the moment. Have you engaged with New South Wales at all to see whether sending people to New South Wales would be more cost-effective? It may not meet the client need as much, but if you are talking about spending close to $30 million—and I imagine the operating costs of this would be pretty extensive, and recruiting the right staff would be difficult—and we are going to have between five and 10 people accessing that service, is there a point at which this is just not viable?

Dr Brown: That, indeed, was one of the pieces of advice. We said to the minister that we need to actually go back and review that. We have had ongoing discussions with New South Wales Health over at least the past five years, and we are continuing to have discussions with them. However, the reality is that, for a range of reasons—one is about their capacity, as they currently utilise most of their capacity most of the time; there are some legal issues relating to different legislation and the challenges of transporting consumers between settings in the ACT and New South Wales for any judicial proceedings; and there are some consumer-related factors, for example contact with families and rehabilitation back into the community in a supported way—the ultimate decision, or the advice to government, is that we should still proceed with a facility in the ACT.

The issue of the size of the facility is one that we have considered. There is a very valid issue there, not only around economies of scale but also in terms of ensuring that we are not building a very small, isolated facility which might be a breeding ground for poor practice. That is again one of the pieces of advice that we are currently compiling to put back to the minister in terms of the ultimate composition of this facility.

MR HANSON: In terms of consultation with local residents, I am aware of a number of local residents who believe that they were not consulted properly and I believe that there are a number of facilities around there. There is a children's petting zoo across the road; they have raised some concerns. Are you confident that those concerns have

been addressed?

Ms Gallagher: I do not think we can meet the concerns. I think we have to go into this project, and it would be good if all Assembly members would get behind it, knowing that you are never going to get community agreement about where to locate a facility like this. I know that there have been some discussions with the owner of the petting zoo, in particular. There was some community consultation; people will always say that there was not enough or there should have been more, and perhaps that is the case. This will go through the normal planning processes once it is designed et cetera. But I think some of the concerns along Mugga Lane relate to the actual location of a facility of this type there. I do not know what you can do about that other than try to continue to work with them around the design and get an understanding of the work that is going to be done there and involve them as much as we can in all stages of it. We will try to do that, for sure.

MR HANSON: Are there any supps on the adult secure mental health facility?

THE CHAIR: There might be some supps there. Speaking of the facility location, what other secure facilities are located adjacent to Quamby?

Ms Gallagher: There is the periodic detention facility, which has been there for as long as I can remember. Quamby, obviously, was a secure facility. I think some of the concerns raised by the local residents have been about the type of people that might be residing in the facility. We have just got to deal with that sensitively as we work through the next stages of the project. We have searched for land. We have searched for the ideal location. Quamby has its own challenges in the sense that the land itself is not great; it is building on the side of a hill. But it is land we own; it is land that can be used; it is quite well located between the hospital and the AMC in terms of where it is situated. So there are strengths to the site as well. We just need to work through the next stages and consult with people, particularly those who are against the project proceeding there, as closely as we can.

THE CHAIR: In that consultation with residents, did they express any concerns about the location of the periodic detention centre on the same campus?

Ms Gallagher: I do not believe so. I do not recall that being a concern. I think the main concern was the petting zoo and that kids go and have parties there. It was the co-location of that with a facility of this type. I think those issues can be managed, and should be managed, appropriately.

MR HANSON: I think the issue stemmed from the scope of works or the design. It said that the facility was not meant to be located in the vicinity of facilities that were accessed by kids and so on. That is my understanding, and that is why that one is a particular issue.

"Staging and decanting—moving to our future": could you explain exactly what that is, when it is likely to be completed, what the cost is and any issues around it?

Mr Carey-Ide: Sure. I might take the latter—

Ms Gallagher: There are multiple completion dates. There are a lot of projects within staging and decanting.

Mr Carey-Ide: Further to the minister's comment, the completion date for staging and decanting is likely to be aligned very closely to the completion date for the whole of HIP.

MR HANSON: Of the what, sorry?

Mr Carey-Ide: The whole of the health infrastructure program, noting that staging and decanting in its two appropriations is about equipping the directorate to make a number of moves, to undertake a number of refurbishments that are complex and difficult in their nature, that decant spaces to provide a working environment for new projects as well as to appropriately place staff in the context of their working days. For instance, we are trying to embrace a philosophy of having clinical spaces that are purely occupied by people who deliver clinical services rather than putting in administrative spaces. Essentially, it is the infrastructure, if you will, that actually supports or enables the health infrastructure program to be rolled out.

MR HANSON: I am really not quite sure I understand what that all means.

Ms Gallagher: It is where you put everyone while you are building.

MR HANSON: Thanks, that is simpler.

Ms Gallagher: The hospital had quite a lot of non-clinical staff in it, and as we are regaining space within the hospital, we are having to move people out. They are going to a variety of locations.

MR HANSON: Off-campus, the admin staff?

Dr Brown: Some are on-campus and some are off-campus. For example, some staff have been relocated to Curtin to the old emergency headquarters there. Some staff have relocated from the main hospital building across the other side of the street into the administrative buildings, freeing up space that we can therefore—

MR HANSON: So is the plan to then move them back once this is all refurbed or not—just to keep them spread out?

Ms Gallagher: I think it is to maximise the use of a hospital as a clinical treating space. When I became health minister there was ward space that was used just as offices. That is now ward space, because we need it. Ideally, the only thing you have going on at the hospital is the work that needs to be done at the hospital and you move other things out.

MR HANSON: It sounds a little bit ad hoc in terms of moving someone here and someone there.

Dr Brown: It is a series of dominos—very complex, intertwined dominos—but it is certainly not ad hoc.

Ms Gallagher: It is actually highly organised because it is all based around continuity of service. You have to keep everything going while you are moving people around the campus or into new work spaces. I do not know if you can give a couple of specific projects in the staging and decanting over the last couple of years.

Mr Carey-Ide: Sure. The old ESA headquarters at Curtin have been one of our major projects where we have been fitting out that facility in four stages. We are currently at stage 3. We are decanting a large number of people from other sites, predominantly the Canberra Hospital campus, to that campus, who do not need to be on the Canberra Hospital campus to provide the services that they provide. That has actually freed up spaces on the Canberra Hospital campus for more appropriate relocation of staff away from the main clinical buildings on the Canberra Hospital campus.

It also stretches across to Calvary hospital campus. We have supported Calvary hospital in the last year to free up spaces, such as the minister has already described, that were ward spaces. This practice of turning ward spaces into office areas is pretty common across Australia, in my experience over 30 years. We have now been able to free up space for approximately 50 beds at Calvary hospital because we have supported the relocation of 80 administrative staff from the main hospital campus to a facility in Thynne Street at Bruce.

MR HANSON: My next question I have is on the health infrastructure program project management. My recollection was that that was going to be outsourced and now it is being done internally; is that right?

Ms Gallagher: That is right. It was outsourced for the first three or four years. At the end of that contract we took that on. We took that work back in to Health.

MR HANSON: Has that freed up money?

Ms Gallagher: We are still having to pay for the project management, but it was more about four years into the project, knowing what we know now, how to best manage the project going forward. After a lot of consideration and a lot of careful planning, the decision was taken that we could do it more cost effectively and more efficiently by running it with suitably qualified people. We have had to bring on staff to do this, to actually run it within the Health Directorate, not having another party doing it and then that party dealing with the then Procurement Solutions, which was the arrangement before—having that much more streamlined.

MR HANSON: Clinical services redevelopment phase 3.

Ms Gallagher: Is it a general question?

MR HANSON: Yes. Some of these projects have been reprofiled, and I want to see whether they are subject to delays and why that is or whether there has been any budget increase. And just remind me exactly what they are as well, as we go through.

Mr Carey-Ide: Certainly. The clinical services redevelopment funding received its third appropriation in the last budget. The funding itself is to provide support for the

relocation of services such as infrastructure services as opposed to relocating people as we have already described in the staging and decanting. It looks at major infrastructure and it assures that the enabling works are undertaken where it is necessary to do so that are required to support the health infrastructure program.

It is really important for us to understand that the Canberra Hospital campus is an old campus, that the infrastructure works that are in place, such as fire ring mains, for example, plumbing and electricity, are very aged systems now, and pretty routinely need to be investigated and updated so that we have that infrastructure in place to support what is actually happening on the various sites.

The CSR3 that you have specifically asked about is not specifically fully allocated as yet. Some $860,000 has been expended as at the end of December last year, and a number of contracts have been let around infrastructure that amount to $23 million. But that work is still to be completed and will unfold over the coming years.

MR HANSON: "Enhancement of Canberra Hospital facilities (design)": is that just design work?

Mr Carey-Ide: Yes. This relates to the clinical services buildings at Canberra Hospital.

Ms Gallagher: This is design work that was commissioned in the last budget for the two tower blocks—the tower on buildings 2 and 3. I have delayed that project. It is currently delayed. Again, it is a large amount of money, and we are—

MR HANSON: It says $41 million.

Ms Gallagher: That is for the design of the first stage.

MR HANSON: So that is designing—it is $41 million?

Ms Gallagher: Yes. As I said, this is the biggest phase of the redevelopment. It is the wards, the operating theatres, the intensive care unit. In replacing the existing tower block, there will be a new, state-of-the-art tower block. So the expectation is that it would be around an $800 million building, and this is the design of the first stage of that.

As we have been working through this project, I have been wanting to be convinced that it is what we need to do at this point in time. I have also asked for learnings of the first four or five years of the health infrastructure program to be considered now as part of this. So I have delayed that, because I am not convinced we need to move to this right at this point, with some of the opportunities at the subacute hospital, Calvary, now that we have reached agreement with them, and some of the capacity that we can create on the Canberra Hospital site. With the limited capital dollars available to the budget at this point, I am not convinced that we need to spend $40 million on the design of a tower block.

MR HANSON: Does that consequently delay the rebuild of the tower block?

Ms Gallagher: It was going to be supplementary to the existing tower block. I guess what I am trying to work through, and I am still waiting on the final information coming from Health to me, is basically that we need to deliver the beds we need to deliver on time, and that is clear. But does it have to be delivered in this way? And if we did not deliver it in this way, in what way should we deliver it? I cannot give you a definitive answer other than I am not convinced we should be spending $40 million on the design of a—

MR HANSON: Until you have got that first bit sorted.

THE CHAIR: Mr Hanson, please let the witness finish her answer.

Ms Gallagher: No, that is all right.

MR HANSON: If you go back to the original design, the original plan with the new tower block, the $41 million design, is that going to be adjacent or on top?

Ms Gallagher: On top of the flat part of the hospital.

MR HANSON: Yes, so you build that new tower block, and what happens with the old tower block?

Ms Gallagher: There is a variety of things you could use it for.

MR HANSON: So it would remain? It is not going to be demolished?

Ms Gallagher: Under the new tower block scenario, the work that is currently in the old tower block would move to the new tower block. So you would have an empty building, and then the choices are to demolish it or fit it out for other uses at the hospital. So those decisions have not been taken.

MR HANSON: What is the time line now for working out essentially what the path forward is?

Ms Gallagher: I would like to be able to make some decisions in the lead-up to the budget in the next couple of months.

THE CHAIR: Mr Hanson, we will get some other members to ask some substantive questions.

MR HANSON: Sure. We might come back to this. I have a few more.

THE CHAIR: Minister, do you have a breakdown of who goes to which hospitals in terms of bed days in emergency department beds?

Ms Gallagher: Who goes to—

THE CHAIR: For example, do Tuggeranong residents exclusively use Calvary or do Belconnen residents use Canberra Hospital?

Dr Brown: I can respond to that. We do have some analysis of the flows. It would be natural to think that north side people go to Calvary and that south side people go to Canberra Hospital. In fact, there is quite a substantial flow of people from the north side to Canberra Hospital. That might be in part based on the nature of their need and in part based on perhaps a previous association with the hospital. So if they have received care there previously, they might automatically go there, or they may be receiving outpatient care there and therefore elect to go to the emergency department there. I am taking this from memory, but I think it is in the order of about 20 to 25 per cent who actually come from the north side to receive services at Canberra Hospital. The flow the other way, from the south side to Calvary hospital, does exist, but it is of a smaller order of magnitude.

THE CHAIR: You have already done some analysis on that patient flow. Is this all flow that is being driven by the previous relationship with Canberra Hospital, or are people on the north side in Belconnen choosing to go to Canberra Hospital rather than Calvary, based upon their own decision making?

Dr Brown: We have not gone down to that level of detail in terms of surveying individual consumers who have presented. But we do know that some people present there who have not had a previous association with the hospital—and some have.

THE CHAIR: Thank you. Ms Berry.

MS BERRY: Minister, I am interested in this year's result for the number of births in the ACT compared with when the government came into office and what plans the government has to meet the growing demand.

Ms Gallagher: We are not seeing a baby boom, but we are seeing a baby boom in the public hospital system. The baby numbers across the city are staying largely in line with what was expected, but the numbers coming to the public health system are increasing. I think in this annual report we have got the highest number of births in public hospitals—4,433. In fact, that has gone up a little bit more, to 4,490. That is a six per cent increase on the previous year and about 1½ thousand babies extra over a 10-year period. That is presenting us with some challenges. The major explanation for that has been, first, the excellence of the infrastructure we now have in place at the women's and children's hospital. And there is also the nature of the changes to the rebates through the private health system. That has affected that change, and it has been quite noticeable since those changes were brought in.

What are we doing? We are reviewing the model of care at the women's and children's, as a sort of unrelated matter—being in the early stages of the hospital's life, having a look at how that is going. I should say that of the 1,100 babies that have been born at the women's and children's, from the figures I saw there have been seven complaints received about feeling rushed around discharge. We do need to have a look at it. That is based on the fact that we provide 10 days postnatal care in the community, which I think is about three times more than any other jurisdiction. The normal Midcall would be three to four days post delivery; we provide 10 days to any mother that wants that.

I think that the capacity at the hospital in the first stage has been an issue. I think it

has presented the workforce with some stress around managing the number of births and the number of women wanting to birth. We are working through that with the staff and also looking at how we use the birth centre.

When stage 2 is opened, having the purpose-built rooms will be fantastic. The expectation is that women will go into the labour, birthing and delivery room and stay there for their whole experience rather than, as at the moment, being moved to delivery and then to postnatal.

The other issue is what we do on the north side. It is all interlinked in a way—how we manage demand. The women's and children's is what it is, and we are going to work with that capacity. We now need to concentrate on expanding capacity on the north side. We have done some of that with the continuity of care program expansion into Calvary. We will have the birth-centre-like rooms built. It was one of our commitments, and we will move on that. And then we have to work with Calvary and get a good understanding of what current demand is to look at what we do on the north side of Canberra.

MS BERRY: I guess you will build excellent services, so you will need—

Ms Gallagher: Build it and they will come.

MS BERRY: That is it. Thank you, minister.

THE CHAIR: Any supplementaries?

MR HANSON: I do. The changes to the Medicare rebates that that were made by, I think, Tanya Plibersek: when that occurred there were a number of concerns raised by obstetrics groups and others, including the coalition. They were saying that if you essentially increase the amount of out-of-pocket costs for childbirth, people will migrate from the private health system to the public health system.

Ms Gallagher: Yes.

MR HANSON: That was disputed at the time by you, I think, and certainly by the federal government.

Ms Gallagher: I think you should go and have a look. I am not sure I disputed it. From memory, I said that we would keep an eye on it.

MR HANSON: The predictions, as you have just said, have come true.

Ms Gallagher: The predictions have come true because the private obstetricians have not adjusted their costs. This was all about ensuring that reasonable costs were charged for delivery of a baby. Women in the ACT, because the private obstetricians have not restructured their costs based on the cap that is in place—I think it is anywhere from $5,000 or $6,000 out of pocket for a woman to give birth in the private system; that is a lot of money when you can go to the Canberra Hospital and have a baby. I am not disputing that it has had an impact; it has had an impact. But I think there was also an expectation of having to manage what was an uncapped

charging regime—which I think everyone accepts the taxpayer should not foot the bill for—and restructuring a business. We have not seen those adjustments take place yet.

MR HANSON: When—

Dr Brown: Can I just add to that? In recent discussions, some of our private colleagues indicated to me that, certainly in most of the other eastern state jurisdictions, there has not been the same experience that we have had here in the ACT: there has not been the change from private to public sector. So I think there is something unusual going on in the ACT that is not necessarily occurring across the country.

MR HANSON: When you were planning for bed numbers and so on, did you factor that in at all or did you just assume it would not increase?

Ms Gallagher: When we made the plans around the size of the women's and children's, that was not a factor that was known, so it was not included in the planning. Our planning was robust. It was built on the birth rate in the public system with some growth, and it was only minor growth. And, as we have seen, the births overall are not increasing at the same rate the shift to the public system is increasing. Based on what we knew then, the data, our planning was right. But we have had this big change, and now we are dealing with that. My view is that we need to make sure we are building up our capacity on the north side to deal with that now.

MR HANSON: The other issue is the model of care.

Ms Gallagher: Yes.

MR HANSON: Which is designed for women to leave after 24 hours.

Ms Gallagher: So that they are able to leave.

MR HANSON: The ANF warned that that would lead to problems, and obstetricians did as well, because of the complexities with older women giving birth, obesity and so on—that it just would not work. And that seems to have been the case. I have had a significant number of women come to me with concerns about being essentially pushed out, as they see it, of the women and children's hospital before they feel that they are ready to leave. I have circumstances where women have been essentially discharged or kicked out and have had to go up to Calvary to try and get treatment up there.

Ms Gallagher: Have you referred those matters to the health system?

MR HANSON: Complaints have been made. Those complaints have been made.

Ms Gallagher: As I said in the beginning, out of 1,100 births, we have had seven complaints lodged.

MR HANSON: My understanding is that the people that have made those complaints have made complaints through the system, and I certainly encouraged them to do that.

What are you doing in response to that to make sure that that situation does not occur?

Ms Gallagher: We are reviewing the model of care. And could I just say for the record that I do not recall the ANF ever telling me, warning me, about this issue. I have heard them make that claim a number of times publicly. I have gone back through my notes as much as I can, and I have not seen any record of that. I do not recall it other than, I think, quite late: whilst construction of the hospital was underway, they raised some concerns around it directly with Health. We need to look at the model of care and see whether it is meeting the needs of the patients who are using the hospital. And that is what we are doing.

MR HANSON: All right.

THE CHAIR: We have some supplementaries from other members, Mr Hanson, on this issue; I will go to them and then come back to you.

MR HANSON: Sure.

Dr Brown: I was just going to add, in relation to that, in terms of that review, that we are bringing in external experts to undertake that review of the model of care.

THE CHAIR: Minister, you made a point around obstetrician cost restructuring not happening in the ACT. Is there any evidence that that has happened in other jurisdictions?

Ms Gallagher: When the commonwealth moved to cap in this area, I think, from memory, the ACT obstetricians were charging the highest. I remember a media interview—it may have been Dr Foote and Nicola Roxon, who were debating the issue. From memory, the issue in the ACT has been the very high costs—much higher than in other jurisdictions. That could perhaps go to the issue of what we are seeing.

THE CHAIR: Have the obstetricians presented any rationale for those costs?

Ms Gallagher: It is their business, so I am sure there is a rationale behind it. I guess what we had expected, and I think what the commonwealth had expected, is that there would be some changing of fees in line with the changes to the rebates. But based on what we are seeing in the public system, we are not seeing that yet. Also, to some extent Calvary are winding back their private birthing service on the north side and concentrating it at John James, so there are probably fewer private birthing options than there have been in the past.

MS BERRY: I have a supplementary. There are a high number of people coming to the birthing centre. It is a beautiful birthing centre. I think we have all had a chance to visit the place; if I was going to have another child, it is certainly somewhere that I would choose. Is that the reason? Is there any evidence that it is not just about cost in the private sector—that, because it is an excellent facility, people are choosing to have their children at the centre?

Ms Gallagher: I think that is part of it, yes. You only had to be there at the open day to see everyone walking around saying how lovely it was and how much they were

looking forward to having their babies there. That is excellent; that is exactly what it was built for. I remember speaking with private obstetricians who, when we were planning the women's and children's, were saying, "Just be aware that if you build these fabulous facilities, women are going to want to birth there." And they are.

MR HANSON: In addition to the concerns that have been raised with me by mothers, I have had a number of midwives approach me about their concerns about the environment—under a lot of stress, very concerned about the model of care. What has been done to address those concerns? I know that there are staff shortages, and that is one of the reasons why the birthing centre is operating at capacity. I think it is at 50 per cent. What are we doing to make sure that those staff concerns are being addressed?

Dr Brown: We might ask Liz Chatham, the Executive Director for Women, Youth and Children, to speak to the issue of how the staff concerns are being addressed. In part, I think it is fair to say that there was some stress in the very initial phase after the move. That in part related to the demand and in part to the settling-in process. Some of that has moderated a bit over time, but we do acknowledge there are some continuing concerns. Ms Chatham can tell you about how we have managed that.

Ms Chatham: Staff have raised concerns with me. In the beginning stages of moving in, staff raised concerns with me about staffing. We have recruited as many extra staff as we can, including agency staff, to fill the gaps. We have also put on extra staff to manage on shifts.

MR HANSON: Do you think that the concerns were simply around a lack of staff or were there other concerns being raised?

Ms Chatham: It is not that we ever had a lack of staff rostered on; it is actually managing the gaps in staff when there has been sick leave. We always staff to the right ratio.

MR HANSON: So there were no concerns with the rostering as such, or other concerns raised about the model of care by the staff?

Ms Chatham: Not really, no.

MR HANSON: With the staff that you are then recruiting to bring in—agency staff and full-time staff, I assume, that you are trying to recruit—are you looking overseas?

Ms Chatham: We certainly are. We are attending an expo in New Zealand this weekend to recruit midwives.

MR HANSON: What sort of numbers are you looking for in terms of full-time staff?

Ms Chatham: I have not got exact figures in front of me, but I think we are looking at about 10 FTE.

MR HANSON: Are you optimistic?

Ms Chatham: Yes, I am optimistic. We have had some interest in coming to the hospital. I think the new hospital has actually attracted staff and there is an interest in coming to work in Canberra. About 50 per cent of that, about five of the staff, is new FTE that we are seeking to support the service.

MR HANSON: So the bed shortages in the birthing centre are related directly to staff or are there actually—

Ms Gallagher: In the birthing centre?

MR HANSON: Yes.

Ms Gallagher: We have the birthing suite and then the—

MR HANSON: Sorry, in the birthing suites. Where are the shortages of staff and beds?

Ms Gallagher: There would be shortages across the board.

Ms Chatham: They are shortages across the board. The birth centre is fully staffed, it has a full staff complement and it is working at the same level that it worked at prior to moving in to the new hospital. The vacancies in staff are across the different areas. There are vacancies in the birth suite; there are vacancies in the antenatal and postnatal wards and in the antenatal clinic area. So it is just a small number of vacancies across those areas, in each area.

MR HANSON: In terms of the transition of patients to Calvary, there were a couple of issues where mothers were diverted to Calvary because there was not any capacity. Has that occurred?

Ms Chatham: I think that is misrepresentative of how it was. Calvary public and ourselves and Calvary private have always worked very closely in managing demand across ACT. It is very important that our service maintains its tertiary capacity to receive high risk women into the hospital at Woden, who are set up, particularly with our NICU and our FM unit, to care for women at the highest risk, not only in Canberra but in the surrounding areas. For as long as I have been there, and previously, when we have demands on our bed space, we have always worked in partnership with Calvary, public and private, to look at ways of reducing the risk of having to send a woman to Sydney by sending them to Bruce for care. That is our current strategy and it has been our past strategy.

Ms Gallagher: It has not historically been well understood that in the future we have to run a network in maternity services. We have to get acceptance that, at times, a woman who wants to birth at Canberra Hospital may birth at Calvary when it is busy, just like in every other jurisdiction. Every single other jurisdiction does it. In Sydney, perhaps, because you are only going from Sydney to Sydney—one place—maybe from the southern suburbs to the eastern suburbs to birth, it is not such a big issue. But here it seems to be that it is a disaster if you are forced to birth at Calvary. That is actually just running a safe maternity service. Hopefully, what we will get out of this demand planning is a better understanding of how the two hospitals work together to

deliver the care. In nine out of 10 cases, of course, women will get the hospital of their choice, but at times they might not. That is going to be the reality of a bigger city, I think, and some of the demand pressures.

Ms Chatham: We also work with John James for the same reason. We will look everywhere we can to find a bed for women and babies in Canberra before we make a choice to move someone to Sydney.

MR HANSON: How does that work? Do you purchase the bed from them?

Ms Chatham: We have done, yes.

MR HANSON: Stage 1 is complete, and you have decanted people into temporary facilities. I know we had some sort of jostling about what is temporary and what is not temporary last time. When do you anticipate that stage 2 will be completed and the staff will move out of those temporary facilities?

Ms Gallagher: It must be September.

Ms Chatham: The finishing date for when we take ownership of the building, I think—and I am looking at Grant—is September. That is completely on track, I understand, at this point. There will then be a commissioning period and then we have to refurbish the areas—the paediatric areas that are currently used by maternity then have to be refurbished. So there is a stage 3. It will hopefully be fully operational for the birthing and for the paediatric services by the end of the year.

MR HANSON: Stage 3?

Ms Chatham: Yes, stage 3, in refiguring.

MR HANSON: A third of a hospital? It is not half a hospital; it is a third?

Ms Gallagher: The paediatrics area is what is currently being used for birthing. So when they move out, paediatrics will move in. There need to be some adjustments made for paediatric patients.

MR HANSON: That was a supplementary, wasn't it?

THE CHAIR: I thought that was a substantive question, Mr Hanson. But that is all right; you can have another go.

MR HANSON: I would like to get back to the infrastructure, if we could. The next one I will look at is "staging, decanting and continuity of services". We have talked previously about "staging and decanting—moving to our future". But there is another project called "staging, decanting and continuity of services", which is $19.4 million. What is the difference between the two staging and decanting projects?

Mr Carey-Ide: Essentially, it is around time. The initial appropriation, as you have suggested, was for $22.3 million, with a separate appropriation of $19.4 million to support the ongoing nature of the staging and decanting works. They are called

different things simply to differentiate between the two appropriations.

MR HANSON: The whole thing is pretty much the same?

Mr Carey-Ide: Absolutely.

MR HANSON: The central sterilising service: what is happening there?

Mr Carey-Ide: The central sterilising department project is actually being reviewed currently. The scoping for that project had significantly changed in that there was a mismatch between the scope and the budget, and we have halted the project or paused the project.

MR HANSON: What was the project—to build a new facility?

Mr Carey-Ide: Establish a new sterilising department on the campus at Canberra Hospital.

MR HANSON: On the campus?

THE CHAIR: Mr Hanson, please let the witness answer the question fully before you start with the next question. It is not a conversation; it is question and answer.

MR HANSON: Who is allowed to talk now? I'm scared!

THE CHAIR: Have you finished, Mr Carey-Ide?

Mr Carey-Ide: I have, thank you, Dr Bourke.

MR HANSON: May I go?

THE CHAIR: You may go.

MR HANSON: They were going to move from their site to another facility that was going to be where?

Mr Carey-Ide: They are currently located at Mitchell. They are operating from there.

MR HANSON: I have had a tour. It is very impressive.

Mr Carey-Ide: They still are to relocate to the Canberra Hospital campus, underneath the existing building 12.

MR HANSON: But that is on pause because?

Mr Carey-Ide: Because there is a mismatch between the scope of the actual project and the budget available to it. We are doing what we should be doing in properly managing public moneys and making sure that we have got the budget matched to the scope of the project as well as ensuring that we have got the objectives of the project actually achieved.

MR HANSON: What does that mean? You have not got enough money?

Ms Gallagher: Yes.

MR HANSON: Okay.

Ms Gallagher: The budget approved—I cannot remember what it was exactly.

Mr Carey-Ide: I am sorry; I do not have it in front of me, minister.

Dr Brown: It was about $18 million.

Ms Gallagher: About $18 million, and I was advised that the costs had escalated, I think to $25 million.

Dr Brown: Something like that.

MR HANSON: Right.

Ms Gallagher: So not good enough.

MR HANSON: How do you get around that?

Ms Gallagher: Now there is $18 million available, so they reassess the project—

MR HANSON: How do they squeeze it into $18 million? It is still the intention to move it to TCH, though?

Ms Gallagher: Maybe not.

MR HANSON: Or is that part of—

Ms Gallagher: Maybe not as part of it. Those options have not come back to me. I am advised that they are looking at the scope of the project and the location of the project. I have to say that it is also complicated somewhat by the decisions we need to take around building 2 and 3, because the whole major redevelopment of the hospital is interconnected with all other aspects of the hospital project. It is all being examined.

MR HANSON: Okay.

Ms Gallagher: But that is what is going to happen. If you get money for projects and they come back and say, "Sorry, they're over," they are just not going to proceed until other solutions are found.

MR HANSON: Do you have any contingency within the whole scope of works, or has the project got its own contingency?

Ms Gallagher: It has its own contingency, and then there is some capacity within the continuity of service staging and decanting. There is some capacity to transfer funds

where they are needed. But again the major thing is that I have to be convinced that that is the right thing to do.

MR HANSON: What happened in this case to get the difference between the original $18 million and the $25 million? What went wrong? What changed?

Mr Carey-Ide: I do not think it is right to describe anything as having gone wrong. What has actually happened is that a range of fundamental issues that need to be included in scoping a project have been explored in planning the project. Those issues, along with the aged infrastructure at the Canberra Hospital that I referred to earlier—

MR HANSON: Does that mean that things were not included in the scope that should have been included in the scope?

Ms Gallagher: Or the appropriate cost of those was—

MR HANSON: Was missed?

Ms Gallagher: Was misunderstood, underdone or—I do not know what the word is.

MR HANSON: Undervalued?

Ms Gallagher: Yes, that is it.

MR HANSON: That is the one.

Ms Gallagher: Undervalued. I think it can be demonstrated that there have been unforeseen costs. We have had some. I know that with the women's and children's they found some underground infrastructure that they did not know existed there, and then we had to deal with that. That is reasonable, but the review of this project has not come back at this point.

MR HANSON: Known knowns and known unknowns or something?

Ms Gallagher: Yes; there are more than you would like.

MR HANSON: Okay. I go to the north side hospital specification. It is no longer north side hospital, is it? It is University of Canberra hospital?

Ms Gallagher: Public hospital.

MR HANSON: Public hospital. There is the specific project here which is about getting the original $4 million, but it might be an opportunity to talk more broadly about where the whole project is at.

Mr Carey-Ide: Thank you for your question, Mr Hanson. This is a very exciting project for us, particularly in the service and capital planning branch, because we get to actually build on a greenfield site, and it makes it so much easier than the current projects we are undertaking.

This hospital, of course, is announced as a brand-new subacute and non-acute facility for the people of Canberra and to support the southern region of New South Wales. It is proposed that it will have up to 200 beds. It is essentially a centre that will provide a centre of excellence, if you will, for subacute service provision in the ACT as well as support the ongoing challenges around demand for acute beds, both on the Canberra Hospital campus and at Calvary hospital, by taking out of those facilities patients who do not actually need to be in places where acute care is provided.

That not only has the advantage of freeing up those acute beds but allows us to provide appropriate spaces for people who require a longer admission for non-acute care or subacute care to receive that in a much more pleasant environment, to receive it in a facility that is actually purpose built. You would recall, Mr Hanson, my role previously, having pleaded aged care and rehabilitation—

MR HANSON: I do recall.

Mr Carey-Ide: This building is dear to my heart, because people have been spending long periods of hospitalisation recovering in a rehabilitative framework but within an environment that is not built for that purpose.

MR HANSON: Sure. In terms of the people who have been relocated or where beds have been relocated from TCH or Calvary, what is the number of those? Of the 200 that are new, how many are essentially replacing existing rehab beds?

Mr Carey-Ide: I do not think the number is in front of me at the moment. I am happy to take that on notice and provide the figures.

MR HANSON: I am just curious about the—

Mr Carey-Ide: We should note, though, that those figures would reflect current and past demand. We are building up a facility that can take up to 200 beds, so it is very much a facility that is built for the future as well as for the current demand.

MR HANSON: I acknowledge that, but I am trying to work out what that figure is. Let us say there are 100 beds between TCH and Calvary now which will be either closed or turned into acute beds. What is the number of new beds that will become available? If you want to take that on notice, that is fine.

Mr Carey-Ide: Yes.

Ms Gallagher: Yes.

MR HANSON: And I am interested in the time lines for this project in terms of when it will become operational. I assume that it will be done in a staged process, will it? You are not going to open 200 beds on day one?

Ms Gallagher: You would not necessarily. The hospital will be built in time. But yes, you would not necessarily open 200 beds on that day.

MR HANSON: When is the opening day? When is the ceremony?

Ms Gallagher: I am not going to get tied into that at this point in time.

MR HANSON: Aren't you? When do we get our fluoro jackets and our hard hats ready?

Ms Gallagher: I have learnt my lesson. First things first.

MS BERRY: Can I ask a question, chair?

THE CHAIR: Yes.

Ms Gallagher: First things first. We need to reach final agreement with the University of Canberra over some legal matters, which I understand is imminent.

Mr Carey-Ide: Yes.

Ms Gallagher: And then we have got—I think we have got a person on now, do we? A commercial adviser or—

Mr Carey-Ide: We had the commercial advisers appointed. They have actually started their work to provide advice to government around the commercial options for procuring the actual project managers, the builders, as well as the design consultants. We are currently in an assessment process for applicants under a tender process for project director for that facility. Jon Barnes is currently acting in the role of project director for that facility.

THE CHAIR: Mr Hanson, some others have supplementary questions; we will come back to you.

MS BERRY: Thank you, chair. Regarding the proposed new hospital, what sorts of other services will it be able to provide to the community?

Ms Gallagher: I think it is still being determined, really. The focus will be on the rehabilitation-subacute kind of care. That is the job of the hospital there. I think there is opportunity with the University of Canberra, with the space that they will have and the use of their students, to look at other things, perhaps outpatient clinics and things like that, that we can use students for. It makes sense to have those partnerships; we are building it on a university site. It will be located within reasonable distance of the health hub at the University of Canberra. The new GP superclinic is under construction there at this point in time. There are opportunities, but the priority for the government is to just get this one done. That is what our funding will be used for.

MS BERRY: A supplementary, chair?

THE CHAIR: Yes.

MS BERRY: How will the relationship between the new hospital and the university help with staffing and things like that around the students?

Ms Gallagher: We are hoping that there will be a very strong link through the students coming through the university, and I think the university hopes the same thing. There are benefits for both parties. First, the University of Canberra will get to market itself as a university with a hospital, and really be the premier health regional university. And we get to access all the new students coming through from the early days of their course right through.

MS BERRY: And—a supplementary—I understand UC is the nursing—

Ms Gallagher: Yes, it is the main nursing. Signadou do some nursing too.

MS BERRY: So that should address any future concerns that we might have with staffing for midwifery and nursing?

Ms Gallagher: Yes, ideally.

MS BERRY: Contribute to it.

Ms Gallagher: There will not be midwifery services on offer there. The university have their midwifery-only course now, and I think the first graduates are coming out of it into the hospital. They are a good source of nursing skills, but I think for this facility as well, it is the allied health professionals that they train as well who will be very useful.

THE CHAIR: How is this subacute hospital at the University of Canberra going to work with Calvary hospital? What is the proposal for a relationship there?

Ms Gallagher: It will be part of the network of hospitals. I expect that there will be lots of discharges from Calvary to the subacute facility, as there will be from Canberra. So it will have to work very closely. That is part of all of the work that we put in in the last few years, to get that network understanding in Canberra—that there are different hospitals fulfilling different roles, yet all of them have to work and communicate together. So there will need to be a very strong connection.

THE CHAIR: In a previous answer we talked about patient flow. I think there was an estimate of about 25 per cent of Belconnen patients travelling to Canberra Hospital. What is your projection for a reduction in that as a result of the opening of the subacute hospital, if they are travelling down to TCH for outpatient services and whatnot?

Ms Gallagher: Those were questions around the ED. The subacute hospital will allow for Calvary to grow as an acute hospital. It will be able to have greater acute services. At the moment it is a major provider of subacute, whether it be in mental health or aged care. It has a proportion of its beds currently fulfilling that role. By shifting the beds around, you are growing capacity in your acute hospital. If some people are making choices about which hospital they go to based on that, in the future, Calvary growing into a larger hospital will ensure that people on the north side feel that they have an excellent service in Calvary where their needs will be met.

THE CHAIR: Do you think there will be a reduction in people from Belconnen going to TCH?

Ms Gallagher: There could be. You cannot stop people going to whatever hospital they like, wherever they like. I think part of it is building up capacity, skill and expertise. As you are building up capacity in acute, you are building up your staffing; you are building up a whole range of specialties. I think that will help Calvary in the long run, too.

MR HANSON: With the time line for when you will tell us the cost and anticipated completion date, have you worked out when that will be? Is that going to be in this year's budget or will it be in next year's budget?

Ms Gallagher: It is certainly being considered as part of this year's budget. But, as I am learning all the time, I think it is hard at this point of a project to say, "It will be open on this date." The next milestone really is to agree on what the financing is going to be and then move to the design phase. The expectation is that the design phase will take anywhere from 12 to 18 months, and then construction can start at the conclusion of that. The expectation is that it is about a two-year build. It is potentially three to 3½ years to get the thing open.

MR HANSON: Peak demand is in about 2020. Is that still what you are anticipating in terms of patient increase?

Dr Brown: 2022.

MR HANSON: So well before then?

Ms Gallagher: Yes.

THE CHAIR: We might move on to some more substantive questions from other members. Minister, could you update me on the progress of the Belconnen enhanced community health centre, which is expected to be completed this year?

Ms Gallagher: Yes. That is a project that Hindmarsh are doing for us, aren't they?

Mr Carey-Ide: Yes.

Ms Gallagher: Local members will have seen that going up outside Belconnen town centre. It is a very exciting project because it is going to be the first of our kind of super health clinics. It will give us the opportunity to have traditional hospital-type services operating in the community, which is very exciting. It is a bit of a test of the future of health care. That is going well, with a September completion.

THE CHAIR: Could you provide us with some more detail about the extra services that Belconnen residents can expect from this new facility?

Ms Gallagher: I am just looking at the list. It has breast screening, renal medicine. We have examples outside hospitals. We have the self-care dialysis unit in Weston now, and we have some on the non-hospital side but within the campus at Canberra

Hospital. But this will be set up for outpatients and dialysis in a community health centre, which we have not had before. It will have the usual dental, pathology, community-based nursing and child health, an obesity service—again, a new one. There will be similar services around diabetes, alcohol and drug, aged care and rehab, and mental health services. I have probably got most of them in there.

THE CHAIR: With the dental services, will that be child dental or child and adult dental?

Ms Gallagher: Child and adults, yes. I do not know if you have had the opportunity to have a look at Gungahlin's dental—

THE CHAIR: Not yet.

Ms Gallagher: You should go and have a look. It is amazing. Even some of the new units in the Civic dental service are very good.

MR HANSON: It always strikes me when I visit that there are a lot of chairs and not many dentists.

Ms Gallagher: How often do you visit the dental program?

MR HANSON: I have been around a few times on visits.

Ms Gallagher: As an MLA.

MR HANSON: As an MLA, yes.

Ms Gallagher: I thought there was something more sinister going on!

MR HANSON: No problems with my teeth, that I am aware of.

THE CHAIR: That is always the issue.

MR HANSON: Do you know a good dentist, Chris?

THE CHAIR: Me. Did you have another supplementary?

MR HANSON: Actually, it was a genuine question. It does seem to me that there are—

Ms Gallagher: When you walk around?

MR HANSON: Yes, there were state-of-the-art chairs and they looked very impressive, but there are never very many dentists.

Ms Gallagher: They probably had you visit at a relatively quiet time. That is the first thing I would say, and the dentists work particular sessions.

Dr Brown: We are fully recruited with dentists, but, of course, we have other dental

therapists and other professionals working in the suite.

Mr Carey-Ide: I think it takes us to an important part about the health infrastructure program, which is understanding that we have actually built everything for the future. So it is possible that you will see chairs, for example, in the dental clinics not operating because it has been built to accommodate future capacity rather than the demand that is actually in place today. It is an important element in understanding what HIP is about.

THE CHAIR: Are there any further supplementaries?

MR HANSON: Not on Belconnen, no.

THE CHAIR: A substantive question, Ms Berry.

MS BERRY: Yes, I do have a question regarding what the government is doing to increase the capacity in the neonatal intensive care unit.

Ms Gallagher: The new neonatal intensive care unit is currently—I am sure we are going to be eclipsed by some new unit soon—the best unit in the country. But there are a couple of units that have been modelled on ours and are being built. So I do not know how long that will last. There have been extra cots provided for in that neonatal intensive care unit. In fact the staff had a bit of a celebration there the other day to mark the final "We're in and we've bedded down the services in the unit".

Walking around there, the thing that struck me the most was that previously—I do not know, Mr Hanson, if you visited the previous NICU—the NICU was essentially a large room with cots, the higher dependency unit. There was no separation. Then you had the babies that were getting better and the third bit was the babies who were about to be discharged. But everyone was in together. The machines were all going "beep, beep, beep" together. The parents were all located together. There was nowhere for parents to grieve if they lost their baby or were dealing with the trauma of going through what they had just gone through.

The thing that struck me about the new unit is that there is none of that. The babies are in purpose-built rooms where there are probably three cots. There is personal space for the parents. It is just quieter. The neonatologists will tell you that they believe—and they have no evidence to prove it—that the babies are calmer in that environment. I think it is going very well.

MS BERRY: Have you had any feedback from people using the unit?

Ms Gallagher: Yes, I have spoken to a couple of parents who have used it. I have to say it was an area where you do not get a lot of complaints. It is not an area of the hospital where people are complaining, when your babies' lives are being saved by doctors and nurses. Former parents were really involved in the design of the new unit. So they were at the celebration I went to the other day. Their involvement was acknowledged in that. It was actually about saying, "Look, when you were here, what didn't work for you, and let's build that into the building." But the feedback from the staff, and through them the parents, has been excellent.

Dr Brown: Overall it is much more family friendly. That is partly because of the design, because parents are able to spend much more time at the bedside. Mums are able to express milk by the baby's bed, and they are able to be there and engage more with the treating professionals as well. There is also some rooming-in capacity within the facility. So it enables some of the parents to increase their parenting skills, those who feel that they require that, prior to taking their newborn home. There have been lots of positive comments in regard to that enhanced capacity from the new design.

Ms Gallagher: The other thing that has worked well is Ronald McDonald House. A lot of their beds have been taken up by New South Wales parents using the NICU. Just to have the ability to stay at the hospital while your baby is in hospital has taken a lot of stress away for parents and allowed for mothers to feed through the night and things like that.

MR HANSON: Well done for your donation, as well.

Ms Gallagher: For the?

MR HANSON: Donation on 2CC.

Ms Gallagher: It was a ticket to their ball, I think.

MR HANSON: You are going to miss it?

Ms Gallagher: Yes, I am out of town.

MR HANSON: They had a telethon.

THE CHAIR: It is 11 am. The committee will now adjourn for a short break, and we will resume at 11.20.

Meeting suspended from 11.02 to 11.23 am.

THE CHAIR: Members, we shall resume. Mr Hanson, I think you have a substantive question.

MR HANSON: It is up to me, is it?

Ms Gallagher: I think that is probably debatable—whether it is substantive or not.

MR HANSON: I have been very nice this morning, minister.

Ms Gallagher: Unusually nice.

MR HANSON: Some of the staff probably want some more entertainment from me.

THE CHAIR: Members, witnesses, we are not going to have a discussion. Members are to ask questions; witnesses are to answer them.

Ms Gallagher: Indeed, chair; my apologies.

THE CHAIR: That is how this works.

MR HANSON: And my apologies, Mr Chair. The minister, I am sure, will not do that again. I was just having a chat outside to a couple of staff. We were talking about outsourcing and I was reflecting on things like imagery and pathology where there are commercial organisations in this jurisdiction that do that and there is imagery and pathology within the directorate.

Ms Gallagher: Yes.

MR HANSON: Where is that balance between what the directorate provides and what is sourced commercially—particularly for those two, but there might be other areas like that as well? I was just interested in your view of that. There seems to be a dynamic tension there in terms of the directorate taking up what would be viewed as commercial business. Have you had any discussions with commercial enterprises—pathology, imagery and anywhere else—about those sort of issues?

Dr Brown: Yes, we have had some discussions in relation to some of those issues. I think it is fair to say that across the whole sector you have public sector services and then you have private services, whether it is in pathology, imaging or any other specialty area. There are some tensions there, but by and large, as a whole, the system tends to find a reasonable balance.

Certainly in the ACT there have been some discussions, particularly in relation to pathology, less so about imaging. Government has a view—and we have discussed this with the minister—that it has responsibility to provide a range of services free of charge to the community of the ACT in terms of servicing their pathology needs, and it is looking at what that balance is in terms of meeting those needs in the ACT.

Ms Gallagher: If we go to the core of the issue—and I have had approaches from both private imaging and private pathology—it is: "Have we got a deal for you. We can come and provide all of this to the community and you do not need to be in this space." That sounds really good, because there is no doubting that in imaging and pathology workloads are really under pressure; we have had to put more staff on in both of those areas to deal with the demand for different types of tests.

The issue is that I think the work that most would be interested in is the high volume, low cost work. What it would still mean for Health is this: we would become the provider of all the expensive niche tests that are not going to be provided by the private sector because there is no money in it. That is fine; we do that at the moment in pathology. We are the provider of those high level services. But people also rely on ACT Pathology to have their high volume, low cost work done. We need a balance.

The work we are doing—and it will change over time as the private capacity builds up; this is certainly the case in imaging, where there have been quite a number of expansions of services in the private sector that will ease some of the pressure on the public system—is to run a public service that at its core provides an equitable service for those who need it, so it still needs to provide the full range of services but does not

seek to compete with the private sector. We are not actively out there trying to generate business for the public system. We do not need to do that. We are a good enough ad for ourselves. You will see some changes in pathology in the next few months based on that. That is looking at the role of our community collection centres—how many we have, who they service. I think that will be well received by the private sector.

MR HANSON: So a sort of transition from public to private or outsourcing it to the—

Ms Gallagher: No. We run a number of community collection centres, so it is looking at whether we need to run all of those. Certainly the private sector will tell you that we do not need to run any of them. Based on the workload we are dealing with in pathology in particular and the need to concentrate our efforts in particular areas, there is an argument to wind back some of our community collection centres over time. But it is not something we would do immediately; it is something we would do in consultation with the workforce, making sure that the community understood what we were doing and that there was still a range of choices for people available as we look at rebalancing our work. In the last few years we have had to put on quite large numbers of staff to deal with the volume of work coming in; we need to be able to manage that volume a bit better.

THE CHAIR: Any supplementaries on that?

MS BERRY: No.

THE CHAIR: I have a substantive question. Chief Minister, on page 8, with regard to e-records, what progress has there been in making available personally controlled e-health records in the ACT, including services provided by Canberra and Calvary hospitals?

Dr Brown: We might ask Judy Redmond, our chief information officer, to come up and speak to that. While she is coming, I can say that Calvary was one of the wave 2 sites as a pilot site around the establishment of the personally controlled electronic health record. There is a lot of foundation work that the ACT has been progressing. My understanding is that we have successfully uploaded a discharge summary from the ACT into the PCEHR, but I will hand over to Judy and she can tell you the specifics.

Ms Redmond: We have not quite loaded a discharge summary up to the live production environment for the national PCEHR, but we will be going into production next week. The ACT will be the first jurisdiction to connect to the national PCEHR. We are going to be enabling the upload of discharge summaries commencing from next week. And we will be enabling the capacity to view the national PCEHR record from the ACT Health Directorate clinical portal from April-May of this year. We are quite significantly ahead of the other jurisdictions. We are also rolling the ACT Health Directorate clinical portal across to Calvary public hospital. In April-May, Calvary will also have these facilities.

THE CHAIR: What does "personally controlled" mean within the personally

controlled health record terminology?

Ms Redmond: Obviously this is a national record of the personally controlled health record. A consumer can have complete control over the national records. For starters, they can choose to either have one or not have one; it is a completely opt-in process. Secondary to that, they can actually nominate which particular providers or which organisations they choose to share their information with; there is a capacity within the national PCEHR record to indicate who you may wish to share your information with. Equally, you can opt to have a national PCEHR record and you can indicate some documents which you may wish to keep hidden and only provide access to that information on the provision of a code to a health service provider to allow them to have access to that secondary information.

THE CHAIR: What are the advantages of a personally controlled electronic health record?

Ms Redmond: It is not intended to replace the records within a health service. For example, it is not intended to replace the records that we maintain within the Health Directorate on consumers. The concept around it is to have a summary of a person's information. The Australian community are quite mobile, so it is having the capacity to have access to that information wherever you may be. With people who are ill and who are visiting another location for a holiday or who locate to another state, it will be much easier to share that information and have that transference of that information if it is held in the national health record.

Dr Brown: I might just add to that. There is also capacity within the PCEHR for you to have access to your record of all prescriptions, PBS medications—and, indeed, your Medicare items as well. If I go into mine, and I have registered, I can go in and see the dates when I actually saw which doctor and had which particular procedure or investigation. It has also got childhood immunisation records. So it has got a lot of information available there—information that people keep in their head in a rough sense but on which they do not necessarily have the detail.

Ms Redmond: They are also looking at future functionality being continually added to the record. For example, the Department of Health and Ageing are currently looking at a national blue book—the early childhood information being made electronic and having provision within the national record to provide that.

THE CHAIR: So what you are really talking about is almost a dual record system where you will have your internal records, which clinicians will complete, and then they will need to summarise that—or is there an uplink automatically into the national health record?

Ms Redmond: We need to comply with the necessary security and privacy controls around the sharing of information. So yes, there are rules around it. As a consumer, if you opt in to have a national PCEHR record, unless you indicate otherwise, you are consenting to information held in other places to be uploaded into your record. It is up to a consumer to indicate to us that they do not wish to have a record sent to the PCEHR record. So we are putting in the checks and balances to be able to capture that consent information. For the upload of discharge summaries, yes, it will be an

automated process. If a person has a PCEHR record, unless they provide us with information to say that they do not wish to consent to the information being sent—and we will be capturing that information—the discharge summary will be automatically uploaded if you have a record.

THE CHAIR: What would be the risks for clinicians relying upon a national health e-health record which is patient controlled where that patient may or may not be fully revealing all of their health in that record?

Ms Redmond: I am probably not the best person to ask about clinical behaviour.

Dr Brown: I can perhaps respond to that. The same risk exists if the patient walks into the room and reveals certain information and does not reveal other information. Practitioners need to be fully aware, and they are, that this is an aid in terms of providing information; it is not necessarily guaranteed to provide all information, as I said and as is the case now when someone walks into the consulting room.

THE CHAIR: The report also refers to a community-based clinical record system. Can you explain what that is?

Dr Brown: I think that is not part of the PCEHR. I am not sure which page you are referring to, but we do—

THE CHAIR: Page 8.

Dr Brown: We have a number of electronic medical records, which is what Judy was referring to before. The medical record is essentially like the patient notes that historically have been done in written form. The PCEHR is a health record, so it is a summary. But we do have a new community-based clinical record. I will ask Judy to speak to that.

Ms Redmond: We are looking at implementing a community-based clinical record starting off with the community care program in the community health area within the Health Directorate. Initially we will be rolling out to the allied health services within the community care area; from there we will be moving to community nursing. The idea will be to move away from the paper-based records and have the electronic capture of patient information in the community-based services through an electronic system.

We have worked very closely with the clinical areas to develop this system. It is trying to improve the "shareability" of information, to reduce the duplication of information, because patients that are seen by the community-based services are often seen by a number of different services within the community-based area. We have worked with the clinicians to come up with a list of items that we think are global, so items that will only needed to be captured once and reviewed by the clinical areas, and then some service-specific templates for reporting their clinical information. It also works on creation of the care plans, task lists et cetera, to help inform and enable enhancements to the way that the clinical care is delivered.

MS BERRY: Dr Brown, you mentioned the collection of information around

immunisation. Can you talk to us a bit more about the government's strategy for immunisation?

Dr Brown: Yes. We do have an immunisation strategy. Dr Kelly, our Chief Health Officer, will be able to tell you about that in great detail. We work in collaboration with primary care very much in terms of delivering immunisation across the territory. And we actually have very good results in terms of the overall coverage. But Dr Kelly might speak to that in more detail.

Dr Kelly: Thank you, Dr Brown, and thank you for the question. Ms Berry. We are very proud of our immunisation rates that have routinely topped the country in terms of rates for childhood immunisation over many years. And whilst we have challenges, particularly in Aboriginal health, in making sure that we continue to strive to improve those rates, the rest of the population is doing exceedingly well. In all of the cohorts that are measured in every jurisdiction, we routinely top it or are always in the top three. So we exceed the targets which are generally 90 per cent in each of those cohorts for young kids.

As to your specific question about the immunisation strategy, we have had an immunisation strategy for a number of years too, and that comes up for renewal from time to time. In the latest one I asked my staff to be a bit more ambitious in what they would like to see and what were the things that were emerging as new issues, and to address those in the strategy.

One of the areas where we can improve and should be doing more is adult immunisation. We are particularly looking at immunisation against influenza, but there are others as well. Other areas, as I have mentioned, specifically include the Aboriginal and Torres Strait Islander population of the ACT, to make sure that we are doing it in a culturally appropriate way, the best we can in terms of protecting that particularly vulnerable group.

There are a range of other measures that have been introduced into the strategy. It is a five-year plan. It was launched by the minister recently.

MS BERRY: Supplementary.

THE CHAIR: Yes.

MS BERRY: Regarding the changes to the demographic in the ACT, with new people coming here from other countries, how are we communicating to them around the immunisation strategy, particularly for their children?

Dr Kelly: That is certainly a challenge we have with all of our preventive services and, indeed, clinical services, although they are not my specific responsibility. But we have a multicultural society here, and much of our information is available in different languages, or, if necessary, interpreter services are also available. But someone else would be able to speak to that. We have identified particularly Aboriginal and Torres Strait Islanders as the main group.

Many countries where refugees and migrants come from also have very good

immunisation programs. So the people that come from other countries are not a specific group that we are concerned about at the moment. But we keep a close eye on those figures.

MS BERRY: And as somebody who has not been immunised yet against influenza—

Ms Gallagher: What? Ever?

MS BERRY: Ever—I know!

Ms Gallagher: Dr Kelly will see you outside.

Dr Kelly: The Assembly has a program.

MS BERRY: It is funny you should mention that, because I did see the program, and I am a bit embarrassed that I have never been immunised. You all looked at me like I am going to catch the plague. Yes, I will definitely go ahead and do that and encourage all my friends who are adults to go and get the influenza immunisation, if that assists at all.

Dr Kelly: I look forward to seeing you in the queue.

MS BERRY: I do not know that I can say the same. But anyway!

Dr Kelly: The immunisation for flu changes each year, and the program will be starting soon. I think the commonwealth were making an announcement today about the launch of the new program. But we have already had flu immunisations pre-positioned and ready to go. There is free vaccination available to high-risk groups. The elderly, people over 65 or over 15 in Aboriginal and Torres Strait Islander people, pregnant women, people with chronic diseases—all can receive free immunisation under that program.

As you mentioned, we do actively look at ways that we can do this—not that members of the Assembly are particularly at risk, because you are so young and fit—but there is an option here and, similarly also in the hospital setting where we are very keen, as part of the new immunisation strategy, to increase staff uptake of immunisation as well.

THE CHAIR: Supplementaries.

MR HANSON: No supplementaries.

MS BERRY: But have you had your influenza shot?

MR HANSON: No, it is not due.

THE CHAIR: He does not answer questions.

MS BERRY: Sorry.

THE CHAIR: You may ask a substantive question, Ms Berry.

MS BERRY: It is my turn?

Ms Gallagher: It is a tight ship you are running here, chair.

MR HANSON: He is brutal, isn't he?

MS BERRY: I have a question—

Ms Gallagher: It is like root canal.

MR HANSON: We could have done with him last year a couple of times, I reckon.

THE CHAIR: Thank you, members. Thank you, minister. Ms Berry.

MS BERRY: Thank you, chair. Minister, it is the start of the deathcap mushroom season.

Ms Gallagher: Dr Kelly.

MS BERRY: I have a particular interest in this, because I had a box of mushrooms delivered to my home from a paddock in Goulburn—happy birthday, Goulburn—so I am personally interested in this, but also given the tragic deaths of two people in January 2012, what action has the directorate taken since the deaths last year and moving into the—

Dr Kelly: It was a tragic occasion. It was on New Year's Day last year. There was a chef of Chinese origin who actually, as a special gift to his colleagues, prepared these mushrooms, which he thought were actually some other type of mushroom that were edible, the straw mushrooms with which he was familiar in other settings. And the problem with the Amanita phalloides, which is the deathcap mushroom, is that it is incredibly toxic. One teaspoonful is enough to kill an adult. There were two deaths, and there was also another person who was severely sick from that episode.

So we instituted a lot of community information and so forth last year, after that episode. I would say that that is building upon a lot of work we do every year in conjunction with TAMS in relation to signage in places where we know the mushrooms tend to be. And it is usually associated with oak trees, but it can be in other places as well. There is a grove very close to my house, and when I did see those mushrooms last year about this time—the usual time is around March when it gets a bit cooler and a bit wetter—there were another six types of mushrooms in that same place. So our general message has been: don't pick mushrooms.

There are people within the community here in the ACT but particularly people visiting from other parts of Australia who will routinely forage for mushrooms. So we decided on that message rather than: don't pick this type of mushroom, because, for most people that are not expert, it is a danger.

The main things we did were an enhanced re-education of the community last year,

and we went to universities, schools, to the tourist information people through Canberra Connect, various ways that we could think of, particularly giving information to people visiting the ACT or people who have recently moved to the ACT.

We worked very closely with the multicultural group within government, and I particularly pay tribute to Sam Wong, who is the community leader there. His links with the Chinese community were particularly useful. And through that actually, the minister and I—I am not sure if you have seen the DVD—had a DVD sent to us by Chinese television where we both gave an interview, and that was broadcast throughout Australia and, I believe, also internationally. There was a lot of international interest actually at the time about that. It is a rare event in Australia, although these types of mushrooms are found in other parts of the world as well.

THE CHAIR: Clearly, the campaign has been successful in that we have not had any more incidents of consumption of deathcap mushrooms, but has this proclamation against mushrooms resulted in a lower harvesting of wild mushrooms in the ACT? Do you have any evidence for that?

Dr Kelly: Unfortunately not. I do not have any evidence. So I cannot really say one way or the other. I was in Sydney recently where they had a specific program on the local ABC radio about harvesting mushrooms in the Blue Mountains area, and they actually referred to this case as well. But they were very much advocating the collection of mushrooms.

The deathcap mushrooms are not the only poisonous mushrooms that are around. So, in general terms, as I say, our message is: do not pick them. There are commercial mushroom growers, and there are a wide variety that are available at markets and even at the larger supermarkets.

THE CHAIR: I suppose it would be difficult to find out what the success of the message would be with people harvesting in the community?

Dr Kelly: Yes, very difficult. The other thing we have done is that there was a paper published in the *Medical Journal of Australia* by colleagues at the Canberra Hospital who have dealt with the clinical aspects of this over the years. And we have formed a very close link there in terms of response to any future issues like this. And we will continue to work with TAMS on the signage and the community communication.

THE CHAIR: Which other mushrooms are risky in the ACT?

Dr Kelly: There are a number that grow in various forests around the place that university students particularly seem to be interested in. But I do not think I should go into great details there. I have never tried them, by the way.

MR HANSON: You seem to have a particular interest, Mr Chair.

THE CHAIR: I am just assisting but I am not giving evidence.

Dr Kelly: Many of them are quite edible, and there are others that grow in the pine

forests that are huge, big, chunky sort of meaty things which are apparently very tasty. But I will leave that to others to decide. I think the general sort of precautionary approach is: do not pick them.

THE CHAIR: Substantive question, Mr Hanson.

MR HANSON: The national capital hospital and its owner, Healthscope, I understand want to do a development of the hospital. It is 37 beds and a number of other things. It is $55 million worth of investment, but that seems to be clogged somewhere in term of negotiations because of car parking or some such thing. Can you expand on where we are at with that?

Dr Brown: We had a meeting with national capital recently. My understanding is that that is now progressing. They have lodged a DA, or are close to lodging the DA. There were some concerns, obviously, around car parking. They will be expanding into space that is currently occupied by car parking. That, obviously, needs to be addressed as part of that DA application. We have been working quite closely with them in relation to those car parking concerns. As I say, the advice to us was that they are very close in terms of lodging that. I think those issues have been resolved.

MR HANSON: That is good. It is a busy campus in terms of all the redevelopment. Is that going to affect the sequencing of when things get done or essentially will they be able to once the DA goes through—assuming it is approved—get on with that? Is there a concern with the amount of works being done?

Dr Brown: Obviously, it is a very busy campus but my understanding is that, in terms of the timing of the lodging of their works, the works on stage 2 of the centenary women's and children's hospital will be complete before they start. I think they have an anticipated starting date late this year or early next year. It actually will work quite well along with the work that we are doing on our side of the campus.

MR HANSON: Okay.

Dr Brown: I do not believe there are any impediments on either side.

MR HANSON: Do you use nat cap much in terms of purchasing beds? Obviously, when we talk about EDs and so on, one of the problems is lack of beds. It would seem that—

Ms Gallagher: Not lack of beds. People in beds. Too many people in beds.

MR HANSON: People in beds—a lack of spare beds, I should say.

Dr Brown: I might ask Mr Thompson to speak to the specifics of that.

Mr Thompson: We do from time to time. There are a couple of issues that always need to be taken into account in doing that. Firstly, there is the availability of beds at nat cap itself. In recent times they have been very busy. Therefore, the availability of beds has been limited. But we remain in regular contact with them to identify whether or not they would have that spare capacity.

The other thing, of course, is that without necessarily purchasing beds, we can look at those patients with private health insurance and look at transferring them across to national capital hospital, assuming that they have got their insurance and a doctor who will accept their care. That has a similar sort of effect and is often the best solution.

MR HANSON: Right.

Mr Thompson: In terms of the actual purchase of the bed, the other thing that we look at is to try and get a block of beds as opposed to a couple of single beds. It is usually not consistent with good patient care to have a single patient who is a patient of our hospital in another hospital where the doctor has to go across and the nursing staff are not necessarily familiar with the care. So there are a few things that we always have to take into account.

MR HANSON: So with those two issues—firstly, buying blocks or whatever, when have you last done that?

Mr Thompson: I cannot say with certainty, but I am happy to take that on notice.

MR HANSON: Can you take it on notice. I am interested in when it has last been done, how many beds were purchased and for what purpose. I would like to get a bit of a feel for it.

Mr Thompson: Yes.

MR HANSON: In terms of private health insurance, I think we understand the oversubscription—well, it is not oversubscription. We understand the fact that more people in Canberra have private health insurance but do not seem to use it. Are you trying to encourage people who are admitted into Canberra Hospital to go to nat cap or elsewhere for continued treatment? How does that work?

Mr Thompson: It varies. A patient is able to elect to be a private patient at any point during their care. So there are some people who will be initially admitted, maybe have an initial surgical procedure and then get transferred to a private hospital for follow-up care. Similarly, however, we can look at patients who are presenting to the emergency department and, on presentation, after they have been assessed, we give them the option, if they have private health insurance, to elect to go straight to the National Capital Private Hospital from the emergency department, at which point they do not ever become an admitted patient of the Canberra Hospital.

MR HANSON: Just to nat cap—

Mr Thompson: Nat cap, John James. It is much less with Calvary private at Bruce.

MR HANSON: I guess that they are doing the same thing over there.

Mr Thompson: Exactly that. There is no sort of preferential treatment. It is about where the doctors practise. Of course, some doctors practise at nat cap, some at John James. If someone has a choice of doctor, then that is always an influencing factor. It

is based on personal choice, availability of beds and availability of the doctors to accept the care.

MR HANSON: Do you have stats on that—how many from ED were admitted straight to nat cap or somewhere else and how many have been transferred from a bed in TCH to somewhere else?

Mr Thompson: I have not got them, but I believe we can at least have a look at trying to get you something that gives you that information.

Dr Brown: We will have a look, but I am not sure what we will be able to produce.

Mr Thompson: Yes.

MR HANSON: If you do have something, I would be interested in what that is. I assume that when you do that you have then freed up a bed. In essence, you have transferred the liability elsewhere.

Mr Thompson: Yes.

MR HANSON: I imagine that you would encourage people to do that. What do you do to try to facilitate that and make that easier for patients to encourage that to happen?

Mr Thompson: Yes, we have staff who work with patients to explain the admission process and, in the emergency department, what their options are in terms of patient election, as it is called. So we actively follow up. Similarly, even after someone has been admitted to the hospital, we have the ability to review that, and the ward clerks and staff on the wards also work with patients. So we do actively encourage it.

MR HANSON: Is it a process where you deliberately try and identify who is private and then—

Mr Thompson: We ask them. There is no obligation for someone to declare that they have private health insurance. We do not push it if they are not prepared to declare it. So we just work with them, encourage them and explain what the benefits associated with private health insurance are.

MR HANSON: Sure. If someone identifies that they are a private health patient, what scope is there then to have them treated within the public hospital as a private patient?

Mr Thompson: They can elect to be treated as a private patient within the public hospital. What we try to do in those circumstances is facilitate their choice of doctor. Sometimes, of course, that is not always possible, depending upon the availability of the doctor, but we do whatever we can to do that. We look at giving them access to private rooms, if there are private rooms available. We support them to make that choice.

MR HANSON: Again, do you record the statistics of how many—

Mr Thompson: We record that, yes.

MR HANSON: I just want to try to get a view of what that is as a percentage in terms of people getting transferred, people being treated within the hospital as a private patient and so on.

Ms Gallagher: One of the issues for us is that—once you are admitted to the hospital, what is the incentive, other than possibly a choice of doctor and potentially a private room, to have to carry out-of-pocket expenses on top of your hospital stay when you are going to be treated in the same hospital by potentially the same doctor? So it is a real challenge for us. I think the other thing is the relatively low level of private beds available for use by patients presenting to the public system. The public system has 800, almost 900, beds available. Nat cap and John James together would be a very small fraction of that. They are often full with private patients coming in through the private system. So there is not huge scope.

MR HANSON: Have you got a sort of strategic plan that you have developed in any way between the public and the private health systems? Obviously, there are opportunities there to identify where there are particular bodies of work that could perhaps be farmed out or certainly where there would be beds where you would say, "Look, we will guarantee you a certain number of blocks that we will purchase," so that it can actually encourage the private system to increase the number of beds that they have got and take on staff.

Dr Brown: We do meet regularly with the private hospitals. We, in fact, have a committee that meets on a regular basis. The issues of their particular areas of interest and their capacity are discussed at each of those meetings. The aspect of private care is factored into our strategic service planning as an important factor that we look at in all of the projections that we actually undertake. Obviously, there is a degree of subjectivity in those forecasts, because things can change, as they did, for example, with the obstetrics, the maternity services. But it is an aspect that we look at regularly.

MR HANSON: We have had this discussion before, but that 17 per cent of people that use public is above the national average. If we were able to transfer that to the private system—

Ms Gallagher: Yes.

MR HANSON: that would be a—

Ms Gallagher: Yes, that would be great if the match of what was provided in the private system was there. The other challenge we have is that the private system is not going to go anywhere where they are not going to be able to run a business model associated with it. So that will limit its scope into services that might be helpful for us. The two things do not necessarily go together. We talk with Calvary. They have got some private plans for the north side. We have certainly been talking with them about what would be good if they entered into the private health system. One area they would be looking at is day surgery—again, high volumes, lower cost. But that would still help. It would still assist. So we do talk.

Mr Thompson: Just to add to that, if you look nationally, the statistics are fairly clear that the range of private hospital services available in Tasmania, the ACT and the Northern Territory is much more limited than in the larger jurisdictions. That is for the sorts of reasons the minister was just talking about. They need to operate as a business. They need, therefore, to have critical mass in areas where they can make money. Low volume, highly complex services are not typically the areas that private hospitals expand into. Working with them, we have to acknowledge the limitations of the relatively small size that the ACT provides for them.

THE CHAIR: We will take some supps from other members.

MR HANSON: Sure.

THE CHAIR: Minister, just on this topic of patients with private health insurance using public hospital beds, in your assessment of other jurisdictions has anybody in Australia had any success in moving those patients over into private beds?

Ms Gallagher: I think that in the larger jurisdictions where the choice is available, you will see a higher utilisation of private health insurance that we do not seem to have. As Mr Hanson said, there are very high levels of private health cover. We have got the highest in the country and the lowest utilisation of it. That mismatch has to be partly explained through the scope of services. It is also explained by the high quality of public service that people enjoy. We have very high utilisation of our public hospital system. I think it is second only to Northern Territory, from memory. They have their own unique reasons for that. I think the larger jurisdictions are able to deal with it in a more comprehensive way than smaller jurisdictions can. That, again, places additional pressure on the public health system.

MS BERRY: Minister, we are talking about the capacity of public hospitals in the ACT and purchasing beds spaces from private hospitals. Could you update the committee on the current public hospital bed capacity and how it compares to when the Labor government came into office?

Ms Gallagher: Yes. We have got about 900-odd beds.

Dr Brown: 930.

Ms Gallagher: 930. The last budget has an allocation for new beds that will be coming on through the financial year. They are a range of different beds—critical care beds, medi-hotel beds and general beds, from memory. Then there were some additional hospital-in-the-home beds. We have gone from, I think, below average in beds per thousand to sitting on the national average now.

MR HANSON: 2.6.

Ms Gallagher: Yes. That has taken a lot of money and a lot of beds to actually get up to there, but we are there now. There is no doubt we have significantly increased bed capacity from when we came in. And that has been a conscious decision; it has been an expensive decision, but it has also allowed us to provide a much wider range of services. So there were 670 beds when we came into government. We have put on an

additional 264, and that has given us a reasonable complement, but we are going to have to continue. I think our election commitments had around another 170 beds or bed equivalents factored into them. So that is where we have to continue to keep growing.

MR HANSON: I think 2.6 is the figure, is it not?

Ms Gallagher: Yes, 2.6 per thousand.

MR HANSON: The point is, though, that when you consider the number of New South Wales patients that we have overnight and if you were to discount that—30 per cent or whatever that is—then we are actually well less than the 2.6 per head of population. It would be wrong to say we are at the national average, would it not, if you look at the reality of the ACT population?

Ms Gallagher: Catering for the 660,000? Is that what you are talking about? So, instead of comparing our bed numbers to 360,000, comparing our bed numbers to 660,000?

MR HANSON: Yes, but then there are other hospitals around the region that you then have to take into account.

Ms Gallagher: Yes, you count them.

MR HANSON: But what I am saying is that, specifically for the beds that we count in the ACT, when you look at the ACT population and you come up with that figure that is 2.6 for the population, the reality is that, of those 900 beds, maybe only 600 or 700 are actually available for ACT residents because the rest are occupied by New South Wales patients. I suppose it is more of a comment that we are still below national average when you look at that bed count per thousand. It is a bit of a misleading figure.

Dr Brown: I think it is a difficult figure because the denominator is taken on the ACT population, and, yes, we do cater for those people from surrounding regions who come in to access care here. However, it would not be appropriate to take the total number either, because, as you rightly recognise, there are regional hospitals that actually service those populations. But, yes, in terms of your general comment, there is still pressure on our beds because of the service to the regional New South Wales population.

MR HANSON: I know this access block seems to be going the wrong way at the moment. It seemed to have improved but it has slightly deteriorated in the last quarterly report; is that right?

Ms Gallagher: Access block is not going to be a useful figure.

MR HANSON: Bed occupancy would be better.

Ms Gallagher: It is going to be looked at as that under the national partnership arrangement.

MR HANSON: So bed occupancy had gone up?

Dr Brown: Bed occupancy had gone up and this year it came down again just slightly in the 2011-12 year to 88 per cent. But, yes, there is continuing pressure on our beds.

Ms Gallagher: For sure.

Dr Brown: There is no doubt about that.

Ms Gallagher: I do not think we are saying there is not. And that is why we have got another 170 to put into the system. But it has taken almost 10 years to get 264 beds commissioned. The beds are easy—the space, the staff, the infrastructure around it and the cost are the issues. They are very expensive.

THE CHAIR: Minister, the ACT public service Aboriginal and Torres Strait Islander employment strategy has a target of doubling ACT public service numbers of Aboriginal and Torres Strait Islander employees by 2015. What progress has been made in the Health Directorate in this regard?

Dr Brown: I am not sure if Mr O'Donoughue is able to speak to this. We looked at this at our recent meeting of the Aboriginal and Torres Strait Islander health group. We are currently sitting at just one per cent. We have 0.94 per cent of our current staff who identify as Aboriginal and Torres Strait Islander. I am just trying to understand these figures that they have just put in front of me. It was 0.94 per cent in 2013, and that has been relatively stable. I am sorry, I cannot quite make sense of that table.

We have an inclusion officer employed within our people strategy and services branch who has been working to look at increasing the opportunities for Aboriginal and Torres Strait Islander people as well as people with a disability. So we have a dedicated officer. We have a number of traineeships and scholarships that have been made available specifically for Aboriginal and Torres Strait Islander people. I do not know the exact number, but certainly specific attention has been paid to this area in line with the strategy.

THE CHAIR: Apart from traineeships and an inclusion officer, are there any other strategies that you have seen working in other jurisdictions that you propose to introduce in the future?

Dr Brown: There has been the opportunity to develop mentoring arrangements, particularly with having Winnunga health service available—we are working in partnership with Winnunga as well—and also identification and training of Aboriginal and Torres Strait Islander people in terms of increasing their participation in recruitment and retention strategies. So we are undertaking a number of things as part of our reconciliation action plan. This is one of the specific activities within the RAP plan.

THE CHAIR: And what sort of steps are you taking to promote understanding and diversity within the workforce generally?

Dr Brown: We have some cultural competence training, which is an essential training requirement particularly for front-line staff. And we have been looking at how we can best deliver that. In fact, work has been done to revamp the actual training package as well.

THE CHAIR: There has been a long-term history with collecting health data about Aboriginal and Torres Strait Islander people. What steps have you taken to ensure that your clerical staff who are collecting data about people are appropriately identifying Aboriginal and Torres Strait Islander people?

Dr Brown: And, again, work has been done on this. I might ask Mr O'Donoughue to speak to that.

Mr O'Donoughue: Thank you for the question, Dr Bourke. As Dr Brown has indicated, we have been doing some work over a number of years to try and improve the ascertainment of Aboriginal and Torres Strait Islander data in the ACT. It is a curse of small numbers that it is difficult for us sometimes to demonstrate with significant results the effectiveness of the programs we operate. To give you a key example of that, it is difficult for us to provide reliable data on life expectancy of the Aboriginal population in the ACT because of the size of the population.

One of the primary strategies we have been trying to improve our data ascertainment through is by encouraging all staff to use the standard ABS question—"Are you of Aboriginal or Torres Strait Islander origin"—every time they deal with patients throughout the patient journey. We provide staff with some scripting and some support to cover off those rare occasions where they may get an adverse reaction from people who ask, "So why are you asking me that question? Would you treat me any differently if my answer was one way or the other?" We provide staff with the support that they are asking that question because we know that health outcomes in these communities are poorer than the rest of the community and we need the data in order to improve our service delivery.

That program has been going well, and we have been running training programs for staff on asking the standard question. It is something that I address in a short orientation session that I do with all new staff as part of our induction program.

THE CHAIR: Supplementaries?

MR HANSON: The bush healing farm is an opportunity for increased employment of Indigenous people. Where are we at with the bush healing farm?

Ms Gallagher: The DA is online.

Mr O'Donoughue: Thank you, Mr Hanson. The development application was notified publicly on 9 March—so last Saturday—in the press and by notice on the gate of the property. So that is the latest development application which addresses some of the concerns that have been previously raised in response to our earlier development application.

MR HANSON: In terms of when it is going to be built, have you got an updated time

line?

Ms Gallagher: We need to go through the planning process. That really will dictate the next steps from here. The design is done, I think. We know what we have got to build, so once we get through this planning process, it is the last hurdle.

THE CHAIR: Substantive question, Ms Berry.

MS BERRY: Minister, could you please update the committee on the government's commitment to the NDIS, especially in relation to mental health?

Ms Gallagher: I might let Dr Brown take the detail, but we are certainly at the table. We are active supporters of the NDIS. I was very pleased to see the legislation pass through the House of Reps I think yesterday. So that is excellent. And now there is a lot of planning going on here locally. It will certainly change the way we provide support to people who have a disability and, indeed, to people who have a mental illness.

Dr Brown: We are participating as part of the task force to actually undertake the planning. The ACT is not going live until 1 July 2014. Some of the other pilot sites are, of course, going live in July this year. The issue of where mental health fits within the NDIS has been the subject of quite considerable discussion. I am not sure it is absolutely finalised now; it is ongoing. But at this stage it is looking at supporting those people who have—and Mr O'Donoughue can assist me here if I get this wrong—an enduring disability associated with their mental illness.

A range of services that are currently funded here in the ACT provide that type of service that will come within the scope of the NDIS. So we are currently going through the process of looking at what services are within the scope of the NDIS and what will be remaining within Health as clinical services as opposed to disability services. Ross might like to add more detail to what is actually currently underway.

Mr O'Donoughue: We have been in touch with all our funded non-government organisations in the mental health sector. Those services, that number about six, who we think have aspects of their service that are in scope for NDIS we have notified. We have chosen to roll over all the funding agreements in the mental health community sector for a 12-month period to keep them all together. But we anticipate that for about six organisations there will be a transition in the future to a new funding model under NDIS. So we are working with those organisations going forward. It is primarily those organisations who provide ongoing supported-accommodation-type services for people with an enduring mental illness.

MS BERRY: I did attend one of the information sessions on the NDIS last year. There is some time before it actually starts to form and is implemented in the ACT, so how does the government propose to continue to consult with people in the community who have an interest in and a need for the NDIS?

Ms Gallagher: Minister Burch is leading that work. She has commissioned a task force and they have been undertaking, as far as I can see, a lot of community discussion, and there are community connections in that group, specifically to keep

the communication going, because it is a time of great change. Even though we are not going live in 2014, people in the disability sector—not necessarily in the health sector—will see an increased level of service over the next 12 months, because we have been putting more money in and the commonwealth has provided some money, essentially transition funds, in the lead-up to 1 July 2014.

MR HANSON: The nurse enterprise bargaining agreement is coming up. I believe they have put in—

Ms Gallagher: The nurses, the doctors, the VMOs—everybody's is coming up.

MR HANSON: Everybody?

Ms Gallagher: Everybody. It is going to be a bonanza, a festival, of enterprise bargaining.

MR HANSON: Have you received a submission from the nurses?

Ms Gallagher: Yes.

MR HANSON: My understanding is that it is pretty substantive.

Ms Gallagher: Is it five per cent maybe? Five per cent per annum.

MR HANSON: Five per cent per annum?

Ms Gallagher: Yes, it is five per cent per annum over a four-year agreement with a range of improvements to conditions.

MR HANSON: How is that going to play out from now? What is the process?

Ms Gallagher: We will bargain with the nurses. There is a bargaining unit. They have started discussions. Health have been doing their work in terms of some changes they would like to see. We start getting around the table and talking with them. We cannot afford five per cent. I have already said that, unless it is offset by efficiencies driven through the agreement, in which case five per cent might seem very reasonable. But at this point we are not close to reaching agreement. The VMOs had their session last night. They are not happy with the wage offer that has been put on the table at two per cent per annum. That is a little different in the sense that that will head off on an arbitration route, I expect. It has every other time. But they are all going at the same time.

MR HANSON: What is the time frame for those?

Ms Gallagher: 30 June. That is the expiry. You can keep it going. The world does not end on 30 June. It would be great to have it dealt with by then, but the whole of ACT government is going at the same time. I would be surprised if it is resolved by 1 July.

MR HANSON: Have you responded formally to that yet?

Ms Gallagher: I am not sure that it came to me. I think it might have gone to Health and I was copied in to it. I would not normally get involved at this point of the EBA. I will get involved at the right time, willingly or unwillingly.

Dr Brown: We have a process of engaging in those negotiations. We have started it with the VMOs. Last night was the first meeting. We have been awaiting documents going to cabinet and the core agreement before we commence the formal negotiations with the other unions around—

MR HANSON: In your budget projections have you pencilled in an amount in anticipation?

Dr Brown: We put in what Treasury told us to put in.

Ms Gallagher: Yes, you put in a notional amount, but we never say what it is, because then that shows your hand. But there is a notional amount factored in. Usually we argue about the difference between the notional amount and what the ambit is, and then we usually reach some agreement within that. We have not had industrial disputation of any significance since 2001. I would prefer to keep it that way, but I think this EBA round is going to be a real test.

MR HANSON: Yes. I will watch with interest.

Dr Brown: Can I read into the record a response to one of the questions on notice? The percentage of private insurance utilisation in the public hospital is 7.4 per cent.

MR HANSON: And you will get me the other one in terms of the—

Dr Brown: We are trying to, for the other one.

THE CHAIR: Minister, on page 169 of the annual report it says in 2012-13 the population health division will establish an ambient air quality monitoring station in the Belconnen region. What is the role of the station and where will it go?

Dr Brown: We might ask John Woollard to respond to that.

Mr Woollard: The location has not been finalised yet. We are still working through negotiations on a final site. We have been looking at a couple of sites. We are looking around the Florey area. We are at the final stages of that. The station will look at a number of parameters. It will look at particulate matter, PM10, PM2.5. It will look at ozone, carbon monoxide and nitrous oxides. It will be the second performance monitoring station in the ACT. The first one is in Tuggeranong and it has been in place for a number of years. It will provide comparable data to that station for the north side of Canberra.

THE CHAIR: In your consideration of sites, what sort of site analysis or space is required if you are looking around Florey?

Mr Woollard: The national environment protection measure under which the station operates has very clear and concise requirements in terms of proximity to roadways,

other buildings and so on. I have not got those with me at the moment, but there are very clear criteria in terms of where you can locate it. So we work through that process. Obviously we wanted to have a station that was on the north side of Canberra. We have one on the south side, and the north side is where there is a lot of growth, obviously. We have worked through that. We looked at a number of sites in the north Canberra area. As I said, we are in the last stages of finalising a particular site and then moving to a DA process.

THE CHAIR: Would this station have helped during an incident such as the Mitchell fire?

Mr Woollard: No. The stations are about providing long-term trend information about ambient air quality. They are not about picking up spikes in terms of particular incidents such as the Mitchell fire.

THE CHAIR: What will be the benefit to the community of the station?

Mr Woollard: The benefit to the community is that we will actually get regular data for the north side of Canberra against those parameters that I mentioned. So we will have an indication of what the particulate matters are in that area—ozone, nitrous oxides and so on, in terms of air quality. It will give us an assurance that we have good, clean air.

THE CHAIR: What is the relevance of that to public policy?

Mr Woollard: If we were to find that we had a deteriorating air quality in the Canberra area, we would then be looking at why that was the case and then you could look at reducing emissions. We do not expect to see that at the moment. There is no indication that there is a deteriorating air quality, but it is a matter of providing that assurance to the community.

Ms Gallagher: It is a requirement for us to have one under the national agreement—an additional one.

MS BERRY: I have not seen the one at Tuggeranong, being a west Belconnen girl. How big are they?

Mr Woollard: Relatively small. It is like a small site shed with an amount of equipment in and on that site shed, and it is fenced off and secure.

MS BERRY: Can the minister update the committee on the GP aged day care service which commenced in March 2011 and whether any evaluation of the service has been undertaken?

Ms Gallagher: Yes, it has been undertaken. In fact the evaluation report is sitting on my desk for me to read in full. I think I got it during the week. It has certainly been quite successful. It was one of our funded initiatives hopefully to ease some pressure off the emergency department and also provide people in aged-care facilities with access to GPs. It has had some limitations as well, even though they have tried to be flexible. I think it was really for patients who had an existing GP who, for one reason

or another, could not get to them. The evaluation is in. I am not sure if someone can answer better than me, because I have not read the evaluation yet.

Dr Brown: Mr O'Donoughue might be in the best position to give the detail about the evaluation report.

Ms Gallagher: It is certainly serving a purpose. We have had 1,617 referrals since commencement, 980 referrals received from March 2011 to June 2012 and there are 61 general practices involved in it. So it has certainly grown from when we launched it. The feedback I have had from GPs is that it is useful. I have had the same thing from residential aged care—people living in residential aged care. One of the issues, which I am not sure the evaluation deals with, which I was going to follow through, was for people who did not have a GP but were in a nursing home for one reason or another.

Mr O'Donoughue: In the broad, as the minister said, the evaluation overall is very positive. I believe there were 41 patients in the last month who were enrolled with the service. It had a slow start but it grew over time and it is now very well subscribed. There have also been some challenges around staffing of the service. It has not always been easy to recruit staff to it, and that required some adjustment to the remuneration arrangements. There was always consideration given to whether the model could be expanded. It is essentially a locum arrangement for people with an existing general practitioner who is not able to attend either a person isolated at home or in residential aged care during their normal business hours. There are some people who do not have a current general practitioner who either struggle to get into a nursing home because they do not meet that criteria or who are in a nursing home and do not have that service available to them. So we are looking at whether the GPADS model could be expanded to accommodate some of that unmet demand.

MR HANSON: Who has got the contract? CALMS?

Ms Gallagher: Yes.

Mr O'Donoughue: It is between the Medicare Local and CALMS, Mr Hanson.

Ms Gallagher: Yes.

MR HANSON: What is the value of the contract? What is the cost of it?

Mr O'Donoughue: I do not have that detail.

Ms Gallagher: I cannot recall. It was part of that $12 million GP fund; it is a component of that. But we can certainly provide that to you. The evaluation, I see here, found that per GPADS consultation it was $358 per occasion, so it is relatively expensive, but five times lower than the cost of an ED presentation with an ambulance transfer, which is what we were trying to avoid, which is a cost of $1,500.

MR HANSON: Is that a rolling program now? That $12 million was—

Ms Gallagher: It was certainly funded recurrently, yes.

MR HANSON: It is?

Ms Gallagher: Yes.

MR HANSON: Okay.

Ms Gallagher: But mindful of the evaluation that was being done.

THE CHAIR: Any more supps? No? Mr Hanson, a substantive question.

MR HANSON: Thank you. On page 103 there are some statistics about mental health occasions of service. It indicates that, for children and youth services and for older persons services, we were not meeting targets, and that was mainly due to staff shortages. I would like to specifically ask about staff shortages within mental health and then probably expand into other areas where we are having trouble with staff, particularly specialists, and what we are doing about it.

Dr Brown: In mental health, certainly there were some staff shortages that were experienced that did impact on meeting targets. They were in child, youth and older persons, as you said. We have undertaken some recruitment, and my understanding is that that position has improved. I cannot say whether or not they are fully recruited at this point in time. I am getting a no. I know that, in addition to that, we had some four additional positions as part of the budget in the 2012-13 year that we have fully recruited to for mental health. But some of the challenges in the age group of the older and younger clients remain.

In terms of your question more broadly around recruitment, we do continue to experience shortages in some areas from time to time. This morning we have already talked about maternity services. In terms of nursing, overall we still have some shortages, but it is not a particularly large number. I am not sure if the Chief Nurse is able to actually give me a specific there. We of course had the intake of the graduate nurses in February. We actually were not able to fully subscribe the number of positions available; there were not sufficient nurses taking up all of the offers that we made. So there are ongoing challenges in nursing although they are less than they historically have been.

In medicine, this year we took in 95 interns, which is a substantial increase on the 72 that we had previously. And we have had some expansion of some of the other junior medical officer positions as well.

In the specialist area, we do have some areas of vacancy—for example, geriatricians. We have had trouble attracting a full complement of geriatricians. Haematology is another area where we have had some shortages and some difficulty in actually recruiting, despite our attempts. But there are other areas—for example, gastroenterology—where we have been able to successfully recruit. And, in fact, even in haematology, I understand we have got three starting—two in March and one in May, from memory. Is that right? Yes. It is an ongoing challenge, but overall I think we are doing well in most areas.

Ms Gallagher: In this annual reporting year, there were an additional 49 doctors, bringing the number to a total of 739 medical officers, which excludes VMOs. Some 188 nurses were employed in 2011-12, bringing the total to 2,579. And there were 43 extra allied health professionals, totalling 955, and another 22 health assistants last year. The pressure is on—it is—but we are able to recruit and grow the workforce at the same time. I have just had a note passed to me to say that the new graduate intake in February was 67 nurses and the number of graduates retained from 2012 was 63. That is excellent. We are retaining the graduate nurses.

MR HANSON: We had some discussion yesterday in care and protection that retention has improved, probably because of employment conditions. As unemployment is going up, there are fewer options in the federal public service, which is always an issue.

Ms Gallagher: A bonus for us, yes.

MR HANSON: Yes, so it is having a net bonus, ironically, for organisations within the ACT government. Are there any gaps in services, either through staff shortages or capacity issues, where people are being sent to Sydney? I remember that a couple of years ago there was a shortage of, I think, radiotherapists or radiologists; it meant that patients were going to Sydney to receive treatment. Have we resolved some of those issues?

Dr Brown: Certainly with the radiation therapists we were able to recruit additional. I think we had a small number of vacancies in more recent months, which, again, I think, we have recruited to. I am just trying to think, across the breadth of services, whether we have got any issues at the moment.

Ms Gallagher: I think there are some; there are always going to be some. I saw a brief about children in cardiology, for example.

Dr Brown: That is a separate issue. That is not a recruitment issue.

Ms Gallagher: No, but we are sending—

MR HANSON: I was specifically thinking of where there are—

Ms Gallagher: There are people sent to Sydney from time to time for various reasons.

MR HANSON: I understand the economies of scale where we in the ACT do not provide a particular service.

Ms Gallagher: Yes.

MR HANSON: But this is particularly where we do provide that service but, for one reason or another—and usually it seems to revolve around staff—we are not actually able to meet the demand.

Dr Brown: I cannot think of too many. We still have problems with the inpatient geriatric service, because we had a shortage of geriatricians. But the service has still

been delivered; we have just delivered it more in the community setting rather than in an inpatient setting. It is not as though we are without the service at all. Off the top of my head I cannot think of any specifics.

MR HANSON: In terms of graduates from the ANU Medical School, obviously there has been an increase in the number of interns, and that is great.

Dr Brown: A substantial increase.

MR HANSON: Yes. Is that sustainable? Is that something that we are going to be able to keep going? And how does that fit with foreign students? Are they going to be able to complete all of their studies? Is there now a guarantee for foreign students as well? I know that that was an issue for foreign graduates from the ANU.

Dr Brown: This has been an issue nationally. ACT took a particular policy decision last year; it will have to relook at that in the coming years. Professor Bowden is here as our principal medical adviser and executive director of medical services at TCH; he may be able to speak in more detail about the interns and the innovative work that we are doing in terms of how we are organising the interns.

Prof Bowden: There are about 100 ANU graduates each year; it varies between 90 and 101 or 102. This year there will be 99 graduates who we anticipate will graduate. Last year we retained 67 per cent, nearly 70 per cent, of the ANU graduates. That included the CSP group, which is the commonwealth supported group, and the nine full fee paying international students. All of those students were offered positions and all took that up. In addition, we have taken students or graduates from interstate; about 15 from New South Wales came to work with us. In addition, we took a small number of commonwealth government supported places; three of those took those places up and they have a return of service obligation. That is a very short—

MR HANSON: What are they for? They are for defence doctors, are they?

Prof Bowden: No, they were international full fee paying students. Last year there were about 3,500 graduates across the country—that will peak in another two years—which represents a doubling of the number of medical graduates since 2002. It has been a long time coming. We have seen this as an important issue.

We have accommodated the additional numbers. For example, we have doubled from 50 interns to 96 interns since 2008. The way we have dealt with that is by making some quite significant changes to rostering practices. I think everyone is aware that the hospitals have a bit of a funnel effect during the day: most people are employed during the day and then you drop down after hours sequentially so that there are fewer doctors available to provide care. We have changed the rosters to make sure that the cover after hours is better and tried to match the number of doctors against the clinical needs so that we push them a little bit later in the day so that we do not have everybody coming on at 8 o'clock.

We have also looked at clustering of the clinical units in a way that has not been done before. So the junior docs work across units more than they have. This is new, and people are adapting to it, but the feedback that we have had so far has been very

positive. We will be doing much more formal evaluation of that in the next few weeks.

MR HANSON: And you are confident that the supervision and training are not diminished as a result of doing it that way?

Prof Bowden: In fact, we believe that the opportunities for supervision and training increase. For example, we now have a consultant who is rounding on the weekend and will have the opportunity to have a junior doctor with them on the round. That is a great chance for both efficiencies, because you will be helping to discharge people a bit more quickly, and that junior doctor gets direct one-on-one teaching and training by rounding without the busyness of the week.

There are challenges, and I think that there are some senior doctor workplace arrangements that will evolve over time as we progress towards a 24 hours a day, seven days a week work rostering. But the opportunities for training within our system are good. I think that we just have to look for slightly innovative solutions, which is what we have done with the junior doctors, and so far it is going well.

MR HANSON: Turning to the long term, there was that increase when I think nine new medical schools across Australia led to a doubling in the number of graduate doctors, so we have gone from 50 to about 100. At the moment, I guess there is a bit of a shortage, so that is good. But the retention for doctors, I imagine, is pretty high. Has anyone done the long-term projections to say, "If you keep that going, do we reach a point where we have got too many doctors?" Or does the need for growth counter that?

Prof Bowden: Health Workforce Australia have done a lot of modelling on this. The belief is that by 2025 we will be close to having a self-sustaining Australian health workforce—not completely, as there will still be some areas where there is a need for international people, but the current modelling suggests that we will be about right by 2025.

MR HANSON: So the numbers are about right. What about narrowing down into the ACT?

Dr Brown: That is for medical.

Ms Gallagher: That is for medical, yes.

Prof Bowden: That is for medical. That is just for the medical graduates.

Ms Gallagher: Yes.

MR HANSON: Yes, narrowing down to the ACT; that is about right? Do you see that 100 being maintained or do you think that is going to trim down again?

Prof Bowden: There are a couple of things. It is a great thing to have locally trained doctors working within our hospital system, but we do not see that that is the only destination. We have to make sure that we train them in a way that allows them to

move anywhere in the country. We have to produce a doctor who is sellable anywhere, any place in Australia or overseas. So we are working very hard to do that. As they move into what we call the vocational training programs—their specialty training—we see that they are well placed to do that. In some areas, they will have to go interstate. We can do physician training in the main completely within the ACT. But we do not want that. We want people to go elsewhere and then to come back and bring back the skills and experience that they have from elsewhere.

Our idea is that we do not train 100 people and expect them to then move up in a simple cohort forever and that is the only doctors that we have. However, we are doing some modelling of the junior workforce at a more senior level—so registrar, advanced trainee level—to see what the needs over the next five to six years will be. For some specialties, we have got a clear need for local people to come and move into those, because at the moment we import a lot of people from interstate. That will change in some areas, but a lot of pressure will be brought to bear in other areas where we are already quite well stocked, if I can use that term, with local people.

MR HANSON: In terms of GP training, have we got enough places and are enough people going into GP training to resolve some of the shortages there?

Prof Bowden: GP training has seen a major turnaround in the last few years. In fact, we would have to see it as a great success. In respect of the local demand for training positions, at a junior level for first and second years post-graduation and at a registrar level we are now at the point where we are starting to choose. Instead of actively encouraging people to consider general practice, it is now at a point that there might be more applicants for the positions that are available.

MR HANSON: Is the number of positions adequate? It was increased by five recently, was it not? Is that adequate to meet the growth projections? Do we need more?

Prof Bowden: I am afraid I cannot answer that. I am not across those growth projections. But what I can say is that there is enormous pressure on training. As you can imagine, if you are training in general practice, you do not have the same ability to spread the training and supervision requirements across a number of people. So it is very intensive for those practices. We have a number of people who nurture and sustain that workforce. We have been very successful, for example, in maintaining the positions in the ACT because of the success of our programs relative to other places in Australia where they have had those positions taken away from them.

THE CHAIR: Minister, on page 189 of the annual report reference is made to Still Ticking, the men's dementia group, and the Belconnen Aged Day Care Centre remaining within the Health Directorate's aged day care program and operating from the Belconnen Health Centre. The report seems to imply that these could be outsourced to non-government groups, as has happened in Tuggeranong. Is that the plan?

Dr Brown: Sorry, can you repeat the question?

THE CHAIR: Of course. I might have the wrong page number there.

Ms Gallagher: Yes, I think so. My page 189 is blank. I might have the trick one. But it is about the aged day care service.

THE CHAIR: It is the men's dementia group, Still Ticking, and the Belconnen Aged Day Care Centre. They are within the directorate's aged day care program. They operate out of Belconnen Health Centre. The report seems to imply that they may be outsourced. Is that going to happen?

Dr Brown: I can give the background to this. We did have a service in Tuggeranong that was operated from within ACT Health. When we were looking to make the changes in preparation for the refurbishment of Tuggeranong health centre, that was one of the services that we did make a change to. It was actually outsourced after a process of extensive consultation. But a decision was taken at that time not to do the same with Belconnen, where there is a similar service operating. So we operate the service at Belconnen. We do not operate the service at Tuggeranong.

THE CHAIR: What sort of consultation was undertaken during the outsourcing proposal?

Dr Brown: Look, I can probably—

Ms Gallagher: A lot.

Dr Brown: There was a lot. Yes, I am just looking to see whether Linda Kohlhagen is here. She will be able to tell you in some detail the extent of that consultation.

Ms Kohlhagen: We employed an external consultant who helped to undertake the consultation. We met with a range of service providers, but more importantly we also met with the participants of the aged day care program and their carers. We also had a comprehensive consultation program with staff concurrently.

I add a comment in respect of Belconnen. It had initially been suggested or thought that the Belconnen aged day care program might go into the new health facility. It is actually staying in the current one. It is staying in its current location. It will not actually be moving into the new facility either.

THE CHAIR: What is going to happen with the existing Belconnen Health Centre when the new one is up and running?

Ms Gallagher: There have not been any decisions taken on that. We have not as part of the move to the new building and selling off the old one—it is obviously on prime land there in Belconnen. I think we have to consider its future. But no decision has been taken on it.

THE CHAIR: So there will still be some services operating from that site?

Ms Gallagher: There may be for some time. Obviously, the economic development side of government is going to need to consider what to do with that. There are different pieces of work going on around that area of Belconnen. So there is no

immediate need to shift people who are not going to the other one. But it comes to this issue that we have touched on: what role does the public health system have when there are other providers, and at times more expert services, and our dollars are stretched or our workforce is stretched?

They were some of the issues that we looked at with Tuggeranong. Was this the core responsibility of the public health system, to provide a day care service for elderly people, or was it more appropriately provided by the aged-care sector? It is the same level of service. I understand the important social reasons behind having a service like that, but should Health be the one delivering it? I think that is probably still an open question.

Ms Kohlhagen: There was a very good transition from our service to the new providers. It happened in January. We had a lot of our staff who continued to work. The first week when the clients went to the new provider, our staff also were there with them as well so that there was an easing transition. We certainly have not had complaints since it has occurred.

The feedback was that the new facility was very good. We worked with their transport providers so that there was also no additional impost or changing impost around their transport arrangements. So it is hopefully as seamless as possible. We had regular updates with people throughout the journey as well so that they knew what was going on and who they could contact if there were any concerns or issues about where things were up to.

THE CHAIR: If there are no supplementaries, Ms Berry has another substantive question.

MS BERRY: Minister, could you provide details of the alcohol and drug services early intervention pilot program and the factors of its success in the ACT? Page 161 is the relevant page.

Dr Brown: This initiative was commonwealth funded. Just to introduce it while Ms Bracher is getting settled, this was a program that was initiated through commonwealth funding. It is part of the national binge drinking strategy. It commenced in July 2010 as a three-year pilot program. The program was part of a national program, as I said. It has been evaluated in the ACT. The ACT program has been deemed to have been a success. I do not think the same has been said necessarily for the entirety of the national program. It is focused on young people less than 18 years of age who have been caught intoxicated with either alcohol or other substances. Ms Bracher might have more details that she wishes to provide.

Ms Bracher: That is a fairly good summary, actually. We have been running this program in conjunction with the police for three years. It was an extension of a program that we had sort of started to grow with the police prior to three years ago because of community need. The young people are diverted out of the court system into our alcohol and drug counselling service. They are obliged to attend with their family. If the family does not attend, they are not diverted out of the court system. It is a family service.

It is a one-off counselling service. The data that I have seen, which will be published I believe in the evaluation report, is that something like 80 per cent of those families who attend those services have not had in that period of evaluation another contact with policing for binge drinking. That is data for the ACT. That has not been replicated in other jurisdictions. We have a very close relationship with the courts, with the police, and with our alcohol and drug service.

MS BERRY: Did you say there was an evaluation report?

Ms Bracher: There has been an external evaluation report undertaken as part of that commonwealth funding. That is why Ross and I were arm wrestling to come up to the table. Ross's area has been—we did not evaluate it. It was done separate from our service delivery area to keep the separation of service delivery from the evaluation. That report is being finalised currently and will come through to the minister for her consideration in time.

MS BERRY: Why do you think there has been so much success in the ACT for this program?

Ms Bracher: I think it is the very close relationship with Policing, not only in the youth domain but across all ages. We have our community mental health policing initiative. We have a very active relationship with the police. We are close by the police. We have close relationships with the senior management of ACT Policing to work very closely in respect of the community need.

Our counselling service is very well skilled. We have social workers, psychologists and nurses that have done post-graduate counselling. We have a very skilled team that actually do this work with young people and families. There are other factors that are highlighted in the evaluation report. For example, there are some children or some young people that it has not been successful for. The social demographic of those families plays a part in either the success or the lack of success of diverting children or young people out of the court system for binge drinking.

MS BERRY: Did you say 80 per cent?

Ms Bracher: Yes, and I would have to check the data in the evaluation report, but the data I recall is that somewhere in the order of 80 to 90 per cent of the people that we see through the alcohol and drug youth diversion service have not had a repeat interaction with the police and, therefore, with us.

Dr Brown: Mr Chair, could I read a response to a question on notice? In relation to GPADS, the expected expenditure for the 2012-13 year is $572,625. If I could just correct Mr O'Donoughue, I think he said that 41 patients had been seen in February. It was, in fact, 46. The Medicare Local are the primary organisation with whom we hold the contract, but they do work closely with CALMS.

THE CHAIR: Before I adjourn, I would like to remind members that the committee has resolved that supplementary questions are to be lodged with the Committee Office within four business days of receipt of the proof transcript of this hearing. The committee asks that the ministers respond within 10 working days of the receipt of

those questions. Answers to questions taken on notice are to be provided five days after the hearing at which they were taken, with day one being the first business day after the question was taken. The committee's hearing for today is adjourned. The committee's next public hearing on annual reports is on Friday, 22 March 2013 from 1.30 pm with the Minister for Disability, Children and Young People.

The committee adjourned at 1.00 pm.