LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING, COMMUNITY AND SOCIAL SERVICES

(Reference: Annual and financial reports 2012-2013)

Members:

DR C BOURKE (Chair)
MR A WALL (Deputy Chair)
MS Y BERRY
MS N LAWDER

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 5 DECEMBER 2013

Secretary to the committee:
Mr T Rowe (Ph: 620 50129)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

Privilege statement

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Amended 20 May 2013

The committee met at 9.32 am.

Appearances:

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

Health Directorate
- Brown, Dr Peggy, Director-General
- Trickett, Ms Elizabeth, Executive Director, Quality and Safety Branch
- Kennedy, Mrs Rosemary, Executive Director, Business and Infrastructure
- Thompson, Mr Ian, Deputy Director-General, Canberra Hospital and Health Services
- Hall, Dr Michael, Clinical Director, Emergency Department, Canberra Hospital and Health Services
- George, Ms Jacinta, Acting Executive Director, Service and Capital Planning
- Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
- Kelly, Dr Paul, Chief Health Officer, Population Health Division
- Woollard, Mr John, Director, Health Protection Service
- Lamb, Ms Denise, Executive Director, Capital Region Cancer Service
- Bowden, Professor Frank, Chief Medical Administrator, Canberra Hospital and Health Services
- Kohlhagen, Ms Linda, Executive Director, Rehabilitation, Aged and Community Care
- Chatham, Ms Elizabeth, Executive Director, Women, Youth and Children
- Greenfield, Ms Joanne, Director, Health Improvement Branch

THE CHAIR: Good morning everyone, and welcome to this public hearing of the Standing Committee on Health, Ageing, Community and Social Services for its inquiry into annual and financial reports 2012-13. On behalf of the committee, I would like to thank you, Chief Minister, for appearing today in your capacity as the Minister for Health, and Health Directorate officials for attending this meeting.

This morning the committee will be examining the following areas: acute service, output 1.1; mental health, justice health and alcohol and drug services, output 1.2; public health services, output 1.3; cancer services, output 1.4; rehabilitation, aged and community care, output 1.5; and early intervention and prevention, output 1.6. We will conclude at 1.30 pm.

Can I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement that is before you on the table, the pink card. Minister, could you and your officials confirm for the record that you all understand the privilege implications of the statement?

Ms Gallagher: Yes.

THE CHAIR: Thank you. I remind witnesses that the proceedings are being recorded by Hansard for transcription purposes and webstreamed and broadcast live. Minister, before we proceed to questions from the committee, would you care to make an

opening statement?

Ms Gallagher: Thank you, chair, yes, I will make a few opening remarks. I start by thanking the committee for inviting us here today. As you can see, we probably have everyone we need here to answer your questions.

Overall, the ACT health system continues to provide very high quality and effective care for the people of the ACT and, indeed, the surrounding region. Our health services have had yet another busy year in the financial year 2012-13, and this is continuing into this financial year. We had, in the financial year covered by this report, approximately 6½ thousand people working across the ACT public health services to deliver direct care to patients or to support those providing that care. These staff provided care for over 100,000 people who were admitted to the hospital, 120,000 people who attended emergency departments, 350,000 outpatient occasions of service and hundreds of thousands of community-based services.

Across the community our population is the healthiest in the nation, which is very good, with ACT residents having the highest life expectancy of any Australian jurisdiction.

In terms of specific areas within the directorate, last financial year we exceeded our target for the number of people removed from the elective surgery waiting list. It was the highest on record for the ACT and continues to reduce the amount of patients waiting longer than clinically recommended time frames.

In the emergency department, both our emergency departments continue to progress towards the NEAT target, and I am sure we can discuss that at length during the hearing.

In cancer services, the treatment services are meeting all of their major categories—urgent, semi-urgent and non-urgent. In terms of other areas we have the aged-care assessment team, which shows that we are meeting the national response time for in-hospital assessments. Our mental health services continue to lead the country, certainly against the rates of seclusion, or the very low rates of seclusion. This has been something that we have maintained over a couple of years now.

We also achieved the target of less than 10 per cent of mental health clients returning to hospital within 28 days of discharge from an ACT public mental health unit, which is very positive. We exceeded the national average for our participation rate in the cervical screening program. BreastScreen ACT has a number of initiatives underway to raise awareness of its screening service, particularly within the target group—women aged 50 to 69.

In relation to dental care, the ACT had the lowest jurisdictional rate for the mean number of teeth with dental decay, missing or filled teeth amongst children aged between six and 12. That shows the effectiveness and the quality of our public dental program and the focus on prevention, early intervention and treatment. We also met our target percentage for the number of dental emergency clients seen within 24 hours.

The ACT has also continued to see a decline in the rate of 12 to 17-year-olds who

smoke regularly, which is a result which is significantly lower than the national rate. Again I am sure all committee members would agree that is a very positive outcome.

This year the ACT Health workforce plan has been finalised and the ACT Health Aboriginal workforce action plan implemented Health Workforce Australia initiatives to support national health workforce reform.

An evaluation report confirmed that the walk-in centre model for the treatment of people with minor illness or injuries is a safe and effective means of providing primary healthcare services, whilst highlighting that it did improve access to free extended hours primary healthcare services.

In 2012-13 we opened stage 1 of the new Centenary Hospital for Women and Children, and I am sure we can discuss the health infrastructure program during the committee hearing. The Gungahlin Community Health Centre was also opened during this reporting period.

The radiation oncology department commenced operation with a fourth linear accelerator, which has assisted in light of increased demand for radiotherapy treatment services. We have improved our prosthetics and orthotics service by implementing a triage clinic to better manage the needs of clients, resulting in a significant fall in the non-urgent waiting time.

In addition, the Australian Council on Healthcare Standards assessed ACT Health across the board for re-accreditation, and the ACT health system did very well, with 28 marked achievements, 18 extensive achievements and one outstanding achievement, with full accreditation provided.

Those are some of the areas of health in a nutshell. For me, it has been another privileged year of working with some exceptional people who are very dedicated to delivering high quality health care to the people of the ACT, and I look forward to continuing in that role into the future.

THE CHAIR: Thank you, Chief Minister. I might kick off with a question. Of course, the community appreciation or patient appreciation of our health services is particularly important. I noticed today that the ACT healthcare patient satisfaction survey has been released. What do the results of that survey show?

Ms Gallagher: This is a six-monthly survey that is done. I think in this sample it was just under 4,000 respondents—measuring, really, all aspects of their care across the health system. It is used and watched pretty closely. Overall there were very positive results. We are seeing increased improvement in the level of people who are satisfied or very satisfied with the care that was provided, which is probably the key thing you want to keep your eye on. There are other areas relating to staff quality which, again, was responded to very positively by the patient feedback around how patients are treated in relation to the respect and dignity of the treatment provided. It also identifies areas where you have to continue to improve. That is what the survey is for, really—to focus on those areas which emerge for more focus.

Some of them are not easy to respond to—things like making sure that the hospital is

a restful place. That is genuinely difficult, particularly in the older parts of the hospital. I think it is easier in some of the newer areas where single rooms have been provided, but in a ward environment I think that is genuinely difficult to address. Issues like parking come up and issues like personal security—having your own belongings stored somewhere so that you feel they are safe, and those kinds of issues. Dr Brown can continue, but it does feed back into how we look at our services and look at how we can respond and change.

Dr Brown: I might add to that in terms of the areas that the minister highlighted as areas for particular focus on improvement. For example, with the restfulness of the hospital, it is challenging because hospitals are 24/7 operations, although we do try to make the environment quiet at night. We have, however, taken on board that feedback. We are undertaking a research project in relation to noise levels at night and how we can look to implement and change those.

In terms of some of the issues that were raised around how we best ensure that we are appropriately involving consumers and their families in the planning of their care, with things like appropriately providing for storage, we have appointed a patient experience leader to work across the hospital and put a focus on the experience of our patients and consumers within the whole hospital. That is a somewhat unique appointment across hospitals of our size, but I think it is a very positive change in terms of the system focus on patient and family-centred care. Of course, things like the new health infrastructure program and the new buildings that we are providing do help in terms of looking at noise levels, storage facilities et cetera.

Food is always one of those issues that comes up. We have done a lot of work around our meals system. We have a new MyMeal system that is now able to ensure that patients can order the meals that they want, that they are delivered on time and that we are constantly monitoring things like the temperature of the food and that sort of thing. So there is a lot of focus on that area as well.

THE CHAIR: With those 4,000 respondents, how did you choose them or how did they respond? What was the means of their selection?

Dr Brown: The methodology? I would have to ask Ms Trickett, the executive director of the quality and safety unit, for the details of the methodology, but we do employ an independent company to undertake these surveys for us. I think they are primarily mission and postal?

Ms Trickett: Yes, that is right. UltraFeedback was the group that was employed by ACT Health to run the patient satisfaction surveys. Over a six-month period in the second half of last year is the report that we are mentioning today. It is for patients who have been discharged from hospital after at least a month. It is sent to a wide range of patients. We get a response rate of about 30 per cent, which is pretty normal for most surveys, and we take all of those reports into consideration. It really is a random selection of patients. So we get a good cross-section of patients rather than it being all paediatrics or all aged care et cetera.

THE CHAIR: So these are people who have actually been in hospital for a month?

Ms Trickett: They have been discharged for more than a month.

THE CHAIR: Okay.

Ms Trickett: They have been in hospital maybe only for a short time.

THE CHAIR: You talked about noise levels at night. How do you manage that in the older parts of the hospital? Is that something where you are looking at interior design or architecture, or are there other solutions available?

Dr Brown: We might just ask Rosemary Kennedy, who is the executive director for business and infrastructure and I think is looking at that work around the project at night. Some of it relates to just how we do business at night in terms of nursing staff, where they actually work, and being mindful of noise and anyone who is coming into and out of the actual ward space close to the sleeping areas. Rosemary, are you able to say more?

Mrs Kennedy: There is a project looking at how we can reduce noise levels in the hospital, particularly in relation to TVs and people entering and exiting the ward space, being mindful that people are trying to sleep—also, closing doors so that the noise does not travel as significantly and, where possible, everybody being mindful that people do really need to get their sleep when they are in hospital. So it is looking at as many options as possible to reduce that noise. Obviously where people have single rooms or there are two people in a room, the noise is less disruptive than where there are, perhaps, four in a room.

THE CHAIR: Thank you.

Dr Brown: Just to add to that, one of the things that does help is actually raising the awareness level, so measuring noise levels and being able to feed back to staff around that. That is one of the things that can assist in keeping it at the front of mind for staff when they are working in the evening. So we are looking at ways in which we can do that more routinely as well.

THE CHAIR: Of course, that also centres around perception; your perception of noise when you are working is a lot different from your perception if you are trying to go to sleep.

Dr Brown: That is right.

THE CHAIR: Members, any supplementaries?

MR HANSON: I have one, Mr Chair.

THE CHAIR: Mr Hanson.

MR HANSON: Thank you very much. The independent company that conducted this survey was?

Ms Trickett: UltraFeedback.

MR HANSON: Is that the same group that conducted the staff culture surveys?

Dr Brown: No. The company that does the culture surveys is Best Practice Australia and New Zealand.

MR HANSON: Why is it that if the results of this patient survey can be released, you are withholding the results of the staff culture survey?

Dr Brown: I would say that we have not actually withheld the results of the culture survey. What we have withheld is the full report. That is because we signed a contract with Best Practice Australia and New Zealand which requires us to maintain their intellectual property. It is commercial in confidence because of the methodology they use, and they want to protect that. But we are quite happy to provide the actual results, as we provide the actual results of this.

MR HANSON: Do you have the full results of the latest staff culture survey, and when was that conducted?

Dr Brown: The last one was 2012. I think we have presented those results in a range of ways. Certainly I present them every month at the orientation of new staff, and I think we presented information here previously.

MR HANSON: We have had problems getting it before.

Dr Brown: That is because we have signed a contract with Best Practice Australia and New Zealand not to release the whole thing.

MR HANSON: Are you going to continue working with them, which essentially keeps some information privileged, or are you looking at other contractors that would be able to provide a more comprehensive view of the staff culture?

Dr Brown: I would doubt that any of the commercial providers in this space would be willing to put their intellectual property completely out there for the market to see. Our intention is to conduct another survey in 2015. We have not selected the provider yet, but it is likely that we will look favourably towards Best Practice Australia and New Zealand, simply because of the continuity it gives us.

MR HANSON: Can you point me to where those results from the 2012 survey can be found?

Ms Gallagher: There was a report provided.

Dr Brown: Yes, but I am very happy to provide you with the summary report.

Ms Gallagher: It is an overview report. It is not going to give you everything you want, which is what you have been after, I think, for the last couple of them. But you can certainly have the information that has been presented to staff in general.

Dr Brown: I can give you a summary now in terms of the level of engagement. We

currently sit at the level where 36 per cent of staff feel engaged, 46 per cent are swinging voters and the remainder, which I think is probably 18 per cent or something like that, are disengaged. They have significantly reduced the disengaged and increased the engaged. We compare very favourably to the benchmark for public sector government health care, where engagement sits usually at about 28 per cent average. Our quality of employee working life has improved over each successive survey, and 61 of the attributes that they mentioned were seen by staff to have improved.

MR HANSON: Is that report broken down into specific areas within health?

Dr Brown: They have six different ways they describe culture. At the lower end they call it blame plus or blame. At the higher end they talk about a culture of ambition and success. Across our hospital, we break it down into work units. I can provide you with a graph that shows the distribution across the work units—

MR HANSON: So it breaks it down by work units?

Dr Brown: Yes. I can also show you the comparison for public sector government health care. In terms of the distribution across our organisation we compare very favourably to public sector government health care, which is predominantly in lower end cultures. We have a much more normal distribution across the different types of culture. That clearly says we have got some work to do in some areas, and we do not deny that. We have never denied that there is work to do. But when you look at it in context, it is a positive result.

THE CHAIR: Ms Berry, a question?

MS BERRY: Thank you, chair. The national emergency access targets, it seems to me, are a very flat way of measuring the success of a flow-through department like emergency. Is there any data available about where the blockages occur that prevent patients who would otherwise have left emergency and are taking up bed space?

Dr Brown: Sorry, would you mind just repeating the question? Is there any—

MS BERRY: Is there any data available about where blockages occur?

Ms Gallagher: So it is really about patient flow through the hospital?

MS BERRY: Yes.

Mr Thompson: We have mapped this in a lot of detail. I have got a particular project underway that is specifically looking at this issue, by the name of project Venturi, which relates to physics and air flow. I can explain it further if people are interested, but I suspect it is not at the top of people's minds.

Ms Gallagher: It is certainly a niche area.

Mr Thompson: Yes. I will summarise the main issues. There is no question that what we have at the moment is a significant issue around barriers to discharge and that the

availability of nursing home places is a significant contributor to that. As a historical average, we probably have about 10 patients within the hospital waiting for nursing home placement. At the moment it tends to be sitting more around the 25 to 30 mark. If you think about that in the context of a hospital, that is effectively operating with 15 to 20 fewer beds than we would normally have. So there is that issue. And there are other aspects associated with discharge which contribute to the difficulties through flow.

We also have internal working processes around how quickly patients are reviewed and accepted by the inpatient teams. Again, we have got data on that that can highlight areas of focus. There is a lot of work underway that we are currently looking at in that regard as well.

Probably the other broad issue that is worth focusing on is the investment in additional bed stock. Currently we have a program to bring on further beds, and refurbishment is happening at the moment in the tower block at the hospital. Once those refurbishments are completed, we will have additional beds, which will also assist us to move patients more rapidly through the emergency department.

MS BERRY: Does the data pinpoint whether people are moving to other branches of acute care or to external?

Mr Thompson: Yes, it does. We have broken it down and have a very clear picture as to different parts of the hospital and the success or otherwise. I am happy to provide some examples, if you are interested, on where the difficulties arise more and most frequently, if that is what you are interested in?

MS BERRY: Yes.

Mr Thompson: For example, if you think about it, probably the group of patients that take longest in the emergency department are older people. This is where I am talking about our internal processes. It is not meant to be a negative or dismissive comment, but for an older person with complex health conditions, it can take a longer time to understand exactly what is going on and work out what the treatment plan is and, therefore, which part of the hospital is most appropriate to refer them to. So areas like older people tend to have longer lengths of stay.

The areas where we are getting very good improvements are in areas like chest pain. We established a chest pain evaluation unit earlier this year, and that has seen a significant improvement in the speed with which people with chest pain leave the emergency department to be admitted to the chest pain evaluation unit for further testing and evaluation of their conditions to assess what the appropriate care is.

MS BERRY: At the entry point for the emergency department, how will the expansions to the emergency department affect access targets?

Mr Thompson: We have recently opened up an expanded section of the emergency department. That coincided with the introduction of a new model of care within the emergency department, streaming people into more and less acute streams. It is early days, but we are starting to see improvements in both timeliness and the national

emergency access target performance arising from that. It is worth emphasising that those improvements have been in the context of what is very clearly the busiest period that we have ever had in the emergency department. To put that into context, it was a couple of years ago that 200 presentations a day was a very busy day for the emergency department. We have just had a four-week block where the average number of presentations a day was 200. It has changed incredibly rapidly, but even in that context, particularly with the work the emergency department has done on this new model of care and utilising the additional space, we are still seeing steady improvement in timeliness and performance.

MS BERRY: I am just relating to the staff in the emergency department. I had a chat with a few of them a couple of weeks ago, and I was surprised at the longevity of the people who work there. I wondered what the reason could be, in a particularly challenging work environment like the emergency department.

Ms Gallagher: Adrenalin junkies.

Mr Thompson: I cannot comment in detail; Dr Hall, who is the director of the emergency department, is probably better able to answer that question than I am.

Ms Gallagher: I did not know you were here, Michael. I would never have said that.

Dr Hall: Thanks for the question. The emergency department is an area of high flux. If you looked at our staffing profile, you would see that we have a large portion of long-term staff; we also have a large portion of very new staff. In both the medical and nursing workforce we take very junior people, because it is a good environment for learning and training. Some of them will stay; others will move on to other areas, because the skills that we provide and teach are also valuable in other parts of the hospital.

I note the culture survey that Dr Brown mentioned before. Our emergency department has consistently ranked basically right at the top of the potential models for culture survey over both of the last two surveys. In fact, in the survey before last we recorded the record ever figure for satisfaction ratings for an emergency department in a public hospital in Australia. So despite the perceptions, I suppose, that are sometimes given, the staff do enjoy their job. They like caring for patients, and although they work in a stressful environment, we try to make it as sustainable for them as we possibly can.

MS BERRY: You have just mentioned moving the staff to other areas in the hospital.

Dr Hall: Yes.

MS BERRY: In the conversations that I had with some of those staff, they had moved out and then come back to the emergency department.

Dr Hall: Yes, that is quite common. Because emergency is a very generalist area, our staff have the skills to perhaps move to any other part. Often they will go off for particular projects. If you look in our hospital at, for example, organ donation, the medical response teams or even around some other projects within the hospital, most of those staff, or a large proportion of them, have been long-term members of the

emergency medicine workforce. Some of them like those roles. Others find themselves missing the clinical contact that emergency is full of and, as such, will come back.

There is something of a rotating door. We always have the perception when someone leaves emergency, either medical or nursing, that they will generally be back at some stage. We do have some advantage. We are a much more flexible space than others. So for nursing and medical staff that want to work part time or that want to work unusual shifts, because of the large numbers of people we have we can often accommodate that much better than the ward environments can.

MR WALL: I have a supplementary on that matter. You mentioned that there is a mixture of long-term permanent staff and newer staff.

Dr Hall: Yes.

MR WALL: What sort of reliance does the ED particularly have on temporary or agency staff?

Dr Hall: From a medical point of view, essentially zero. We do not use agency staff. If I look back over the last 12 months, we have used one agency staff member and it was essentially to cover long-term sick leave, a very specific position. From a nursing point of view, I cannot give the exact figure. It is very low. Because it is a highly specialised area, our agency workforce is tiny. We tend to use the hospital casual pool or ex-emergency department staff members to fill vacancies we have through sick leave, because for agency staff members to work in emergency, it is a very difficult role for them to walk into.

THE CHAIR: Could you tell me what progress has been made on the development of the paediatrics stream in the emergency department?

MR HANSON: I have some supplementaries on the NEAT data before we go to that, if that is all right?

THE CHAIR: We are talking about the emergency department and it is a supplementary.

MR HANSON: The question was specifically about the NEAT data, as I understand it.

THE CHAIR: Thank you. I will chair.

Ms Gallagher: We are going to stay in the ED for a while, so—

MR HANSON: We are staying in the ED for a while?

Ms Gallagher: I imagine.

MR HANSON: So what is your ruling on that? I mean—

THE CHAIR: I just ruled, Mr Hanson.

MR HANSON: It is a case of—

THE CHAIR: Mr Hanson! Mr Hanson, you are a visitor. Please show some respect for the chair and come to order.

MR HANSON: I will show respect for the chair.

THE CHAIR: I am asking you to come to order.

Ms Gallagher: In relation to the paediatrics emergency department?

THE CHAIR: Yes, the paediatrics stream.

Mr Thompson: It is still in the—

MR HANSON: That is a no, is it?

THE CHAIR: Order for a moment.

Mr Thompson: Sorry.

THE CHAIR: That is a warning, Mr Hanson.

Mr Thompson: The paediatric emergency department is in its planning stage with the view that the plans will be completed later this month and then proceed to development application. There has been quite an extensive consultation process involving the staff who work in the emergency department looking at different options and arrangements. It looks like we have settled on the preferred option. It is now with the architects to put the final touches to a plan that we can then submit for development application.

THE CHAIR: Thank you very much. I think you had a supplementary, Mr Hanson.

MR HANSON: Yes, thanks very much. On the NEAT data, what is the target—64 per cent Canberra-wide, is it?

Ms Gallagher: Yes.

MR HANSON: And where are we at in terms of that one? Do you break that down between Calvary and TCH?

Dr Brown: Across the agencies for the 2013 year ending October, from memory, we were at 58 per cent across the ACT.

MR HANSON: Across the ACT.

Dr Brown: There is a differential between Calvary and TCH, I think. Someone might have the figures to hand. Yes, for Canberra Hospital at the end of September it was

50 per cent and Calvary was at 64 per cent. Sorry, that was 2012-13. That is not the latest. Someone is going to bring it to me, but Calvary was at 65 per cent.

Ms Gallagher: It is because it is done quarterly.

Dr Brown: The reason that there is a differential between—yes, overall, Canberra Hospital was at 53 per cent and Calvary was at 65 per cent at the end of October. The reason that there is a differential between Calvary and TCH probably relates to two main factors. Dr Hall may wish to add to this. One is that Canberra Hospital, as the major tertiary referral hospital, gets a lot more complex cases coming in. They have a larger number of people who are actually admitted for care. Of course, for the people who are admitted for care, generally speaking, we actually achieve lower results overall than the non-admitted ones.

Having said that, in term of comparisons to other hospitals, for admitted patients we actually perform very well. But that is the reason for the differential between the two.

MR HANSON: Sure. Are the funding targets attached to meeting the 64 per cent?

Ms Gallagher: The reward payments are attached, but there is agreement that they can be rolled over to the ultimate target of 90 per cent in 2015. So we are not going to get them this calendar year, but we will not lose them.

MR HANSON: But if we have to get to 90 per cent by 2015, I imagine that we are not going to get there. What are the reward payments?

Dr Brown: The reward payment for last year was in the order of $800,000. I think it is a similar figure—

MR HANSON: So it is rolled over.

Dr Brown: It is rolled over. Can I correct something? The target for this calendar year, 2013, is 65 per cent. It was 64 per cent in 2012.

MR HANSON: Right.

Dr Brown: In terms of the 90 per cent target, this is subject to quite a lot of discussion nationally. Western Australia, as the jurisdiction that started this ahead of the national reform process, and which has performed the best to date, has achieved figures in the sort of high 70s, low 80s. In fact, more recently they have seen a slight decline in some of their performance. Queensland has had a fairly significant increase in the last 12 months but likewise only in that sort of ballpark—

MR HANSON: So do you think that 90 is unrealistic?

Dr Brown: There is a lot of discussion about whether or not 90 is a realistic figure and, in fact, whether to achieve that you would be putting a lot of additional funding and a lot of additional focus on one specific area to the exclusion of other areas that probably deserve some attention as well.

MR HANSON: This might be a bit of a difficult question to answer. I do not know. But what do you think then is a realistic target that we might achieve by 2015? So we are not going to get to 90 per cent, bearing in mind that we do not want to put all our eggs in one basket. What do you think is a more realistic measure of what we should be aiming for?

Dr Brown: I will perhaps say from a national perspective that I do not think we can pre-empt what might come out of discussions. But I think the sense amongst my counterparts is that something in the order of 75 per cent to 80 per cent is probably a more realistic target for the nation. Dr Hall might speak to Canberra.

Dr Hall: I will add very briefly to the question about the difference between the two hospitals. There is probably another factor, which is that Canberra Hospital is seeing unprecedented growth through the emergency department. Calvary hospital's numbers have been, in fact, decreasing slightly year on year for the last couple of years whereas Canberra Hospital is seeing about six to seven per cent growth annually. Although the annual growth rate for ACT Health appears to be about 3½ per cent, it is essentially double that at the Canberra Hospital campus. So keeping up to targets becomes something of a challenge.

The other factor is, as was pointed out, the different type of hospital. If you look at patients that come to emergency and go home and come to emergency and get admitted, the hospitals are, in fact, very similar in performance. But because Calvary has such a higher proportion of patients that get discharged, that is where those numbers sit higher.

In response to your question overall, that is a giant discussion that goes around the country. No-one has the right answer. But when you go to hospitals that have got their NEAT performance in that sort of 75 to 80 range, they all essentially describe that they fixed the emergency department. The people that work in the emergency department and the people that flow through say that the department is now a pleasant place to work. They believe that they provide excellent patient care and they believe that they have the balance of moving people through quickly but at times with certain complex patients or difficult patients, they spend that extra time that is required.

It is important to note that in the UK, they have brought their targets back slightly. But it is a very different environment. So we cannot compare with United Kingdom practice in terms of four-hour rules and four-hour targets. The other problem with very high targets is that it promotes solutions designed to fix the target—solutions and plans designed to accommodate what can we do to get the patient seen quicker, rather than what are we doing to get the patient seen better? We need to be trying to do both of those—get them seen quicker, but have them having better patient care.

MR HANSON: We visited Calvary on Monday.

Dr Hall: Yes.

MR HANSON: I went with Mrs Jones. We saw some of the work that they are doing around the NEAT targets—reducing the number of steps, essentially—so that they can get better patient flow and get admissions better when MAPU comes online. It

will help with that.

Dr Hall: Yes.

MR HANSON: Have you sat down with them and looked at what they have done in terms of other similar things you can do at the TCH, trying to do something similar?

Dr Hall: Yes, to a certain extent they sat down with us and worked out what we do in that our figures for patients coming into hospital are better than theirs. So the MAPU has essentially been borrowed from our model of what is called the medical short-stay unit at the Canberra Hospital. Yes, we do meet together regularly in terms of how we plan those processes. Again, it is important to note that it is a different hospital. Calvary has a very generalist focus. Canberra Hospital is a subspecialty-driven hospital; so that creates challenges in ownership and management of the patients from that point of view.

But nationally, this is not something that hospitals hide secretly. This is a very open space. There are many different models around the country. Everybody is publishing this. Everybody is sharing this. No-one has the single magic answer. We are all looking at what we can do to improve. Your comment about simplification is absolutely correct. The traditional admission processes in hospitals are incredibly complicated. The simple concept that if you cannot go home, you need to come in is not a concept that hospitals seem to understand sometimes.

But, in fact, in the simplest terms, in an emergency department if somebody cannot go home, they need to come into hospital. But hospitals at times have been dependent on a diagnosis, a team and a plan. We are trying to bring it back to those simple minds that say, "If I can't send you home from the emergency department, or my team can't send you home, you need to be admitted."

THE CHAIR: Minister, how does the fact that the ACT has only two large hospitals and no smaller hospitals affect how this jurisdiction compares in NEAT reports and the way they are calculated?

Ms Gallagher: That is always going to be a challenge for the ACT, I think, because when you look at the peer group, which is probably the most relevant assessment when you are comparing hospitals rather than jurisdictions, you see just how well ACT hospitals are performing. That is because you are measuring like with like, or as much like with like as you can. Every hospital is different.

THE CHAIR: Yes.

Ms Gallagher: But the fact that we do not have small hospitals, country hospitals, that might only see a handful of patients and see them within time certainly helps jurisdictions' targets. There is no doubt about it. There is absolutely no doubt about it at all and that is supported by the data. When we compare ourselves, probably the most like hospital is John Hunter.

Dr Hall: Certainly in the New South Wales region, the only similar hospital was really John Hunter. Around the country, for Canberra Hospital there were really only

about four comparable hospitals in terms of having a regional role, a mixed adult, paediatric, ED and a large trauma load. They were John Hunter, Flinders, Townsville hospital, Brisbane and Joondalup in the northern suburbs of Perth to a certain extent. They are really about it. And Royal Hobart, probably; so I would invite the panel to compare the performance figures for Canberra Hospital to any of those hospitals and we compare very well, because the complexity of the hospital is such that it does create some unique challenges.

As the Chief Minister suggested, both our hospitals sit in the major hospital grouping. Calvary would be the smallest hospital in Australia that sits in that major hospital grouping. As such, it performs really well. But you will see that as hospitals become bigger and more complex, performance challenges have been really dramatic across the country for the big tertiary hospitals.

MR HANSON: A supplementary on triage as well.

THE CHAIR: Just a moment, Mr Hanson, thank you. What you are saying is that if we had small hospitals that we included in our catchment, our figures would look substantially different. What if we included the figures for the patients seen at the walk-in centre?

Ms Gallagher: Yes.

Dr Brown: We have done some informal work looking at if we included, for example, the regional hospitals from southern region—those that have an emergency department.

Ms Gallagher: Which feed into our hospital.

Dr Brown: Which feed into our hospital. If we include them, our performance goes up to 65 per cent. If we include the data from those people who go to the walk-in centre as an alternative to presenting to ED—not all of them would have presented to ED—the performance would go up to the high 60s—68, 69 per cent. The walk-in centre was developed as one potential alternative to emergency department. It is clearly not an emergency department. It is aimed at the one-off more simple presentations, but it does actually have an impact in terms of the NEAT figures if you do include that.

THE CHAIR: Mr Hanson, a supplementary.

MR HANSON: Page 127 of the report has the triage data, so moving away from the NEAT; I want to clarify the table on that page and whether that is Canberra wide or just TCH and whether there is separate data for each hospital.

Ms Gallagher: That information is provided in all of our quarterly performance reports, as I recall.

MR HANSON: For both hospitals?

Ms Gallagher: For both hospitals.

Dr Brown: That is Canberra wide.

Ms Gallagher: But that figure is Canberra wide.

MR HANSON: Are you able to provide the breakdown comparator between TCH and Calvary?

Ms Gallagher: As I recall it, the quarterly reports do.

Dr Brown: I can probably give you the latest, if I can just find it.

Ms Gallagher: It is a similar story, I think, overall between Calvary and Canberra as to reflecting the NEAT data, for the same reason.

MR HANSON: Sure, yes, I am just trying to—

Dr Hall: I do not have the figures in front of me, but, as a summary, they are almost identical. Calvary has a triage performance on category 3s that is significantly higher than TCH's. Otherwise those figures are almost identical between the two hospitals. Of note with current active performance compared to the annual report, there has been significant improvement across both hospitals in category 2 and category 5. Calvary hospital has shown a significant improvement in category 3. Both of them have improved category 4 to a certain extent. It is clear that we have struggled to provide an improvement in timeliness for category 3 patients. I can talk to that if you wish.

MR HANSON: That would be interesting, because that—

THE CHAIR: No, I think we will stop there. I have some committee members with more questions in this area, so I will go to Mr Wall.

Dr Brown: Sorry, Dr Bourke, I can provide the latest figures Mr Hanson was after.

THE CHAIR: Yes, all right. Do that briefly and then I want Mr Wall to be able to ask his questions.

Dr Brown: Mr Hanson, year to date at the end of October for Canberra Hospital, category 1 was at 99 per cent, and I can give you the explanation as to why that is not 100 per cent if you wish.

MR HANSON: No, that is fine.

Dr Brown: Eighty-one per cent for category 2, which is above target; category 3, 45; category 4, 53; and category 5, 82, which is above target. For Calvary, the similar figures were 100 per cent, 85 per cent, 53 per cent, 61 per cent and 88 per cent. So both hospitals have the same challenges in terms of categories 3 and 4.

MR WALL: Page 121 of the annual report has a graph of available beds per 1,000 population in the ACT versus the national average. Over the past three years the ACT seems to have plateaued with the national average. Is that an acceptable level for

the ACT?

Ms Gallagher: Well, it is better than where we came from, which was below the national average. We keep adding beds, and other jurisdictions are adding beds as well. We are adding as many beds as we can with the staff available and the resources available.

Dr Brown: I would just add to that. It is always a balance around how many beds should you have and if you have above the national average in terms of bed stock, then you are going to be running at a higher cost. We actually have a higher cost than the national average, but if we ran even more inpatient beds, we are likely to have an even higher cost of services. So it is about finding the right balance. I know Mr Hanson is probably going to come in and say, "But you're servicing a region, and, therefore, you should have more beds"—

MR WALL: That was going to be my next question, but anyway.

MR HANSON: We have danced this little dance before, haven't we?

Dr Brown: We have, indeed. We are getting very good at it, I think. But I would say that if you are actually going to count the regional population, then you need to count the regional beds. There are beds in all regional provincial centres, and they are not factored into these figures. So if we are going to change the denominator, let us change the numerator as well.

Ms Gallagher: And then we would use the regional data for all the other indicators as well.

Dr Brown: Yes.

MR WALL: Has a direct comparison been done of the region's number of bed spaces per head of population?

Dr Brown: No, we have not done those. It is a bit artificial, because, one, we do not operate them. They provide one level of secondary service; we provide more of the tertiary level service for those regional patients, not the secondary level. So it is very hard to make real sense of doing that. I guess my point is that, in terms of a national average, you cannot just say, "Well, we're serving a regional population, therefore, we should have a higher number."

MR WALL: I guess the flow-on from that would be the bed occupancy rates, which for the reporting period are up to 93 per cent. I note the target was revised from last year's annual report at 85 per cent up to 90 for this year, and it was still exceeded. So that would indicate that there is still a shortage of beds.

Ms Gallagher: Not necessarily. Victoria, for example, has a target, I think, of 95 per cent. If their beds are not working at 95 per cent, then the view of their government is that they are not running an efficient system. They have to be operating their beds and they need to be full 95 per cent of the time, because under their funding arrangement, if they are not, they are going to lose money. The AMA have some very strong views

around what bed occupancy should be, and that means there should be empty beds waiting for people to be admitted into or a higher level of inactive beds. I think probably for us 90 per cent is a reasonable in between. I think the AMA is 85. They say 85; we are at 90. Other jurisdictions require their beds to be run at a higher rate than that around efficiency.

The other issue is that beds are not the only answer to what we are seeing in the growth in demand for health services. You can open as many beds as you like—it would be very expensive and you would struggle to find staff to support them—and those beds would be full. It does not put any pressure on looking at other ways to manage people and their illness—things like hospital in the home, outreach, prevention programs and chronic disease management that happens between the hospital and the primary healthcare providers. They are all solutions. It is a very simplistic assumption to think that all of the healthcare system's problems are around beds and link that to bed occupancy.

MR WALL: What changes occurred between the 2011-12 reporting period and 2012-13 to see that five per cent increase in bed occupancy?

Dr Brown: Certainly one of the factors is we have seen an increase in presentations to the emergency department and an increase in admissions. We have had increased numbers of elective surgery, for example. But one of the things Mr Thompson spoke to before was the increase in the long-stay patients. We have had in that period the closure of I think it was around about 80 beds at Ginninderra Gardens. That has undoubtedly had an impact in terms of the increase in long-stay patients in our hospital. More recently we have seen a slight decrease, but, at times we have had anything up to one to one and a half wards of people who are awaiting nursing home placement. That directly impacts on that sort of figure.

MR WALL: And the 93 per cent figure that was achieved last year, obviously that fluctuates—on any given day it could be higher or lower. How many instances over the past 12 months did that figure hit 100 per cent?

Dr Brown: I do not have an answer to that. We would have to take that on notice.

Ms Gallagher: There were certainly a couple of times when we were really stretched across the public health system and the private system, which is not a position you want to be in too often.

MR WALL: If you could take on notice the number of times that occurred, for how long, the duration of each—

Ms Gallagher: Well, we will do it within reason. I am not going to have people spending hours going back to try and find that. This is the measure we report on. And that is provided here for the information of the committee.

MR WALL: That data should—

Ms Gallagher: I am not going to approve resources of a very busy hospital dealing with bed occupancy at 93 per cent on average and the stress that creates to go back

and do a paper trail of when might this have happened. Within reason, I will look to see how we can assist you.

MR WALL: I would have thought that paper trail would exist for the purposes of generating that graph.

Ms Gallagher: Well, it may.

Dr Brown: We will certainly see what we have got.

Ms Gallagher: It may.

Dr Brown: And if the data is easily—

Ms Gallagher: But within reason. And there will be many, many other questions here which need to be managed as well.

MR HANSON: A supplementary.

THE CHAIR: Ms Lawder, do you have a substantive question?

MS LAWDER: I will defer to Mr Hanson at this point.

MR HANSON: I have a supplementary. In terms of the raw number of beds, what is the total, and can you break that down? You might need to take that on notice, but—

Ms Gallagher: It changes every day. That is the issue. We can provide you with a snapshot, I think—

MR HANSON: The number of beds changes?

Ms Gallagher: Well, it does. If we have a particularly heavy elective load relating to a particular type of patient, then we will need more beds available, for example, in the ICU or in the surgical wards. It does change.

MR HANSON: Maybe I could qualify that and ask: how many beds are available? If you were running at 100 per cent bed occupancy, how many beds are available within the system and where are they located?

Dr Brown: Could I direct you to the figure at the top of page 120, which shows that in 2012-13 we were anticipating having 986 going up to 1,025 in 2013-14. That is with the additional beds coming online with the health infrastructure program. I am happy to seek to break that down to Canberra Hospital and Calvary hospital. I am not sure whether you were wanting something broken down even more than that.

MR HANSON: If you have it, it would be useful. But if you do not, I do not want you to necessarily—

Dr Brown: We will see what we can provide.

MR HANSON: In terms of the stuff that is in the budget and is part of health planning, have you got an annual figure of the total bed number over the next four years? Have you done analysis in terms of need with an ageing and growing population and what the effect of that is in terms of bed occupancy and so on? Are we increasing the number per capita, or are we decreasing per capita?

Dr Brown: We have done extensive work around looking at population projections, service demand projections and, therefore, the infrastructure we require to meet the service demand. We aim to bring online beds each year that will assist us to maintain the level of capacity we require. It is not a direct relationship because sometimes it depends on what we have to do to be able to deliver on the beds. As I say, it is not an absolute straight line, but it is relatively there set to meet the growing demand. That is the whole basis of the health infrastructure program—looking at what the demand is.

It is not focused just on inpatient beds; it is also community services, but as to the inpatient beds, we have a very complex plan in terms of expanding bed capacity through refurbishment of existing space within the hospital, moving people out of what has been historically used as offices and creating bed space, moving things around and then creating additional space through, for example, moving things from hospital to community services and then building new inpatient facilities. That is across both Canberra Hospital and Calvary. It is a very complex set of dominoes, but it is based on the population projections and the requirements.

MR HANSON: I understand that. I am just wondering how we are tracking, whether we are getting ahead of the game or not in terms of how that translates to 2.6 beds per capita. Are we looking at an improvement or an increase or a decrease?

Dr Brown: I might ask Jacinta George as the acting executive director for service and capital planning to speak to the detail of that.

Ms George: As Dr Brown said, we have undertaken extensive modelling of our bed need for the future, and that takes into account population projections, not only by numbers but age, sex, where people live, clinical trends and changing models of technology and health care. I do not have in front of me the proportion of beds to population. That is not the way we undertake the projections. We do it by this complex modelling system. But, yes, we have a plan for an increasing number of beds by meeting the demand, the growth, as well as staging and decanting and moving beds around to meet the health infrastructure program as beds are taken offline for buildings to be built. There is a very, very complex program and set of figures that aim to increase the number of beds available to meet demand at the same time that we are building the new beds.

Ms Gallagher: And these are under pretty constant review because of changes in technology and changing assumptions about, for example, private hospital availability and choice of what the population is using. At the moment, it is not enough of the private system. That can change those projections. I would say it is very closely linked to the commitments we have made in the election. Ultimately, the government's outline of our agenda is the beds we announced as part of the election campaign, and I think this year's budget has 44 extra beds as part of delivering on that commitment.

THE CHAIR: Thank you, Chief Minister. We will move to output 1.2, which is mental health, justice health and alcohol and drug services. Minister, the adult mental health unit was commissioned in April 2012. What difference has it made?

Ms Gallagher: In terms of amenity, it has provided a much more therapeutic environment for people needing adult mental health services. Along with that, there is the new model of care that underpins it. Overall, the transition to the new unit has been very successful.

THE CHAIR: How is the smoke-free policy working?

Ms Gallagher: Very well, actually. Again, there have been meetings held and discussions held with people who were concerned about the implementation of a smoke-free environment. The latest advice I have seen is that, while there are a couple of people who have struggled with the smoke-free environment, overwhelmingly it has gone very well. The feedback, particularly from non-smoking patients, within the unit has been very positive.

THE CHAIR: Were there any learnings from other jurisdictions that helped implement that policy?

Ms Gallagher: Yes, there were.

THE CHAIR: Anything in particular?

Ms Gallagher: An issue at health ministers last month—was that last month?—was the issue of basically implementing smoke-free environments in closed settings. My reading of the mood around the table was that where it had not happened it was going to happen.

THE CHAIR: And, of course, there is that work from New Zealand in their corrections system where their jails are now smoke free.

Ms Gallagher: So are the Northern Territory's.

Dr Brown: And some in New South Wales.

Ms Gallagher: The new jails in New South Wales are smoke free. But the indication from health ministers was that it is not going to stop there and that some of the concerns that were expressed around moving to smoke-free correctional environments, and what was going to happen, just have not been the experience when the change has happened. I think that to get it right you need to get all your consultations right, you need to get your back-up systems, and you need your nicotine replacement. You need all of those programs in place and everyone understanding what is going on. It helps if you have a supportive staff environment, I have to say—if staff are helping. In fact, that was the feedback from some of the other areas when they had moved to smoke-free environments: the main difficulty was dealing with staff that did not want those areas to be smoke free. It does certainly help if you can bring staff along with you.

Dr Brown: I might just add to that. The staff in the mental health, justice health and alcohol and drug division were strongly in favour of implementing a smoke-free environment. Some of the staff were smokers themselves but were strongly promoting that we make this move. We are planning to undertake a formal evaluation of the smoke-free initiative in mental health next year so that we can look at the learnings from that.

THE CHAIR: Can you tell me, also, about the mental health community policing initiative and how it operates with police?

Dr Brown: I might ask Katrina Bracher to speak to the detail of that. It has been an initiative that has been very successful overall. Certainly the mental health staff who work there enjoy the working relationship with the police and I think it has had great outcomes for consumers. The police speak very highly of it as well.

Ms Bracher: The community policing initiative was formally launched a couple of years ago. We had a multipronged service, if you like, in collaboration with ACT Policing, where we had clinicians in the telecommunications area of ACT Policing on four evenings a week when the demand was highest. The clinician in the comms centre there is available for any calls that come in from the police out on the road if there is a concern around the mental health of anybody in the community. That clinician provides advice generally for how people are presenting or specifically if the person is known to be one of our active consumers. That initiative has been extended now to be seven evenings a week.

In the other periods of time, our crisis and treatment team provides that support to Policing. We did our modelling very carefully on peak times in the 24-hour period; that is why we chose those shifts: 2 or 3 o'clock in the afternoon through to 10 or 11 o'clock in the evening are the peak times.

The other component of that initiative is around training for ACT Policing staff and for our mental health staff on ACT police procedures and policies. One of the things that we found very early on was that police had a view of what they thought mental health should and could do, and mental health had a view of what they thought police should and could do under the powers of their respective legislations. We have had a very active training program and cross-sharing of information so that there is a far better understanding of the roles and responsibilities and the pieces of legislation that both groups of staff work within. We have a four-day training program for mental health training of police officers. We have been through some number of hundreds of police officers in terms of training over the last few years.

In the last lot of data that I saw for the outcomes of those policing initiatives, the number of emergency actions that were undertaken by police had actually halved since the beginning of the initiative, so people were able to be brought into the emergency department for assessment voluntarily and with the care of the mental health team rather than under an emergency action through a police officer.

THE CHAIR: Minister, what is the current progress on the secure mental health unit?

Ms Gallagher: There has been quite a lot of progress. Probably the best, most up-to-

date thing is the newsletter, which I was just reading this morning. The committee can have that.

THE CHAIR: You are tabling that for us?

Ms Gallagher: Yes, I can table that.

THE CHAIR: Thank you.

Ms Gallagher: It is probably quicker that way. The architect has been appointed. The draft model of care is out for consultation. There was a community meeting on Tuesday night to talk about it, which included a presentation from a number of different individuals with responsibility for particular areas of the project. It was facilitated by Norman Swan and there were experts available to take people's questions, including police, psychiatrists—

Dr Brown: ESDD.

Ms Gallagher: ESDD for the planning rules. So we just keep moving along with it.

THE CHAIR: What sorts of questions were people asking at that meeting?

Ms Bracher: I can answer that. I was there; I did one of the presentations. There were questions around the model of care, very specifically about the type of people that will be cared for in this unit—who would be eligible, who would not be eligible. There were questions around how that decision-making would occur. We very carefully clarified that that would be a clinical decision, based on advice by a panel of health professionals, for admission into the unit. There were questions around the site location, some questions around that. There were questions from the community about where secure mental health units were located in other jurisdictions and internationally for comparison with the rationale that was used here. There were questions around the security arrangements for the facility and how we would maintain a safe environment both inside the unit, with the care that we provide, and externally, for the immediate local community and more broadly the ACT.

There were questions around the therapy program that we are aiming to roll out. There were questions around discharge from the unit and how that would actually occur. People had an idea that on Tuesday afternoon at 2 o'clock we would open the door and somebody would be discharged, based on people's experience in an acute hospital. We very carefully clarified that the discharge process will be an extended process where leave will be granted based on a person's capacity to be supervised in the community with care around their needs and the family's needs. So the discharge from this unit will be a staged process.

THE CHAIR: Thank you.

Ms Bracher: There was lots of discussion.

THE CHAIR: Ms Berry.

MS BERRY: A supplementary on that, if I could, chair. Just regarding the mental health community policing project, how does that actually work on the ground? If, for example, a person is concerned about the health of a neighbour and they call the police, what happens?

Ms Bracher: The police will make a decision around whether that is an immediate emergency situation and they will implement their own procedures around that. If they attend the site and are worried about somebody's mental wellbeing, their mental health, in the evenings that will go directly through to the clinician sitting in the comms area. During the day, they call our CAT team, our crisis and treatment team, and the clinician in the CAT team will coordinate with the police. Our staff can also go out with the police, and do often go out with the police. Sometimes if we get a call into our CAT team and it is a person known to our service, we will go out first and do a review. Both the police and the mental health services try very hard to divert people into a health system rather than have a police response when it is not required.

MS BERRY: So the police make the referral to the unit?

Ms Bracher: The police make a referral to our triage team; very quickly, the triage team work through their decision-making algorithms as to whether the person needs to be brought into the mental health assessment unit. We try very hard to have that as, in the first instance, a transfer by our mental health clinicians, just in a government car. The next point of escalation would be by ambulance. The next point of escalation, if there are serious safety concerns, would be by the AFP. We try very hard not to get to that point, but on some occasions we do need to use the AFP.

MS BERRY: Thank you.

THE CHAIR: A substantive question, Ms Berry?

MS BERRY: Yes, I do have a substantive question.

MR HANSON: Can I have some supps while we are waiting?

THE CHAIR: Yes, Mr Hanson.

MR HANSON: On the adult mental health facility, the $30,000 tables that broke—have they been repaired?

Ms Gallagher: They did not break; they were damaged—

MR HANSON: It is a fine line, isn't it?

Ms Gallagher: in exactly the situation that they were bought for.

MR HANSON: So they were damaged or the leg broke.

Ms Gallagher: Yes.

MR HANSON: Anyway, that is arguing semantics. But have they been repaired?

Have they been replaced?

Ms Bracher: They have been repaired and they are being well-utilised daily.

MR HANSON: Okay. There were some issues with assaults on staff at various stages. Is that ongoing? Have those sorts of issues been resolved? Have there been any more assaults on staff?

Ms Bracher: Often there are incidents within mental health units that are instances of aggression and violence. There was a peak period a couple of months ago where we had a number of consumers in the unit that had very challenging behaviours and were very distressed. Our staff dealt with those situations admirably and, unfortunately, on occasions, were assaulted.

MR HANSON: Sure.

Ms Bracher: Mostly that is accidentally and as part of the distress related to mental illness. Our staff are quite keen to have it known that they do not have a blame approach to that. But they are also very keen to work in an environment which is safe. All of us acknowledge that when that happens, it hurts; it hurts the person concerned and it hurts our culture and the ambience in the unit.

MR HANSON: Sure, but there were some comments reported, the inference being that essentially the failure to deliver the secure facility meant that the staff at the adult facility were at greater risk. Are we seeing a situation where people who are mental health consumers are in the adult facility who otherwise should be in a secure facility and therefore are putting staff at heightened risk?

Ms Bracher: At the time when we had the very public discussion around the needs of individual, very vulnerable people in the adult mental health unit, I actually asked that question of our clinicians. The clinicians felt that those people would not have been suitable for a secure mental health unit at the time. So, based on what was happening in the unit over that one-month, six-week period, none of those people would have been appropriate for admission to the secure mental health unit based on the model of care that we have got out for public consultation now.

MR HANSON: The staff are okay?

Ms Bracher: Yes. Some staff are still receiving some counselling. We have a very supportive internal team system where staff support each other every day to do this sort of work.

MR HANSON: On a slightly different issue—

THE CHAIR: We will just stop—

MR HANSON: No, this is supplementary to your police question.

THE CHAIR: You have had quite a few supplementaries, Mr Hanson. Ms Berry has been waiting patiently to ask her substantive question. If we have some spare time, we

will come back to you.

MR HANSON: No worries.

MS BERRY: Thank you, chair. During the last annual reports we were discussing the youth step-up, step-down program, and I was hoping that you could update us on how the program is going.

Ms Bracher: The youth step-up, step-down program was opened in Kambah a year ago?

Ms Gallagher: I cannot remember either, so much has happened. But it was recently.

Ms Bracher: Recently. It is operating very successfully. We have had fantastic feedback both from the families and from the young people that are admitted to the unit. The non-government organisation that is running the unit is operating very effectively. With the bed occupancy, we are full all of the time. With the throughput, though, people are coming into the unit and being discharged from the step-up, step-down facility in the eight to 10-week time frame that we were anticipating. As soon as we discharge somebody, there are new referrals that are taking up the places.

MS BERRY: Did you say that the beds are full?

Ms Bracher: Today, I cannot say whether there are six people in the six beds. But, yes, the data that I look at is that we are pretty well running at full occupancy.

MS BERRY: Can you tell us how many clients it has seen over the reporting period from when it opened?

Ms Bracher: I can take that on notice and we can find that out for you.

MS BERRY: Is there any data available on whether it is utilised more heavily by clients leaving the hospital or whether it is by clients stepping up to a higher level of care than is available?

Ms Bracher: I can provide that breakdown as well. My sense, though, is that it is being utilised more as a step down than a step up. But we can provide that breakdown.

MS BERRY: Thank you.

MR WALL: I have a supplementary while we are talking about youth services. Where is the proposed adolescent mental health unit up to?

Dr Brown: We have a feasibility study that we are looking at in terms of how best to provide the beds that are required to meet the need for the adolescent age group. I have not yet seen that feasibility study but it is due in the very near future. Obviously, once we have a look at that, we will be providing it to the minister.

MR WALL: If the feasibility study is under consideration now, what is the estimated time frame for progressing that to an operational—

Ms Gallagher: It depends on the budget, and that depends on what we ultimately decide to do. As I understand it, there are different options available. One of these issues is linked to the size of the jurisdiction, again. Do we need a stand-alone unit versus some capacity attached to another adolescent service? They are some of the challenges, and they will come with different budgets and different time lines.

MR WALL: On the demand side of the equation, how many youth are currently waiting to access health assessments and these sorts of services?

Dr Brown: We currently have provision for inpatient adolescent mental health services if required, because we utilise beds within the adolescent ward. If the young person is unable to be appropriately managed in that setting, on a very rare occasion we do admit them to the adult mental health unit, usually with a one-to-one special, and generally in the most appropriate location within the unit. So it is not as though people are not able to access services now without the unit.

Ms Gallagher: There is a triage relating to assessments. You asked what the waiting time is. For someone who urgently needs to be seen, there is no waiting time. But as with every health service, to manage it, there are steps, different triage points. Someone who needs a non-urgent mental health assessment may have a wait, as clinicians are concentrating on the more urgent cases.

MR WALL: I understand. What is the wait time for each of the triage categories?

Ms Gallagher: I think we provided that to the *Canberra Times* the other day, for different kinds of mental health assessments.

Dr Brown: Are you talking about inpatient or outpatient?

Ms Bracher: Can I just clarify something. There is no wait for inpatient care.

MR WALL: Okay.

Ms Bracher: Just to make that really clear. For our community-based services, we try very hard not to call it a triage category because triage is what happens in the emergency department. But we do have a prioritisation category. Our wait list in our general CAMHS services for urgent care is zero. People are seen when they need to be seen, and if they are not seen by a CAMHS service, they are seen by the crisis and treatment team—the CAT team.

The data that we provided to the *Canberra Times*—and it was reported in the *Canberra Times*—is up to a six to eight-week wait to come in for a full assessment. That does not mean that people are not assessed by phone and as a screening assessment. We can bring people into the health centres earlier for a full assessment, if they need it. All of the people that are on our wait list are very clearly given contact details if their situation deteriorates, and we actually make contact with people that are on our wait list from time to time while they are waiting to come in for that full assessment. We have had significant vacancies in our child and adolescent mental health services that fluctuate periodically. We are actually in an upward swing at the

moment, and we are working very carefully to get through the wait list.

THE CHAIR: A substantive question, Mr Wall?

MR WALL: Yes, I have a perennial question that we seem to be asking in these hearings, about the Aboriginal and Torres Strait Islander bush healing farm.

Ms Gallagher: It is currently before ACAT. There are two separate development application questions that need to be resolved, and the first one is currently with ACAT under appeal. I think they have had hearings in the last week.

Dr Brown: Yes, 19 to 22 November.

Ms Gallagher: We may get a decision before Christmas; we may not. That is around the—

Dr Brown: It is the lease variation.

Ms Gallagher: lease variation component question, so that needs to be solved.

Dr Brown: They are taking a further witness statement next week, I believe. Their consideration will occur once they have heard all of the witness statements. We do not necessarily anticipate that there will be a decision this month. It could be next month. As the minister indicated, the second DA, which is the design and siting DA, will need to be considered after the lease variation matter is concluded.

Ms Gallagher: We are just stuck waiting now because of the objections to the project.

MR WALL: Obviously, ACAT needs to run its course.

Ms Gallagher: Yes.

MR WALL: The development application has not been considered because of the pending lease variation?

Ms Gallagher: The first one had to go in, saying that it could be used for this purpose. That was appealed against, essentially. It has gone to ACAT. ACAT are having quite a long hearing into it. We were hoping for a decision before Christmas, but it sounds unlikely. I think ACAT have gone out and visited the site as well, as part of that. So it has been quite a thorough assessment by ACAT. There is some limited work we can do. We are dealing with some work around the decontamination of some of the area of the land, which has to be done anyway, so that is all we can do at this point in time until those matters are resolved.

MR WALL: Is it perceived that these delays are going to have an impact on the proposed budget for the facility?

Ms Gallagher: Yes, it may. Again, in a sense, we are in a holding zone, and Health have been doing some work, which they will discuss with me in the next month, about the impact on budget, what it looks like now and what we need to do to manage that.

We remain committed to the project overall. It is a very important project and one that the Indigenous community have waited a long time for.

THE CHAIR: Ms Lawder, a substantive question.

MS LAWDER: On page 155 of the annual report it mentions that the division is facing challenges in finding staff to fill clinical vacancies. Can you give me an idea of some of the flow-on impacts?

Dr Brown: We might ask Ms Bracher to speak to that.

Ms Bracher: In all areas of health care I think there are challenges from time to time in finding staff. In our division we have had a relatively stable period for medical staff at both the senior level and the registrar and the training level. So from a medical perspective there has been really no impact. We have managed to maintain our registrar training program through the ANU Medical School very effectively. Therefore there has been no impact on clinical services.

In our nursing workforce we have had some vacancies. I think we sit at around a six to seven per cent vacancy mark for nursing at any given point in time. We tend to use agency nursing staff. We have a casual pool that we use for our nursing staff, particularly in the bed-based services. We are very diligent about making sure we have got appropriate nursing staff for running our rosters there. So in terms of inpatient care, I do not believe there has been an impact, although we do acknowledge that while some agency staff can be very skilled mental health nurses, there is a familiarity and an orientation issue that we have to manage with agency nursing staff.

With allied health professionals, we do have a challenge—psychologists and social workers in particular. For social workers and AOD counsellors in the alcohol and drug services it has been quite difficult to fill vacancies when we have gone out for recruiting. With respect to our ability to do our counselling in alcohol and drug services, it does from time to time have an impact in terms of the wait for people to get in.

In psychology—as I indicated earlier, in our CAMHS service, we have a lot of psychologists in our child and adolescent mental health services—that has had an impact over what was the case previously. About a year ago we were quite short staffed. Six months ago we had filled vacancies and towards the end of the year people are leaving again. So it is an ongoing juggle.

MS LAWDER: Any linkages, do you believe, between staff shortages and something like assaults?

Ms Bracher: Generally, no. Generally I think people make a decision and choose to work in mental health and alcohol and drug services because that is where their clinical passion lies. On occasion, though, individuals may make a choice about moving to a different area of health if they have been unfortunately exposed to levels of aggression and violence which are unacceptable for them or which have had a negative wellbeing impact.

MS LAWDER: To narrow that down even further, what about staff shortages leading to the possibility of assaults on staff in the mental health unit? Do you think there is a linkage there?

Ms Bracher: No, there is no link to staff shortages in the mental health unit, because we keep our staff profile right up there in that unit and also in the mental health assessment unit.

Ms Gallagher: I add that the violence and aggression towards staff is not peculiar to the mental health unit.

Ms Bracher: No.

Ms Gallagher: Unfortunately, it happens right across the board. You would be surprised, particularly from patients and patients' families, what our clinical staff put up with.

THE CHAIR: Mr Hanson, I think you had a couple of supplementaries. We will take those and then we are going to take a break for morning tea.

MR HANSON: A quick one on the secure facility and the forum that you held: some concerns were raised by the Public Advocate about the model that is being used, and the Chief Minister answered some questions in the Assembly. I am wondering if there is any update on that based on the forum that was held or any other detail in response to the concerns raised by the Public Advocate? I am sure you are aware of them.

Ms Bracher: Yes, absolutely. At the forum on Tuesday night no concerns similar to those mentioned by the Public Advocate were raised by the group that were there, other than to say some questions were around women in the unit and how they would participate in programs. Actually, it was not only women but women and other vulnerable people and how they will be kept safe in the unit. It was more generally about safety in the unit; it was not specifically along the lines on which the Public Advocate had been making comments—

MR HANSON: Sure, and what was the answer to that question?

Ms Bracher: The answer to that question is around the assessment of people's individual needs. In that care planning process people will be allowed to move through the unit and interact with other consumers and staff based on their individual needs. In the units we visited in other jurisdictions, sometimes the inpatients were cared for in a one-to-one basis and they did not actually interact with other people. That was based on their assessed need. Over the course of their rehabilitation program, they were able, then, to interact in a group situation. They were then able to interact in an individual situation with staff supervision. So it is a graduated process where people are kept very carefully safe and graduated into interacting with other people.

MR HANSON: So it is case by case as opposed to a particular category?

Ms Bracher: Absolutely, it is case by case. It is not diagnostically driven by their mental health diagnosis, and it will not be driven by what security classification the

general manager of the AMC might have stipulated for somebody detained under the Corrections Management Act either. It will be based on their clinical need and the assessed interactions that people can safely have with each other.

MR HANSON: There has been a recent increase in the number of prisoners at the AMC, and we know a proportion of those people probably would be consumers for the secure facility. Have you looked at that increase in population at the AMC when you have done your modelling for the secure mental health services? It is up to, what, 25 beds now?

Ms Gallagher: Yes.

MR HANSON: The AMC is in a position where it is now struggling with capacity. Why is that? Are you confident the planning you have done for this facility will not result in the same thing—that is, within a year or two, you are at capacity and there is no future—

Dr Brown: Can I answer that. One of the reasons there was a pause from the original plan was to go back and look at the demand for this unit, given that when we originally started the planning we were also planning for the AMC and we have now opened the AMC. We now have a couple of years of AMC data to take into account as well as the new adult mental health unit and other units in New South Wales. So we took a step back and looked at all of those things. The planning for the 25 beds has taken into account the more recent developments.

The other comment I would make is that there is often an association made that I would like to discourage—that is, someone in the AMC with a mental health problem therefore needs to go to the secure mental health unit. That is not necessarily the case. Secure mental health units are there for a very specific purpose. If someone in the AMC with a mental health problem was not in the AMC and needed mental health treatment and got that in the community, the same should apply in the AMC—that is, they would be treated in their current community. They essentially have community-based treatment in the AMC.

It is only where there is an assessed need for inpatient treatment that needs to be with a level of security and specialised skill that these individuals will be admitted into the secure mental health unit. And that is quite a small number of people.

Likewise, you asked a question in relation to people in the adult mental health unit and whether they should be in the secure mental health unit. Again, it is a very select group of individuals who will need the secure mental health unit. Of the things we have to guard against is a change in terms of the threshold for admission into the secure unit. That is why so much work has gone into developing the model of care and articulating that very carefully. We do not want people being put into the secure mental health unit who should not be receiving their care in that environment.

MR HANSON: Based on all these answers, then, I assume 25 beds means that it is going to have 25 patients. As we have seen with the AMC, 300 beds does not mean 300 prisoners—it means 245, or something, because of the different categories. But what you are saying is that 25 beds means 25.

Ms Gallagher: It will mean that. Some issues will be looked through with the architect and the designers and the staff and the experts into how the facility is designed in order to maximise potential for separation based on gender, if that is seen to be required. We will be mindful of that in the design, but, ultimately, it is a 25-bed inpatient facility, a mix of medium to high needs.

Dr Brown: Medium to low.

Ms Gallagher: Sorry, medium to low.

Dr Brown: Acute and rehabilitation.

THE CHAIR: We will take our morning tea break now for 10 minutes. Minister, we have dealt with acute services and mental health and justice health and alcohol and drug services. When we come back, we will be dealing with public health services.

Meeting suspended from 11.08 to 11.26 am.

THE CHAIR: We shall reopen proceedings. Minister, what consultation did the Health Protection Service undertake with industry and stakeholders prior to and since the passage of the food amendment act of 2012, which brought in the need for food safety supervisors?

Ms Gallagher: A lot of work was done. I will let Dr Kelly outline that.

Dr Kelly: Thank you for your question, Dr Bourke. We are very concerned and diligent about food safety here in the ACT, and we have a range of mechanisms for dealing with that. In early 2012 there were changes to the Food Act, several of which came into effect immediately but one of which was delayed until 1 September this year—around food safety supervisors, which your question particularly relates to.

Prior to those changes in the Food Act, regulatory impact statements were prepared. There was a range of consultations, meetings, letters and so forth with industry and affected parties in relation to that prior to early 2012 and when the act was changed. We delayed the food safety supervisor element for 18 months, exactly for the reasons that we did not want to put an unnecessarily rapid regulatory burden onto business and those who were providing food services, and to give them a chance to work through what the implications were for them, to work through also the ability to have grandfather clauses and so forth for people who had done the specific training units that we were requiring.

We were also in contact through that period several times. My colleague Mr Woollard from the Health Protection Service wrote to every registered food business during that period, on several occasions, keeping them up to date with how things were working. We worked with registered training organisations as well, to make sure that those things that we were requiring for the training were available. We had that information also provided to the people that needed to access those services. So we were very confident that we had done everything that needed to be done to make sure that people knew what was happening. I know a supplementary question will come from

Mr Hanson, but I will leave that until it comes.

THE CHAIR: We will get to Mr Hanson later; don't worry about that.

Ms Gallagher: So predictable, Jeremy.

MR HANSON: I don't want to disappoint.

Ms Gallagher: You will have to get some new ones.

MR HANSON: We have not had any questions on this before.

THE CHAIR: Just coming back to what you were talking about there, Dr Kelly, could you outline for the committee what the grandfather clauses are and what that means—as opposed to grandmother clauses.

Dr Kelly: "Grandmother" is also acceptable, thank you, Dr Bourke. There are a number of training organisations throughout the country that have been providing this sort of training—food safety supervisor training. Indeed, part of the reason for bringing in these changes to the legislation was for us to really catch up to surrounding jurisdictions. New South Wales and Victoria have both had food safety supervisor requirements, and therefore there has been training. Because the hospitality industry is rather fluid in where people set their businesses up, and particularly staff in those businesses, it is quite possible that people would have fulfilled those requirements in other jurisdictions and we would recognise that training. So that was one.

Some of the units that we would require within a food business, for example, are covered by chefs and the work that they do. We do want currency, and that was part of the things that we were talking with industry about—how long we would recognise such training for, when a refresher would be required and so forth. That is the sort of grandfathering/grandmothering element I was referring to.

THE CHAIR: You talked about refreshment of training and currency. What sort of time period did you come up with?

Dr Kelly: For that sort of close technical detail, I might hand over to Mr Woollard if he is happy to take that.

Mr Woollard: In answer to your question, five years was the figure we settled on. We felt that it was necessary to have a current qualification every five years.

THE CHAIR: Thank you very much.

MR HANSON: Supplementary?

THE CHAIR: I might go to you later. We will get there; don't worry. Minister, what is the estimated cost of foodborne illness in the ACT each year?

Ms Gallagher: It is very difficult to put a figure on it. I think it is between

$60 million and $80 million—yes, around $80 million.

DR BOURKE: $80 million?

Ms Gallagher: A large part of that comes from lost productivity, with people becoming unwell and not being able to work, with other people having to care for them—that type of thing. There is no doubt that food safety, and getting food safety right, should be a major priority for any local government, any state or territory government. We work very closely with industry, and I think a lot of the educative approach that Health take is not well understood; it is certainly not well publicised, probably because it is not as newsworthy as other things. That approach includes all that work that goes on by the inspectorate to assist businesses, where there are problems, to get things right; to respond to concerns from the community when they are raised; and also to make sure that where we are seeing legislative gaps, we move to respond to those.

Part of the issue around the food safety act at the time was trying to deal with the increase in the availability of food and high-risk food in a whole range of new environments. They were petrol stations, for example, and supermarkets selling ready-to-eat food or packaged food. What we were seeing was things growing much further outside your traditional food business of a registered licensed restaurant, for example, into a whole range of other areas where different food products were being sold and the need to look at how we adjusted our regulatory approach to deal with that.

There is a very strong argument about the situation where a restaurant, perhaps in Dickson, is required to operate a food business under quite strict regulatory requirements, and why a large sporting organisation operating a canteen should not have similar requirements placed on it when it is selling food not dissimilar to the types of food in the restaurant that can cause harm. That is the balance that we have been trying to navigate through: how do you ensure that there is a bit of equity in terms of the regulatory approach and that you are maximising safety to the community despite charities and sporting organisations traditionally being seen not as areas where regulation needs to occur but as areas where it has been a much more ad hoc arrangement based on volunteers' time. That is all very good, and part of the social fabric of our community, but that does not mean that people do not get sick from food from those venues.

THE CHAIR: What are the risks associated with certain foods, especially eggs? I think we have heard about mushrooms in the past. I really want to hear about the sausages as well. Maybe we could get Dr Kelly back and he can talk us through that.

Ms Gallagher: Everyone knows my views on sausages; I have said it a number of times. Read the meat standard—I encourage you all—and you will be vegetarians.

MR HANSON: No lemonade, no sausages, no meat pies.

THE CHAIR: Dr Kelly, what about risky foods? You have told us all about eggs and mushrooms in the past. You have added sausages to your list?

Dr Kelly: Yes. This is an interesting and difficult area. In terms of food safety, let us

concentrate on the acute gastroenteritis risk of eating foods. Eggs are right up near the top, and I will leave that aside for the moment. Mushrooms are a whole different issue: we have had the issue with the toxic mushrooms that are here in the ACT on some occasions throughout the year; that is a toxin issue in relation to the actual mushrooms. The eggs one is a microbiological issue, so it is an issue of bugs being associated and causing illness that way.

What about sausages? Sausages are what we would call low risk food in terms of that acute gastroenteritis risk: if they are stored well, kept cold and then cooked and served immediately, the risk of people becoming sick from gastroenteritis is pretty low. The long-term consequences, however, are somewhat different. Having sausages every day is not good for your long-term health. The way these things work, this will be in a different output class, but if you want to create an obesity epidemic, having sausages as your only option at various places—similar to the fact that the only option we have had at morning tea here is not advisable from—

Ms Gallagher: Which was welcomed by everybody.

Dr Kelly: Everyone ate them. But did anyone have a choice? No.

THE CHAIR: I will pass that criticism to the secretariat.

Dr Kelly: That is right. So that is the issue. But there is quite clear guidance about what is high risk and low risk food from that gastroenteritis food safety point of view, that acute illness point of view. The food safety authorities in Australia have guidance on that. All jurisdictions have guidance on that. We have guidance on that. The minister mentioned earlier our educative approach to these things. We have a lot of information available on our website. It can be sent out in printed form if required. People ask us all the time about these things, including fete organisers, and we give them advice about what they should and should not be serving from that point of view of food safety.

That, in general, for outside of the commercial sector, is our approach. And that has not changed. It has been the same for many years. It was not changed under the Food Act, and that is the way we work with that sort of thing.

THE CHAIR: Could you just reiterate for us what the consequences of salmonella poisoning are.

Dr Kelly: The consequences of salmonella, as I think I have reported here in relation to the events in May this year, can be catastrophic. We had to call the health emergency response centre out in May when we had a large outbreak of salmonella in one restaurant affecting many, many people, with most of those turning up to the emergency departments, particularly at the Calvary hospital, at that time.

More recently, outside the ACT—in fact, somewhat ironically, whilst we were on the front page for what we were doing in food safety—there was a large outbreak of salmonella related to community functions in Brisbane. A woman died. Again, many people were seen in emergency departments or admitted to hospital—some for several days, some for weeks. And that is our experience here. The more problems we have

with foodborne illness, the more likely it is that you are going to get some of the more severe end problems, including death—including one of my own staff members who was affected by the outbreak in May, who had chronic problems with arthritis for several months and had very painful rashes as well. These things are not common, but if you have 100 or 200 people, or in this case over 300 people in this calendar year, in the ACT with salmonella poisoning, we are going to get some of these things. That is why we take our role very seriously from this point of view.

THE CHAIR: As part of your educative function, are you producing a cookbook for fetes?

Dr Kelly: We have produced a cookbook, actually. Poh, the famous person that should have won the first MasterChef, but—

MR HANSON: Do you endorse that position? Is that a government position?

Dr Kelly: We have endorsed her cookbook. But that was not for fetes, although it could be used by fetes. It was advice for people cooking for large groups, but particularly looking to give good information on the obesity side of the issue about healthy food options. No, we do not have a cookbook specifically for fetes, but we do, as I say, have advice. We have recently updated that advice and translated it into 12 languages. We believe our educative functions have actually improved at the same time as we have been balancing and increasing the regulatory components.

THE CHAIR: We have talked about eggs quite a bit, and you mentioned that sausages are actually reasonably low risk. What else is on that scale of risky foods?

Dr Kelly: This, again, is a tricky thing when I am trying to balance giving healthy food advice in the long term versus the shorter term one.

THE CHAIR: Just focus on the salmonella aspect.

Dr Kelly: With the salmonella one, anything that contains raw or undercooked egg products would be high on the list. There are certain other foods that have been reheated, particularly those containing cereals and particularly rice. That was probably the cause of the other large outbreak we had in the same week in May. It was related to poor temperature controls around a rice product. Meat products can also be difficult—not so much sausages, though.

MS BERRY: I have a supplementary. Dr Kelly, we were having a bit of fun about salmonella poisoning, what it can mean and the effect on fetes and things like that, but it is quite severe, as you said, and can be catastrophic. People can die from salmonella poisoning. Talking about those events that happened earlier this year, on Mother's Day, what were the overall costs of those particular events this year?

Dr Kelly: They would be difficult to cost specifically. What I could say is that, for that particular event, we had two events happening concurrently, as I have mentioned. There were 162 cases of gastroenteritis caused by salmonella in relation to a single restaurant over two days. Seventy-eight of these were actually confirmed with the salmonella infection and the others did not get the test or whatever, but we presume it

was the same problem.

There were also at the same time 90 cases of illness from this other restaurant. Many of those ones were milder than the salmonella poisoning. But to take the salmonella one, of those that we know of, many turned up at the emergency department. Others were admitted to Calvary hospital, particularly over several days. They were therefore off work for a week or more on some occasions. They required the acute hospital services that were provided. So there was a direct cost to the Health department from that point of view. I had over 30 of my staff working on the investigation. That meant 30 people were not able to do the rest of their work which is required, and there was overtime and so forth. So there were a whole lot of direct clinical and public health costs in relation to that—laboratory services et cetera—and the indirect costs to the people concerned.

What often happens out of these things is that there are legal actions taken by government against premises that are involved. In terms of cost, more importantly from the business's point of view there is the litigation that comes. I have a lot of sympathy for the people that were affected by this outbreak. They suffered, and as well many of them are in the age group where they are casual workers. So if they were not at work, they were not earning money, with all of the consequences that has from a personal point of view. Those things are still active in the courts, and we do not actually have any real visibility of that.

MS BERRY: That was going to be my next question: what were the fines, if there were any? But that is still going through the system?

Dr Kelly: In terms of fines, we are certainly continuing with our investigation and working with the DPP on that, from that point of view. But on the litigation side, class actions and so forth, unless we are subpoenaed to be a witness, we would not really know specifically what was happening there. We do know, though, that we have had several freedom of information requests by individuals and/or their lawyers acting on their behalf to gather the information that would be required for such a case. So we know that that is happening, at least in the case of the salmonella outbreak.

THE CHAIR: Ms Lawder, a supplementary.

MS LAWDER: For this past year, and perhaps historically, what proportion of these types of food safety cases came from restaurants as opposed to private homes or community—

Dr Kelly: It is a good question, Ms Lawder. With the way that we are notified about these situations, there are a number of steps before we get that information which would then be available to you and to the public. Firstly, I am sure everyone in the room would have had diarrhoea from time to time and most times you do not see someone. So that is a whole bunch of people we do not know about.

The next step is that you go to the general practitioner or the medical practitioner and they do a test. Most times when you go to a general practitioner and you say you have got diarrhoea, they give you a sick certificate or whatever is required, but they do not do a test. So that is a whole bunch of other people we do not know anything about.

The test has to be positive, and for salmonella that will usually be the case, but not always. So if it is negative, they may still have had salmonella but it was clear in the system or whatever, and we do not know about those ones. So we only really get the top part of this pyramid of problems.

The majority of those that are notified to us are not related to specific outbreaks of disease. We, unlike many other jurisdictions, actually follow up with every single case of salmonella that is notified to us. We ask them a range of questions about whether they think they might have been associated with particular restaurants, for example, or how they feel they might have got that.

We are pretty confident that we do investigate those ones. The majority are not associated with restaurants; they are in that other grab bag whereby we do not know where they got it from, really. We cannot pinpoint it. That large outbreak that happened in May was somewhat unusual. We get tens of those per year, usually much smaller than that, where we do find a small cluster of cases that are associated with a particular restaurant. That is when we swing in to look at that restaurant and see if there are any reasons why that might have occurred, and give them advice or actually direct them to fix those problems—and then, at the high end, prosecute for breaches.

We do know that gastroenteritis is one of the very common presentations to general practice. We know that across the country as well as here in the ACT. We do know that it is the same in the emergency department. And the majority of those are not related to restaurants.

I presume where you are leading is: is that a reason to be concerned about fetes and other events? Hand on heart, I cannot say that we have had a major outbreak in relation to a fete or a community event over the recent period. I do mention that that has happened recently in Brisbane, so it does occur. In other places, there was another community event which a student of mine, when I was working at the ANU, investigated in Sydney. I think it was in 2009. Again, over 100 people were severely affected. That was a community event. These things do happen. Can I show absolutely fundamentally that it has happened in the ACT? No, I cannot. But sometimes no news is good news.

MS LAWDER: My thinking is that we get these outbreaks from restaurants that are already subject to quite a regime and we still have occasional severe instances. So what may be the benefit in applying a similar regime to other sectors? But if you feel, hand on heart, that that is an area where there may be potential for a lot of cases, then—

Ms Gallagher: I think the fact that there are so few coming through restaurants actually endorses the regulatory approach. The fact that we do have strict guidelines and inspectors do inspect, that they do shut down businesses, that they do name and shame with prohibition notices on the walls, I think sends a very strong message around the importance of regulation.

In relation to the issues that have come to the public's attention through the sausage sizzle and the alleged emergence of a new squad of quiche police, the issues there are

very real. If you go and ask somebody how hot do you have to cook a sausage at, not many people would be able to tell you, to actually cook it safely. And for how long are you allowed to store it in a metal tray before selling it, before it becomes risky? Again, I do not think many people would be able to tell you.

The issue with the quiche police, and Dr Kelly's team were guilty of providing advice around the ultimate best practice, is that you would not cook a quiche at your home, put it in a hot oven, put it in a cold car with air conditioning, drive through the sun or the rain, get to a school, perhaps have it outside, perhaps have it inside. That elevates the risk of that pastry, with egg. That is the point that Dr Kelly's staff were making. No-one was banning anyone from doing it, but it is not the safest way.

I think that message is very important to get out. You only need to see a small child that is suffering from salmonella. Someone who was sick from the Silo Bakery a year or more ago is still on antibiotics, and had an operation to clear out infection related to that. It is not just a case of diarrhoea; it is much more serious than that.

That is particularly so for vulnerable groups. The woman who passed away in Queensland was 77, I think. So the elderly and the infirm, the disabled children, are the vulnerable people here. You and I probably would get away with it and clear it. But others do not. For us, it is about trying to provide a balance between not being a nanny state and elevating a level of understanding around food safety and having an appropriate regulatory response to deal with the issues. I have to say that I think we have got the balance right.

THE CHAIR: Dr Kelly, are pregnant women one of those vulnerable groups?

Dr Kelly: Yes, definitely. The minister is quite correct; the vulnerable groups are the ones we want to take particular note of. But I would reiterate my previous statement: the more of these things we have, the somewhat rare events of death and serious illness will increase as a proportion. You will eventually get these things. A lot of our work we are trying to do here is to minimise the number of outbreaks, to increase the awareness of food safety issues and to try and decrease the problem for the community.

I have often said—and I am happy to say it again here—that I think the ACT community values the ability to eat food, wherever they get that food from, and to not get sick. I think that is a very key public value that people appreciate. So that is our role and my role, to do as much as I can in that space to ensure that to the best of my ability.

MR HANSON: A supplementary, if I could, Dr Bourke.

THE CHAIR: Okay.

MR HANSON: I remember when this legislation came up. You talked about consultation with industry, and I agree that that occurred. I remember the legislation. I remember the tabling speech and the debate. There was never any mention of community organisations. Was there any consultation done with community organisations as part of this legislation?

Dr Kelly: Thank you for the question, Mr Hanson. The way we did the consultation and how we identified who we should consult with were those that were registered food businesses. It is a bit more complex than that. Certainly, some community organisations are registered food businesses.

MR HANSON: I am not talking about those that are registered food businesses. What I am talking about is the local charity barbecue outside Bunnings, at the school fete and so on. We signed off on a piece of legislation and supported it based on what we were told—that this was going to be targeting the food providers, whoever they might be, in industry. Then we find out that this is going to be targeting local barbies, essentially. I was certainly surprised. I do not know if the minister was surprised.

What happened between us debating a piece of legislation, receiving briefings from directorates, being told one thing, and the next thing somebody is out there targeting a local barbecue from a scouts group? Who made that decision? Who took it from what was very clearly in the space of the food providers who are part of the regulatory system, to go after what you have described as low risk organisations—sausage sizzles—for which there is no evidence of any sort of outbreak? How did that go wrong?

Dr Kelly: Well, I admit we did not consult as widely as we could have, but I come back to my original premise: the legislation passed by the Legislative Assembly in 2001—not last year—the Food Act, clearly states what is in scope and what is out of scope. A number of organisations and events were not registered, and our mistake, if you like, at the time was to assume that we had covered everyone that needed to be thought of and consulted because we had our list of registrants, we had their addresses and so forth and we could get in touch with them.

But the Food Act right back to the beginning in 2001 clearly states that the people covered by this include anyone having an event more than five times a year, so that would include many of the sausage sizzles and so forth. And that was not changed by that legislation. So I do not accept your premise, Mr Hanson, that something went wrong from that point of view. That was not changed in that legislation at all.

MR HANSON: Yes, but you are going back to 2001. We were presented with a bill in 2011 that was very much aimed at responding to some outbreaks that had occurred in restaurants.

Dr Kelly: Correct.

MR HANSON: The Auditor-General's review was quite damning of the food inspectors. As a result of those events, we were given a piece of legislation to debate, and all of the information around that—I assume the minister was of the same mind that I was—was that this was targeting the people who were potentially going to cause outbreaks in the industry. Industry was consulted with, and then somewhere in the directorate someone decided that this meant, "Okay, we can go down and impose this on—

Ms Gallagher: No, no, that is not what happened. As Dr Kelly said, temporary food

stalls were subject to a regulatory requirement already. The new legislation required them to have some food safety training and a food safety supervisor. That is where the concern came. So groups that complained did not think there was a need for $150 for training for a food safety supervisor, and there were some genuine concerns around having a food safety supervisor available at particular times et cetera.

When those concerns were raised with us Dr Kelly and his team started a process with them of going, "Right, okay, well, this is what the law says. We are listening to what you're saying. Let's do a piece of work around how to make that work for you." No-one went after charities, to use your language, to do anything to them. The requirement was to get a food safety supervisor in place and to undertake some training. When those groups came back and said, "Look, that's too much for us. We don't want to do that," we said, "Righto, let's have a talk about how to operationalise this."

The results are that we have exempted the sausage sizzles—against Dr Kelly's advice. I have made that decision based on community feedback. At times politicians have to make those calls. However, the free training that is available is being taken up by many of those organisations and being done. I do not want it to look like there was a conspiracy to mislead either you, the Assembly or those organisations. There was never an intention to make anything too burdensome on charities—

MR HANSON: No, no, I am not looking for a conspiracy, I am just trying to—

Ms Gallagher: So we have tried to fix it.

MR HANSON: What was presented to us in response to a problem was a solution—

Ms Gallagher: But it was building on the Food Safety Act of 2001, and perhaps that is—

MR HANSON: I am just not sure that anybody in the Assembly had a view that what we were voting on was going to have an impact on local barbecues. I suggest that you would be included.

Ms Gallagher: I certainly had an understanding that it would affect community and sporting organisations. I had that understanding. As to the operationalising of the law, when you go back and look at the debate, you made some comments about that and I made some comments about needing the 18-month lead-in time to work with organisations about operationalising what we had put in place. That was done, and towards the end of that 18 months some of these issues were identified about exactly how that kind of high level approach would a work for the people who were having barbecues every six weeks or whatever—the plethora of organisations, small, large, whatever.

I certainly had it in my mind that those large sporting canteens, commercial canteens, that sell a whole range of food to thousands of people every weekend should be subject to food regulation. That was certainly in my mind. As to the minutia of operationalising it to a Bunnings barbecue and what that would mean for that handful of people, when that was raised with me I certainly had discussions saying, "Look,

this was never the intention of the legislation. So what are we going to do to manage it?" Health came back to me saying, "Well, let's make it 12 instead of the five that was passed in the Food Act in 2001. For temporary food stalls that hold five, let's move that to 12," and we had some discussions about that. That would certainly have picked up those people having barbecues once a month, so I went back and had a look at the debate, had a look at what the Assembly had said and felt that that was never the intention.

That is why we have exempted—or we will exempt with the support of the Assembly—barbecues, or however it is going to be phrased in a parliamentary counsel type of way—temporary food stalls that do certain things. It will be hard, because, again, if you are having a barbecue and then having some egg salad sandwiches, that is not necessarily low risk. So it is going to be tricky.

MR HANSON: I look forward to that debate. On a further matter, the Auditor-General's report into the management of food safety, report number 6 of 2011, contained 10 recommendations. Have those recommendations which were agreed to by ACT Health been implemented?

Dr Kelly: Yes, all have been implemented, the last of which is in this annual report around working with the University of Canberra—a very pleasing collaboration with a local provider in this university town—to provide environmental health officer training locally. This will be the first new environmental health officer training course in Australia for some years. In fact, it bucks the trend of most other institutions of actually stopping those courses. That was a recommendation around ensuring we had adequate and adequately trained staff to do the functions of that. All of the other recommendations have been well and truly dealt with.

THE CHAIR: Thank you.

MR HANSON: In this—

THE CHAIR: No.

MR HANSON: In this area—

THE CHAIR: No, we are done with that at the moment. Ms Berry, a substantive question, please.

MS BERRY: I had a question regarding trends emerging from the year 6 activity and nutrition survey. What is being done to combat this? It is on page 156 of the report?

Dr Kelly: Which was the survey, sorry, Ms Berry?

MS BERRY: The year 6 activity and nutrition survey.

Dr Kelly: This relates to a number of the survey programs we have running here in the ACT, three that are under my direct sort of supervision. One is the general health survey, which includes children but it is mostly aimed at adults. The second one is the secondary school alcohol and drug survey, which is a national survey we undertake

here in secondary schools with colleagues interstate. And the third is the year 6 physical activity and nutrition survey, which you mentioned.

All three surveys have quite important information to tell us around about general health issues in the community. Each of them has somewhat different specific questions and emphasis, but the one for year 6 is really around obesity, physical activity and nutrition. We have conducted several of those surveys now and we are looking at those trends. It is certainly part of what has led to our healthy weight initiative and other anti-obesity components of our work over recent months.

MS BERRY: Have you identified some of the trends coming out of those surveys?

Dr Kelly: Yes, there are a lot, and I will just turn to my notes, if I can find them. Specifically for the physical activity and nutrition survey, that has been conducted every three years since 2006. Results from the most recent one, which was in 2012, will not be released until early next year. But the survey monitors and identifies trends in children's general health and wellbeing, as I have said, and charts weight, physical activity levels and dietary intake. All of those things—and this is part of our work with the national partnership agreement on preventative health—demonstrates that we still have a lot of work to do in that age group in terms of improving nutritional understanding and nutritional intake, particularly around fresh fruit and vegetables, encouraging kids to reach the national standards on physical activity and thereby influencing weight.

Obesity in that age group is still a concern. Whilst there is some evidence that it is levelling off, it is still way too high, hence our healthy weight initiative in terms of trying to deal with the issue at a population level.

MS BERRY: What sorts of factors are taken into consideration regarding things like alcohol and kava with young people, particularly around multicultural festivals?

Dr Kelly: We do not cover those in the year 6 one, but, certainly the secondary school alcohol and drug survey is all about alcohol. We do not ask about kava specifically, but alcohol and other drugs are specifically asked about, including tobacco. There are extremely encouraging, very good trends in a decrease, particularly in tobacco use, in that age group. The list of drugs that we ask about, the more illegal substances, they are also trending down. Some of them have almost disappeared completely over the years that this has been running, and we have done this over 12 years now.

MS BERRY: I was interested in kava because of our Indigenous and Torres Strait Islander community in the ACT and the multicultural festivals. What are the effects of kava, and is it actually referred to separately to alcohol when you are talking with young people from those communities or even through the multicultural festival?

Dr Kelly: Kava is an interesting challenge, I suppose. Technically kava is illegal here in the ACT. We have done a lot of work, particularly with the Islander community, not so much Torres Strait Islanders and Aboriginal people. In other parts of the country that is an issue, particularly Aboriginal people in the Northern Territory in relation to kava. But, really, the issue here is the cultural use of kava, which is very prevalent in many Pacific Island countries. It is seen as a very important part of their

culture here in Australia as well.

We have done a lot of work with them over the last two or three years in relation to the Multicultural Festival to the point that we now have a regulation that the minister has agreed to to allow cultural use at that time and on specific applications other times, although the only time we have had an application so far is in relation to the Multicultural Festival.

At this year's festival we worked very closely with the community in our usual educative approach with consultation and so forth. We had a couple of meetings with the leaders of that community to make sure that they understood what was allowed and what was not, particularly in relation to whatever public health risk there may have been to the general public.

Where we landed with that really was to say that the true cultural use within the stalls was allowable. People could be invited in to partake of kava in that setting, but it was not to be sold, it was not to be advertised and it was not to be thrown around willy-nilly as it were. That was a compromise between the really quite small public health risk versus the cultural importance of that particular substance with that community.

The community seems happy with that approach. We are happy. We will continue to monitor that during the multicultural festivals. As I say, they now have the option of applying to the minister for permission to serve kava on other occasions as well. We will wait and see what they ask about.

MS BERRY: What are the effects of kava and why is it illegal?

Dr Kelly: Kava is a traditional drink in the Pacific Islands that has been used for hundreds of years, if not a thousand years. In its traditional form it is somewhat interesting how they sort of prepare it. In some cultures, not all of them, they actually chew it first and then spit it out into a bowl. So there is a whole bunch of other things in terms of safety there. But it is an aqueous substance anyway.

It is a traditional cultural ceremony, particularly in Tonga and invariably in other countries. In Tonga it is a very complex ceremony which can take hours and hours before you get your first sip. So the actual partaking of kava, the amounts that are consumed in a particular session, whilst it may happen fairly commonly over a week—every day even—are extremely small; one cup, half a cup, a few sips.

In the Northern Territory, it was introduced some years ago when I was working there. It was introduced as an alcohol substitute. There it is consumed by the bucket load. When you consume it by the bucket load, it can lead to a whole range of other issues and problems—liver problems, skin problems and people are more likely to have infections. Am I being wound up, chair?

THE CHAIR: No.

Dr Kelly: It was on the basis of work done at the Menzies School of Health Research in Darwin around these effects that led to a national ban and restrictions on what could be actually brought into the country. But kava is used in traditional forms in

other jurisdictions. We have just worked with the community to make it quite clear what it is that we expect, that the AFP also knows what is being enforced or not, and that the community knows what they are able to do as well.

MS BERRY: Thank you.

THE CHAIR: Substantive question, Mr Wall.

MR WALL: I am happy to move on to the next output class.

THE CHAIR: Ms Lawder, do you have any substantive questions in this area? No? Did you want to finish off with a couple of supplementaries there, Mr Hanson?

MR HANSON: No, I am happy.

THE CHAIR: You are ready to move on. Thank you, Dr Kelly. We will move on to cancer services, output 1.4. Minister, on page—

MR WALL: Chair, should it not be my question next?

THE CHAIR: No, we start again.

MR HANSON: Are you starting again at each output, are you?

THE CHAIR: Pardon?

MR HANSON: I was just inquiring whether you were starting again or whether—

THE CHAIR: Yes, we will just start at the top and work down again. If people do not have any questions, that is okay. I refer to output.1.4 on page 160. I notice that there is a new suite new staff, patients and equipment in cancer services. Could you tell me about that and the trend in cancer treatments, please, minister?

Ms Gallagher: What page are we on?

THE CHAIR: Page 160 of the report.

Ms Gallagher: Sorry, what was your question?

THE CHAIR: Reference is made to a new suite of new staff, patients and equipment in cancer services. Can you tell me about that and the trends in cancer treatments?

Dr Brown: Certainly. Whilst Denise is coming up, I will respond in terms of our performance against targets for cancer treatments. We certainly are seeing 100 per cent of cancer patients within the recommended treatment times in terms of those requiring radiotherapy. We have seen a large increase in the volume of patients coming through cancer services, predominantly in the outpatient setting. That is across medical oncology and radiation oncology as well as haematology and immunology that sit within the cancer services directorate. I will hand over to Denise who can give you more detail about the suite of services and staff.

Ms Lamb: Cancer services have experienced a significant growth in demand. To meet that demand we have had an increase through our funding for a range of different staff. Within medical oncology, last year we had an additional medical oncologist commence. Within haematology, we had a new haematologist. Then within radiation oncology, to service the new linac we had one additional radiation oncologist, two radiation therapists and one nurse. Those additional staff have been able to help meet the needs of the increased demand across services.

MR HANSON: I have a supplementary question on that. I remember that there was an issue a number of years ago where there was a real shortage of radiotherapists. Has that been resolved?

Ms Lamb: Yes, actually at this time we are fully recruited for our radiation therapists. We have introduced a range of programs to try and build sustainability within the service. That has included a new graduate program as well as looking at how we can retain our staff through a range of initiatives.

THE CHAIR: Substantive question, Ms Berry.

MS BERRY: Yes, I do have a question regarding breast screening. How many women have received breast screening in the 2012-13 financial year?

Dr Brown: In terms of the number of people through?

MS BERRY: Yes, in 2012-13.

Dr Brown: It was 14,017, I think, from memory, or something like that.

Ms Gallagher: Perfect.

Dr Brown: There you go.

Ms Gallagher: Page 5.

Dr Brown: Pulled that out of somewhere.

MS BERRY: How is BreastScreen ACT working to fill vacancies for ACT women who have their breasts screened?

Ms Lamb: The breast screen program has initiated a range of strategies to try and increase the presentations to the service. A lot of work has been done through working with the media in regards to getting out information on the advantages of screening and why woman should undertake and attend the program. Also, we are looking at working with the Aboriginal and Torres Strait Islander community and the culturally and linguistically diverse community to try and improve the understanding and knowledge within those communities to increase the numbers as well.

A key area that does help increase the numbers is through working with GPs, ensuring that we have promotional information there, ensuring that knowledge is out there, that

we have appointments available for the target age group et cetera.

MS BERRY: Can you update the committee with the details of the recent MOU with New South Wales for breast screens for New South Wales women who work in the ACT?

Ms Lamb: We recently undertook to have an MOU signed off in respect of women who live in the border regions of the ACT and New South Wales but who are New South Wales residents that work in the ACT. Therefore, they have trouble accessing New South Wales services. They can now access ACT BreastScreen. We have undertaken to limit the number of appointments available so that we can ensure that does not impact on the availability of the service for ACT women. In November and December we have screened New South Wales women, but we certainly have not reached that number of available appointments.

MS BERRY: Can you remind the committee of the target age?

Ms Gallagher: Target age group?

MS BERRY: Yes, the target age group.

Ms Gallagher: Fifty to 69.

MS BERRY: Fifty to 69. From age 50 women are entitled to a free breast screen?

Ms Gallagher: From 40 years old you are.

MS BERRY: From 40 years old now?

Ms Gallagher: Yes. But the difference between 40 and 50 is that you are not in the target group; so you will not get a recall. You will not have that automatic contact, basically, unless you initiate it yourself. But anyone from 40 can go. But the target age group is 50 to 69, although I think in New South Wales it is 50 to 74.

Dr Brown: That, I think, is a result of the last federal budget where they made an announcement that they would be planning to increase the target age group from 69 up to 74. But the funding to support that additional group has not yet flowed through. We are anticipating that we will be making that change once that funding becomes available. But at the moment it remains 50 to 69. That does not preclude people over the age of 69 having access to the service.

MS BERRY: To get a breast screen, do you need to have a referral from your GP or can you just go and make a date.

Ms Gallagher: Just ring up.

THE CHAIR: Substantive question, Mr Wall.

MR WALL: I will defer to Mr Hanson.

THE CHAIR: I will go to Ms Lawder first.

MS LAWDER: On page 162 there is reference to issues and challenges. It talks about high workloads and an increase in the number of less urgent patients waiting to be seen in the haematology department. Can you give us an update on how that is going?

Ms Lamb: Over the last couple of years the haematology department had been experiencing a significant challenge in regards to recruiting to the haematology positions. That then required further focus and targeting on making sure that access was available for our urgent and category 1 and 2 patients. For the category 3 patients, the less urgent patients, that wait time did increase. With the recruitment during 2012 of three new haematologists, we have actually been able to start addressing that longer wait time and have got that right down.

MS LAWDER: What kind of level is the wait time at now?

Ms Lamb: At the end of June, for the category 3 patients we had 33 per cent of patients allocated to appointments. In respect of the remainder of those patients, we aim to have them all seen by March 2014.

MS LAWDER: More recently, is that on track?

Ms Lamb: I do not have the current ones, sorry.

Dr Brown: They are the figures up until 25 October. Yes, that is relatively recent. Just to supplement that, the average wait time for category 1, which is due within 30 days, is 21 days, and for a category 2, which is due within 90 days, it is 42 days average. So I think overall it is a very good performance.

THE CHAIR: A substantive question, Mr Hanson.

MR HANSON: Thank you. I had a constituent that approached me about a perceived delay in getting a PET scan. This is a constituent that had cancer, who was in remission and who had a specialist doctor who found a number of masses. He organised a PET scan. There was some delay in getting that PET scan. One of the people that runs the system there identified a cancellation and then rang her and she was able to actually get in—

Ms Gallagher: That is how it is managed, yes.

MR HANSON: So there was a resolution to it. But I am just wondering if you can let me know if there is an issue there in terms of delays, whether people are getting in on time to get PET scans. I am not sure what the categories are there in terms of waiting times for a PET scan, if there is any triaging of categories of emergency and so on.

Ms Gallagher: I will let Ian follow up, but I would say that it is only in the last two years that we have had a PET scan in Canberra. People had previously had to travel interstate if they have needed a PET scan. So we have got the scanner in place and there is a level of demand for it now.

Mr Thompson: PET scanning is organised according to clinical priority, and, accordingly, the more urgent cases are seen first. There is not a formal triaging process that approximates to something like elective surgery in that regard. Building on what the minister said, this is a service we have recently introduced and for which we have been increasing the capacity. However, the capacity needs to be balanced off with a number of particular factors associated with PET scanning. One of them is that to undertake PET scanning you need radioactive isotopes that are not produced locally in the ACT, have a very short half life and, therefore, have to be ordered, brought straight in and the scan performed almost immediately—before the isotope decays. That creates some significant scheduling issues in terms of fitting in cases and creates a limit to the amount of flexibility we can have for that service compared to other services where we can flex up and down as referrals change. It is a service we are increasing, and we provide the flexibility wherever we can, but it has particular constraints.

MR HANSON: Are some patients still being referred to Sydney or elsewhere?

Mr Thompson: Some patients still go to Sydney, yes.

MR HANSON: What is the ratio of those that are getting scanned here and those who are going elsewhere?

Mr Thompson: I do not have that available currently. One of the factors in terms of that is the referral source. We will never be able to determine definitively the number of patients of private oncologists, for example, who have been referred to Sydney because that never touches our system. But I can look to see what information we have about the number of patients who are referred to us who then receive their care in Sydney.

MR HANSON: Is there any consideration to increasing the capacity locally or is it just too expensive?

Mr Thompson: It is being looked at. It is something that we need to consider as part of the budgetary priorities and balancing it with the other priorities. The big transformational change that would happen in regard to this service would be being able to produce the isotopes locally, but that is a major capital investment that is not being seriously considered at the moment. So, yes, within the constraints that are available to us we are looking at what we can do.

THE CHAIR: Where do the isotopes come from?

Mr Thompson: From Sydney. I cannot say off the top of my head precisely where in Sydney. Either a nuclear reactor or a cyclotron are the sources of the radioactive isotopes, but I cannot say definitively.

DR BOURKE: So presumably Lucas Heights.

Mr Thompson: It may be, but it does not have to be Lucas Heights, because cyclotrons are used elsewhere outside of a nuclear reactor as such to produce some of the isotopes.

THE CHAIR: Thank you.

MR HANSON: The cancer centre, there has obviously been a very unfortunate flooding incident.

Ms Gallagher: Yes.

MR HANSON: Can you update us in terms of the delay that is anticipated, when it will come online and whether that is going to increase the cost of building?

Dr Brown: I will answer that. We have had the assessors in assessing the damage and looking at what remediation work is to occur. We have not yet got the final program, but the preliminary advice is that quite extensive work is required and it probably will not be complete until close to the middle of next year, and then we have to do the clinical commissioning work we would ordinarily do ahead of moving into a new facility. Unfortunately, the delay is going to be much longer than anyone would like. In terms of the costs of the remediation, again, this is still being worked through, but we expect it will largely be covered by insurance.

MR HANSON: Sure. So how long is that delay?

Dr Brown: It was due to open in November, and this occurred on the long weekend in September.

Ms Gallagher: So it is several months. We are factoring in Christmas time as well. We had a meeting about it the other day. As much as that can be pulled back, it will be pulled back, but we are giving ourselves a bit of time in that to make sure everything that needs to be done can be done.

MR HANSON: And is that centre going to be new capabilities, or is it going to be a relocation of existing capabilities or a bit of both?

Dr Brown: It is largely a relocation bringing together in one place a range of different services that people with cancer need to consult and facilitating them working together.

MR HANSON: So there is no additional capacity out there. It is more or less—

Ms Gallagher: We have made commitments around growing cancer services, particularly in the outpatients area. So there will be growth in services incrementally. It has always been about a better physical facility with the ability to co-locate a range of specialties that wrap around the patient rather than the patient having to go from one place in the hospital to another to another and that it would be all located in one facility.

MR HANSON: I have got another one, if that is all right, Mr Chair?

THE CHAIR: A supplementary?

MR HANSON: Yes. It is on cancer services. Some cancers get a lot of profile. You would be aware of BreastScreen, which is something we talk about regularly. Minister, you and I have endeavoured to try and raise the profile with regard to melanoma. There seems to be a category of some cancers that are well known and people make an endeavour to raise money for cure and particularly prevention. Are there any others that have been identified where emerging growth in particular cancer is not getting the preventative measures that could be put in place? Melanoma and prostate cancer are examples.

Ms Gallagher: Bowel cancer gets a lot of the pre-screening.

MR HANSON: It seems some get more attention than others at various stages with different ribbons and so on. In terms of the preventative strategies that exist in the ACT, are they balanced? Are there ones we need to put more effort into?

Dr Brown: I might ask Dr Kelly to give his expert opinion from a population health perspective in relation to this question.

Dr Kelly: Thank you for the question, Mr Hanson. As part of the AMAC structure, there is a whole lot of committees, and one of the committee is a screening committee. My deputy, Dr Andrew Pengilley, attended that national committee meeting yesterday where a whole range of issues around screening were raised, and these are all exactly what you are talking about.

On the big national programs, we have the bowel screening program that is funded by the commonwealth. In a sense, we do not have much to do with that. That is a direct mail-out. When you reach a certain age—and some of those ages are being expanded—you are asked to give a sample and send it back. Where we become involved is if there is a positive test, so that then links into our gastroenterology service in the clinical side of the organisation. That is a big program, and that is on the basis that bowel cancer is one of the commonest if not the commonest cause of cancer in both males and females.

You have mentioned the breast screening one, and we are very much involved in that. Whilst there is screening in the private sector, most of it is happening within our service, from reminders and so forth, as the minister has been talking about, as well as the actual screening. And the consequences of that are certainly within our domain.

The other one we are involved with under my area is cervical screening. That is about pap smears and so forth. Again, most pap smears happen in general practice, but we are responsible for keeping the register and informing about rates of testing as well as abnormal testing and, sending reminders and so forth to people who have not had the test in the age group of concern.

On that one, in particular, a lot of changes are afoot in terms of what may happen, particularly in relation to the HPV vaccine, the human papillomavirus vaccine that is now, as of this year, being offered freely through our vaccination service in the schools to males as well as females. So the whole rationale for that vaccination is actually to decrease the rates of cervical cancer. That has been going for quite a while now with girls and they are now in their 20s. As they go through the time when

cervical cancer may be coming, the screening will change, and there are discussions around that.

In terms of other common cancers, you mentioned melanoma. That is of concern. There is no actual official program for that, but people are encouraged to get checked, and the Cancer Council particularly puts out a lot of messages about getting checked and so forth.

You also mention prostate cancer. There is no specific national program for that, but we know, particularly in primary care, a lot of men, are regularly tested. I sit on the National Health and Medical Research Council and we debated at the council meeting last week the pros and cons of that. Essentially, there is a fair bit of potential harm from having a test because of the false positive rate and so forth and what happens to people down the track.

There is certainly a live debate in the ACT as well as nationally about what should be tested in terms of cancer prevention, but it is a very important part of our armamentarium to decrease cancer rates is in prevention and screening.

MR HANSON: An important part of your what?

Dr Kelly: Armamentarium. We take these things very seriously. It is part of what we do.

THE CHAIR: Dr Kelly, a recent MJA article reiterated the current debate around prostate cancer screening. Perhaps you could go into a little bit of depth for the committee about what those particular issues are and the risks to men around either treatment or no treatment.

Dr Kelly: There may be others in the room that will be able to help on the clinical side. Perhaps Professor Bowden can chip in. The issue is that the PSA test, which is the one that is used, was originally brought in as a way of screening people after they had been diagnosed with prostate cancer rather than before they have been diagnosed. In those circumstances it is actually a way of testing whether the cancer has come back, essentially. The problem with it being used as it currently is—as a screening test in clinical practice—is that it is not very good at being accurate enough to be used in that setting. There is a high rate of false positivity, so the test will be high but cancer is not there or, if it is there, it may be so small as to never actually cause symptoms and problems in the future.

What happens when that positive test comes is a whole range of other tests happen after that, some of which are quite invasive and have their own risk profile and can lead to unnecessary testing and even unnecessary operations which themselves have consequences for something that may not have ever caused a problem. But the reality is, once the test comes back, people tend to go on that line and an unknown number will actually end up having unnecessary operations which can cause problems. I will be a bit graphic—impotence, incontinence and so on.

On the basis of those considerations, the National Health and Medical Research Council is saying that people should think twice about having those tests and discuss

it carefully with their doctor. There is advice to the doctors about what they should say to the patients.

Prof Bowden: Peter Collignon and I have been interested in this problem for a number of years because of the infectious disease complications that we see from screening. If I can go back a step, firstly, I would say that I agree with everything that Paul has said. But if we go back and look at the two large randomised clinical trials that were conducted in the United States and Europe in the last 10 years, both of those studies have come out and produced their final evidence. This is the best evidence that there will ever be about prostate cancer screening using current technology.

The American study showed no benefit in screening for prostate cancer in terms of cancer-related death or mortality overall. So the groups who were screened versus the group who were not screened had no benefit. The European study showed a very marginal benefit for screening for men in terms of cancer-related death. So the group of men who were screened had a slightly lower rate of death related to prostate cancer. But, overall, when they looked at the two groups over a 10-year period, they had exactly the same death rate.

This evidence has led the United States public health task force to make an unequivocal statement about prostate cancer screening—that is, there should not be any prostate cancer screening with current technology. The American Urological Association in the last year have dramatically changed their recommendation for prostate cancer screening so that they have now said that men between the ages of 40 and 55 should not be screened for prostate cancer, and that is a dramatic change on what they had been doing in the past. But they do recommend that there is a discussion between the doctor and the patient between the ages of 55 and 70. We all know that if a man is asked, "Do you want to be screened for cancer?" the answer is, "Yes, I do." So we know that that actually turns into cancer screening.

If you look at Australia, there is no prostate cancer screening program, and yet if you look at the Medicare data for PSAs performed and put that against the age group in which that testing is done—and there are lots of difficulties with this, because it is not collected prospectively; it is not collected with a specific intent of working out how many men are screened—and if you do a calculation based on number of men in the age group and number of PSAs which are performed, we end up with a screening rate which is higher than for mammograms. So somewhere between 60 and 65 per cent of the target age group—50 to 70—are screened each year in Australia in the absence of a screening program. You can simply calculate the number of tests that are done in Medicare plus the prostate biopsies which are required following that to work out what the cost to Australia is in terms of a screening program which exists in everything but name.

With respect to the discussion that occurs in Australia—and I had not actually heard that the NHMRC had discussed this recently, so I am very keen to see what their statement is—now I step away from the facts and I move to my opinion. My opinion is that we should follow the American guidelines. I think the American approach has been unequivocal at one level—that is, at the public health expert level—and has moved dramatically at the level of the American Urological Association, which, as you can imagine, are a group of people who have a particular interest and bias in that

regard. So I would think that in Australia there is room for a very careful and calculated move away from prostate cancer screening.

The reason I mention Peter Collignon and I is because we see all of the complications of screening. When a person has a PSA test, if it is positive, you then have to decide whether the person truly has cancer. If you want to do that, you have to have a prostate biopsy, and the prostate biopsy requires a needle passed through the rectum into the prostate. We know that even with antibiotic prophylaxis given at the time of the procedure, the rate of bloodstream infection—E-coli circulating in the blood—is between 0.5 and two per cent. So let us say it is one per cent. One in 100 men will have a bloodstream infection, and we know that the death rate from a bloodstream infection of E-coli ranges from five to 15 per cent, depending upon how old you are and what other illness you have.

We know that around the world people die from this procedure, and they do not have a cancer when the test finally comes back. If you look at that and multiply that by the number of tests which are done around the world, you translate that into a large number of people each year being admitted into intensive care for treatment for serious, life-threatening illness and you have a small number of people who die. In Melbourne a couple of years ago a doctor died under this procedure, and when you kill a doctor, people take notice.

I think that it is an absolutely central issue for us for screening, because we have to have a nuanced discussion about this. On the one hand, some screening works really well and saves lives. On the other hand, some screening works very poorly and, at best, leads to no benefit and, at worst, leads to more harm than good. So it is crucial at a public health level that we do not have a "screening is good" message; we have a "screening for certain cancers is really good" message, and that is what we have to push.

MR HANSON: Can I just follow up—

THE CHAIR: We are going to stop there and move on to the next area.

MR HANSON: I will be very brief, Mr Chair.

THE CHAIR: You can always put it on notice, Mr Hanson. We will move on to output 1.5, rehabilitation, aged and community care. Do you have a substantive question, Ms Berry?

MS BERRY: Yes, I do. From all the research and the discussion that has happened, the importance of healthy lifestyles and nutrition to geriatric patient outcomes is clear. Is there work being done with rehabilitation, aged and community care to promote these preventative health elements?

Dr Brown: We might ask Linda Kohlhagen to come up to the table and speak about what is happening within her division.

Ms Kohlhagen: Could you repeat the question?

MS BERRY: Yes, I can. It was regarding the research and discussion about the importance of healthy lifestyles and nutrition to geriatric patient outcomes and whether there was work being done within rehabilitation, aged and community care to promote these preventive health elements.

Ms Kohlhagen: There has been a specific program that we have done with our dieticians within the hospital to ensure that we do better screening of malnutrition in the elderly. There has been quite a lot of work done from an inpatient perspective. There is also work that we do in our community nutrition team. They run some healthy eating cooking classes for people that may not have traditionally been big supporters of cooking or been the primary person who cooked the meals in the family. That tends to be generally men as well. That often has a nutritional basis to it—that education session that they run as well. So we have programs that we target for our inpatients as well as for our community teams.

MS BERRY: You mentioned cooking class programs being mostly for men who have then become the primary carer or have lost their partners.

Ms Kohlhagen: Yes.

MS BERRY: Are they in that sort of age demographic—

Ms Kohlhagen: They could be predominantly older people, because, unfortunately, that is when they may have lost their partner. But it is not necessarily just for men. It is certainly trying to, as Dr Kelly spoke about, teach people the skills of how to cook and it is also incredibly important in stressing the nutritional value of what they cook. From the inpatients' perspective, it is really about screening and then what people actually do to improve their nutritional status, both when they are in the hospital system and when they are discharged.

With respect to some of the other programs, there is our falls program. This is a multidisciplinary program that involves nursing staff, physios and OTs and it can have links with our geriatricians. It is very much a proactive approach so that people who are at risk of falling or who have fallen undertake a multidisciplinary assessment and then a range of strategies can be put in place.

MS BERRY: Regarding the cooking classes, I do not know that there is any way you could measure whether or not that has worked and whether people are going into their homes and using the new skills that they have learned.

Ms Kohlhagen: I cannot tell you exactly how they measure the effectiveness of the classes. Some of the routine ways that they do is looking at efficacy scales as part of the class—actually asking the participants if their knowledge of activities or nutrition has improved as part of their participation. But I can certainly find that out, if you like.

MS BERRY: It would be interesting to have an exit survey of that, to see if it was actually working or not. Also, regarding lifestyle changes and exercise being able to assist geriatric patients with regard to pain and type 2 diabetes, are there facilities and services that ACT Health provide to support this?

Ms Kohlhagen: There is a range of facilities and services that we do. The role of exercise, unfortunately, is not just the responsibility of the health service. We certainly run some targeted education programs and exercise programs. But an important part of that, once individuals have learnt the skills and improved their fitness, is to integrate them so that they are able to continue those exercise programs either in community gyms or at home. We have a range of gymnasiums within our health centres, and there is a large one at the Canberra Hospital as well. We employ both exercise physiologists and physios who have a role in those activities.

MS BERRY: When you are talking about people using those skills when they leave, once they have learned those skills, do you work with senior citizen organisations or the sorts of organisations that might provide jazzercise classes or things like that?

Ms Kohlhagen: We do not directly work with them but we certainly can refer and talk to our clients about the range of options. Some people like classes and some people would be happier just to walk around—I was going to say on a sunny day but not today, possibly. But there is a range of ways that you can exercise to maintain your health and improve it as well.

MS BERRY: Do you provide them with some information about some of the groups that they might be able to join, like the Heart Foundation walking groups and things like that?

Ms Kohlhagen: Yes.

THE CHAIR: Mr Wall.

MR WALL: I wanted to ask about the aged-care assessment team. There has been an increase in the wait time from referrals to assessments being carried out due to a staffing shortage. What is being done to address that?

Ms Kohlhagen: I am pleased to report that we are meeting the target now, as of 31 October. Unfortunately, our ACAT team had quite significant periods of leave, both planned and unplanned leave, in the last 12 months which then affected their ability to undertake all the assessments. There has also been around a 12 or 13 per cent increase in total referrals to the ACAT team. So they have had to manage an increase in demand as well. With respect to staffing levels, I understand they are full, and we have also got access to casual staff. It takes a period of time to be able to train an ACAT assessor so that they can undertake, obviously, the assessments. We have access to some of the casual staff so that if we have another situation where we have staff shortages, we can call on them to assist.

One of the other things we have done is that within our division we have had a very small team that processes and does a lot of work around our referrals. We have been able to rejig that slightly so that we have been able to provide additional support to the ACAT team, because a lot of referrals are made to the ACAT team where people may be ringing up to find out just in case or wanting some information and they do not actually need to have an ACAT referral. So if we can use administrative staff to try and flush out and respond to those calls appropriately, it allows the ACAT assessors to do the clinical work. I think that is also having a positive impact.

MR WALL: You mentioned there had been an increase in demand for the services?

Ms Kohlhagen: Yes.

MR WALL: What has been the cause of that increase?

Ms Kohlhagen: Probably just the population ageing, because it is an aged-care service. So as we are all getting older, people are needing to look at their options. The previous minister for ageing said on the radio, "You should be prepared," and there was a direct increase in referrals to the ACAT team that particular week as well. But it is a factor or a reflection of an ageing population.

MR WALL: What plans are in place to potentially grow that team?

Ms Kohlhagen: As part of the commonwealth's aged-care reforms, there is a lot of discussion going on around the role of the gateway and who might do the assessments into the future, which is still being debated. With the ACAT assessments in the past, you might have had to have one for low care and then have another one in 12 months time. Those assessment requirements are also being looked at. So you might not necessarily need to have as many different types of ACATs into the future. But they are being discussed, I understand, at the commonwealth level at this point in time and we are yet to know what the full impact might be on our ACAT team itself.

THE CHAIR: Mr Hanson, a substantive question.

MR HANSON: Yes, I would like to start by thanking you very much for the tour on Tuesday through the Belconnen health centre and the new one in Gungahlin. I really appreciate it. It was good to see. They are certainly impressive facilities. I hope that they achieve what we want to achieve. In line with that, can you update me on where we are at with Tuggeranong? Also, what is happening with the old Belconnen health centre? Is that being disposed of, is it being used by Health or what is happening?

Dr Brown: To start with Tuggeranong, the refurbishment of the Tuggeranong Community Health Centre is still ongoing. We anticipate the completion of that in the first half of next year and, following a period of essentially clinical commissioning, moving back in. We expect it will get up and running in the first half of next year. Was your second question about the Belconnen health centre?

MR HANSON: Yes, the old site. What is happening there.

Dr Brown: We have moved the bulk of services that were located there into the new Belconnen Community Health Centre. What remains there at the moment is the aged day care service. We are currently undertaking a consultation with the relevant community—as in the current client groups—in relation to the best location for that service going forward. That consultation is still underway. So we do not have a final determination in relation to that service yet.

MR HANSON: Long term, though, is that site going to be disposed of or sold?

Ms Gallagher: I think that is the expectation. Yes, it is a pretty prime block in Belconnen.

MR HANSON: Yes, absolutely. So it is not going to be retained as part of the Health infrastructure.

Ms Gallagher: I think Health have some short-term need for it. If they had their way, they would fill it with something or other. It is an active debate around the table. But my expectation is that ultimately it will be disposed of.

MR HANSON: Okay. In terms of future growth in rehabilitation the plan is that that would move to the new subacute hospital. Can you give me an update on where the planning is at for the new subacute hospital?

Ms Gallagher: Yes, we can. At a high level, there is some work being done to finalise a deed of agreement between UC and the ACT government about really setting out obligations for the project, use of land, ongoing commitments to the facility, maintenance, approvals from UC. That has taken a bit of time to get right, but I am very confident that we are almost at the end of that. Then running alongside that some work is being done—I might get Jacinta up here—to progress the design elements, construction costs, models of care et cetera that will go into the building.

Ms George: We have finalised the service delivery plan which defines the project. That is ready to go out for consultation. We continue to work with the university about defining the university areas and the shared areas with the university. That work has commenced recently and is ongoing.

The models of care for mental health, rehabilitation and aged care are being developed. Mental health is more advanced than rehab and aged care, which has recently begun. We are now looking to appoint a principal consultant or go to that second stage of procuring a principal consultant or a design team to start early in the new year so that we can start the design work on UCPH once we have settled the scope, decided finally on the scope, and the budget for that project.

MR HANSON: In terms of the new facility, is it still running at about 200 beds or—

Ms George: The scope that is in the service delivery plan is for 140 overnight beds and a number of bed equivalents in day services for rehabilitation, aged care and mental health. So 25-day places as an alternative to the traditional overnight care.

MR HANSON: Of those 140, is that mostly comprised of services currently being provided but that are going to be relocated out of TCH, Calvary and elsewhere? What percentage of that is new services?

Ms George: They are predominantly services that exist and that are going to be expanded, integrated and changed to be more in line with contemporary rehabilitation. For example, mental health rehabilitation, which is currently provided as part of Brian Hennessy Rehabilitation Centre, will have a much more—I am probably speaking for Katrina here—rehabilitative function so that people will go through the facility rather than living there for as long a period of time as they do at the moment. It is very much

focused on rehabilitation, getting people out to the community.

MR HANSON: In terms of the design and the footprint, what is the plan in terms of space being put aside for additional capacity? One of the problems seems to be, based on the experience at TCH, that trying to build on an existing campus is very difficult. It is like a Rubik's cube in terms of moving things around. I think it is all going to be one story, is it not? Are you creating an area that is going to be an exclusion zone for future development? What is the thought about that?

Ms George: We have briefed that we need expansion space. At the moment, we are only at concept design stage, because we are still locking in the scope. On that concept design there are dotted lines around a footprint for expansion. We are also talking about briefing the design team about whether we also provide for expansion upwards. At the moment the concept design is actually over three storeys—underground basement level, the main hospital services level and another level for the university and our office accommodation.

MR HANSON: Okay; so that—

Ms George: But it may not end up like that.

MR HANSON: Yes. And, minister, I know that you are loathe to sort of put a date—

Ms Gallagher: Yes, I am.

MR HANSON: Because I will come out with a press release saying that you are late.

Ms Gallagher: You will hold me to it, yes.

MR HANSON: That is right. But are you able to give an indicative range perhaps—I am happy to put on record that I am not going to hold you to it—just so we can get a bit of an idea about when we can anticipate that this will be coming on line? I am talking about a frame; not a particular date, perhaps, but a range.

Ms Gallagher: There is a difficulty in giving you dates; so I am loathe to do it. Part of it relates to the fact that cabinet has not taken a decision, has not got information before it to make budget allocations which will actually deliver the project. My expectation would be that it would be commissioned and certainly operational by—see, I cannot even get the words out. It is not coming naturally. There are a couple of dates I could give you—

MR HANSON: There is no trust there, is there? No trust. It is only when we did melanoma screening together—

Ms Gallagher: That we broke through, you reckon. Good news, bad news day, was it not? "I am fighting fit."

MR HANSON: You probably had the same joy—

Ms Gallagher: Yes, I was hoping you had a couple of moles on your neck.

MR HANSON: to hear that I was fighting fit.

Ms Gallagher: Look, it is very difficult at this stage to give you a date.

MR HANSON: You obviously know what it is.

Ms Gallagher: There is a range of possibilities and it depends ultimately on actually reaching agreement with UC about the use of the land, signing off on the dotted line on that and then agreement around the budget and the delivery method. If we choose a private financing model, as some hospitals have used, that can add in another year or so to get the specs, because it is a lot more work done up-front around the specifications and outputs that we want to get. I am just not going to give you a date. I think that is the best thing today. As soon as we have—

MR HANSON: Open and accountable.

Ms Gallagher: I am being open in the sense that the decisions that will inform the date have not been taken. When they are taken, I will be sure to let you know.

MR HANSON: You will be open about not telling us.

THE CHAIR: Okay, we are going to move on to—

Ms Gallagher: I will. When it has got to a reasonable point where we can give a date, I will give the date.

THE CHAIR: We are going move on to output 1.6 now, which is early intervention and prevention. Minister, could you tell us about Canberrans' life expectancy and the focus on early intervention and preventative initiatives?

Ms Gallagher: I will get Dr Kelly back. Canberra does lead the nation in terms of life expectancy. That is excellent. I am sure we have all got an interest in that. There are emerging concerns, though, around the health of our community. I think they are well documented and understood. Certainly, there is growing literature that children being born today might not enjoy this life expectancy if we do not deal with some of the very significant health epidemics or poor health epidemics that are going on. So this is an important indicator which guides decisions that areas of Health make about what are priorities. It is very much linked to some of the preventative health work that we do and some of the initiatives like towards zero growth, the healthy weight initiative.

THE CHAIR: So you are talking about obesity?

Ms Gallagher: Yes. Do you want to add to that?

Dr Kelly: I think the minister has said everything that needs to be said about life expectancy. It is a pretty blunt instrument. We cannot afford to be complacent. Yes, one of my key roles—I think about it every day when I get up—is about keeping the life expectancy higher than the rest of Australia. I am not sure that I actually succeed in that every day, but many of the things we do in prevention and population health

are to try and achieve that aim. The minister has quite clearly articulated that there are clouds on the horizon in respect of this, obesity being one of the major things because of its link with chronic disease—what has been described as the tsunami that is upon us now and will get worse into the future. Obesity is very much an underpinning for many of those chronic illnesses.

THE CHAIR: Speaking of early intervention and prevention, how are our vaccination rates going?

Ms Gallagher: They are very good as well. We certainly either lead on the indicators or are second and third. It fluctuates. We have some small populations, particularly around our Indigenous children's immunisation rates, in respect of which we are leading the country in one reporting period and then we drop dramatically. That may be because a handful of children have missed their scheduled immunisations.

We do watch them very closely to pick up any emerging trends or areas of concern. I think there is still room to improve. We are sitting around 90 per cent on average when you look across all of them. Yes, the low 90s. I think our highest rate is in 15 months and younger where we are number one at 93 per cent. For cohort 2—that is looking at two year olds—for Indigenous children, we are at 87 per cent, but we are at 100 per cent in the other two categories for Indigenous children. With small populations, we do move around a bit. But overall I think an average of 91 to 93 is good when there is probably about a five per cent conscientious objection or whatever—people that you are not actually going to convince.

THE CHAIR: Sure.

Ms Gallagher: There is probably still a couple of percentage points where—

Dr Brown: Vaccine refusers.

Ms Gallagher: Vaccine refusers; that is right. That is a better word for them. I think that there is still room to improve and get the messages out about the importance of immunisation, and we do that.

THE CHAIR: Turning to those figures around vaccination of Indigenous children, of course, the age cohort is probably around about 100 kids or thereabouts.

Ms Gallagher: Yes, it is small.

THE CHAIR: Given that vaccination is a fairly important strategy in the closing the gap campaign, what sort of efforts is the directorate making to advance vaccination for Indigenous kids?

Ms Gallagher: Yes, do you want to speak to that, Paul?

Dr Kelly: Thanks for the question, Dr Bourke. You are quite right; it is certainly essential to the closing the gap campaign. In many parts of the country, but not all, vaccination rates are lower for Indigenous kids compared with other kids. In the Northern Territory, in fact, it is the opposite; they have very good rates, for example.

Here, as you pointed out, we have very small cohorts of kids going through. For the three age groups that we actually measure, there are only about 100 Indigenous kids in each of those. So if five kids do not get immunised for some reason in that group, you start to drop below the recommended or target levels. It becomes quite an individualised kind of approach to finding those kids and offering the service. We do that very much in partnership with Winnunga Aboriginal medical service as well as with the Medicare Local. The majority of our immunisations in that young child age group are in general practice, in fact, or, in this particular situation, with the Aboriginal medical service.

THE CHAIR: Ms Berry.

MS BERRY: I have questions particularly regarding the HPV vaccine and noting that there has been a much lower uptake for year 7 boys for the HPV vaccine. Do you have any idea why this might be the case?

Dr Kelly: Are you getting that from the report, Ms Berry?

MS BERRY: Page 169.

Dr Brown: This, of course, is a program that has only recently started for boys as opposed to girls, where it has been established for a number of years. I am sure Dr Kelly is able to speak about it in a bit more detail, but there was a catch-up program to include not only those in year 7 but some in year 9 as well. Paul, are you able to provide that information?

Dr Kelly: Yes. I talked about this a little bit in relation to cancer screening earlier. The human papilloma virus vaccine was introduced for teenage girls with a catch-up program for older girls and young women some years ago now, and that has been very successful. It was shown to be safe. The federal government funded an expansion of that program in the budget before last, I think it was, whereby they were able to procure enough vaccine to also cover boys. It was handed to the states and territories to roll that program out.

This is really the first year of that fully-funded free vaccination for boys. That is probably the explanation as to why the uptake is not quite as high as for girls. It is one of our school-based programs, so we certainly should be aiming to get towards 100 per cent. The vaccination program—and we may need someone else to talk about that—works throughout the territory over an entire year. So if someone is away for an occasion, they may not get the vaccine, and in the case of HPV vaccine, it is actually three doses. So if you miss one of those, you are not counted as you have not had the full lot. That is the reason why it is not 100 per cent, for example.

THE CHAIR: Mr Wall, substantive question.

MR WALL: My question is around workplace safety. I note that the Comcare reporting which has previously been in the annual report is missing in this year's version. Is that able to be provided to the committee?

Ms Gallagher: Sorry, I missed that.

MR WALL: This year there is an absence of the Comcare reporting in the annual report but in previous years that has been included—the number of Comcare claims lodged and not reported.

Dr Brown: Sorry, Mr Wall, if I can direct you to page 175.

MR WALL: There we are.

Dr Brown: Under "staff health and wellbeing", it provides the number of accepted claims for compensation at 113 for 2012-13, 89 for 2011-12, and I can advise year to date for this current year it is down at 82, from memory, from yesterday's meeting. So it is actually tracking below the 2012-13 performance.

THE CHAIR: Ms Lawder, a substantive question.

MS LAWDER: I am interested in the bit on newborn hearing screening on page 170. It says that screenings are provided to every newborn. Are you capturing home births, people who leave hospital on the same day? Is it 100 per cent?

Dr Brown: I might ask Elizabeth Chatham, the executive director for women, youth and children, to speak to that, but there certainly is a program to capture those infants that leave hospital in a very short space of time.

Ms Chatham: All children are screened in the ACT. That happens in the private and public hospital system. If a child is missed for some reason, there is a follow-up program that captures them. For people that have home births, they also can be contacted. It is up to the midwife care provider in the home birth to give that information to the woman.

MS LAWDER: I understand that. I was asking: are you screening 100 per cent currently?

Ms Chatham: Yes.

MS LAWDER: So they give them the information and 100 per cent of those home birth people present or are getting the screen?

Ms Chatham: The numbers that I think are included in this only count the women that are actually counted—who deliver in the public or private hospitals in the ACT. I think there are very few women birthing at home, but they certainly have the information and they can be contacted.

MS LAWDER: If there is a confirmation of hearing loss or deafness, how many of those babies go on to, for example, get a cochlear implant?

Ms Chatham: I do not have that information here. They are referred on to a hearing service, but I do not have the data.

MS LAWDER: Do you know how many the government funds per year?

Mr Thompson: I do not have the figure but we can provide that.

Dr Brown: Yes, we have just extended it. From memory, it is five to eight per year and we have just added an additional—I would have to check the actual numbers—four or five per year.

MS LAWDER: Is there much of a waiting list?

Dr Brown: I am not aware that there is.

Ms Gallagher: I do not think so.

Dr Brown: Again, we can—

Ms Gallagher: I spoke to some parents who are involved in the cochlear implant—I am trying to think of the name—organisation. They came and spoke to me at my kids' disco the other night, and they were just thanking—

MS LAWDER: Did they tell you it was too loud?

Ms Gallagher: They were saying they really appreciated the extension of the program. I thought, "That's good; it's filtered down." They were very positive about the program and the effect it has had on their very young child who has had access to it at a very young age. We can get some more information for you.

MS BERRY: A supplementary on that. Sometimes hearing loss is not picked up in babies straightaway. As children move through the preschool and primary school system, how do they get tested for hearing loss?

Ms Chatham: The maternal child health nurse screening program regularly screens children from nought to five, and when they enter school they are screened again at the kinder check, which is done in the first year of school in the ACT.

Ms Gallagher: And then a letter is sent home to every parent saying that their eyes, ears and height have been checked. I think we took weight off in the end, didn't we? It was offending too many people.

Ms Chatham: We put the weight on. We just do not put the BMI on.

Ms Gallagher: Right, we took BMI off. So you get a mini report, and whether or not you need follow-up.

Ms Chatham: And where to be followed up and how to be followed up.

THE CHAIR: How does that compare with other jurisdictions?

Ms Gallagher: I am not sure.

Ms Chatham: Not every jurisdiction offers a physical check of children starting

school. That is not unique to the ACT but it is one of the few jurisdictions that do offer that physical check in school. But the maternal child health nurse program is across all the other jurisdictions.

Ms Gallagher: But we are pretty generous with that, I think. Historically, that is the way it has been.

THE CHAIR: Any supplementaries, Mr Hanson?

MR HANSON: Yes, I have some questions in this area. Robert de Castella's program that was discontinued: what is the ongoing discussion with him as to whether he will be providing any programs, either publicly or privately funded? And what is the plan to fill that gap?

Ms Gallagher: There are ongoing discussions with Mr de Castella. We had a very strong response to the new health grants program, the $2 million program that we have now targeted to obesity. I think we had applications in the order of $11 million for that $2 million, and Mr de Castella's application was one of them. We are doing a two-stage process with this program. So that people do not have to put too much work into their applications, they go through a gateway—if you meet the criteria, you can go to the next stage. That is ranked by an independent panel of advisers and experts.

Mr de Castella's program did not make the second round and was not ranked inside that to progress to the second round. Health are discussing with him a particularly targeted program to complement the public obesity service that we are establishing. I am not sure whether that is ultimately going to be successful but discussions are happening.

Part of the SmartStart program was a broad population assessment. A lot of the effort went into assessing and then a small part of it was about, once children in that high risk group were identified, working with them. I have asked that work be done with Mr de Castella about focusing in on those children at that very high end and seeing if there is some opportunity there.

MR HANSON: How can kids be identified if there is no scanning process?

Dr Brown: We already undertake a range of screening programs separate to the work that Mr de Castella was doing. And part of the concern was that there was a duplication of effort. I will ask Joanne to speak to where we are at in terms of discussions.

Ms Greenfield: Thank you. The minister is exactly right; Mr de Castella's program was in the first round of the healthy Canberra grants. We had an unprecedented number of applications. It was over a six to one ratio for the money we had available. So it was really competitive. Even though there was merit to some programs, they just could not be funded. The $12 million would not go down to the $2 million that was available.

Mr de Castella was informed that he was unsuccessful in that first round. He has a proposal in in the smaller innovation fund round. That process has not been concluded

yet. Dr Kelly and I met with Mr de Castella on 2 December, and we asked, just as the minister said, for some more detail about his e-help program and the specific budget. We now have that from him and we are working on that budget with him to look at how we can make it more efficient. As to some of the screening programs that are in place that you were told about earlier, the kindie screen can identify those children. There is no need for the SmartStart program to do that. And the Medicare checks that are done with GPs can also identify them.

We have facilitated those discussions with Mr de Castella so that children can be identified. We have also facilitated discussions with Mr de Castella and the paediatricians to make sure we are joining up the referral pathway so that the children are screened, they are detected, they can potentially have an intervention and they have the right medical supervision.

The state of play is that we have the initial budget from Mr de Castella. I am going to talk to him and his team again on Friday to finalise that budget. Then there has to be an internal and then an external process about where we might get any funding from. There is still no guarantee of that, but the process is still ongoing.

THE CHAIR: Minister, you mentioned the public obesity service. Could you tell us a little bit more about that?

Ms Gallagher: That was funded in this year's budget, and that is providing the skeleton of a service that will be built upon in future.

Dr Kelly: Built on very leanly.

Ms Gallagher: Yes, leanly. That is really targeted to those people whose weight is severely affecting their health. It will, in time, look at issues of access to surgery for some high level interventions to support people. For some people perhaps surgery is the only option. We do not currently provide that on the elective surgery public program. It is really establishing the service to deal with morbidly obese people and the subsequent health effects and trying to wrap around a whole-of-health response to that.

THE CHAIR: So that will include a preventive and early intervention approach?

Ms Gallagher: Yes—educative and medical responses as well as ongoing management of those individuals.

MR HANSON: We have had a bit of discussion lately about fizzy drinks in supermarket aisles and so on. Can you elaborate on any plans that you might have in terms of the supermarket aisle proposal and any potential restrictions or regulations around fizzy drinks?

Ms Gallagher: We are progressing with the towards zero growth healthy weight action plan. That has identified a list of actions in the back. The ones that relate to supermarkets and regulations form part of table 2. They raise more complex issues and need to go through a separate process of regulatory impact analysis.

In terms of implementing this as a whole, there are six working groups—I think it is six—that have been established across government. I have met with all the leaders of those working groups to ask them where are things up to in the areas that they are responsible for. I have to say that the focus in the first instance is on things that perhaps are not as controversial—getting water as a drink of choice, looking at working with the canteens and looking at incentives to encourage active and healthy lifestyles. The gentle kind of approach is the priority. But I do not think I would be doing my job properly if I were not at least at a minimum raising the very significant issues around the impact obesity will have on our community, to which access to junk food and the prevalence of poor food and drink of no nutritional value are contributing factors.

The ACT government has limited ways it can influence these things, and, ultimately, the community may have a discussion and decide that the status quo is fine and we need to look at other ways of educating people around the harmful effects of junk food and soft drinks. But we at least have to start with the discussion and go through a risk process. We have done it with tobacco. I think there will be pressure in the future around alcohol. One of the big issues coming from the sort of excessive use of alcohol, particularly by younger people, and the subsequent violence is around the prevalence of alcohol and the normalisation of alcohol as something you get at the supermarket because it is right in your face.

These are discussions the community needs to have. I am happy to, in a sense, participate in it and lead some of the work, and we will be mindful of the community's response to it. I know it is easy to run a nanny state argument about these issues of regulation, but I would rather be putting it on the table and discussing it than ignoring it, because the issues are so real.

MS BERRY: Minister, can you give us a snapshot of the situation regarding and obesity? What is the problem in the ACT?

Ms Gallagher: Around 25 per cent of children are overweight or obese and for adults it is more in the order of 63 per cent, I think. The projections if we do nothing is for that figure for the adult population to be 80 per cent by 2025.

THE CHAIR: How many teaspoons of sugar in a glass of soft drink?

Ms Gallagher: A 600 ml bottle, I think, has 16 teaspoons of sugar—something around that.

Dr Kelly: That is correct.

Ms Gallagher: And it has no nutritional value. So you drink it all, get all the sugar and then you are still hungry and go and have a doughnut.

THE CHAIR: We are going to draw it to a close there.

Dr Brown: Dr Bourke, can I read an answer in?

THE CHAIR: Briefly.

Dr Brown: The answer to the cochlear implant question: our base in 2012-13 was 12, and we are increasing by three each year over the next four years. So that will be an additional 40.

THE CHAIR:. Before we adjourn, I remind committee 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 ministers to respond within 10 working days of the receipt of those questions. Answers to questions taken on notice are to be provided five business 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 is adjourned.

Meeting suspended from 1.30 to 2.31 pm.

Appearances:

Barr, Mr Andrew, Deputy Chief Minister, Treasurer, Minister for Economic Development, Minister for Sport and Recreation, Minister for Tourism and Events and Minister for Community Services

Community Services Directorate
Howson, Ms Natalie, Director-General
Gotts, Mr Robert, Director, Community Sector Project
Matthews, Mr David, Acting Executive Director, Policy and Organisational Services
Overton-Clarke, Ms Bronwen, Executive Director, Housing and Community Services
Collett, Mr David, Senior Director, Asset Management Branch, Housing and Community Services

THE CHAIR: Welcome to this public hearing of the Standing Committee on Health, Ageing, Community and Social Services for its inquiry into annual and financial reports for 2012-13. On behalf of the committee, I would like to thank you, Minister Barr and Community Services Directorate officials, for attending this hearing. This afternoon the committee will be examining community development and policy. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement before you on the table—the pink card. Minister, could you and your officials confirm for the record that you have all understood the privilege implications of the statement?

Mr Barr: Yes, Dr Bourke, thank you.

THE CHAIR: I remind witnesses that the proceedings are being broadcast for Hansard for transcription purposes and webstreamed and broadcast live. Minister, before we proceed to questions from the committee, would you care to make an opening statement?

Mr Barr: No, thank you, chair; I am happy to proceed directly to questions.

THE CHAIR: Ms Berry.

MS BERRY: Thank you, chair. Minister, can you tell the committee what value the community sector is getting from the community sector redevelopment program noted on page 58?

Mr Barr: Thank you. It is a very good question. In short, considerable value in variety of areas. In a moment I will get Mr Gotts to outline the work that has been occurring in this area, but suffice it to say that we are looking to utilise a variety of resources across the directorate in order to assist community sector organisations in areas of governance, financial management, human resources and the like in order to improve the effectiveness and operation of community sector organisations. The project is broader than just back of house, though; it really is about developing capacity within the sector and it is one that has been, I think, very warmly embraced across the community sector in organisations large and small. There are obviously

significant benefits and opportunities for smaller organisations that would not of themselves have the capacity for this sort of development that they have been able to gain access to through the program. Mr Gotts, do you wish to add anything further?

Mr Gotts: Thank you, minister. Following on from the minister's comments—the community sector reform development program is all about the sustainability of community sector organisations in a period of significant change and pressure on them. Working very closely with the community sector, we have designed a series of interventions, a series of modules, that are intended to address the significant issues for community sector organisations.

As an example, the first one, which is currently being delivered, focuses on governance, financial planning and business planning. In a time of change, it is designed to give organisations an opportunity to test their business model against the environment they find themselves in and, with the support of consultants from a panel that we have established, make some adjustments and changes to their governance arrangements, their financial thinking or their business planning. That is being rolled out to 20 organisations. Each of the modules is worth about $20,000, so it is approximately $400,000 of support for community sector organisations. There is a large waiting list for that program. It is proving very popular, as you might imagine. And, as the minister said, it is giving an opportunity for organisations to get assistance that in the normal course of events they would never be able to get.

The program has other modules. These have now reached the final stage of development and will be delivered early in the new year. They include working with government and are designed to help the community sector organisations get a better understanding of what the constraints and issues around government are so that they can take that into account as they do their own planning. Again, there are modules around sustainability. We are very interested there in assisting organisations to look at the world they face and the way they put themselves together. For example, is an incorporated association the right structure going forward when you are facing change and you may not be able to take your membership with you, or should you look at a different model? It is not for us to say what they should do, but we are providing a framework to allow them to look at different ways of doing things.

A great need the sector has expressed to us is a desire for increased collaboration. We are establishing what we are calling a collaboration market, a cooperation market, which allows organisations in the community sector to get together around those areas of collaboration that are important to them. It might be fundraising; it might be back of house; it might be mergers; it might be joint service delivery. Again, it is not for us to say exactly what they should do or how they should do it; our role is to provide the framework in which they can define what areas of collaboration they are interested in and bring them together so that they can do the collaboration and then support that with consultancies and other supports and expertise that we draw from the business sector, the banking sector, the government sector or wherever it is most useful to assist them to actually work out how they might best collaborate to do whatever form of collaboration is important to them.

MS BERRY: I might be completely out of the ballpark with this question, but does that advice or framework work include providing information to small organisations

around how they might apply for grants or contracts from the government, as opposed to larger organisations, who would have the administrative and resource support to be able to put a sophisticated grant application or contract application in but it might not necessarily mean that they can provide the best quality service? Is that sort of advice, framework or information provided under this development project for smaller organisations?

Mr Gotts: It goes some of the way there. We do have a procurement model, and that is designed to do a couple of things. One of those is to help organisations make decisions about whether they should bid for a piece of work or not and better understand the pluses and minuses of doing it and whether it is in their longer term interests and aligns with their mission. We are trying to ensure that they do not get trapped by mission creep. So one part of the work is around that. The other part is unwrapping the mystery of government procurement. Of course, to us, there is no mystery, but in the community sector they can sometimes see it as a mysterious process. So it is about how they can better understand it. Again, we are looking at panels of people that have experience that are able to talk to the community sector and say: "Look, this is how we think when we're doing this. These are the things that are taken into account. There are no underlying mysteries. It's a process, and if you understand the process, then you'll be better able to put in your bids." So to that extent, it is doing what you suggested and making it easier for organisations to target their proposals more accurately to meet the needs of government.

MS BERRY: Finally, the 20 organisations that are part of the project right now—how did they get to be part of the project? Was there an application process that they needed to go to or were they selected?

Mr Gotts: It was an application process. It was a two-stage process, with the first stage being expressions of interest from those organisations who felt they could benefit from this sort of work. Then we put a panel of consultants together. We introduced the panel to the community sector and we had an event in which they all came and met the panel; the panel talked about their various strengths and what they had to offer and there was an opportunity for community sector organisations to talk and chat with the panel members and get a sense of who in the panel would best suit them. Then they sent us some applications. We took them on a first come, best dressed basis, on the basis that those organisations that were most interested in receiving support and most needed the support would be, by and large, the first to do that. What we are seeing in practice is that those that are coming forward are those that are in the most change-sensitive areas, let us say. They might be a housing provider that has been impacted on by a commonwealth government decision—and disability providers as well, which obviously have a change in their horizon. So organisations, in a sense, self-selected for that. And, as I said, we have a waiting list of more for when we are able to deliver more of those.

MS BERRY: Thank you.

MR WALL: Just a couple of supplementaries. How many other organisations are on the waiting list?

Mr Gotts: There are 17 on the waiting list at the moment.

MR WALL: When do you envisage they will be able to access the support?

Ms Howson: I might come in there. Under another program, we are exploring the opportunity to augment the provision of this particular model to the disability sector providers, in particular. That should be something that we finalise fairly shortly, but that is in the domain of negotiations with the National Disability Insurance Agency.

MR WALL: So that will be a separate pool of funding and a separate arrangement?

Ms Howson: That is right.

MR WALL: Between the federal government and ourselves?

Ms Howson: That is right.

MR WALL: How has the community sector development project been funded?

Mr Gotts: It is funded from a couple of sources. Some of the funding comes from the 0.34 per cent co-contribution that community sector organisations have been making; some of the funding comes from resources that the Community Services Directorate has put aside to assist in this, in the form of both dollars and staff. So it comes from a number of sources.

MR WALL: In the feedback I have had from a number of service providers, it strikes me that there is a certain amount of irony in government charging a 0.34 per cent levy to teach them how to be more efficient when generally it is the community and not-for-profit sector that runs circles round government in efficiency and cost saving.

Mr Gotts: I would not presume to tell a community sector organisation how to be more efficient. What we are able to do is to pool the resources and, following conversations with the sector as to how those might best be deployed, to then pool them and deploy them back to the sector. For example, $400,000 in the governance and financial management module is, in essence, what they told us they most needed. We are focusing on that and presenting it back to them. It is certainly not me or anyone in our team telling them how to be more efficient.

Ms Howson: The priority of this program is sector development. It is about assisting them to prepare for whatever future they want to pursue. This whole process has been very strongly characterised by co-design. The sector itself is really driving what the priorities of the expenditure are about.

MR WALL: With the expansion or the complementation of the program into the disability sector, will there be an additional levy on organisations, to cover the cost of that?

Mr Barr: Not to the territory government, no.

MR WALL: Okay.

THE CHAIR: A substantive question, Mr Wall.

MR WALL: Minister, on page 127 of volume 1, reference is made to the red tape forum and the work that they have been doing. What progress has been made with the recommendations that the reform advisory group have come up with?

Mr Barr: Quite considerable progress in relation to a number of changes around reporting requirements and the frequency of those pre-qualification changes. I will have some further announcements to make in due course in relation to further red tape reform through the red tape reduction panel that I chair as Minister for Economic Development. We have also had a particular focus on licensing periods, police checks and the like that have implications for community sector organisations. So the issues that have been raised within the sector are being responded to, and we will continue that engagement and respond accordingly in the coming months.

MR WALL: Has the green paper that is referred to on that page been completed?

Mr Barr: Has that, Robert, do you know?

Mr Gotts: Yes, it has been developed, and that is the paper that went forward, attached recently.

Mr Barr: The green paper might be an unusual title for it.

MR WALL: I am using your words.

MS LAWDER: So there is not going to be another?

Mr Barr: No.

Ms Howson: It was certainly, if you like, the expression of the outcomes of that forum in terms of the policy direction that should be taken.

MR WALL: And would you be able to make available to the committee the recommendations that came out as a result of that?

Mr Barr: In due course, yes. We will provide a response outlining what the government is actually going to do, and then you can obviously see all of that at that point.

THE CHAIR: Ms Lawder, a substantive question.

MS LAWDER: Page 59 talks about volunteering policy:

> … the directorate has become inaugural members of the Corporate Volunteering Program …

That is fantastic.

Mr Barr: Thank you. It is.

MS LAWDER: And is it volunteering day today, even?

Ms Howson: It is, yes. It is worth mentioning.

MS LAWDER: It says that, as part of that, five directorate staff can participate in one volunteering event per year. Has that taken place? What events, what activities, did they participate in, and how did you decide who was going to participate?

Ms Howson: We are working this program through with ACT Volunteering. An organisation approaches the directorate and sets out the scope of the volunteering activity. And in the last episode, it was Pegasus—that is my recollection, Mr Matthews, is that correct?

Mr Matthews: There was an event at Pegasus. There has been one subsequent event. I will just have to check the location of that, but Ms Howson is correct in that the way that the scheme works is that we take advice from Volunteering ACT about worthy places for us to deploy our voluntary effort, and our staff are very keen to engage in those activities. They can be a whole range of activities such as supporting ground maintenance, helping with other maintenance tasks and just generally supporting the infrastructure that organisations are using to provide their services to the community. That is an ongoing program and something that the directorate remains committed to.

Ms Howson: And given that it is volunteers day, if I could add, the volunteering culture within the Community Services Directorate, I think, is very high. Aside from the three days that are allocated through the enterprise bargaining agreement, staff will very frequently volunteer in their own time to support a number of community-based organisations that we not only fund but strongly believe in work that they are doing.

MS LAWDER: What is the take-up rate of the three days in the agreement? Does everyone do three days?

Ms Howson: I might need to take that on notice. But just to give you a specific example, my sense of it is that, as I said, we would be high performers in that context. Particularly around this time of year, staff are very eager to use that time available to support organisations, support the community.

MS LAWDER: And what is the process? Is there an approval of the organisation?

Mr Matthews: The way the provision works is that it is a condition under the enterprise bargaining agreement. So, essentially, staff within the Community Services Directorate can make an application to have some of their work time recognised for voluntary work that they are undertaking. That can be formally part of the corporate volunteering program, but it is not restricted to that. It could be for a range of volunteering activities that an individual public servant might wish to take. So they do have to submit to their supervisor a leave form, an approval form, to have that leave recognised for that function. But as Ms Howson has emphasised, it is something that we strongly commit to and support within the directorate and widely encourage.

MS LAWDER: I agree. I am just wondering about the process.

Mr Matthews: The way the process really works is that, as is the case in normal leave arrangements, people seek approval of their supervisor. And it is something, of course, we are focused on in the Community Services Directorate, but it is a provision that is available across the ACT public service.

MS LAWDER: My question was about the type of organisation. You might say, "I want to go and volunteer in Nicole Lawder's office." Is that an appropriate request, just to give you an extreme example? What is that process for deciding what is appropriate and what is not?

Ms Howson: I think just in general, as with, I guess, any culture of giving, it is what intrinsically motivates the individual to give their time back. I think there are provisions within the enterprise agreement which define the types of organisations or the nature of the volunteering activity. And I think we would always have an eye to any potential conflict of interest in providing approval.

Ms Overton-Clarke: Because of the staff that we have in the directorate, it tends to be generally non-government organisations that are traditionally the sorts of organisations that we fund. And, indeed, in terms of our general work with the non-government sector, we encourage volunteering, but also part of the training and professional development that we do in the directorate often involves casual secondments with the non-government sector as well. So I guess there are a range of ways that we ensure that there is that sort of cross-collaboration. But it is generally with community sector organisations in the human services area, I guess.

Mr Matthews: Other examples might be the National Multicultural Festival or Floriade, those Canberra-wide events that people are very committed to and that, of course, have a very large voluntary component. So it can be related to non-government organisations or just generally a spirit of community giving.

MR WALL: Just a quick supplementary on the volunteering policy, it says that as a result of the membership of the corporate volunteering program, five directorate staff are able to participate in one volunteering event per year. Is that one event through Volunteering ACT? Could I have a bit more clarification on what that is alluding to?

Ms Howson: It was the particular program that I mentioned in relation to Volunteers ACT.

MR WALL: So that was Pegasus?

Ms Howson: That is correct.

THE CHAIR: Minister, could you tell me about the Flynn community hub stage 2, which is referred to on page 62 of the report, and the future plans for it?

Mr Barr: Yes. There has been considerable development and progress with the redevelopment of that particular site, one that has a reasonable amount of history for me over a seven-year period. So it is nice to be here at the point that these new

facilities can be made available. Mr Collett might wish to talk you through the final stages of construction.

Mr Collett: Certainly. As the minister commented, the physical construction works have been completed now. The second stage, which followed on from the first stage, which was, in fact, the childcare centre, is being completed, including the external works. The certificate of occupancy has been issued. The community is able to make use of some of the spaces that are available there for casual use. And some of the community organisations which were selected to move into the facility have moved in or are in the process of moving in after the Christmas break.

THE CHAIR: Which ones have moved in or are moving in?

Ms Overton-Clarke: Marymead and the Belconnen Community Service.

Ms Howson: And the childcare.

THE CHAIR: And which ones will be moving in after Christmas?

Ms Overton-Clarke: I think other components of those funded programs.

Mr Collett: Yes.

THE CHAIR: And you mentioned the community's casual use of the facility. Has any of that taken place yet?

Ms Overton-Clarke: There is going to be an event, through the Belconnen Community Service, for a day of disability. I am not sure exactly when that is, but it is within the next couple of weeks, for the hall.

MS LAWDER: Sorry, what was that, International Day for People with a Disability?

Ms Overton-Clarke: Yes.

Ms Howson: There are a lot of events over the fortnight that commence on the day of the International Day for People with a Disability. And I think Ms Overton-Clarke was just saying that the community space in Flynn will be used for a disability-related event.

Ms Overton-Clarke: That is right.

THE CHAIR: Can you tell me how the Holt and Cook hubs are going?

Mr Collett: They are going well.

THE CHAIR: That is succinct, yes. I will pay that one.

Mr Collett: There has been relatively little turnover in the tenancies. The maintenance requests have been attended to. The facilities seem to be bedding down well and are playing an important role in providing not only community facilities but,

through the spaces that are available, the halls for community use, something of the community role that the schools played when they were being used for that purpose.

THE CHAIR: In particular, the hall in Cook is available for community groups to hire. What is the level of usage of that particular facility?

Mr Collett: It is not in constant use, but my understanding is that the usage is continuing and significant. We can get some figures on that for you.

THE CHAIR: That would be good. And who manages it?

Mr Collett: I believe it is one of the tenants.

Ms Overton-Clarke: At Cook?

Mr Collett: Yes.

Ms Overton-Clarke: Yes.

THE CHAIR: Which one?

Mr Collett: Again, I would need to get you those details.

Ms Overton-Clarke: Can I just clarify that the Belconnen Community Service is using the hall at Flynn on 20 December for an all-abilities dance.

THE CHAIR: Could we go to page 64. Can you tell me about the work involved in the study into establishing men's sheds across Canberra.

Mr Collett: Men's sheds are an important function and are fully supported by the community. There are a number of men's sheds already in the territory, and the utilisation of those is significant. We have men's sheds at Gungahlin, Hall, Holt, Kaleen, Melba, Page, Dickson and Tuggeranong, and in Forrest, Monash and Harrison. So you can see that there is a good spread of men's sheds through the community. They range, in terms of the type of accommodation and the type of activities, from the traditional men's sheds with woodwork and minor mechanical repairs going on—as is the case with Dickson, for instance—through to groups that meet regularly, discuss men's issues and provide support and fellowship for men in the community.

The work we are doing on the study is to try and determine potential areas which are underserviced at the moment. We are particularly keen to see the men's sheds integrated into a broader community services offer. Some of the more successful of the men's sheds have been combined with community organisations or other groups.

We have been in discussion with COTA about the possibility of a men's shed in their vicinity, that they might play a role in. We are also particularly interested in the capacity of land developers or builders who are undertaking projects to include space for community activities, community services, including men's sheds. Quite recently, we were able to negotiate a community centre with one of the joint venture developers

in the new Gungahlin area, which saw a space being returned to the community, if you like, for their use. So we are exploring those possibilities of working with developers and builders to integrate space for men's sheds in future development projects.

THE CHAIR: With respect to space, which is obviously the key issue for men's sheds, to start with, at least, that is being done on a case-by-case approach, one of taking advantage of flexible opportunities?

Mr Collett: A combination of that and of interest from groups. Obviously, simply building space and facilities does not guarantee a successful operation. It does not in itself provide for successful management of those facilities. We would also be looking to piggyback off initiatives coming out of the community around the formation of men's groups and men's sheds.

THE CHAIR: I have a question around the Kaleen Giralang men's shed. I understand they are having some difficulties looking for space. Is there some issue that you are aware of there?

Mr Collett: I am not aware of that but I can take that on notice.

THE CHAIR: Fantastic. Whilst we are still dealing with men's issues, I understand, from volume 2, page 311, that you have funded the Canberra Men's Centre Inc for two programs, including "working with the man". Could you expand on that for us, please?

Mr Collett: We might need to take that on notice. No, Mr Matthews can assist.

Mr Matthews: The working with the man program is actually a partnership with the Office for Women. The Canberra Men's Centre is an organisation with a range of programs in our community that are supporting men in a variety of different ways. The emphasis of "working with the man" is very much around family violence issues and supporting both increased awareness and skills development and particular supports and interventions to assist men that may have had a lived experience involving family violence or may, through their lives, somehow touch on that issue. They might be a child, a friend or a peer of men dealing with family violence issues. So it is an important intervention.

Obviously, it is part of a broader approach to domestic violence prevention. Supporting men, providing information to men and supporting men to support each other are all very critical strategies to educate the community and support men to deal with the issues that are taking place in their lives which may contribute to violent behaviour on their behalf.

THE CHAIR: Does that articulate with the white ribbon campaign, or does it sit in the same space?

Mr Matthews: Yes, it is in the same space. Obviously, the white ribbon campaign is a very important public education campaign which is about men taking responsibility for violence prevention and showing their support for women and children remaining

free of violence. So it is broadly consistent with that approach. It is more at a personal level. The working with the man program is about providing practical support and assistance. It is part of a suite of programs that the Canberra Men's Centre provide. So it is part of a complementary set of initiatives. They obviously provide a range of other support services to men, and this is one component of those.

MS BERRY: I have a supplementary. Regarding the Flynn community hub, once BCS and Marymead have moved in—or have they moved in now?

Ms Overton-Clarke: Yes.

MS BERRY: And there are others moving in after Christmas, I think you said. Will that be it, then? Will the hub be full?

Ms Overton-Clarke: We are looking for one more tenant. We have the luxury that we do not usually have of looking across the organisations that we have on our and Property Group's waiting lists to identify another organisation who would be able to take up the remaining space.

MS BERRY: You say there is an organisation that runs the community space at Cook. Is there one that runs the community space at Flynn?

Ms Overton-Clarke: Yes. That is the model that we operate under. There is usually one major tenant who will also take on the job of doing the hall bookings. That is the arrangement that exists across all of the community hubs that we have.

MS BERRY: Regarding the Holt community hub, the Holt preschool, what is happening with that? Page 63 of the report talks about the Holt preschool building.

THE CHAIR: Last time I was out there, there was some building work going on.

MS BERRY: That is right.

Mr Collett: That is correct. The release of a site in the immediate neighbourhood for a preschool has meant that the need for the reutilisation of that refurbishment of the preschool has diminished. We have had a call for expressions of interest for alternative uses. Anglicare, through a program that they run, were the successful applicants. Currently we have architects engaged in preparing drawings for upgrading the services to meet current requirements and providing accessibility to the building. That work is expected to be started on site early in the next calendar year and can be completed before the end of the first quarter of next calendar year.

Going back to the question about the management of the hall at Cook, it is managed by Companion House, who, as Bronwen indicated, are one of the larger tenants in the hub. They also keep records of the usage. I will have to get those for you, so I will take the second part of the question on notice.

THE CHAIR: Coming back to the Holt preschool, you said Anglicare were taking over that space. What sort of services are they going to be providing there?

Mr Collett: Disability services, support for people with disabilities in the form of social events and skills training.

MR WALL: I have a follow-up on the men's sheds. I understand that the multipurpose sports facility down at Tuggeranong was completed some time ago. There has been a fair delay in the Tuggeranong Men's Shed getting access to the purpose-built space at that facility. Has that been resolved yet?

Mr Collett: It has been resolved. It was a slightly cumbersome arrangement where the contracts were tied up with the completion of the archery facility, and we were working with our colleagues in Territory and Municipal Services. So there were some frustrations in getting the final defects listing cleared up and the final completion of the building, but my understanding is that that has now been completed and the men's shed group now have access to that facility.

MR WALL: So they have got the keys and are able to access it?

Mr Collett: I believe so, yes.

THE CHAIR: Ms Berry, a substantive question.

MS BERRY: I was interested in the LGBTI Community Advisory Council. It is having its anniversary soon or has had its anniversary. How is that coming along?

Mr Barr: The council meets bimonthly. The next meeting is tomorrow.

MS BERRY: It is timely, then.

Mr Barr: I meet with the chair and deputy chair, also on a bimonthly basis.

MR WALL: Minister, twice a month or every second month?

Mr Barr: Every second month. The primary focus of work this year has been around a couple of pieces of legislation, particularly the one Mr Corbell introduced in the final sittings this year around the amendments to the births, deaths and marriages act. The advisory committee established a subcommittee to work specifically on those issues. The advisory group have also provided advice and input into the sport and recreation inclusive sport project. They have had a presentation from the leader of that work within sport and recreation.

They have also provided advice to government on events and the opportunities for greater LGBTI engagement in the city's events calendar. An example and a useful starting point for this was the award-winning Qwire having a role in Canberra Day activities in the centenary year, as part of the Canberra Day concerts. There is, I think, opportunity for further engagement, looking at how organisations within the LGBTI community, of which there are a large number of small organisations, can work together to better access government grant programs in events and community development. So we have had a bit of a discussion about how that can be facilitated.

The other key areas that the committee has focused on have been in education. There

is a subcommittee around schools and they are looking at some of the work that has been undertaken in jurisdictions like New South Wales and Victoria—the proud schools program, for example. Also, in aged care, a subcommittee has held a forum recently with aged-care providers in the city, looking to ensure a greater sensitivity to LGBTI issues in aged care.

With respect to the program coming up, the meeting tomorrow will be an opportunity for members of the committee to put forward ideas for the 2014 agenda. My discussion with the chair and the deputy was about focusing the first meeting of 2014 on going into more detail on each of the proposals put forward. I have also asked the advisory committee to provide government with advice on the new brand campaign that we are running and ways that the community can become more involved there. We are also looking at how we can, as an advisory group, provide greater support for the SpringOUT festival. It is a volunteer-run festival that occurs in November of each year.

MS BERRY: I have a supplementary regarding education. Did you say there is a subcommittee set up on education?

Mr Barr: Yes, there is a group working specifically on issues in schools, and also on access to higher education, TAFE and the university.

MS BERRY: You talked about the different programs that are happening interstate. In the ACT are you aware of any schools that are running programs around inclusiveness or diversity?

Mr Barr: Yes, there are a number. When I was education minister, we started work on a program similar to what was occurring in New South Wales and Victoria. I must confess that in the couple of years since I have not been education minister I have not followed as closely the development of that program. We had a major cross-sectoral education forum that was attended by representatives of public, Catholic and independent schools a couple of years back, on the International Day Against Homophobia. There was a variety of options and ideas put forward that individual school communities would pursue. I can point to Stromlo high as an example of a school that has taken an active leadership role and prepared resources. The kids themselves developed resources for utilisation across the ACT education system. From some small seed funding and a couple of conferences that have been organised over the last 12 to 24 months, there has been a pretty significant level of engagement across the education system.

The challenges now are about getting a deeper engagement. What you see is that school communities and community organisations, who are perhaps already highly aware of the issues and challenges that are confronted, or that some students confront, within the education system, are highly engaged. I do not think that has quite permeated through the entire education system yet. I think the work that this particular subcommittee are undertaking and the advice that they will provide to government will be useful in terms of a broader and deeper engagement within the public school system. I know they have had a particular interest in wanting to work with independent and Catholic schools. It would be fair to say that the level of engagement varies and there are perhaps some obvious reasons why some particular independent

and Catholic schools have not wanted to engage. But I do not want in any way to suggest that that is a general statement of an entire sector's response. It is not; there has been some quite intense and important engagement coming from some Catholic systemic and independent schools. Others have had no interest at all. That is what it is.

MS BERRY: Is that from primary and all the way through?

Mr Barr: There has been a particular focus initially on high schools and colleges, but it would be fair to say that some of the issues that particular students who identify as LGBTI are experiencing have their origins in primary school.

THE CHAIR: Mr Wall.

MR WALL: Minister, page 61 makes reference to the health and safety committee for carers. Has it already been established, and how is it tracking?

Ms Howson: Are you right to take that, David?

Mr Matthews: Yes, I am. This particular item is sitting under this output class because the centre of the department, policy and organisational services, is supporting the Office for Children, Youth and Family Support on work health and safety issues for foster carers. So it is an area that I am responsible for. We have been engaging with foster carers for the last year or more to look to establishing processes with them about managing work health and safety issues for carers. That has involved the establishment of a committee, which we have jointly agreed. It is a tripartite committee that involves not only representatives of carers and the directorate but also the non-government organisations that have a role in supporting carers. So it is a structure where we each share responsibility and work together.

We have spent most of this calendar year working with carers and agencies to establish the structure and the mechanism for that committee. We have reached agreement on that. We have had a number of meetings through the year to consolidate that and to begin work. The next and final step of that will be confirmation of our carer representatives. We are supporting the carers to actually undertake an election process where they will go across the caring population to identify individuals that might have an interest in being involved in that. We think that is a very important part of the process. At the completion of that election process, the committee will be fully operational. But I would like to advise the committee that we are still working in engaging on the issues, and we will be holding our next meeting in February 2014.

Ms Overton-Clarke: It is probably worth segueing here and just explaining that what we try and do as well is to make sure that all the different parts of the directorate join up around some of these issues. In terms of the community sector reform work, we are acutely aware of red tape issues or additional costs or burdens that go on to non-government organisations. We make sure that in all those areas we are identifying the barriers to non-government organisations being able to do their work in as streamlined a way as they possibly can and looking at removing those where we can, be it about additional cost or administrative load. Part of the point of this sort of work is to really be able to identify where we can streamline things for organisations and the volunteers who work for them.

THE CHAIR: Ms Lawder.

MS LAWDER: Thanks. I have a question about the equal remuneration case project. Can you explain to me how it works—when you are getting funding through the federal government, when you get it and then when you disburse that further to other community organisations?

Mr Barr: It is a contribution from the ACT government and from the federal government. From memory, it is $57 million, $25 million-odd from the commonwealth and $32 million from us.

Mr Gotts: Thereabouts.

Mr Barr: Yes. We have put forward a process that the commonwealth has agreed with in relation to the distribution. We are targeting those employees in the ACT who are the most disadvantaged in terms of their current salary arrangements. What is different in the ACT from elsewhere is that, through successive rounds of enterprise bargaining and the more generous indexation arrangements that the ACT government has provided to community sector organisations, about 80 to 85 per cent of the community sector workforce in the ACT is paid above the award. That will obviously vary, depending on the community sector organisation and the nature of the individual's work within that organisation.

In the first couple of years of our allocations into the community sector organisations, we have had a particular focus to ensure that those who are the lowest paid and the most disadvantaged are brought up to the Fair Work Australia benchmarks as quickly as possible. Each year over the nine years that this particular funding has rolled out, more and more organisations have received additional funding from the commonwealth and the ACT in order to ensure that wage levels across the entire sector are increased according to the agreements that we have undertaken.

I think you could best categorise the ACT's circumstances as wanting to help the lowest paid first; we have done that and put a real focus on that in the first few years. The payments are made in December of each year; as each year progresses, more and more organisations are receiving more and more funding under the program.

MS LAWDER: When does the ACT receive the funding from the federal government? Is there a lag?

Mr Barr: Yes; we get allocations on an annual basis.

Mr Gotts: The agreement that the ACT has with the commonwealth means that we get payments from the commonwealth every year following the production of a report that shows the commonwealth which organisations have been paid. As the minister indicated, payments to community sector organisations are a combination of funding that was sourced from the ACT and funding that flowed from the commonwealth through the ACT government to community sector organisations.

MS LAWDER: When community sector organisations pay their staff, is there a

period where they have to absorb the increase before they receive their funding from the ACT government?

Mr Gotts: Essentially, no. The way it works is—

MS LAWDER: Is "Essentially, no" the same as "No"?

Mr Gotts: It is not. There is a fine distinction, which I will explain. The way that it works is that organisations that are subject to the decision, the equal remuneration case order, are required to make payments no less than those in the order on the first payday of 1 December of every year. That is when the liability arrives. We determine what the impact is on the organisations. We make them an offer. We say, "This is what we think the amount that you are due is." They can discuss that with us if they think it is not accurate. And then we make the payment.

We have made offers to all of the 53 organisations that are eligible in 2014. Those offers went out a week or two ago. We have had responses from some 20 organisations accepting, and payments for those are in the process of being made. There is a processing delay in actually making the payments, but it is not very long; it is less than two weeks, to my understanding. There are other organisations that want to discuss it with us. For example, we were contacted today by an organisation that told us they believed we had made a mistake in their favour and that we would pay them too much. They said could they please discuss it with us and adjust the payment accordingly. So for them, that will take a bit longer. They are unconcerned, and their advice to us was that they are unconcerned, if it takes a bit longer: they are happy to cash manage for a fortnight or two while that happens. So it is a situation where we can get the money out quite quickly. Other organisations need to take it to their boards to get approval, and that can create a practical delay there.

The way it worked last year was that there were no delays where organisations needed the money. It is looking as though it is working that way this year as well.

MS LAWDER: I certainly take your point, minister, about working on the lowest paid workers first, but doesn't that perhaps also leave the entire sector open to people continuing to shift into the public service or other better paid positions? You are right that most of them are paid above the award, but that is because of the economic environment in the ACT, so there is a constant sort of migration of people—

Mr Barr: Not at the moment, I think we can safely say, in terms of public sector employment in the ACT. I think it would be fair to say that there is not a huge amount of recruiting going on, so that problem will not be one we will confront in the next period. Time will tell how long recruitment freezes are in place, but it would seem that the public sector is shedding staff. If the Public Service Commission report from earlier in the week is any indication, the level of voluntary separation from the commonwealth public service has halved in recent times. I do not think that is going to be the challenge it once was, but I accept that in a period of expansion of public sector employment it certainly was a challenge for community sector organisations. The intent of the fair work case and the equal remuneration is well understood and acknowledged by the government and I hope it is honoured in the longer term by the federal government too.

THE CHAIR: Minister, perhaps you could tell us about the status of the taxi smart card project mentioned on page 60. I notice it was being introduced this year.

Mr Barr: Yes. I had the opportunity to perform a launch of this particular program a little while back. It makes a big difference for users of the service and also for the operators in terms of the speed and efficiency of processing claims. It is now all done like a touch card; it is all electronically processed. It has removed a significant amount of paperwork for both the users and the drivers. Is there anything else to add, David?

Mr Matthews: Just to inform the committee that the scheme is currently operational. As of 30 November, there were approximately 3,400 members of the taxi subsidy scheme. We have issued over 2,200 smart cards, so the vast majority of users have already received smart cards and are using them in taxis. The ones to whom we have not issued smart cards at the moment fall into a range of categories, but the vast majority of them have not used the scheme in the previous 12 months, so they are not active users of the scheme. We have attempted to contact them on multiple occasions and they have chosen not to put in an application for a smart card. That offer, of course, is open; the cards are issued free of charge, and we will continue to make contact with or receive inquiries from any user that wants to continue to access the scheme.

The other thing, of course, is that we are running a dual system at the moment to make sure that we minimise any disruption to users of the scheme. So we are still accepting paper-based vouchers until the end of the calendar year, and some people are still using those. We are obviously supporting people to migrate to the new arrangements.

We are very conscious that in a lot of cases the scheme is used by elderly Canberrans or Canberrans with disabilities. Particularly with some elderly Canberrans, they are taking some time to converse with us and talk with us about making sure that they can understand the way that the new system works and that they will not be disadvantaged. There are a number with gross motor impairment that have really welcomed the introduction of the cards so that they do not have to juggle on their lap the filling out of a paper-based form at the end of their particular journey.

To date, the scheme has gone very well. Of course, with a change with a scheme of this nature, we will continue to work through any issues that arise with either individual customers or Cabcharge, who are the provider of the scheme.

THE CHAIR: Very briefly, minister, could you tell me how the microcredit program will work in partnership with the Lighthouse Business Innovation Centre and Westpac?

Ms Howson: Again, I will ask Mr Matthews to go into the detail of those two programs, but they are both well in train.

Mr Matthews: The microcredit program was an initiative of the most recent budget, so we are still relatively early in the life of that scheme. I would like to pay credit to the previous brilliant ideas program run through the Office for Women and lighthouse, which offered a number of small business opportunities to women.

Essentially, the expanded microcredit program looks at taking that successful model and making it more available, increasing the number of citizens and target groups that can seek eligibility under that. We have held some quite detailed discussions with lighthouse about how they will expand their particular program and, importantly, how they are going to consult with relevant community groups. For example, one of the target groups of the expanded program is the Aboriginal and Torres Strait Islander community, so it will be important for lighthouse to consult with local community organisations and the elected body about the best way for that scheme to be operated and promoted. Also, there are other target groups, including young people.

The scheme is a successful model that could work across a range of different groups in the community, but how the scheme is marketed and how we support applicants to access the scheme will need to be different. That is the nature of the conversations we have been having with lighthouse. We are expecting that scheme to commence in a phased arrangement early in 2014.

THE CHAIR: Thank you. Before we adjourn, I would like to remind committee 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 from this hearing. The committee asks ministers to respond within 10 working days of receipt of those questions. Answers to questions taken on notice are to be provided five business days after the hearing at which they were taken, with day one being the first business day after the question was taken.

Mr Barr: We may be able to give you some information on a couple that were taken on notice right now.

Mr Collett: They are very quick answers, with your permission, chair?

THE CHAIR: Okay.

Mr Collett: In relation to the question about Tuggeranong men's shed, they in fact have access, as I indicated, and they are moving in on Monday. In relation to the Giralang Kaleen men's shed, they have recently acquired—and you may be aware of this—a shed from the local discounts group, which has been disassembled and is currently in the local depot yard. They only approached us earlier this week about the possibility of moving that onto the Kaleen community hall site. We have established communications with them and will be assisting them in that endeavour.

THE CHAIR: Excellent; thank you.

The committee adjourned at 3.32 pm.