LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING, COMMUNITY AND SOCIAL SERVICES

(Reference: Annual and financial reports 2013-2014)

Members:

DR C BOURKE (Chair)
MR A WALL (Deputy Chair)
MS M FITZHARRIS
MS N LAWDER

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 26 FEBRUARY 2015

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

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 20 May 2013

The committee met at 1.05 pm.

Appearances:

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

Health Directorate
Brown, Dr Peggy, Director-General, ACT Health
Thompson, Mr Ian, Deputy Director-General, Canberra Hospital and Health Services
Bowden, Professor Frank, Chief Medical Administrator, Canberra Hospital and Health Services
Kelly, Dr Paul, Chief Health Officer/Deputy Director-General, Population Health
Carmody, Mr Paul, Deputy Director-General, Health Infrastructure and Planning

THE CHAIR: Good afternoon, everyone, and welcome to this public hearing of the Standing Committee on Health, Ageing, Community and Social Services inquiry into annual and financial reports for 2013-14. Today the committee will be examining the ACT Health Directorate annual report.

I have a few housekeeping matters which I need everybody in the room to observe. All mobile phones are to be switched off or put into silent mode. Witnesses need to speak directly into the microphones for Hansard to be able to hear and transcribe them accurately. When witnesses speak for the first time they each need to state their name and the capacity in which they appear, and only one person is to speak at a time.

Minister and officials, can I confirm that you have read the privilege card lying on the table before you and that you understand the privileges implications of this statement?

Mr Corbell: Yes, thank you, Mr Chairman.

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

Mr Corbell: Yes, thank you very much, Mr Chairman, and thank you to the committee for the opportunity to appear before you this afternoon. I just want to make a brief statement about the broad strategic objectives and achievements of the ACT Health Directorate for the financial year that this report deals with.

In 2013-14 we saw a record number of presentations to the ACT's hospitals across a broad range of areas, including our emergency departments, birthing suites and in the elective surgery wards, and we continue to see this growth in presentations. During this financial reporting year the government delivered the new Belconnen Community Health Centre and refurbished and expanded the Tuggeranong Community Health Centre, providing expanded health services to manage acute and chronic conditions in the community setting.

The government also doubled the number of nurse-led walk-in centres in 2013-14, as

we promised at the last ACT election, by opening two new centres, one in Belconnen and one in Tuggeranong. The territory exceeded its national elective surgery target by removing more people off the surgical waiting list than required, resulting in the ACT meeting eight of the nine components of the targets in 2013. Results in elective surgery have shown improvement over recent years, with 65 per cent of people admitted for surgery on time in 2010-11 and up to 85 per cent admitted on time in 2013-14.

The annual report that we are dealing with today shows that the public health system provided 11,780 elective surgery procedures in 2013-14, the highest number ever performed in a single year in the ACT. Our health system saw 125,890 present to our public hospital emergency departments, which is a six per cent increase compared with the same period in the previous year. And we also saw the highest number of births ever recorded for a single year during this reporting period.

The ACT continues to enjoy the highest life expectancy of any jurisdiction in the country. Since opening in 2010, our walk-in centres have experienced 73,392 presentations up until June 2014. According to the latest report on government services, we continue to be a national leader in reducing the use of seclusion and restraint in our mental health inpatient settings.

The government's continued investment in health infrastructure has also seen successful completion and delivery of the Canberra Hospital emergency department and intensive care unit expansion, as well as the delivery of stage 2 of the Centenary Hospital for Women and Children.

Another significant achievement during this reporting period was the reduction in the public dental waiting list. As of 30 June 2014 there were 932 people waiting for non-urgent restorative dental services, compared with 1,659 clients waiting at the same time in the previous year. The actual waiting time for restorative treatment as of 30 June 2014 was three months, compared with 7.73 months as of 30 June in the previous year.

All of these achievements highlight the hard work and dedication of the ACT Health Directorate and its staff—doctors, nurses, allied health professionals, administrators and a whole range of other people right across the directorate. The government will continue to focus on the delivery of health facilities that meet growing demand in our community, as well as through the resolution and achievement of our ongoing health infrastructure program. With that, Mr Chairman, I and my officials are very happy to try and answer your questions.

THE CHAIR: Thank you, minister. We might start with strategic indicator 3.4. I see that the national benchmark has been met for handwashing. Could you tell us how this has been achieved, please?

Dr Brown: Yes. We are very pleased that our performance in terms of hand hygiene has continued to improve and both hospitals—Canberra Hospital and Calvary hospital—now exceed the national benchmark and continue to improve into this year.

There has been a concerted effort in terms of educating staff about the importance of

it, starting with our medical students and going through all of the various disciplines. There have been audits conducted across the hospital. The results are distributed back to the relevant areas to ensure that they are aware of them. Each ward has its own result and that is displayed so that everyone is aware of their performance and of the need to continue to improve their performance.

THE CHAIR: Could you tell us more about the education campaigns which you alluded to there and which were discussed in the *Canberra Times* in April last year?

Dr Brown: I might ask Mr Thompson if he can elaborate on the detail of the education campaigns across the various areas.

Mr Thompson: What we have is an education campaign that is undertaken on a number of different levels. Some of it is targeted to our patients because obviously one of the best ways of teaching staff about whether or not they are meeting the required care standards has been feedback from patients, so encouraging patients to understand what to expect from the health professionals that are providing care for them.

We have also developed promotional videos. We have on-the-spot training, so to speak, where we have staff members who attend at workplaces to work through the different approaches that can be undertaken. We have more formal classroom-based education, electronic learning packages as well as an audit program, which of course is the source of the data for the results you see in the report—an audit program to measure the effectiveness of it.

THE CHAIR: So are some occupational groups more compliant than others with handwashing?

Mr Thompson: There is a difference between occupational groups. We tend to have higher rates amongst nursing and allied health staff and lower rates amongst our medical staff. We have started programs in relation to that. Dr Brown mentioned earlier about approaching the medical staff from the time they are undergraduate students. We have also got direct approaches to the staff who are working with us as well.

THE CHAIR: Are some areas in hospitals better at handwashing than others?

Mr Thompson: It is not an absolute, uniform result across all hospitals. One of the pleasing aspects of it is that we are seeing improvements across the board. One of the things that we have done is to put up in different ward areas very easy to read, visual displays of how the handwashing rates are going and that means that all areas are aware. Of course it means that patients and the community are aware as well, and that gives direct feedback so that the individual work areas can see how they are performing.

THE CHAIR: I think the hand hygiene association put up some stuff on their website which indicated that dental clinics within hospitals are running at 88.7 per cent or something like that. Is that correct? Is that borne out by your data?

Mr Thompson: I cannot say with certainty what the result is for ours, but I can try and get that information back to you.

THE CHAIR: So perhaps you could tell us how important handwashing is to reducing nosocomial infections.

Mr Thompson: Sorry?

THE CHAIR: How important is handwashing to reduce nosocomial infections?

Mr Thompson: It is one of the primary means that infections can be passed from either patients to patients or staff members to patients. What we have seen over quite an extended period of time is that the rate of hospital-acquired infections at Canberra Hospital has reduced consistently. It is not solely due to hand hygiene, but poor hand hygiene is very closely associated with increased infection rates.

THE CHAIR: So apart from strategic indicator 3.3, which looks at golden staph infections, what other indicators do you have internally to indicate the incidence of nosocomial infections?

Mr Thompson: We monitor that on a daily basis, looking at the infection rates in different areas. That gets reported routinely through what we call monthly scorecard reports where the data for different divisions is reported it to me and ultimately up to the executive of ACT Health. Where there are incidents and trends that seem to be out of step with what we would expect, we have a very active infection control team who can respond and provide advice or identify what possible causes there may be for those rates.

THE CHAIR: Minister, this is probably a fairly significant area because, according to one recent article, there are two million additional hospital bed days in Australia resulting from these kinds of infections. I am not sure what that translates into in ACT terms but it is clearly a lot.

Mr Corbell: That is right, Dr Bourke. The level of infection as a result of poor hand hygiene is an issue that is recognised in our reporting framework because of its significance. Whilst I am not able to quantify exactly how that translates into prevented bed days or measures like that, what I can say is that it simply makes sense to focus on good hand hygiene. That is why it is a strategic indicator in the local hospital network reporting framework. I think what is pleasing is that we have a comprehensive audit process in place.

Audits are undertaken across workplaces in the hospitals. There is, as Dr Brown has mentioned, training—for example, for medical interns—but then there is also a focus on making sure that this is an ongoing training activity. The auditors come around and audit how effective handwashing practices are. Also, they identify deficiencies by working with staff on the ground in making sure that they are aware of the appropriate practice and are following through with that on a regular basis. So it is an audit and training function, and certainly the results are good. We need to continue to build on those, but I am very pleased with the direction it is heading.

Dr Brown: Healthcare consumers have been engaging us in discussions. They are very keen to look at volunteer consumer auditors, and this is something that we have explored with our interstate colleagues. It would be quite innovative—it is not something that we have agreed to as yet—but they see the power of consumers actually being, I guess, empowered but also engaged in the dialogue with healthcare professionals around the importance of handwashing and hand hygiene.

THE CHAIR: I am just concerned about this emphasis on education, given that it seems from most of the reports that doctors are the worst when it comes to handwashing and that they are also the most educated of workers in the hospital already. You would think that they would already be the ones who were leading the charge in handwashing. What do you think about that as policy, minister?

Mr Corbell: I think there will be a variety of compliance across a range of different workforces, so I do not think it is fair to characterise or single out one particular part of the workforce over others.

THE CHAIR: I was not singling them out; that is what the data shows.

Mr Corbell: To the extent that there are cultural issues, I do not think that it is confined to one particular profession or area of speciality. I think it is an issue that can arise in a range of different settings and that is why we work closely on the ground with staff through the audit process and through the training process.

THE CHAIR: Are you concerned that the national benchmark is only set at 70 per cent? That means that 30 per cent of not washing your hands when you are supposed to be washing is regarded as nationally acceptable.

Mr Corbell: I would have to seek some advice on how that figure was determined, but clearly it sets a level, recognising what is considered reasonable in the hospital setting the program. I am not an expert on that sort of benchmark setting, so I would be happy to seek some further advice on that. Perhaps Professor Bowden might like to come up, if he can. He can speak more from the medical side of things and the perspective of doctors on this matter. Frank, of course, is an expert on infectious disease.

THE CHAIR: And the author of the paper in the *Conversation* too.

Prof Bowden: I am an infectious disease physician by training. May I be perhaps a bit more open about my colleagues? The minister is being very gentle, I think, towards doctors. It is a historical fact that Semmelweis first identified that hand hygiene was an important means of saving people's lives. If you go back to the original paper, the people who complied with his rulings were the midwives and the nurses who worked in the hospital. The doctors did not believe it because they could not possibly believe that they were responsible for the transmission of infections.

Having said that, the good news with the hand hygiene campaign across Australia has been that compliance amongst doctors, which has always been the lowest, is now reaching the levels that the rest of the community were at five years ago. So there has been a substantial increase in the compliance. Some of it is to do with the new doctors

moving into the health system who have all been schooled in the hand hygiene mantra and the move out of the older doctors who do not really think that it matters as much. But we have still got 10 per cent to go in some areas, or five to 10 per cent in some areas, with doctors to reach the benchmark. I was not hopeful that that would occur five years ago, but I am now very hopeful that we will reach it.

In answer to the question about the benchmark, though, which I think is a very important one—how could we accept that a 30 per cent failure rate is okay?—it is quite likely that the hand hygiene group in Australia will move that benchmark up. The figure has not been set yet, but it could be that 80 per cent compliance is the benchmark that we will get. It was an important approach to begin with, because to set it so high that nobody thought it was achievable would have possibly been counterproductive. Now that people have shown that they can attain that, the national group are going to move it even higher.

MR WALL: A supplementary if I could, chair? Handwashing, you would think, would be a fairly elementary part of working in a health centre. Why are we setting a target at 70 per cent as being acceptable? Yes, Calvary and TCH have exceeded that, but only marginally. However, we still have over one in four occasions when handwashing is not being done properly. Excuse my naivety; I am not schooled in health, but would it not be considered elementary, much like wearing a seatbelt in a car? Is it not something that you do automatically every time you come in contact with a patient?

Prof Bowden: You are giving your age away because when I grew up it was not elementary that you wore a seatbelt. I can remember the times when people were giving every single possible excuse not to wear a seatbelt: "Oh my God, what if a truck was coming towards me and I did not have time to take the belt off so I could jump out the window?" They are the same things that we have heard from doctors and nurses. It is truly a cultural thing.

In a hospital, surgeons would not dream of going into an operating theatre without spending five minutes washing their hands—the first wash is even longer—to get themselves ready to perform a procedure. If you walk into a room called an operating theatre where everybody is watching what is going on, a break in that sterile technique is seen as a major failing. Then people walk out into the rest of the hospital, the rest of the healthcare setting, and do not seem to think that the germs might possibly follow them or that they might be relevant.

It is a fundamental and surprising cultural belief. Therefore, it has taken as long as it did for public health approaches like seatbelts to get into people's minds that things too small to see actually might be very, very important in terms of health.

MR WALL: I guess the difference, though, in this situation compared to the seatbelt analogy I used is that this is in an employment setting. The government, as the ultimate employer, can institute a policy and you have a fair number of tools at your disposal to use with staff so that they comply with this. Why are we still trailing and having an issue of hand hygiene?

Dr Brown: Can I add a comment before we respond to that particular question? When

we are measuring compliance with hand hygiene, we talk about the five moments in time. There are five different steps or points of time in which handwashing needs to occur. To say that we are achieving it 72 per cent or 75 per cent of the time means that we are achieving that 75 per cent compliance with all five steps. It may well be that the other 25 per cent are complying with four or three of the steps but not all five.

THE CHAIR: But that is only when they are being watched, when they know somebody is watching them.

Dr Brown: Yes, and I am not saying that as an excuse. I am just saying that I do not wish it to be understood that the other 25 per cent are not washing their hands at all. They are not washing them as completely as they should in accordance with the five moments in time, but it is still a relevant context to the statistics. In terms of your suggestion about the tools that are available to us or the avenues to engage with staff, I would say that we try and engage with staff, educate them and improve their compliance in a way that brings people along rather than try to use a big stick approach. But, obviously, at the end of the day if we cannot get to the benchmark or exceed that, we will continue to look at what other means are available to us.

Prof Bowden: When a circumstance of an individual being completely resistant to the idea is brought to our attention, there is a letter written to that person and a visit from one of the infectious disease doctors. We call that "academic credentialing" which is a nice euphemism. People receive that information and in some circumstances people have changed. In others there has been less happiness with the message. But if we had gone in at the first point by saying to everybody that this will lead to some sort of sanction, we would not have achieved what we have achieved now.

The other really important point is that this is not handwashing now. While people do wash their hands with soap and water, and you should do that every hour, the reason that we are winning is alcohol-based hand rubs. The beauty of alcohol-based hand rubs is that if they also contain chlorhexidine, which is an antiseptic, that gives a residual kill of germs on your hands. So you can actually break the rule in the sense of touching somebody and then going to the next person. As long as you have still got the alcohol on your hands with the chlorhexidine, there is a residual kill. We do not need to achieve 100 per cent compliance with every person every single time to reach a tipping point where the infections fall away.

THE CHAIR: Do you have problems with people complaining that they do not like the way their hands feel after the alcohol rub, that sort of tackiness?

Prof Bowden: That is a lot to do with the brand that you use. Some of the brands have got an emollient in them which people do not like because it does make the hands feel a bit greasy. The most popular brands are the ones which purely contain alcohol plus chlorhexidine. They do not leave any residue, but you still do need to rinse them off.

The beauty of alcohol-based hand rubs is that while people thought they were going to make their hands worse—because of the role of infection in a lot of dermatitis—they did not appreciate that although dermatitis is an immune response to surface bacteria, reducing bacteria makes many people's dermatitis better. When we started, people were saying that their hands were going to dry out, that this was going to be terrible.

The data actually shows that people's hands are better, apart from the very small—but very, very important—group of people who are chlorhexidine allergic.

If they have a sensitivity to it, that is different, but there are always sensitivities to everything that people come in contact with in the health scene. So it is a very good story across the board. Once people get a sense of what is the reality rather than just the fears, you see major changes in the workforce. I think we are right at the cusp.

MR WALL: I will start by directing my question straight to you, Mr Corbell. Obviously emergency department wait times have been a long discussed issue, particularly when it comes to TCH. I was curious as to what changes you are intending to make to the emergency department as the renewed health minister?

Mr Corbell: Thank you, Mr Wall. The government will be continuing its program to expand capacity at our emergency department. First and foremost, that is the priority project for me, as the new health minister. It is to see the number of beds in the emergency department grow and to see the establishment of the new paediatric ED capability at the Canberra Hospital. That project is due to commence on the ground, in terms of the initial works for decanting elements of the existing ED into new facilities, to facilitate construction, by May this year. So that is a very important project and that is my primary objective as health minister when it comes to the ED of the Canberra Hospital, which is obviously where a lot of the pressure is. It is to create a number of beds, to grow the number of staff and to get that expansion project underway.

MR WALL: You currently have, I think, the second lowest rate in the country of patients seen on time. I think we are equal worst with the Northern Territory for the number of ED visits that are completed within four hours. Why are we continuing to be one of the worst jurisdictions in the country for these measures?

Mr Corbell: A complex range of circumstances is driving this. The first is obviously the significant increase in demand. The increase in presentations is at an all-time high. We are needing to manage that extraordinary increase in demand that we are seeing in our EDs. That is why we are focused on alternative settings for those circumstances that should not see people ending up at the ED. The walk-in centre capability is very, very important in that context.

Equally, we need to continue to work on the through-hospital circumstances associated with ED. This relates to people who need admission following presentation at the ED, making sure that there are timely mechanisms to move people through from the ED into the general hospital wards and making sure that that frees up or maintains some capacity in the ED for new presentations.

All that work is an ongoing reform with the workforce in the ED and for the hospital as a whole to make sure that we are doing everything we possibly can to meet that demand. But ultimately we need also to increase capacity. That project is funded in the budget and I am anticipating substantive works to be underway in May this year.

MR WALL: Looking at the tracking of the territory over the last number of years, if we wind the clock back to 2004-05, when you were last the health minister, Mr Corbell, we had the statistics at 58 per cent. In 2005-06 it was at 52 per cent. They

were the worst in the country. Wind the clock forward 10 years to where we are now and we are still trailing. So ultimately what lessons have you learnt and when is the ACT going to have an emergency department that is not trailing the national average?

Mr Corbell: It is worth highlighting that our emergency department is one of only two in the territory. As the previous health minister has indicated, and as I will continue to indicate as well, we are dealing with a tertiary treatment hospital. It is providing services not just to the city but to the broader area. It is dealing with a very broad range of complex and very intensive conditions that people present with. Major trauma and emergency trauma have to be dealt with through the ED.

In other jurisdictions, as we know, the measurement of performance at a statewide level, for example, will capture a range of hospitals. These include small, rural and regional hospital that do not deal with that daily significant major trauma, as well as the big metro hospitals that do. So there is an evening out of performance between the ones that are not very busy and the ones that are very busy.

We do not have that luxury in the ACT. We are a small jurisdiction and we have an enormous bulk of work going into just one facility that is trying to deal with both a range of lower acuity circumstances as well as major trauma. That is going to show up in our statistics, and it does. Katy Gallagher, when she was the minister, made that very clear. That will be a task for me to continue to explain: why it is that we sit at that particular range.

That does not mean that there is not room for improvement. There is always room for improvement. My focus is on increasing capacity at the ED and on increasing timeliness. But at the same time there needs to be recognition that our hospital system is very different from a larger jurisdiction which has many, many hospitals, some not very busy in their EDs, some extremely busy but they get evened out at a statewide level in terms of performance.

When you compare our performance in terms of major trauma centre-type functions for a hospital, a tertiary level of treatment, with similar hospitals, you see similar levels of performance because of the types of presentations that they are dealing with.

MR WALL: If the issue is the way the statistics are gathered and the ACT being a small sample dealing with an acute type of patient, what would be the benchmark for the territory? What would you convey to the committee as the target that the ACT is most capable of reaching?

Mr Corbell: This is an issue that ACT Health has looked at comprehensively. I think Mr Thompson can help you with that.

Mr Thompson: The way this is done nationally is that we have peer grouping of hospitals. Each hospital, depending on the size and complexity of the care they provide, is allocated to a peer group. The comparisons are drawn within the peer group. That gives us a much better feel for how each of the hospitals is comparing against other hospitals.

MR WALL: What hospitals are Calvary and TCH peer grouping with? If it is easier,

can you take that on notice and provide an answer?

Mr Thompson: I do not have a comprehensive list of the hospitals, but I can give you some examples. The Canberra Hospital is a tertiary hospital. Its peers include the big hospitals across the country: the Royal Brisbane, the Hunter Hospital. It is St George in Sydney, Royal Melbourne and all of those sorts of hospitals. So they are the comparators used.

MR WALL: Mr Thompson, are you able to take this on notice and provide a list of peer groupings for the two primary hospitals in the territory?

Mr Thompson: Not a problem.

MR WALL: Thank you.

Mr Corbell: To follow up further on your question, Mr Wall, in relation to the reporting period that we are dealing with for this annual report, ED timeliness did continue to improve in this reporting year compared to the previous year, across all categories. Despite a six per cent increase in demand over 2013-14, overall timeliness improved by 10 per cent compared to the result in the previous year. We are seeing an increasing trend, an ongoing trend—the latest ROGS data confirms this—of improvements in timeliness.

This would highlight that the work being done in our hospitals is continuing to deliver results. Whilst there is still more work to be done, we are seeing some good results. For example, Canberra Hospital's timeliness in this annual report improved from 46 per cent in 2012-13 to 54 per cent in 2013-14; at Calvary hospital, their ED went from 58 per cent to 69 per cent. So we are seeing across both of our public hospital emergency departments significant improvements, and that is going to be very, very important to focus on.

MR WALL: The reason I ask is that if the national average is something that is not necessarily going to be attainable because of the nature of the ACT, then what is the benchmark target? We are making substantial investments as a jurisdiction. As the minister said, there are more beds, more staff, more resources. If we are just throwing money at it without a target or an intention of knowing what we are trying to achieve, how do you measure the effectiveness of that investment?

Mr Corbell: Our targets are the national targets, but, as we discussed, the national targets do not reflect the particular circumstances of the ACT in terms of our size. Now, that is the national target and there are a range of reasons why we are in that national framework. But you have asked, I think, some good questions about how we compare amongst peer hospitals. That is something that we can provide. We have got a range of peer hospitals that we can benchmark against and we can provide you with some further information on that.

MS FITZHARRIS: I do apologise for being late and holding up the minister and officials. My apologies. In relation to the increased demand, are you able to break down in any way the nature of that demand? And in relation to alternative services provided, for example, through the walk-in centre, is it possible for you to measure

how many people coming into the emergency department might otherwise have been able to have been seen in the walk-in centre?

Dr Brown: In terms of the triage categories that present to the emergency department, we use a scale of one to five. Category 1 is those who need resuscitation and need to be seen immediately, category 2 is an emergency to be seen within 10 minutes, and so on. Categories 4 and 5 are the semi-urgent and non-urgent, generally to be seen within 60 minutes or 120 minutes. It is not immediately transferable to say that categories 4 and 5 do not need to be seen in the emergency department and they could go elsewhere. Some certainly may fit within that category, but not all. You do find that, from time to time, people who present and are triaged in the lower categories still need urgent treatment and/or admission.

I do not think we have actually done the calculations in terms of those presenting to the ED who could have been seen at the walk-in centre. What we do, however, is to try and promote the walk-in centre as an alternative. There is information available on our website. We promote the walk-in centres quite widely. There is information available in the emergency department that provides the other alternatives. And it is not just the walk-in centre. After hours it is the CALM service. There are GPs. A pharmacist can be of assistance in some circumstances. We do present the other options for people as well.

MS LAWDER: Supplementary question?

THE CHAIR: Supplementary.

MS LAWDER: You mentioned categories 4 and 5. I note that on categories 3 and 4 we are a bit behind the target. What steps are you taking, minister, to try and reach those? It says "clinically appropriate time frames".

Mr Corbell: All those time frames for each of the categories are based on what is deemed to be clinically appropriate. The answer, I guess, is the same as I gave to Mr Wall, Ms Lawder: it is a combination of increased capacity, extra beds and dedicated capability in relation to paediatrics that is going to be very valuable. Then there are issues around workflow, patient flows through the hospital, improved protocols and arrangements in relation to effective and timely discharge from the wards of patients that do not need to be in the wards anymore, enabling movement of patients who do need to be admitted from the ED through to the general hospital wards and so on.

Those remain the areas of focus to make sure that we are able to free up capacity. It is all about freeing up capacity in the ED as promptly as possible. Once a person has received the treatment they need, it is getting them to move through to another part of the hospital if that is where they need to go or, alternatively, enabling them to leave the ED so that we can free up capacity.

A good example of this is the work we are doing with the ACT Ambulance Service. The ACT Ambulance Service now has the capability to electronically send data on patients in terms of their cardiac condition where they are responding and bringing someone to the hospital with a suspected heart attack. Because that data is able to be

transmitted en route to the hospital by the paramedics, we are avoiding the need for those people to even go to the ED. They are going straight to cardiac care in the Canberra Hospital and they are being treated immediately in that setting. That means that we are diverting more and more of those cases away from the emergency department.

That is an example of using technology and changes to work practice and workflow on the part of the doctors and nursing teams and delivering better care because it means that patients who are experiencing a cardiac-related condition get their treatment sooner. It is actually saving lives, it is speeding up our timeliness of care and it is reducing demand on the ED. It is a good example of how some of this range of measures come together to address the issues we are talking about this afternoon.

MS LAWDER: Presumably the target will remain the same for the year we are currently in. Do you have any preliminary indication of whether you might get to achieve the targets this year or exceed the target?

Dr Brown: No. We report a whole-year performance against target. We obviously look at it as we are tracking through, but the actual target is set on an annual basis. We do acknowledge, though, that we historically, I guess, have been challenged in categories 3 and 4.

The one thing I would add is this. We do not have Dr Mike Hall with us today, but as the clinical director of the emergency department he has spoken to the committee in previous years about this particular indicator of timeliness. What this measures is the time from when the person first presents to the emergency department to the time of the first intervention. Whilst it is important from the point of view of the patient experience, obviously not wanting undue delays to the point of intervention, in terms of the actual outcome for the patient it does not have as much validity as, for example, some other measures, like the total time spent in the emergency department.

I think I have spoken previously about the fact that there are different ways of achieving this. In the ACT we do not provide you with a Panadeine as an intervention when you come into the emergency department—which would stop the clock and actually improve our performance—unless a Panadeine is what is actually required. If you require a Panadol, we give that, but that does not stop the clock.

So there are subtleties in terms of the interventions that are undertaken that actually influence this indicator. We have to be careful about making comparisons across jurisdictions where there might be different approaches to the intervention.

THE CHAIR: Ms Fitzharris, a substantive question?

MR HANSON: Supplementary.

THE CHAIR: No. We will just work down the line, Mr Hanson; we will get to you.

MR HANSON: Everyone else got a supplementary, Mr Chair.

THE CHAIR: Thank you.

MR HANSON: Are you saying that I cannot have a supplementary question on ED?

THE CHAIR: I am saying that we will get to you with some questions after members have had their questions, Mr Hanson.

MR HANSON: If I can, Mr Chair—

THE CHAIR: No, you cannot, Mr Hanson.

MR HANSON: It is the first time I have been in a committee where a member who is in that committee and has sat waiting patiently for 45 minutes—

THE CHAIR: Mr Hanson, you are not a member of this committee. Would you please relax. You will get your turn; don't worry.

MR HANSON: I am very relaxed. I have had 45 minutes to relax. But I think it would be appropriate and fair if I were allowed to ask a supplementary on the emergency department waiting list.

THE CHAIR: Order, Mr Hanson! Mr Hanson, you have had your say. I am chairing the committee; I have said you can wait. Ms Fitzharris, a substantive question.

MS FITZHARRIS: Thank you, chair. My question is in relation to output 1.2. In particular, in July 2014 the Belconnen Community Health Centre started running an adult mental health day service. Are you able to tell me a bit more about that service and what it will look like as it transitions into the University of Canberra public hospital? It is particularly mentioned on page 47.

Mr Corbell: Thanks, Ms Fitzharris. This is proposed as an interim measure until the adult mental health day service is fully instigated at the new University of Canberra public hospital. It is envisaged that ultimately this service will be delivered at UCPH. The service is designed to provide treatment for adults and will offer subacute support aimed at trying to avoid people needing to be admitted to acute psychiatric care at the Canberra Hospital in our psychiatric area. The focus is on day treatment, transitional support for those people who have been discharged out of the acute psychiatric setting and also assisting with reintegration into the community. It is a very good example of the subacute services that the government is focused now on delivering as a step between, obviously, those acute treatments that put more and more demand on our public hospitals and the development of a much more complex and comprehensive subacute setting to avoid the need to go straight to the most expensive, demanding, time-consuming, resource-hungry type of service.

This project will review and develop mental health services that are currently being delivered to adults. A new model of care is being developed for this. This will be worked through with stakeholders in the community so that we are providing a really good level of support to people with mental illness under psychiatric conditions who are caught up in acute treatment in our psychiatric unit and who should not be going back there with that level of regularity, who should be able to be supported more effectively through the delivery of services in the community and day settings.

That is what will be delivered at Belconnen health centre for now until UCPH is up and running, then UCPH will be able to deliver those services.

MS FITZHARRIS: How is the Belconnen Community Health Centre going overall? Are you finding it is servicing the local Belconnen community or are people coming from other parts of the city to visit it? Do you feel the community has a good understanding of what services are available in the centre?

Mr Corbell: Certainly the project has been very well received. The rebuild of the community health centre has been very well received; it is a fantastic new facility in the Belconnen town centre. In terms of the catchment, if you like, and who is utilising the service, I will defer to others who can assist with that.

Dr Brown: I am not sure I can actually answer that. I am looking for Jacinta George as the acting executive director. I am not sure whether she is in a position, as an acting executive director, to answer that in terms of the catchment area. It is a service for adults—a day hospital service—so I am anticipating, and Jacinta might nod at me, that it is a whole-of-territory approach for adults. She is nodding.

MS FITZHARRIS: So this is the first time this particular service has been offered anywhere in the territory—the mental health day service?

Dr Brown: Yes. It is a new service as part of the spectrum of mental health services in the ACT. Yes, it is.

MR HANSON: Supplementary, Mr Chair.

THE CHAIR: Later, Mr Hanson.

MS FITZHARRIS: May I ask some questions about the Gungahlin Community Health Centre and the services that are being offered there? It is in relation to a survey that was released yesterday by the Gungahlin Community Council, which asked a specific question: "Would you like to see a nurse-led walk-in centre at the Gungahlin Community Health Centre?" There was an overwhelming yes to that. Are you able to talk a bit about the current services at the Gungahlin Community Health Centre and possible plans for a nurse-led walk-in centre in the future?

Mr Thompson: I can answer the second part first; it will be a quicker answer. At the moment we do not have any plans for a walk-in centre at Gungahlin. We have recently expanded from one to two. What we have seen with two is that use of the walk-in centres is close to double the use of one walk-in centre at the Canberra Hospital. That is showing that there is definitely interest and demand from the community for the services, but we do not have any specific plans for Gungahlin. What we provide out of the Gungahlin health centre is a range of community nursing, maternal and child health services, dental services, mental health services and allied health services in the broad. I am happy to expand on specifics.

MS FITZHARRIS: Are they available for everyone in the community or just for certain groups or ages?

Mr Thompson: Most of the community health services operate on a referral angle and eligibility basis. In other words, to receive the service you need to be referred from another service or have specific eligibility criteria. The maternal and child health services are available to the entire community but specifically are for families with young children. Dental services have criteria around income levels and concession card status—to be eligible for them—in the main, as well. So there is a mixture. But the bulk of the services are similar to a GP, for example, where you can just book an appointment because you want to see a physio. You need to be referred and meet the eligibility criteria.

MR HANSON: Can I have a supplementary?

THE CHAIR: It is Ms Lawder's turn now.

MS LAWDER: Minister, I think back in 2005—you were the Minister for Health at that time—you began issuing health services quarterly performance reports which were available online. In February this year—this month—you were asked when the July to September 2014 health quarterly report would be released, and you answered:

> That report was prepared for the purposes of the administration of the Health Directorate.

I am just wondering if you were planning to make that available and, if not, what might have changed between how important it was to make health performance available versus perhaps not.

Mr Corbell: The answer to your question is yes.

MS LAWDER: It will be published?

Mr Corbell: Yes.

MS LAWDER: Do you know when it will be publicly available?

Mr Corbell: I do not have the exact date, but I anticipate it will be soon.

MS LAWDER: Soon? I think one of the first ones was available only nine weeks after the end of the reporting period.

Mr Corbell: Yes.

MS LAWDER: It has now been quite some time since the end of September.

Mr Corbell: My understanding is that there has been a delay partly due to the transition in portfolio and then because of the passage of the Christmas and new year break. That has led to some delay.

MR HANSON: The statistics change depending on the minister, do they?

Mr Corbell: Absolutely not. It is simply a case of reporting through to the minister with the change in portfolio. It is normal for the minister to be advised of the outcome of the report before it is made public; that is just standard procedure. The bottom line is that it is my expectation, and it will be my practice, that those reports will continue to be made available on a regular basis.

MS LAWDER: Online?

Mr Corbell: Yes.

MS LAWDER: Thank you.

THE CHAIR: Mr Hanson, some questions.

MR HANSON: I am just wanting to clarify: am I allowed to follow up from the previous questions or do I just get a single substantive?

THE CHAIR: Just start asking questions, Mr Hanson, and we will see how we go.

MR HANSON: See how we go? All right. I will start with a new question and then we will go to some follow-ups, if I could, on some previous ones.

THE CHAIR: Yes, sure.

MR HANSON: I would like to go to the issue of tick-borne diseases and Lyme disease in the ACT. I know that there has been some discussion about this with regard to it being an evolving area and what ACT Health's response is. I know the federal government has taken some steps. The chief medical officer has released some publications, some documents. Could you give an explanation, please, as to where we are at with particularly Lyme disease? I have been approached by a number of constituents who are concerned about this and what the current status is with Lyme disease.

Mr Corbell: I will ask Professor Bowden to come back up. He is best placed to deal with the specifics of that.

Prof Bowden: Lyme disease is a very important issue in Australia at the moment. There are a number of people around the country who are suffering from a wide variety of complaints who believe that they have contracted Lyme disease. Therefore, it has become something where, a number of years ago, the chief health officer of the commonwealth called together a working party to look at it because of the concern in the community.

I find this a very vexed clinical problem, and I would be very careful here to steer away from any individual patient conversations at this level. The first thing to say, though, is that Lyme disease is an important emerging disease around the world. In Europe and the United States, when it was first identified in 1977, it was one of the new diseases where people were thinking we had reached the end of infectious diseases and it became quite clear that we had not. As the environment changes, as the climate changes and as humans interact in a different way with the environment, we

have new diseases which appear which previously had not affected us.

Lyme disease is real. Lyme disease affects hundreds of thousands of people in America. It is principally—almost exclusively—transmitted by tick. It does not spread from person to person. In Australia, however, we have no evidence—and I stress that there is absolutely no evidence—of the existence of the *Borrelia* which causes Lyme disease. It has been looked at many times, through thousands and thousands of ticks, through thousands of what are called sentinel animals which are tested for antibodies to *Borrelia*. We know that these are animals that are bitten by the same ticks that humans are. At no stage—never—has there been, in a reliable laboratory, and I will come back to that in a moment, a finding of the organism which causes Lyme disease in Australia. That does not mean that it does not exist, but it means that if it does exist it is incredibly rare. And to our knowledge there is no individual who has been infected with *Borrelia* in Australia. We have to look at the evidence for that.

Having said that there is no Lyme disease in Australia, let me say that tick-borne disease is very real. Ticks transmit rickettsial disease, which is called spotted fever or tick typhus. They can also transmit Q fever. We know that the paralysis tick is a real threat to our animals, if not to humans. So it is not to say that ticks do not transmit disease in Australia, but, with all of the testing that has been done of animals and all of the testing that has been done with humans, there has not been one person who has been found to have Lyme disease which would meet the criteria of the European or the American authorities.

There are a number of laboratories around the world, particularly a very famous one in the United States, which charge individuals many thousands of dollars to do testing for Lyme disease which does not match with other accredited laboratories. Unfortunately, this is a fact of laboratory practice—that all tests require calibration against other laboratories. Every single laboratory test that exists produces false positive results, and the vast majority of people who present with a positive test for Lyme disease in Australia have a false positive result. When it is sent to an accredited laboratory, that accredited laboratory does not find evidence of the disease.

The second thing is that not one person in Australia who believes they have locally acquired Lyme disease—not people who have travelled overseas and bring the Lyme disease back but the people who believe they have acquired it in Australia—presents with the Lyme disease that is seen in Europe or America. They present with a constellation of symptoms which are real and which are troubling—and those people need to have help and attention—but none of them look like Lyme disease as anybody else around the world would know it.

Unfortunately, we are in a situation where there is a group of people with a constellation of symptoms. I could characterise it as perhaps a bit like chronic fatigue. Those people are searching, quite understandably, for help and for a cure. Again, because of the internet, this has changed so much in the last 10 years, because of social media and the ability of people to get online and seek information from others. You know how easy it is for something to move all around the world very quickly. The Lyme disease in Australia story is shared by a whole lot of people with similar symptoms.

The problem—Mr Hanson, this, to me, is the ethical issue that we have to deal with—is that the people who believe they have Lyme disease are seeking treatment with antibiotics intravenously for up to 12 to 18 months. There is no guideline anywhere in the world that says that antibiotics should be given for Lyme disease—even confirmed Lyme disease—for 12 months. The longest period that is recommended by the centres for disease control and American Infectious Diseases Society is four weeks. To go to 12 months or even 18 months by intravenous treatment is extremely risky. The benefit, even if there was a benefit, is completely outweighed by the risk of the antibiotics. We are aware of patients who have died from the complications of the drip—not in Australia but, it is published, around the world.

In a randomised controlled study of patients who had this constellation of symptoms, in a chronic fatigue type syndrome, who got antibiotics and those who did not, there was no difference in the outcome between the two groups but there was an increased risk of side-effects in the group who got antibiotics.

If we believe in evidence-based medicine, which is what everybody is aspiring to practise in Australia, that means good evidence—in other words, randomised controlled trials, being the highest level of evidence available. If we believe in that, if we wish to ascribe to it, our ethical and professional responsibility is to say to people, "There is no indication for prolonged intravenous antibiotics in this case, because not only do we know it will not help you but we know it could hurt you."

That is the position of the ACT infectious disease group; that is the position of the hospital. We are very sympathetic to people who are suffering from what they believe to be Lyme disease. We are very sympathetic to them and we will offer them the supports they need, but the answer is not 12 months or 18 months of intravenous antibiotics.

MR HANSON: Thanks; I appreciate it. Do I get another?

THE CHAIR: Yes.

MR HANSON: I want to go back to the ED question before when we were talking about demand. There was a demographic study that was done a number of years ago. I remember I FOI'd it and it came in boxes and boxes. I looked at the analysis of what patient demand was going to be out into the future. I assume, from the narrative that we have played out in this committee and other forums over a little while, that that understated the demand. What work has been done to look at the projections of what the demand is going to be? We know that year by year it seems to always exceed what was planned; that seems to now be just the regular narrative. What are you doing to try and look at what those projections are so that we can anticipate—with the growth in the region, with the growth in the ACT, with an ageing population or whatever those factors are—that this is the demand we are going to confront, so that we do not endlessly have the situation where, year by year, we seem surprised by the influx of people into the emergency department and other areas of the health system?

Mr Corbell: I think a lot of work was done during my predecessor's tenure, in particular. I might ask Dr Brown to talk a bit about that.

Dr Brown: Indeed, the projections that were done did underestimate the actual attendance that we have seen. The ACT, however, is not alone in that. The phenomenon of increased presentations to emergency departments is being experienced in, I think, all jurisdictions across Australia. No-one entirely understands exactly why that is the case.

But because we have experienced it and it has placed pressure on our system, we have been looking at this. We did do some drilling down last year, and we are continuing to do some work with the Medicare Local to look at some of the specific factors in relation to the types of people who are presenting. That will help inform what might be alternatives in terms of other services that might be offered. We have looked at things like the geographical spread, the age groups, the particular DRGs or diagnostic groups within the different genders, for example, and the different age groups, in terms of what is contributing to the presentations—

MR HANSON: Do you have any results yet or are you still in that process?

Dr Brown: We have some results. As I said, we are continuing to do some work with the Medicare Local to drill down further.

MR HANSON: Is there a view in terms of where that demand is going to go? Is it going to continue to increase or is it going to peak? Is it exponential or is it moderate?

Dr Brown: It would certainly be a sustained growth. I have a figure of seven per cent in my head for the last 12 months as the percentage growth in ED presentations. I think that is the order that we have seen. I am looking at the data: it is six.

MR HANSON: Close.

Dr Brown: Close.

MR HANSON: I also remember that it was meant to top out. There was going to be this growth and then we were going to reach 2020, when it was to reach a particular peak in that growth because of a number of factors, including ageing, and then it was going to plateau. Is it still the view that we are going to go at six and then we are going to peak at a point?

Dr Brown: The peaking was based on the demographics and the rate of ageing that we have got; then it is going to steady out. But, as I said, the growth in presentations to the ED exceeded what the projections were, and it has been a phenomenon that has been observed around the country. I would be fairly brave to make an absolute prediction here and now about exactly what is going to happen in 2020, but we are looking to understand the contributing factors more to inform exactly what other strategies might help moderate it.

MR HANSON: I go to another point: where are we at with the Canberra Hospital? A few budgets ago there was $41 million put in. That was then taken out. There has now been $23 million of that money used for an emergency department resolution, but I heard Dr Hall say that that should not be viewed as a permanent solution. Where are we at in terms of the Woden campus, the Canberra Hospital campus, and its

redevelopment, particularly the tower block? That was a body of work that seemed to be going full steam. Some $800 million was going to be put into the budget. There were announcements made and promises made. Then, from a public point of view, that all stopped. I am sure there is good work going on behind the scenes, but can you give me an explanation as to where that work is at and what the planning is for the Canberra Hospital—in particular, the tower?

Mr Corbell: Yes. This is the redevelopment of buildings 2 and 3 at the Canberra Hospital and the establishment of a range of services as part of that work. Detailed planning is underway in relation to that project. It is subject to budget cabinet consideration at this time, but it is a critical part of the rebuild of the Canberra Hospital and it is the most significant capital commitment the territory will have to consider at the Canberra Hospital. That detailed analysis is currently at a well-advanced stage of development to allow the government to determine how that project can or should proceed.

MR HANSON: Sure. One of the issues that I have had, and I have had a number of quite frustrated people come to me, is that people saw announcements that there was going to be a rebuild of the tower block, there was money committed, things were happening and it was visible—and then it has just gone broadly silent. People do not know what is happening in terms of that redevelopment of the Canberra Hospital. People at reasonably senior levels that I have spoken to in the medical fraternity are saying, "What is happening? We were told that this was the fix, and now that is off the table." I appreciate that work is going on and cabinet has to make decisions, but are you able to present some sense of where we are at, what is going to happen and when a decision is going to be made for those people that are concerned? Obviously, the absence of information creates that vacuum. Is it on the website somewhere? Is there information available that presents that view?

Mr Corbell: It is interesting you mention this, Mr Hanson. I was having this discussion with my officials today. It is important—

MR HANSON: I noticed that we were all saying the same thing on the news last night, if you caught it. We were all having the same conversation.

Mr Corbell: If you watched the news, you would have thought we were all in agreement, but I think we were talking about different types of leadership. That said, I think it is important that we refresh our communications around what is happening with health infrastructure programs, because ongoing efforts are in train right now. Whether it is the delivery of the new secure mental health facility, the bush healing farm or the work on the University of Canberra public hospital, big elements of the health infrastructure program continue to move along. Equally, on TCH campus itself, ED expansion and preparatory works for redevelopment of buildings 2 and 3 are underway.

I am keen to make sure that the community better understands the scope and scale of the works that are ongoing. I will take your comments as some endorsement of that approach, Mr Hanson, and I will be continuing to work with my officials to make sure we are getting an up-to-date picture out to the community. In relation to building 2/3, it is at a very well advanced level in terms of advice for government.

MR HANSON: Is this the existing tower block or the ones adjacent to it?

Mr Corbell: No, it is not the existing tower block; it is the buildings adjacent to the existing tower block that require significant redevelopment and preparation for, potentially, staging for a new tower block there. That is the work that is underway.

MR HANSON: Those are the big chunks I am trying to get my head around. What is in place? Is there going to be a new tower block or not? Is it going to be just a refurb of the current ones? If we are going to put a new tower block in, what is the sequence? Do we build a new tower block and then decant or is it going to be done progressively? And then what do you do with the old tower block? These are the sorts of questions I am being asked and that I am asking myself. They are pretty reasonable questions. I remember that three or four years ago there were answers to all this. I was shown answers. I was shown briefs and so on. I was shown the budget that was there to do all this. Then, all of a sudden, it has been a vacuum.

Mr Corbell: I do not think there has been a vacuum. What we are doing is working through the delivery of what are very big chunks of rebuild of the Canberra Hospital—multi-hundred million dollar projects. Building 2/3 is the first stage of that. The redevelopment of building 2/3 will allow us to completely redevelop those two buildings and construct it in a way that provides a podium. That can then, as part of a subsequent stage, be a new tower block facility at TCH. That is the work that is underway at the moment. No final decisions have been taken on this by the government at this time because it is subject to detailed analysis, but this is a staged approach to the redevelopment of infrastructure at the Canberra Hospital. That is necessary when we are doing major construction works.

MR HANSON: I have no issue with it being a staged approach; it is the obvious way to do it. The problem is that if the community is drip-fed stage by stage there is no sense of what the whole plan is. You get told it is for building 2/3. We need an overview: "These are all the major bits going on. We are doing the detail work on building 2/3. Then we will do the detail bit on this." You need a bit of a sense of what is happening, what the estimated time frames are and maybe an estimated budget. That body of work, which had all the moving parts and when it was going to happen, was available. That then got taken off the table, seemingly. The $41 million was taken out and your—

Mr Corbell: No; it has not been—

Mr Hanson: Your predecessor said the $800 million for the tower block was on hold. Can you present to the committee that outline plan, so to speak, of what is going to happen over the next decade?

Mr Corbell: We can certainly provide you with some further detail on notice, but perhaps I will address some of the main points. The 2013-14 budget provided $40.78 million for forward design of main clinical services and inpatient units for the Canberra Hospital. Work was completed in February 2013 for a future facility profile for the hospital, and this looked particularly at the issue of staging and it looked at how works could be delivered in more manageable blocks of activity.

As a consequence of that, we have gone back and looked at how we manage issues for buildings 2/3 and we are now doing the detailed assessment of the delivery of that project: costings, delivery models and the detailed scope of works. So all that work is underway right now and that has been prepared in the context of the government's deliberations for the coming budget.

THE CHAIR: Minister, we might move to strategic indicator 2.1. Could you tell us what are the characteristics of frequent flyers to emergency departments?

Mr Thompson: They vary, but probably the most common thread, if we are talking about frequent flyers, is people who have chronic and/or complex care needs. It might be a single illness or a number of different illnesses that they have and usually less than ideal support in general practice or community-based specialist care. What you will see is a lot of people presenting with chest pain on a regular basis. Also drug and alcohol and mental health problems will at times be some of the primary factors that people present with. There are different disease groups, but, generally speaking, it is the chronic complex care needs.

THE CHAIR: More men? Some people have indicated that.

Mr Thompson: I do not have that data. I can see what information I can provide to you.

THE CHAIR: Do you regard it as a significant issue?

Mr Thompson: It is a significant issue. When I last looked at it in detail it was not an issue that was really the cause of the growth of the overall pressure on the emergency department. However, it is a significant issue for the individuals concerned because frequent presentations to the emergency department are rarely the best way to manage their conditions.

We have a number of chronic care programs in place and the means to try and engage people in services more routinely, rather than leaving them to rely on the emergency department as their primary source of care, and they are successful to a degree, but there are still some people who have this profile of presentations.

THE CHAIR: The reason I ask that is that one study indicated in a Perth hospital that it was less than five per cent of presentations to EDs, which would indicate that it is of a low order of significance. Another paper from Dr Liu and Dr FitzGerald from the School of Public Health at the Queensland University of Technology indicated that repeat users, frequent flyers, reportedly place relatively high pressure on ED resources and are copping blame for ED congestion. A range of other papers seem to indicate that this is a significant issue.

As you correctly focus, it is more around people's management, and maybe not enough of these people are seeing specialists or being appropriately managed. So what is the government doing about this? I know the previous minister announced an allied health initiative, a podiatry clinic, back in 2012, which was intended in some way to tackle frequent flyers.

Mr Thompson: The broad approach that the government has been taking for funding over a number of successive budgets in recent years has been developing a capacity to deliver chronic care programs. We have chronic care programs available to people, depending on their needs and circumstances, and we have home-based care that we can provide to people with the ability to contact care coordinators where they are concerned about an exacerbation of their condition.

We have self-management programs teaching people what are the signs and symptoms to look out for and what are the best ways to respond to those, and to maintain their health rather than to have a deterioration. We have more active care coordination for people with unstable conditions and who need more high-level support, and we have post-hospital rehabilitation services so that if the condition requires hospitalisation we have the ability to try to return people, as far as possible, to their previous level of functioning.

THE CHAIR: At the ACT Clinical Senate in 2013 it was stated that clinical handover often fails with frequent flyers and that there should be a flag in the system that picks up these patients to channel them into multidisciplinary care. Has that been attended to?

Mr Thompson: We have a register that has been developed by the chronic care program that operates out of the Division of Medicine to try and address that very issue. What we have is identification of people who meet the criteria for the chronic care program, one of which is frequent attendance to the emergency department. Once they are registered, each time they have contact with health services that information is available.

One of the issues that we have got, of course, is that the Canberra Hospital and health services and ACT Health is a component of the care provided there. A lot of chronic disease is managed in general practice. What we are trying to do through a program called health pathways is to work with Medicare Local and local GPs to try and connect up more effectively in general practice and ACT Health provided services.

THE CHAIR: But there was a paper in 2006 which indicated that improving multidisciplinary case care management for frequent flyers actually increased their attendance at EDs.

Mr Thompson: It is a very difficult situation and it has been the subject of considerable investigation over many years. Yes, I am aware of some of those findings. There are a number of reasons why you get similar findings for those sorts of interventions. One of them actually is that through these programs you raise people's awareness of their health conditions and you get an initial effect where they seek health more actively than they have done previously because they are now aware and concerned about the potential ramifications of what is going on.

That can moderate over time, but it is a feature of some of these programs that the effect that you get by introducing very intensive care coordination is additional use of health services but not necessarily commensurate improvement in their outcomes. That is why I think one of the keys here is risk stratification and titration, so to speak,

of the care that is provided. So we are providing the response according to the level of need of people, rather than seeing them all as one size fits all.

THE CHAIR: Moving down the league tables of referenced articles, we will go to the *Herald Sun* report of June 2014, which stated that in Victoria one in eight emergency treatments at the EDs were regarded as frequent flyers. Is that the sort of scale that we are seeing here in Canberra?

Mr Thompson: I have to say I do not have that figure in my mind at the moment. There are definitional issues, but I can take that on notice and provide you with that information.

THE CHAIR: So how do you define the frequent flyers here?

Mr Thompson: For the purposes of the analysis that I have done most recently, I was looking at three or more emergency department attendances a year. What you get when you do that—and this is part of the issue—is people who have just had a bad year and it is three completely unrelated conditions. So you need to sift the data a little bit more to identify people who are presenting regularly for particular conditions, as opposed to "this week I sprained my ankle; last week I tripped over" and those sorts of unfortunate accident type presentations. There is no hard and fast definition that is available to definitively say that this is a frequent flyer.

THE CHAIR: I take it that, at this stage, you are identifying frequent flyers and you are managing them through attempting multidisciplinary care with their private providers as well as with what is available within the hospital. That sort of ties in with what other people have been saying about a potential gap existing between community home care services in supporting these patient groups.

One American article indicated that there need to be models developed to integrate the medical care of patients with social services. So that is beyond the resources of your directorate. Have you been looking at the models that have already been developed in ACT government, like through-care and strengthening families, to say that you need a cross-directorate approach, and what steps have you taken?

Mr Thompson: We work closely with other directorates on those programs that were actively involved. In terms of what steps, what specifically are you thinking of?

THE CHAIR: There is an example of a patient who comes in in a diabetic coma because they are not getting adequate ongoing care at home, because they do not have somewhere safe in their home to draw up their insulin, so this is really a housing issue. Obviously a cross-directorate response is required there. It talks about the issues around transportation, about employment and all these things which fit into areas which are not within your directorate.

Dr Brown: Government has, of course, published the human services blueprint, which is all about joining up human service systems, and not just public sector. It includes primary care and non-government organisations. The pilot or the demonstration of this is commencing in the west Belconnen region. It is early days in terms of that, but it is all about looking at place-based services. So for people in that

region, what services are on the ground and how do we actually work together as service providers to meet the needs of people in their location and ensure that we deliver joined-up services? We do have a task force that is overseeing this work, and there are some other government steps that have just been put in place in the last couple of weeks, in terms of taking this work forward. The strengthening families initiative that you referred to sits under that umbrella as well.

THE CHAIR: So you are identifying your frequent flyers from ED and translating them into that program?

Dr Brown: It is not just about frequent flyers. This is looking at the needs of particularly the more vulnerable in our population, but everybody really, in terms of how we as service providers actually join up and meet the needs of people in their region, in their place, rather than expecting people to come to the services where they are located and where they are not joined up. As I said, it is early days, but I think it is actually quite an exciting innovation that the ACT is taking forward.

Mr Corbell: So the human services blueprint is really a response that says at its heart that we can identify, and we have a good level of knowledge of, a relatively small number of people in our community who call on government for a range of very intensive services, in terms of cost, in terms of time, in times of attention, all too frequently.

Whether that is in the healthcare or mental health system, whether that is in community family services, whether that is in Corrective Services and the justice system, we know that there are a relatively small number of households where, because of underlying circumstances, they are frequently in crisis. That might be health care related, mental health related, behavioural—a whole range of other factors are driving that.

If we are able to intervene early and work in a very joined-up, collaborative way in providing services that actually address the underlying issues at play in those households, we are significantly reducing the time and needs that they will otherwise have in terms of tertiary referral and support, whether that is health care related or otherwise, and provide greater stability and healthy environments for those individuals and those families to actually get their lives together and live productive, stable and well-supported lives.

So that is the focus of the human services blueprint and it is something that I think can be realised here in the ACT because of our size and scale. We do know where the families in crisis are, we do know where the individuals in crisis are, and we are able to intervene more proactively to try and address these issues and, therefore, reduce costs to the territory and to the taxpayer, free up services to meet other demands and, fundamentally, provide better lives and help people in these circumstances to have more dignified and better lives than they would otherwise have. So that is very much the response.

THE CHAIR: Good. I am particularly pleased with this approach because that is certainly what we have been doing in Aboriginal health services for the last 30 years: developing holistic, multidisciplinary approaches, multi-philosophy approaches to

people's problems.

Coming back to the specific issue of ED frequent flyers, I would like to hear in the future that there is some articulation of that group of people, once you have appropriately defined them, into those kinds of programs. If the *Herald Sun* is in the ballpark, there is a significant amount of work that has been done there that could be improved. And if these are indeed very sick people who do need to be in EDs, which I suspect is the case, then they need to be better managed and have their preventive and primary health care managed in a better way to achieve the kinds of outcomes that we would all want as a community.

Mr Corbell: Sure, and I think that is the point—the last comment you make there, Dr Bourke. It is about recognising that it is those underlying factors that are leading people to go to the ED. There might be an underlying mental health issue, or it might be an underlying social issue or social environment that is driving people to the ED for that sort of critical crisis type intervention. So by addressing those underlying issues you are reducing the need and the requirement, if you like, for those people to end up in the ED.

THE CHAIR: I think the difference is that I am very focused on the targeted approach. Mr Wall, a substantive question.

MR WALL: Thank you, chair. Minister, I go to strategic objective No 8, which is bed occupancy. My understanding is that the national target set, and the target recommended by the AMA, is that we do not exceed 85 per cent bed occupancy in the hospital system. Eighty-five per cent had previously been the target in the ACT. In recent years this has changed from 85 per cent to 90 per cent. I refer to a number of articles that have been written in the paper and particularly to an email that the emergency department executive director sent, in which he stated, "We know the Canberra Hospital is frequently operating at capacity levels over 95 per cent."

In relation to a question taken on notice that I think you answered, Mr Corbell, the answer was that the highest daily occupancy rate between July 2014 and September 2014 was 93 per cent. I guess the question is: how frequently is the hospital operating at levels close to or over 95 per cent? What is the actual peak operating capacity that the hospital has hit, given that we have got an executive director saying that it is in excess of 95 per cent and the minister saying it is at 92 per cent?

Mr Corbell: Thanks, Mr Wall, for the question. For this annual report that we are dealing with, the total was 90 per cent and the result was 90 per cent. So we met the target in the reporting year that the annual report before us deals with.

MR WALL: Just to clarify there, minister, the target in the annual report is an average over the calendar year?

Mr Corbell: That is right. That is the target. It is a mean percentage of overnight hospital beds in use.

MR WALL: What was the peak occupancy rate that the hospital hit in the reporting

period? You can take that on notice if you need to.

Mr Corbell: At any one time?

MR WALL: Yes.

Mr Corbell: Obviously it varies throughout the year and, indeed, throughout the day. I would take some advice from officials as to how that is most accurately reported, but I am happy to take it on notice.

MR WALL: And also into the subsequent period from the end of the reporting period through until, say, the beginning of February, if you could?

Mr Corbell: Again, I would have to take some advice as to what would be the most accurate figure to report, but I am happy to take that on notice. The point to be made about this is that we have focused very, very strongly on increasing our overall capacity. There are now 1,048 beds across the public hospital system. That is a 56 per cent increase on when the government was first elected, so we have significantly increased bed capacity.

In terms of extra capacity, in 2013-14 a broad range of beds were introduced. There were 10 general inpatient beds at Calvary public. They opened in July 2013. There were five new beds in the Centenary Hospital for Women and Children. That was in November 2013. There was an additional inpatient bed at Calvary public in January 2014, four beds in the stroke service at Calvary in March 2014 and eight rapid assessment beds at the risk unit at Calvary public hospital in March 2014 as well.

That is a significant investment. In 2014-15 a further 31 inpatient beds are determined to be opened and another further six-bed equivalents through expansion of the hospital in-home services. So we continue to focus very, very strongly on building capacity. I think those figures speak for themselves in terms of the work that we are doing there.

MR HANSON: I have a supplementary.

THE CHAIR: No, you will have to wait, Mr Hanson. Ms Fitzharris—

MR WALL: Can I continue, please, chair?

THE CHAIR: Sorry.

MR WALL: It was reported, I think it was in October of last year, by emergency department specialist Associate Professor Richardson, that occupancy was between 110 per cent and 120 per cent, depending on how you count it. Is it merely a matter of how the calculations are done as to what the result is?

Mr Corbell: Mr Thompson can assist you with that, Mr Wall.

Mr Thompson: No, obviously we do not have more than one patient in a bed at any given point in time and so—

MR WALL: There are plenty of chairs in hallways.

Mr Thompson: But we are talking about bed occupancy here. There are a lot of different numbers bandied about in terms of what bed occupancy is. But, for example, if you look at a 24-hour period you can have, depending on the type of service, a number of patients in that bed for that 24-hour period. If you are counting in a way that does not understand that, that is where you can get the 110 per cent and 120 per cent figures.

If the question is: are there times where we have 20 per cent more patients than the hospital has beds to care for, the answer is no. We have never reached that point. What we have is a situation where there is transition through beds where the total number of patients cared for in that 24-hour period might be like that.

Mr Corbell: That reflects people moving in and out of the hospital. Turning to your question, Mr Wall, about how we are tracking most recently in relation to bed occupancy, for the financial year to date, to the end of December, which is the latest period we have got figures for, we are tracking at 86 per cent bed occupancy across both hospitals.

MR WALL: Is there a breakdown, minister, between Calvary and TCH?

Mr Corbell: No, not before me at this moment, no.

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Thank you. Throughout the report there are references to the health system as a whole. In the previous financial year you would have planned on patients going to their GP but obviously the federal budget then announced the possibility of a GP co-payment. What does that mean for health services in Canberra, should that co-payment be agreed? What does that mean for pressure on the hospital, for outcomes for patients perhaps choosing either to not go to a hospital and wait or to not go to their GP in general? Could you elaborate on that?

Mr Corbell: Yes, thanks, Ms Fitzharris. The most recent ROGS report provides some very useful data in this respect. We already have the highest percentage of consumers reporting that they will put off a visit to their GP because of costs. So of any jurisdiction in the country, we already have the highest percentage where consumers report that they will not go to a GP because they are concerned about cost.

Clearly, if there is a policy decision on the part of the federal government to further increase the up-front costs of seeing a GP, that is not going to have a good impact on those figures. So what does that mean? It means that either people are not seeing a doctor when they could very well need to or they are going to go to services where they know they will not be charged. That is more and more likely going to be our emergency departments.

The introduction of a co-payment, any sort of up-front increase in the cost of seeing a doctor, is only going to increase the percentage of people who report putting off

seeing a doctor because of concerns about cost, and that is going to be more significant in the ACT than it is in other places because we have already got the highest percentage of consumers in the country saying they would put off seeing a GP because of cost. So it would be a retrograde step.

We need to be focusing on ways to get more people to see their GP, or other forms of care for matters that are less are serious than the need to see a GP, such as our walk-in centres, and that is where our focus is. Any move on the part of the federal government to increase charges to see a GP is going to work counter to all the other strategies we have been working on with the profession, both nurses and doctors, over the past four to five years. It will be retrograde and will no doubt end up with our seeing more people in our emergency departments who should not be there.

MS FITZHARRIS: What is the current status of the potential co-payment? Are you talking to your ministerial colleagues nationally and talking to the federal government about that and how you plan for that, given that there has been now eight months of uncertainty since the original announcement and a lack of clarity about what the actual policy will be?

Mr Corbell: We have not received any further formal advice from the commonwealth on the status of that proposal. I have not had the opportunity to attend a meeting of health ministers since my appointment to this portfolio. There has not been one since my appointment. However, what we do know, and what is on the public record, is that the revenue associated with the co-payment proposal is still live in the federal budget.

It is still an active part of the federal budget. It has not been pulled out of the federal budget. All the revenue assumptions behind it still sit in the current federal budget papers. So we can only assume that until or unless there is a change that factors that revenue out, it remains federal government policy. The new federal health minister has indicated now that there needs to be a so-called value signal, which I assume is a co-payment of some sort.

MS FITZHARRIS: Is the health system as a whole seeing any impact of that uncertainty at the moment—like patient behaviour changing in any way? I think after the first announcement there were some reports about pensioners in particular who were worried and turning up to their GP to talk to them about whether they should get in to see them now. Are you seeing that in any way in any part of the health system already?

Mr Corbell: Certainly the AMA is reporting that there is anxiety amongst their clients on this issue and particularly from those people who can least afford it. People are raising it.

Mr HANSON: Have a chat to Andrew Leigh. He has got a position on it.

Mr Corbell: Medicare Local and the local AMA certainly report that it is an issue of concern.

Mr HANSON: Have you spoken to Andrew Leigh about these concerns?

THE CHAIR: Mr Hanson!

Mr HANSON: I know that he supports it.

Mr Corbell: Andrew Leigh is not the minister or the shadow minister for health.

Mr HANSON: He is the assistant shadow treasurer, is he not? Talk about confusion. It is very confusing.

Mr Corbell: I am very happy to address this on the basis of what is publicly stated as federal government policy—

Mr HANSON: There you are.

Mr Corbell: and federal government policy assumes a very significant level of revenue from a co-payment measure. The federal health minister has said that there needs to be a value signal, which I can only assume is some sort of Orwellian newspeak or—

Mr HANSON: Mr Chair, we are speculating about a policy that may or may not ever happen in the federal parliament. Is that appropriate?

THE CHAIR: Mr Hanson, come to order or you can leave.

MR HANSON: I am just—

THE CHAIR: Mr Hanson, come to order!

MR HANSON: I am just asking, Mr Chair, on a point of order, whether this is a relevant line of questioning for the ACT health minister—speculating on federal policy. Normally such things would be ruled out of order.

THE CHAIR: Thank you, but my experience of annual report hearings is that they are a relatively free and open discussion on a range of matters. This is well within the health portfolio and relates to the previous question. I think we will break there for afternoon tea.

Sitting suspended from 2.48 to 3.12 pm.

THE CHAIR: Ms Lawder, a substantive question.

MS LAWDER: I have a question about public health, about cases of food poisoning. I note that from 1 September 2013 all food businesses in the ACT had to have food safety supervisors. I remember discussing this at last year's hearing as well. I wonder if you could tell me, in the past year, covered by this annual report, how many food poisoning cases were reported in the ACT by restaurants and commercial premises, private homes, community activities, and aged-care or nursing homes.

Mr Corbell: I will ask Dr Kelly to give you some details, Ms Lawder, but before he does that, let me say that I think some of the categories you asked for will have to be

taken on notice. I can give you some general figures. In terms of inspections of premises by food safety inspectors over the past three years—these are calendar years, I am advised—the figures are 2012, 1,994 inspections; 2013, 2,351; and 2014, 2,334. In terms of the number of improvement notices that were issued or prohibition orders put in place over the same three-year period, in 2012 there were 294 improvement notices and 25 prohibition orders; in 2013 there were 363 improvement notices and 14 prohibition orders; and in 2014 there were 395 improvement notices and, again, 14 prohibition orders.

In relation to the issues you asked about concerning instances of food poisoning in different types of premises, I will defer to Dr Kelly. He may like to also give you some further context.

MS LAWDER: Would you like me to repeat the question?

Dr Kelly: If you would not mind. Sorry, I was dealing with a related issue out there in relation to hepatitis A.

MS LAWDER: Sure. I was interested to know, in the period covered by this annual report, how many reported cases of food poisoning there were in four different categories—restaurants and commercial premises, private homes, community activities or organisations, and aged-care or nursing homes. I can make up a total from that myself.

Dr Kelly: Thank you, Ms Lawder, for your question. Food poisoning remains an issue here in the ACT. We report the various parts of that in various ways. Some of the cases of food poisoning are notifiable diseases. One of the ones that the committee would be most familiar with is salmonella. We have had some very large outbreaks of salmonella poisoning related to food premises in the last couple of years, but not in the time covered by this report. So that is one of the things we look at.

In terms of notifiable diseases, as part of the public health law, when someone is diagnosed with a disease such as salmonella it needs to be notified to us. We follow up every single case of the ones that are notified to us. So we have a good sense of the ones that are notifiable diseases. Of course, the notifiable diseases element relies on several things. Firstly, the person has to feel sick enough to go to visit their medical practitioner. The medical practitioner has to think about it being a disease that they should do a test on. The test should be sent to a recognised laboratory. The laboratory needs to do the test and it needs to be positive. So anything that we do report, and we report regularly on those notifiable diseases, is only a subset of what is actually going on out in the community.

I would particularly make note of that in relation to aged-care facilities. That is one of the areas that you are interested in. Quite regularly we have diarrhoeal illness or gastroenteritis in aged-care facilities, but that is not necessarily one that is diagnosed as or part of notifiable diseases. We have very good and close relationships with aged-care facilities, and over the years we have really worked with them in terms of infection control and so forth to minimise those outbreaks of infections. But usually that is not food poisoning as such; it is often something called norovirus, which is transmitted from one person to another.

So who do we investigate? If it is a notifiable disease such as salmonella or, most recently, hepatitis A, we follow up each of those cases individually and try to make a decision as to whether we can minimise the public health impact of that problem. Of course, the health of the particular patient is dealt with in clinical services. In relation to food premises, for example, we regularly respond to complaints from the public—or when we get notified of a disease and it shows that that person may well have had that problem from a food premise—and take the appropriate action. The minister has already talked about some of those things in relation to improvement notices, which is where we find a relatively minor breach which can be fixed easily, or a prohibition order, which is a more major breach of public health safety, in which case it will lead to closure of the restaurant, for example.

To answer your exact question about the numbers from each of those categories, I am not sure that I will be able to answer it in total detail, but certainly we can look at that for the notifiable diseases. I will have to take that on notice.

MS LAWDER: I would appreciate that—and also for each of the three years prior.

Dr Kelly: Certainly.

MS LAWDER: The same categories that you look at for this year. I would appreciate that.

Dr Kelly: Yes. In terms of what we have seen in the food industry, there has been an improvement. If we look back on those figures that the minister has already quoted, there was a big issue about three years ago; that was widely publicised in the press and we have taken a lot of steps to improve that. I think the way that those prohibition orders and improvement notices have changed over time demonstrates that we are starting to get to a good place. There is more work to do, and certainly we can look at carrots as well as sticks in relation to this, but that is what I would like to say about food premises.

MS LAWDER: We have had a couple of incidents recently—some aged-care or nursing home incidents—and I think I read today that we have had our first confirmed case of hep A from berries in the ACT. But also we had a foreign object in bakery products in a supermarket. Can you tell me a bit more about how ACT Health responded to the bakery example?

Dr Kelly: It has been a rather busy couple of weeks in relation to that, and thanks again for your question. Specifically in relation to the bread incident, this was a complaint from a customer who had purchased bread from a Coles store in Gungahlin. On that same day, we very rapidly went out to Coles and had a discussion with them; they took immediate action in terms of investigating what had happened. It appears that a piece of metal had come off the equipment that they use to make their bread in store. It was only that one store that was the problem. We engaged with Coles and they immediately took that process out of action and removed the bread products from the shelves. In discussion with their higher authorities in Melbourne—their head of quality assurance, as I think the particular individual I spoke with at the company is called—they organised themselves to get in touch directly with anyone who had done

online shopping at that store or who was a member of their loyalty program, by email. They also put out social media messaging. We mirrored that with local media in relation to that. We have not had any further reports of problems with the bread.

In terms of the hepatitis A story, that, again, has been running a lot in the media. This brings into question a lot of issues in relation to food safety more generally. It is a national, and indeed international, issue. There have been well-publicised similar outbreaks of berry-related hepatitis A in Europe over the last few years.

You could see a positive and negative side to that story. The positive is that hepatitis A is actually an extremely rare event in Australia. In the ACT in the last couple of years, we have had fewer than five cases, whereas in many countries in the world which have poorer hygiene standards hepatitis A remains a major public health problem. We have eliminated it to an extent here in the ACT and in Australia so that hepatitis A is rare, and most cases are from people that have travelled overseas and eaten things that are contaminated with hepatitis A.

What has changed in recent times, though, is the increased internationalisation of our food system. If I was a travel medicine doctor and you were heading off to China, I would warn you not to eat the berries and/or to have a hepatitis A vaccine. Now we have those same berries coming to Australia, and that has become an issue. I can confirm that, yes, whilst we have been in session here the first case in the ACT related to that outbreak has been confirmed; they are currently in a stable condition at the Canberra Hospital.

MS LAWDER: I note that the annual report mentioned that health inspectors went to the previous year's Multicultural Festival and there were a couple of instances of problems where people were exposed to food. Do your officials go to other events, like the show, as well? The Multicultural Festival was not specifically targeted?

Dr Kelly: Actually, we do specifically target the Multicultural Festival, and there are reasons for that. Firstly—it was not the case this year—it is often on the hottest weekend in the year. And the Multicultural Festival is a huge event. It is a fantastic event for Canberra and attracts not only large crowds but a large number of community groups who are not as familiar with food safety issues as commercial operators, for example. Also, a number of commercial operators come from interstate and from the ACT itself. There are limitations to what can be done in those sorts of areas in terms of keeping food cold, for example. No-one has a running tap in the multiple food venues, so handwashing facilities and so forth have to be thought about in advance.

We take very seriously our responsibilities in educating the public as well as the providers, the volunteers and so forth that work on the stalls. Over the months leading up to the Multicultural Festival, our officials spend a lot of time at various forums to educate those groups. We believe that that preventative approach has been very positive over the last few years that we have been trialling it.

This year, for the first time, we had inspectors right throughout the festival. Previously we limited it mostly to Saturday and some parts of Sunday. This year they were there on Friday night, all day on Saturday through till midnight and also on

Sunday. They made 295 inspections during that period. There was a very small number, fewer than 10 instances, where we needed to confiscate food as a protective measure for the public. Mostly, even during that period, it was an educative approach. During those 295 inspections, it was mostly minor things that were found and they were able to be fixed. Handwashing was one of the major ones in relation to that.

So that is the Multicultural Festival. We do keep an eye on other events through the year when needed. If there are complaints from the public, we do respond. And there is the licensing component of food venues. For example, there is the show, and the National Folk Festival would be another large gathering.

MS LAWDER: Thanks.

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Thank you, chair. I have a supplementary about the hepatitis A case today. Do you have a role in informing the community about this particular case recorded in the ACT and the person who is in hospital? Is that right? Has that been the normal case throughout the country in relation to people who have contracted hepatitis A that has been linked to that particular brand of berries?

Dr Kelly: There are several questions there, Ms Fitzharris.

MS FITZHARRIS: Sorry.

Dr Kelly: Yes, I do have a role. It is currently, during these four hours, being taken up by my deputy, Dr Pengilley. In relation to this, this is a national problem—in fact, international. We are working very closely with the federal government in terms of their food safety arm as well as the Department of Health. The chief medical officer, in particular, has taken a leadership role in relation to that. One of the roles they have had is actually collating the information about positive cases around Australia rather than each of us, as states and territories, going out individually. That is where that information has come from today—part of the updated national figures. We are following up in relation to that.

Nothing has really changed. We have a local case, yes. That person is in hospital but will recover, I am sure. I can confirm that, yes, it does appear to be associated with that same group of berries that has already been withdrawn from the market. So in terms of prevention for the wider population of the ACT, there is no further action to take. We have really saturated the airwaves and put out as many direct mailings and so forth that we can think of, through schools, childcare centres and aged-care facilities, and through the media, in various ways, so that people are aware of that. We have also checked with the places where these berries are generally sold, which are all the major supermarkets and IGAs. They have complied with that withdrawal of the product, and we are keeping an eye on the situation.

As I say, hepatitis A is rare here, but it is definitely one of the ones we follow up directly. We ask very specifically about whether people have been exposed to these berries and report that through to the national authorities when it is required.

I have got a feeling there was third part of your question. I am not sure.

MS LAWDER: This is a new one, sorry, if that is all right.

THE CHAIR: No; we are still on supplementaries, Ms Lawder. I have a supplementary there. You talked about restaurants or food outlets and carrots. We have seen sticks. What sort of carrots did you have in mind?

Dr Kelly: Some years ago now we consulted with the community around a food hygiene labelling system, otherwise known as scores on doors. We have got a whole range of things where we somehow punish the offenders, but this would be a way of promoting good practice and, importantly, increasing transparency for the public about good hygiene practices in the food sector. Where this has been tried in other parts of the world—for example, in many major centres in the US, such as New York, San Diego and Los Angeles; in Toronto in Canada; in Copenhagen and, in fact, in the whole of Denmark; and in Singapore and so on—several things have been noted. Compliance with food safety in general has increased; good businesses have done better; the public have demonstrated a better understanding of food hygiene and also been more positive about eating out; and food-borne illness has dropped. On that basis, we did some economic modelling and so forth at that time. That is still an option, and it is an option for government. It has a cost involved in terms of keeping the quality control, particularly the inspection regime and so forth. It is still a live option, but it is really with government to consider how that might progress, if at all, here in the ACT.

THE CHAIR: When would you be making a decision about that, minister?

Mr Corbell: That is a matter that I am giving consideration to at this time, as is the government as a whole. I cannot speculate on the time frame on that at this time, but it is before government at the moment.

MR WALL: Dr Kelly, is there a breakdown of the statistics that are kept as to the incidents of food-borne illness resulting from commercial establishments compared to domestic?

Dr Kelly: I think that relates to Ms Lawder's previous question. I can certainly give an answer to that, but, as I said, with the caveat that we can only really talk about notifiable illnesses. There are a whole range of people that have gastroenteritis and we do not know exactly because we do not know about them. They have to go to their doctor to get their test, and one way is that we will be notified. Or sometimes it is through the complaint mechanism for issues that may be related to particular food establishments; then we do a further investigation. But it is quite selective in relation to that.

MS LAWDER: Just one more supplementary.

THE CHAIR: Sure.

MS LAWDER: Is it the case that hep A is also quite contagious or infectious so that other people—I am not saying they will—may catch it from that person?

Dr Kelly: Yes, and I think that was the third part of Ms Fitzharris's question, which I forgot to answer. In relation to this and, indeed, any hepatitis A outbreak, there are three things for us as public health authorities: one is to make sure that the care for that particular person that has the disease is being dealt with by the appropriate clinical authorities.

The second thing, if we can identify a source, is to stop the source. Then the third thing—you are quite right—is that that person with hepatitis A is infectious. It is one of the diseases that can be transmitted from person to person as well as via food and water. That is where we do have the opportunity. Hepatitis A has a very long incubation period. So we have a couple of weeks after the diagnosis of a person who is then infectious with hepatitis A to offer vaccination, for example, to their close contacts. Part of our investigation is to not only see if we can identify where the hepatitis might have come from but also identify if there is anyone we can assist. That procedure is happening with this particular case right now.

I turn to the berry incident and why we have not gone out with a mass vaccination campaign, for example. In relation to hepatitis A and the berries, one estimate in relation to this current outbreak is that up to 400,000 people could have been exposed across Australia. An enormous amount of berries are consumed. About 20,000 one-kilo packets per week are distributed. The logistics of that sort of exercise would be difficult to know.

We are also not quite sure yet—we are still investigating this with Food Standards Australia and New Zealand—which exact batches of the product are associated. It appears that it is sort of early January that is the problem, but it may have been earlier and it may have been later. As I say, it has been blocked now because they have withdrawn it from sale.

THE CHAIR: Mr Hanson, do you have a question?

MR HANSON: I do. My question is about costs around the health system and in particular the Canberra Hospital and the public hospital system. I think the Grattan Institute put out some research that identified that by comparing peer hospitals the Canberra Hospital is the most expensive in Australia—about 25 per cent more than the national average for peer hospitals.

The previous minister made comments about the sustainability of the health budget. She previously said that the current six per cent to eight per cent growth needs to be brought to a figure closer to five per cent. We have had discussion in this forum before about the ever-increasing health budget and how, if it were allowed to continue, at some stage it would subsume the whole ACT budget. What steps have been taken to address some of those cost issues?

Dr Brown: I think that this is a very important issue. I would say at the outset that if you look at the percentage increase in the health budget over the past decade you will see that over recent years we actually have been reducing the level of growth. Government has forecast that by 2017-18 it would like to see that level of growth to five per cent or just below. I think this year it was 6.7 per cent growth, as opposed to going back five years, where it was closer to nine per cent to 10 per cent growth. So

we have been doing a lot of work in terms of reducing that level of growth, but—

MR HANSON: How are you are doing that? Can you tell me what those measures are? Is it a little bit here, a little bit there? Are there any strategic measures?

Dr Brown: Mr Thompson can talk about the detail of it, but I think it is about a very close application of the dollars, how they are spent and how we are controlling the expenditure. Ian, did you want to speak to that?

Mr Thompson: Yes. We have had successive savings targets for Canberra Hospital and health services. The strategies that we have been putting in place are ensuring that we have got very strict controls over purchasing and the use of consumables, ensuring that as much as possible is under contract rather than bought on an ad hoc basis, which usually is a means of reducing control.

We have reviewed and overhauled the rostering practices in nursing and medicine in particular. We have looked at reducing overtime, ensuring that the staffing profiles are appropriate for the demand in different areas of the hospital and ensuring that the rosters are as efficient as possible. There has been a focus on the management of overtime to ensure that the overtime that is being done has not been routinely rostered in. That has happened in the past.

We are ensuring that it is based on a particular demand and the need to respond to staffing shortfalls or an unexpected number of presentations to the emergency department. It is those sorts of issues. In the main, the approach to date has been around ensuring the efficiency of our management practices. That has yielded substantial savings over the last couple of years.

The next step that we are working on is more about the efficiency of our services to ensure that the services we provide are appropriate to the needs of the community and that we are organising our services in such a way as to get the best effect for services, but that is a much more complex piece of work.

Mr Corbell: And that relates to work around workforce redesign, which is actually part of the health infrastructure program. There is a specific element that deals with workforce redesign. That, as Mr Thompson says, has to be addressed on a service area by service area approach because every service area is different and has established practices and procedures that have to be reworked with clinicians, with nurses, with allied health staff to deliver better efficiencies.

The other point that is worth making, and I know my predecessors made it as well, is that there are some underlying base issues that are much more difficult to address when it comes to our costs. That includes conditions of employment such as superannuation and wage levels. Obviously the government is not in the business of reducing the wages of nurses, doctors or other staff. Obviously people have superannuation entitlements which are long-term liabilities for the territory that are not subject to change once they are commenced.

These are the types of issues that make it more difficult to address some elements of our cost base. It is because of historically more generous superannuation schemes

linked, for example, to the commonwealth schemes and the costs associated with those and historically more generous rates of pay, some of which relate, for example, to the need to be able to attract and retain staff in what would have then been a small regional hospital activity compared to people in Sydney and Melbourne. So there are things like that that sit historically in our base that make managing some elements of cost more difficult.

MR HANSON: With regard to the recruiting and retention of staff, how is that going? Where are the gaps?

Mr Thompson: Globally, which is not to say there are not some gaps, we are probably better placed for medicine and nursing than we have been, at least for as long as I am aware of. That is related to a large degree, I believe, to the changed outputs from universities of both medical and nursing graduates. What we are now seeing are substantial increases in medical graduates, the ANU Medical School obviously being our primary source, as well as increased nursing graduates from local universities and from interstate.

That means that our capacity to recruit and retain doctors and nurses is much better. Probably on a whole in allied health we are doing better, but there still are some gaps in specific professions where there are relatively low numbers and they are hard to recruit. One of the issues is that Canberra is not of sufficient size to train the full range of allied health professionals that we need in the health system. We rely on interstate recruitment. That always creates a challenge or a potential barrier to recruitment.

THE CHAIR: I have a supplementary question, minister. The Independent Hospital Pricing Authority on Wednesday released the national efficient price and national efficient cost determinations for Australian public hospital services for 2015-16. Are these within your expectations of what we were talking about before, about the financing of our health system? What are the implications of that determination for the ACT?

Mr Corbell: Look, there is no doubt that the release of the latest assessment of the national efficient price does not come as any particular surprise to the government, for the reasons that we have really just elaborated on. Issues around workforce and service redesign are opportunities to further improve efficiency, but, compared to other jurisdictions like Victoria that have had over a decade of using a detailed process of cost units for managing costs within the health service, we do not have the same history. Victoria are the best performing jurisdiction in the country, but they are also the jurisdiction that has used that unit pricing approach the longest. So they have been able to achieve efficiencies over an extended period of time.

For jurisdictions that have come later to that process, like the ACT, we are still on that journey. That is why workforce redesign is important. Equally, the same factors we were just talking about in relation to base costs around wages and around conditions are historic in nature. They have built up over time, dating back well before self-government. There is a need to recognise that that is a bigger challenge for us to achieve the more efficient price identified by the authority.

THE CHAIR: But that determination from the authority recognises regional

differences. Surely those regional differences that are experienced by the ACT are accounted for in that determination?

Mr Corbell: No.

THE CHAIR: What representations have you made to the authority, or has your predecessor made, to have that rectified? It seems to be an issue.

Dr Brown: It is and it remains an issue, I believe, for the ACT. It was in fact a condition of the ACT signing up to the national health reform agreement. I think Chief Minister Stanhope originally made an agreement with the Prime Minister—

MR HANSON: That is right. We signed up first and then discovered the bar. I remember it well.

Dr Brown: and it was subsequently pursued by Chief Minister Gallagher. We said that the ACT does have some particular issues that need to be taken into account as part of this pricing arrangement. Unfortunately, the commonwealth has not taken those factors into account, or IHPA has not taken them—

MR HANSON: Mr Stanhope was the first to sign up, was he not?

THE CHAIR: Order, Mr Hanson, please! You are not giving evidence. You are here to ask questions, so just calm down, please.

MR HANSON: I am just asking a question.

Dr Brown: IHPA has not actually taken those into account in the determination about the national efficient price. We have continued to prosecute the argument and we continue to raise the issue with IHPA, but at this point to no avail.

THE CHAIR: Mr Hanson.

MR HANSON: I just note that it was the ACT that signed on first to that reform, so perhaps further negotiation would have helped.

If I can turn to the issue of quality of care, we have heard a number of stories of late emanating from the health system about quality of care, and the Health Care Consumers Association executive director has said that the quality of patient care needed to improve.

I have to say that I have heard—and it is a bit anecdotal but probably an increasing view from constituents—that sometimes the care that they are getting does not meet expectations. I am talking about particularly elderly patients and the food that they are getting, the care of those patients and their rudimentary treatment, I suppose. Have you had a look at that issue? Is that an increasing concern or does it just seem to have greater public awareness at the moment?

Mr Corbell: This is an issue that is certainly on my radar as the new minister. Certainly the feedback I am getting anecdotally from some consumers indicates that

people are concerned about some aspects of their care when it comes to things like listening and responding to particular causes of concern in relation to, as you say, food or other matters like that. These are legitimate concerns for consumers to have, because it goes to their hospital experience.

Whilst there is no doubt that the quality of their medical care is very, very high, there are instances—I stress they are a relatively small number of instances but still instances—where the engagement on the part of staff could be more proactive and more responsive to consumer concerns.

I am very keen to do further work in this area. We are doing a range of things already that are designed to improve these aspects of the consumer experience. For example, the introduction of assistants in nursing is designed to help with some of those sorts of tasks and to free up nurses from having to focus on that rather than the work they really need to be delivering. We need to look at how we use assistants in nursing and other more junior staff to assist with some of those tasks.

That is an example of one thing that we are doing. We are focusing on simple things like sleep disturbance. We all know that when you are in hospital, trying to get to sleep is not necessarily the easiest thing if you are there for an extended period. We are working at having an environment that promotes sleep, in terms of how staff work, particularly during sleeping hours, noise, light, those sorts of issues, and having a much stronger focus on creating an environment which is more conducive to a healthcare consumer getting some reasonable sleep when they are in hospital.

So these are the types of issues. I am not saying they are all the issues, but these are the types of issues that we are focused on. I have certainly raised with the director-general my intention to ask how we can further improve that. How can we further improve the consumer experience in relation to not just their medical care, which I have no doubt is of a very, very high standard, but all the things that sit around that that often can see patients unhappy during their stay? That is very much something of concern to me as well.

MR HANSON: I am not optimistic that I am going to get another question, so just in case I do not, can I just take this opportunity to thank you, Dr Brown, for your services to ACT Health. I have enjoyed our sparring in these committees over a long period of time, probably more than you have, but I wish you well with your future.

I had an opportunity to test out the health system on Tuesday night with my eight-year-old in the emergency department. I would like to thank everybody that was involved. I passed it on to the executive director, but certainly I would like to thank you and the health staff for the service that you provide. Thank you.

Dr Brown: Thank you, Mr Hanson.

THE CHAIR: Minister, on page 24, the chart showing bed capacity illustrates an impressive growth over the years and that we are meeting the national average of 2.6 beds per thousand people. Can you tell us more about this increased bed capacity and if the population figures you are using included the regional New South Wales users of the hospital?

Mr Corbell: In relation to bed capacity, I did give quite a comprehensive answer earlier about the total number of beds, so I just draw your attention to that in terms of increases in bed capacity over the last couple of years and also what is projected. In terms of factoring in New South Wales—was that your other question?

THE CHAIR: Yes, within the population numbers.

Mr Corbell: Sorry, whether—

THE CHAIR: When you are citing a number of 2.6 beds per thousand, are you using the population numbers from the surrounding New South Wales area or merely the ACT?

Mr Corbell: No, it is ACT based—ACT population.

THE CHAIR: Okay. That may well be an issue, given that the surrounding catchment area is significantly larger than the population of the ACT, is it not?

Mr Corbell: Yes, but Medicare funding obviously flows to jurisdictions and then there are transfers associated with where those people actually use services, so that is captured in that arrangement.

THE CHAIR: Mr Wall.

MR WALL: Just a quick supplementary, if I could. Minister, just following on from Dr Bourke's question, if the ACT, in particular TCH, does serve as the highest level of care possible for the region, including the New South Wales area, how is it that we then do not take into consideration that capacity or that population pool that the hospital services when we look at that 2.6 beds per thousand population? Ultimately it is servicing a pool of people larger than is residing in the territory, and we need to have capacity for that. Why is that then not taken into consideration?

Mr Corbell: First of all, hospital services are funded on a jurisdiction by jurisdiction basis. Fundamentally that is the way the relationship works between the commonwealth and the states and the territories. It is on a jurisdiction by jurisdiction basis. It is not on a regional basis—not a region by region basis. The Medicare agreements that are in place between us and the commonwealth and between us and other states, particularly New South Wales, provide for mechanisms to capture cross-border flows and to attribute payments and costs where the occasions of care happen.

Obviously most people in the ACT are going to use ACT hospital services when they need them, but that is not the case for people in New South Wales. Yes, a significant number will, but we cannot calculate exactly what that number will be every year, and it will depend on the nature of the service they need as to whether or not they come to the ACT or whether they go to some other health service in New South Wales. So that is why the Medicare agreements provide for recognition of those costs on a cross-border agreement basis. Given our geographic location, we get a significant payment from New South Wales every year for the services we provide to their residents who use ACT services.

MR WALL: Is there a differential between what it actually costs the territory to provide that service against what the New South Wales health department contributes to the territory?

Mr Corbell: Yes, there is. New South Wales pays the ACT the national efficient price for the service, and any differential between what it costs us and the national efficient price is a cost that we have to wear.

MS LAWDER: Supplementary.

THE CHAIR: Ms Lawder.

MS LAWDER: Minister, can you just help me out here? We have 2.6 per thousand and you said about 30 per cent of patients come from New South Wales. Does that leave us with about 1.8 beds per thousand, which would be amongst the lowest in the country? How does that work?

Mr Thompson: It is slightly under 30 per cent. I think one of the problems and one of the reasons why we do not present these numbers in a lot more detail is that there are a lot of factors that influence demand in particular for health services, so the socioeconomic status and the age profile of the ACT are factors.

In fact, once the brief period of the next couple of years of activity-based funding ceases, under the current federal government's policy we will be reverting to an age-sex weighted population formula for funding, and what we have seen in the age-sex weighting formula previously is that the ACT gets a relatively small share of federal funding, which is reflected in an assumption that the demand for health services and hospital services for the ACT population is less than the national average.

When you take in factors like age, sex and socioeconomic status, we arguably should be discounting our demand compared to other jurisdictions; therefore, our need to provide a number of beds per capita would in theory be less. The trouble is that it is quite an imperfect science, so the more we attempt to nuance the numbers the more complicated it gets, and in terms of providing clear information as to what the relativities are, it does not, I think, get us much further.

Dr Brown: Perhaps I could just add to that too. I think that we need to keep in mind that we are moving away from a focus just on inpatient beds to actually a focus on providing the appropriate care in the appropriate setting at the appropriate time. Increasingly, we are seeing models of care that are about community or home-based care—things like hospital in the home. A focus on just counting beds is, in effect, fairly crude and it does not necessarily reflect the movement in contemporary models of care.

MS LAWDER: Fair enough, although we often do cite the crude number of beds as a very positive thing.

Mr Corbell: Yes, politicians tend to like bed numbers. That is true, but Dr Brown is right to remind us all that it is a more complex picture than that.

MS LAWDER: So don't other states and territories have the hospital in the home sort of—

Mr Corbell: Yes, they do, but they still also have a measure of beds per capita.

MS LAWDER: So you are saying that we do not really need to have 2.6 beds as per the national average? Is that what you are saying?

Mr Corbell: No, I am not saying that. What we are saying is that it is a more complex picture. That is a measure, but it should not be seen as the only measure of the sufficiency or otherwise of health service delivery.

MR HANSON: Supplementary?

MS FITZHARRIS: Supplementary?

THE CHAIR: All right, a supplementary.

MS FITZHARRIS: With the cross-border payments—

MR HANSON: Bit of favouritism here, Dr Bourke.

THE CHAIR: Yes, there is, Mr Hanson. It is favouritism for members of the committee. You are not a member of the committee. You had a choice. If you wanted to apply to be a member of the committee you could have done that in the Assembly. You did not. You are not a member; you are a visitor. Members have priority when it comes to questions. It is actually in the standing orders and in the companion to the standing orders if you wish to inform yourself.

MS FITZHARRIS: With the cross-border payment with New South Wales, is it correct that the ACT gets its fair share from New South Wales? Does it change year by—no?

MR WALL: It is just us in the room.

Mr Corbell: I think we are going to get into definitional issues of "fair". I think the existing arrangement with New South Wales is a constructive one and a healthy one, but there have historically been points of contention between the two jurisdictions about the amounts due and issues around the timing of payments. Certainly that was the case when I had responsibility for this portfolio previously, but I am pleased to say that those relationships are, I think, on a much stronger basis now than at that time, and obviously the national agreements in relation to a national efficient price and so on help to inform those discussions in a much more objective manner than may have been the case in earlier times.

Would we like to get more payments from New South Wales? Yes, reflecting the cost of delivery and the particular circumstances at play that influence ACT costs, but those are matters we approach constructively with our New South Wales counterparts and will continue to do so.

THE CHAIR: Substantive question, Mr Wall.

MR WALL: If we could go to Justice Health for a moment, I just want to get an update, from the Health Directorate's perspective, on the progress of the NSP at the AMC.

Mr Corbell: Yes. I am in discussions with the corrections minister on that. The most recent advice I have is that this remains in the negotiation stage as part of the enterprise agreement with corrections staff.

As you would be aware, the corrections staff enterprise agreement has a clause in relation to NSP, and that is subject to negotiation in the current bargaining round. I am hopeful that we will see some confirmation as to whether or not the government will be able to proceed with an NSP as a result of the conclusion of those negotiations, but that is still subject to negotiation at this time.

MR WALL: Still talking about the AMC, is the strategic framework for the management of blood-borne viruses at the AMC that was published in August still the current strategy for the management of blood-borne viruses at the AMC?

Dr Brown: Yes.

MR WALL: On the monitoring of prisoners and remandees at the prison, the strategic framework indicates that there is monitoring of the rate of infection, the opportunity for immunisation and testing points during the custodial period of anyone out there. How often are tests conducted of the prison population for blood-borne viruses? That is a starting point; we can go on from there.

Dr Brown: Prisoners are offered the opportunity for testing when they enter the AMC, and I believe periodically thereafter. I think it is three-monthly, but I would need to actually have that confirmed. Not all individuals choose to take up that testing. We are also looking at offering that prior to any release into the community, but again not everyone takes that up.

MR WALL: And in the reporting period or subsequently have there been any instances of infection that have occurred inside the AMC?

Dr Brown: Which reporting period are you talking about?

MR WALL: The 2013-14 reporting period or from July 2014 to now.

Dr Brown: I would have to take that on notice. I am sorry; I do not have those figures in front of me.

MR WALL: The uptake of immunisation amongst the prison population is there. What is the instance of individuals looking to immunise against—

Mr Corbell: Again, we have to take that on notice.

MR WALL: Okay. Thanks, minister. And just a final question on the AMC: what impact does the Health Directorate expect the expansion of the AMC is going to have on the services that are provided out there?

Dr Brown: Again, we are very mindful that with the expansion of the AMC we require an expansion of health services to meet the demand. Our staff within Justice Health Services do a wonderful job and have been, I think, meeting the increased demand over recent years. It is a matter that we are raising with government and factoring into consideration for potential growth bids in future funding rounds.

MR WALL: Okay.

Mr Corbell: In the same way that there is growth in other areas of the health service for health service delivery, it will be considered in the context of the growth envelope and the areas of pressure and demand. It is worth observing, of course, that there is already a heightened level of demand at the prison which is currently resulting in a less than optimal accommodation of detainees. The expansion at the prison facility will provide for more optimal accommodation of that detainee population, but the point remains that there is already a level of enhanced demand which is being met by Justice Health Services.

MR WALL: Just a final question. Turning to the Bimberi Youth Detention Centre, the annual report states that the health assessment that is required to be completed within 24 hours of a young person arriving did not meet the 100 per cent target. I am assuming it is probably only one or two cases, but what is the explanation as to why that did not occur?

Mr Corbell: I am advised that that is due to one health assessment not being undertaken, as the young person involved initially did not provide their consent.

MR WALL: So in instances where someone refuses to provide consent, what is the process undertaken to conduct the health assessment?

Dr Brown: If I can respond to that, we go back to the young person and continue to offer that opportunity. In the 2013-14 year, my understanding is that that young person actually did subsequently consent, and it was, I think, two hours outside of the 24-hour period or in that sort of order. We continue to try, but we have to respect the wishes of the young person.

THE CHAIR: Ms Fitzharris?

MS FITZHARRIS: I have a question about measurement. You have raised on a couple of occasions—I think it was when we were talking about the LHN and the emergency department waiting times and people in various categories being seen—that beds are one measurement, but you said we are really looking at talking about the right care for the person at the right time and the right location.

How do you see that changing, through annual reports over time, around the outcomes for the community? We are a pretty healthy community, so our outcomes are obviously very good, but how do you reflect that in an annual report?

Dr Brown: I thank you for that question. I think it is probably fair to say that historically our health system, as with most other health systems, has had a focus on things like the inputs and the outputs rather than the outcomes, and what we would like to move to is more outcomes-based reporting.

That is quite challenging in Health. We struggle, I think it is fair to say—again as a national comment not an ACT comment—to get clear definitions that everybody can agree on and then actually consistently report on that are not subject to gaining in one way or another, and that is when we are talking about inputs or outputs. So it is an ongoing focus for us, but it is not one that we can move to quickly.

MS FITZHARRIS: Are the national funding arrangements and reporting requirements driving a lot of that in each state and territory?

Dr Brown: Driving a lot of the—

MS FITZHARRIS: Input-output focus as opposed to outcome?

Dr Brown: No, I would not necessarily say that it is just the funding arrangements. I think historically it has been easier to count things like numbers of—

MS FITZHARRIS: Beds.

Dr Brown: doctors and nurses and beds and how many people presented for admission or presentations or occasions of service than to actually look at what happened when that doctor saw that person on that presentation and what was the outcome, and would you have actually had the same outcome if they had been seen by somebody else or if they had been seen in the community and not at the emergency department. That is the level of sophistication that we would like to get to, but we are probably quite a way from it.

MS FITZHARRIS: Thank you.

THE CHAIR: Ms Lawder.

MS LAWDER: I would like to ask about elective surgery waiting lists. It seems like the waiting list has been decreasing since 2010-11. I heard the previous health minister talk quite a bit about the focus on reducing elective surgery waiting lists. What are the drivers of why it has not been reducing?

Mr Corbell: We are actually improving timeliness when it comes to elective surgery waiting lists, and we have been doing so now for a number of years. So in terms of timeliness—that is, people receiving their surgery within the clinically appropriate times—the number of long waits continues to decline.

We have seen—I will turn to demand first—a 50 per cent increase in access to elective surgery over the past 12 years, despite only a 17 per cent increase in the population. So that is the issue that we have with demand. In terms of removals—do you have some numbers on removals?

Dr Brown: 11,700.

Mr Corbell: The number of long waits? I am sorry, Ms Lawder, I am just asking for the number of long waits compared to previous years. At the end of 2013-14 we had 726 long waits. Back in 2009-10 we had 2,220 people waiting longer than the clinically appropriate time for their surgery. So that is a 67 per cent reduction in long wait patients.

I am very, very pleased to see that trend continuing. It is confirmed in the latest ROGS data that came out earlier this year, and that highlights an ongoing trend in the reduction of long waits. So elective surgery long waits are actually going down, not up.

MS LAWDER: I think it was the numbers on the list that I was referring to rather than wait times specifically.

Mr Corbell: We continue to see growth in the number of people receiving surgery, so if you want to say they are on the list at some time, the way we measure our performance is whether or not people on the list get their surgery within the appropriate time frames. Obviously the key indicator is those people who are beyond that time frame, and, as you can see, there has been a 67 per cent reduction in the number of people waiting longer than necessary—longer than they should be.

MS LAWDER: I note from the My Hospitals website that the wait times for elective surgery for malignant bowel, lung and breast cancer in the ACT are below average for all Australian metropolitan hospitals. I think for bowel cancer the Australian medium is 15 days, but at Canberra Hospital we have 21 days et cetera. What are we doing to try and improve those times? It was bowel, lung and breast.

Dr Brown: I think what we need to be mindful of there—we had extensive discussions with the National Health Performance Authority in relation to their choosing to report that data in that particular way—is that those cases that you are referring to there would have been categorised as a category 1, which is required to be done within 30 days. Publishing something that says 15 versus 21 is somewhat misleading inasmuch as they were category 1 and they were done within the clinically recommended time frame.

MS LAWDER: We also do seem to have a lot of people that leave the waiting list. Are they going interstate for surgery because of the waiting time? Do you ask people why they are being removed from the list?

Dr Brown: We do regularly audit the waiting list, and people are removed for a range of reasons. Sometimes it is because they have elected to go privately. Sometimes it is because they have gone interstate. Sometimes it is because they do not need the surgery anymore. Sometimes it is because they are not currently ready for the care, for whatever reason it might be. So there are a range of reasons why people are removed from the list.

MS LAWDER: Do people give the reason of going interstate, and do you know what

percentage that is?

Dr Brown: I do not know what percentage off the top of my head. Yes, sometimes people have indicated to us that they have sought the treatment elsewhere. That is not a high percentage, from my recollection, but I would have to actually go back and get the figures.

MS LAWDER: And there are probably some types of surgeries that we do not do here at all anyway, so people would go interstate; is that correct?

Dr Brown: Yes, there are some surgeries that we do not do here in the ACT, particularly those that have a high level of complexity and where the volume in the ACT means that a practitioner would not actually do the volume to maintain their skill base and therefore be able to do it safely.

MS LAWDER: Okay, thank you.

THE CHAIR: Mr Hanson.

MR HANSON: I get another question? That is good. I turn to non-elective surgery. There have been a number of reports about people who have turned up for non-elective surgery. They have fasted and they have waited all day. They have been sent away and told to come back in two days' time. They come back and they repeat that process three or four times. In some cases they are pretty elderly patients—frail, difficult to get to hospital.

The directorate does not publish any timeliness figures on that; so it is very difficult to have visibility on how that is going. You get a lot of anecdotal stories from patients who say that it is very traumatic. For over a week and a half they had to turn up four times. Their arm or shoulder was broken. It is not a pleasant thing to have a broken limb of some sort, to wait two or three times and to be sent away two or three times. What data do you collect internally on that?

Dr Brown: I will ask Mr Thompson to respond to the detail of that. I would point out that we do almost as much emergency surgery as we do elective surgery—not quite as much, but it is a very large number of emergency surgeries that we undertake. Whilst I appreciate that there are from time to time instances where people have had to wait for longer periods than is desirable, I think we do need to keep in mind that that is a small number compared to the overall total of emergency surgeries that we do.

MR HANSON: The problem is that we do not know, Dr Brown. Anecdotally I get told, "I was there and I saw three other people who had exactly the same experience." I spoke to this elderly lady who had been back two or three times. They are the stories that emanate, but when I then ask, "What are the statistics?" I get told it is very few. But because those statistics are not published, the "very few" line does not actually correlate with the anecdotal evidence I get.

Mr Corbell: I will ask Mr Thompson to answer that.

Mr Thompson: Our information systems currently do not enable us to collect those

statistics systematically. It is something we are looking at as we improve our theatre information systems to get a greater visibility on it. One of the other factors about non-elective surgery is that, like elective surgery, it is categorised. There are urgency ratings. The emphasis is inevitably on surgery that is more urgent, and the time frames are quite different for non-elective than for elective. There are the same sorts of factors around more urgent care taking precedence over less urgent care. They are the predominant reasons why people get delayed.

We are, one, looking at better information through our information systems. We are actually in the process of reorganising our acute surgical service for non-elective surgery to have a surgeon of the day, so to speak, who is available to attempt to minimise delays. We are also bringing online an anaesthetist of the day who can coordinate the flow through the theatres, again to maximise our efficiency. With these measures we are looking to minimise the extent to which people have to be postponed.

MR HANSON: With non-elective surgery, is there a time frame—seven days or—

Mr Thompson: We have got a set of categories. We have got categories 1 to 5—from pretty much straight away to 24 to 48 hours.

MR HANSON: Okay. So assuming that when the patient is told, "Right, you need non-elective surgery. You are category 3," or whatever it might be, what you are saying is that there is no ability to record whether that patient received their surgery within the time frame.

Mr Thompson: Yes. We do not currently have that capacity.

MR HANSON: But this is the problem. How do you then monitor whether your systems are working? Because it could be that every last patient put down as category 3 never meets that time frame, and you do not know.

Mr Thompson: It can—in an absolute sense, yes, but the primary way it is monitored is on a twice-daily basis under the report on postponements. We work very assiduously to try and minimise them. I cannot give you any sort of—

MR HANSON: Sure, but when you talk about balance in the system, there is elective surgery and non-elective surgery. We seem to record one quite rigorously and there is a lot of attention to it. But, on the other side of it, I imagine that the more elective you are doing would put pressure on the non-elective, and vice versa. If you are not recording one side of that equation, how can you make informed decisions about resourcing and what the priority is in terms of theatres and so on?

Mr Corbell: I think the dilemma is the nature of the activity. By its very nature, it is unplanned. Elective surgery is planned. It is scheduled and can be worked through. So the nature of more unplanned—I am not saying that that is unusual in a hospital environment, because it is not—means that it is a more complex task in terms of data gathering. The emphasis has been on shifting more activity for elective surgery away from TCH.

MR HANSON: To Calvary, to—

Mr Corbell: To Calvary and John James. For example, elective orthopaedic joint replacement from Canberra Hospital to Calvary or John James commenced in August last year. Ear, nose and throat surgery is performed at Calvary public. Ophthalmology surgery has gone from Canberra Hospital to Calvary public. Also, for low acuity surgery—gynaecology, urology, orthopaedic surgery—we are looking at options to redistribute to other sites.

Also, we are reversing some flows in some other areas in terms of what surgery can be undertaken at Queanbeyan, for example, or indeed at other hospitals in the broader region, where that is clinically appropriate. So there are a range of responses available to us. We are working very hard at doing that. That is what the surgical realignment exercise is all about. The more elective that we can move away from Canberra Hospital and focus on its role in emergency and trauma, the more that is going to help address these issues that you have raised.

MR HANSON: But you are still not going to tell us the number of people that are being met within—

Mr Corbell: I think that, as Mr Thompson said, as we further improve our surgical systems in terms of data, we will be able to better capture that.

MR HANSON: Okay.

THE CHAIR: Minister, can you give us an update on the new Calvary car park construction?

Mr Corbell: Yes. In relation to Calvary car park, I will fish out the details for you, Dr Bourke. Work is well underway. The site has been cleared. There is a two-stage tender process for the design and construction of the car park. ATCO has been appointed as the head contractor. That occurred in September last year.

We have DA approval. That work has now commenced, with the first stage of works now underway at Calvary hospital. The work will deliver a net increase of 515 parking spaces through a parking structure at Calvary.

THE CHAIR: How many jobs will result from this construction, minister?

Mr Corbell: I would have to ask Mr Carmody for that.

Mr Carmody: I could not give you an exact number of jobs, but a project that size—it is a $17 million build. It is due for completion in December this year. They have just broken the ground to start digging the foundations at the moment. I would expect at its peak it would have somewhere in the order of 150, 200 people, which will be somewhere towards the middle of this year, July-August, and then tapering back down towards the completion.

THE CHAIR: Has that substation relocation work already been done?

Mr Carmody: Yes.

THE CHAIR: It was some ACTEW—there was a—

Mr Carmody: There is a high voltage cable that goes across the site. That is being relocated at the moment.

THE CHAIR: Whilst we are on Calvary issues, in respect of the Calvary ED versus Canberra ED, are there any different demographics that have been noticed there? In other words, do you have different age groups—

Mr Corbell: The answer might depend on where you live. I do not know.

THE CHAIR: That too. Do you have people from Belconnen going to Calvary ED rather than to Canberra ED, or what?

Mr Corbell: All levity aside, I am not sure whether we can answer that.

Dr Brown: We did have a look at this as part of the work we did looking at ED presentations last year. I am sorry; I do not have the figures in front of me and my memory is dimming a little in terms of the specific figures. There certainly was a significant percentage of people from the north side who are accessing the Canberra Hospital emergency department. It is a greater percentage than is the reverse—that is, south side residents who travel to Calvary, although there are some of those as well.

There may very well be good reasons why people from the north side go to Canberra Hospital ED. It is the tertiary referral hospital. Many people, if they are an existing client of the hospital, say, for a specialist outpatient clinic may decide that they want to go where they know or where they believe their medical record is. So they automatically go to TCH rather than to Calvary.

It is one of the things that we are looking at in terms of how we address the increase in growth in presentations to the ED. We are looking at appropriate pathways to care and whether or not we should be educating people that if you have an uncomplicated presentation and you live on the north side, Calvary is your best bet, and likewise for the south side.

Yes, there is some crossover in both directions. It is greater going to TCH than the other way, from the south side to Calvary. As I say, there are some good reasons why that might be the case. But there is certainly a cohort, we believe, who probably should go to their regional facility. We will be looking at how we can educate the public about the best options.

MS LAWDER: Supplementary?

MR WALL: I have a supplementary, just while we are talking about where people present at hospitals. There was some discussion over the Christmas break as to whether or not the government was looking at instituting a policy of delegating where maternity patients would be sent to deliver. What is the current arrangement and the reasoning for stipulating or applying such a policy?

Mr Corbell: No decision on that matter has been taken. However, in general terms it is worth making the observation that in most jurisdictions there is delineation of roles across different hospitals. For example, low acuity, less complex pregnancies occur in particular locations. Births occur in particular locations. Hospitals like TCH would generally, as a tertiary referral hospital, deal with the more complex, more dangerous births that need a higher level of care and support, both pre and post-birth.

The challenge we have is that there have been some significant changes in relation to, for example, the Medicare safety net. That has meant that it is much more attractive for people to utilise public birthing services than to use their private health insurance for births. We have seen a significant reduction in the number of births happening in the private hospital sector in the ACT and an increase in the number of people electing to use public alternative services for the birth of their child and children.

That, combined with obviously a great new facility at TCH in terms of the centenary hospital, has meant a significant increase in demand at TCH. We are going to have to look at how we manage that demand moving forward, because we have to make sure that the sickest babies, the most vulnerable pregnancies, get the care they need at TCH. And then for women who have healthy pregnancies, healthy births, we need to look at whether or not there should be options that say, for example, "Can you have your birth at Calvary if you live close to Calvary?"

We need to have a look at that. No decision has been taken on that. But it is the case that Health are advising me that we need to look at the issue. I have asked for some further advice from Health in relation to demand in particular so that I can make a decision on whether or not we can go out and have a conversation with the community about how we manage that demand.

At the moment we have got a large number of low acuity or healthy pregnancies where birth is happening at TCH which could be managed and could be provided with very good care at the public birthing facility at Calvary. We need to look at these issues a bit further. I need to take a decision then as to whether or not we are going to have a conversation with the community about that.

MR WALL: What increase in demand did TCH experience with the opening of the new women's and children's hospital, compared to prior to that facility coming online?

Mr Corbell: In the year 2011-12 through to 2012-13 there was a 10 per cent increase in access to birthing at the Canberra Hospital. That has remained steady since that time. We saw in 2014-15 that it escalated again, with an increase of six per cent as of December last year. That is a lot of additional births at TCH, given that I think we have about 3,500 across the territory.

Dr Brown: It is 4,999 births across the territory.

Mr Corbell: Approximately 5,000 across the ACT.

MR WALL: From that increase, though, what figures or what data have been collected to show what proportion of those were patients that typically would have

gone through the private system and are now going public? The other question is: of those births that are happening at TCH, how many are out of area?

Mr Corbell: It is the case that, in terms of births at TCH, as the territory referral hospital we get the highly complex, risky pregnancies at TCH. That is as it should be; that is its job. In terms of neonatal intensive care and support, women do need to come to TCH for their births there.

That is really the issue we are trying to address. We want to make sure that, at the NICU level and at the next level down, TCH is available to provide the specific care that those women and their babies need. With the lower, less complex cases—the more routine births, if you like—we cannot afford a situation where we are accommodating a larger than preferred number of lower acuity pregnancies and births at TCH at the expense of our capacity to manage the complex births. I do not think anyone wants a situation where a complex, high risk pregnancy and birth cannot be accommodated at TCH when they live in the city or the region. That is the issue we have to look very closely at.

MR WALL: Just going back to the question, minister, how many births that you would describe as low risk are occurring at TCH that are ultimately by patients that are attending hospital out of area?

Mr Corbell: At the moment we do not have "out of area".

MR WALL: People on the north side go to Calvary; people in the south go to TCH or the like. Certainly you are doing some sort of modelling as to the number of instances that are currently occurring where people are travelling across town, say from Gungahlin or west Belconnen areas to TCH.

Mr Corbell: We are looking at it the other way around. We are looking at it in terms of underutilised capacity in other parts of the health system. For example, what is the capacity at Calvary, in their public birthing services, that is currently not being utilised and could be utilised? We are also looking at the total number of presentations at TCH that fall into the difficult categories of acuity. That is the way we are approaching that question—and, from that, making a decision as to whether we need to give consideration to policy that sees more low acuity managed in suitable maternity services that are not at TCH.

MR WALL: So there could be the instance where a mother is sent from the south side—Woden or Tuggeranong—out to, potentially, Bruce, where Calvary is located, to deliver there if it is a low risk pregnancy, under that policy?

Mr Corbell: No decisions have been made in relation to that, but if we were to proceed on a postcode basis, it would mean that for people who lived on the south side, their hospital would be Canberra Hospital.

MR WALL: The reason I asked that is that I asked how many are people travelling across town past one hospital to the other.

Mr Corbell: Yes. The policy approach—

MR WALL: If you are not looking at that aspect, how can you say that the inverse will not happen?

Mr Corbell: I am saying that, for the purposes of determining whether or not we have a postcode referral, we are looking at demand and capacity at the respective hospital sites. From that, the government will need to make a decision as to whether or not we have an approach that says, "You go to your nearest available hospital rather than the hospital of your choice. Okay?" At the moment the policy is to go to the hospital of your choice. We may need to give consideration to saying, "You go to the nearest available hospital suitable for your pregnancy."

MR WALL: When would a decision be made on what the nearest suitable hospital is for what stage in the pregnancy? Would that be—

Mr Corbell: That would be a clinical decision in consultation with the mother, based on clinical criteria.

MR WALL: But ultimately, at the end of the day, if a labouring mother that lives on the north side and is determined to deliver at TCH presented there midway through labour, that is where the delivery is going to occur?

Mr Corbell: Obviously expectant mothers take their care very seriously and, with their carers, midwives and doctors, they work through how they propose to give birth. We all understand that is how expectant mothers and their partners work through these issues. There are plans put in place about where the care will be provided, how it will be provided, the nature of the birth and so on. Obviously, if there are complications or unexpected matters, those are dealt with as and when they arise. We are not going to be saying to somebody, if they present and they are in labour, "You are going elsewhere." It will be dealt with appropriately where the mother presents. But we know that this care is planned in consultation with their midwife, their doctor and so on.

MR HANSON: Supplementary.

THE CHAIR: No. Ms Lawder?

MS LAWDER: I was next. I want to come back to Calvary car park. Minister, you said that they have cleared the ground and things are well underway.

Mr Corbell: Yes.

MS LAWDER: Your other official, whose name escapes me—

Mr Corbell: Mr Carmody.

MS LAWDER: He said that the foundations were being laid and everything was progressing.

Mr Corbell: Yes.

MS LAWDER: How are we going against the project plan so far?

Mr Corbell: We are on time.

MS LAWDER: When were the foundations laid?

Mr Carmody: The first holes were dug—I have got a photograph this morning—I think yesterday. This week. This is the first hole.

MS LAWDER: Excellent. That is all I wanted to know.

THE CHAIR: Thank you.

MS FITZHARRIS: Supplementary on the maternity services. Are the services for low risk pregnancies largely midwife led or led by an obstetrician? And do they differ across the two hospitals?

Dr Brown: We have a range of options. We have two approaches in terms of continuity of midwifery care at Canberra Hospital. That model is also available at Calvary hospital, but then there are the more traditional models involving an obstetrician. There is also the option for shared care with GPs. I do not actually know the breakdown between the midwifery model and the traditional. I do know that the uptake of the continuity of care midwifery model has been increasing and is very popular. We certainly expect it to continue to be in high demand.

MS FITZHARRIS: Can I follow up on that? Would the increased demand for the service at Canberra Hospital probably come from the quality of the infrastructure, do you think?

Mr Corbell: I do not believe so, no; that is certainly not the advice to me. The main issue is Canberra Hospital's role as tertiary referral for high risk pregnancies.

MS FITZHARRIS: Right.

Mr Corbell: Whether it is at the neonatal intensive care level or at the special care nursery level, that is Canberra Hospital's primary role as a tertiary referral. Then, obviously, it is also providing low risk low acuity services for what we would consider a routine pregnancy and a routine birth. To the extent that we are taking more of the routine pregnancies than we would otherwise prefer, that is putting pressure on our capacity to provide special care and has flow-on effects in terms of the overall management of neonatal intensive care. We have to have regard to that, because I think everyone would agree that we must make sure we maintain our capability to provide that neonatal and special care level support in TCH.

MS FITZHARRIS: Thank you.

Mr Corbell: That is for babies both from the region, because we are taking a lot of babies from the region in that respect, and in the ACT.

MS FITZHARRIS: Thanks.

THE CHAIR: Mr Wall, a substantive question?

MR WALL: Thank you, chair. Just to touch on mental health briefly, it is my understanding that last year the adult mental health unit had a provisional improvement notice issued as a result of a large number of assaults on the staff. What changes have been made to ensure the safety of staff at the mental health unit?

Dr Brown: I can probably answer that, or Ian can. Just to kick off, in terms of responding to those issues, there were episodes of violence and aggression, there was damage to internal structure and there were some concerns around the doors. The provisional improvement notice related to requests for increased staffing and addressing some of the structural issues.

We did increase the staffing within the unit, with an additional nurse per the morning and afternoon shifts each day. That has been continued whilst we work with the ANMF around an agreed benchmark for nursing hours per patient day. We also agreed to recruit a clinical development nurse to be permanently located within Mental Health, Justice Health and Alcohol & Drug Services Division. And the issues around structure have been progressively addressed.

That provisional improvement notice was ultimately lifted after all of those things were addressed—in a very collaborative way, I might say, in conjunction with the staff, the union, and management.

MR WALL: Have there been any issues of assault since the improvement notice was issued?

Dr Brown: Mental health is a difficult environment, as you would appreciate. Yes, there have been other incidents within that environment. Again, we take all of those incidents very seriously. Management continues to meet regularly with staff, and there is an aggression and violence framework and plan in place. Just last week we received some correspondence from the ANMF acknowledging the work that has been undertaken by the executive of mental health and the seriousness with which they have been addressing these ongoing issues in the environment. Again, I would stress that I do not believe that the ACT would be any different from any other acute mental health unit in the country in terms of the challenges that it faces.

MR WALL: I understand that there is a policy to try and avoid seclusions—people being secluded at the health facility. Has that had an impact on these outbursts and assault incidents?

Dr Brown: I do not believe that that is a precipitant of the episodes of violence and aggression. There certainly is a keen desire to minimise the use of seclusion and restraint within the inpatient setting. That is based on the evidence, which suggests that seclusion and restraint actually cause more injuries than they prevent. It is dangerous for consumers to experience seclusion and restraint. It is dangerous for staff who institute seclusion and restraint. There is a wealth of evidence that backs up that claim.

In order to be able to implement a reduction in seclusion and restraint, we have invested in a lot of training for staff, looking at how we identify what are the precipitants for each individual and how we can best respond to those precipitants early. We have instituted changes in the way that staff respond to those early warning signs or to actual incidents. And then we also have a process of working with consumers to review any episodes where there are seclusion and restraint.

That is what has helped us to drive down the use of seclusion and restraint. I would strongly suggest that those particular approaches are the way we should be going, and I do not believe that they are what is contributing to an increase in violence and aggression. We have demonstrated, in fact, that there has been a reduction.

Despite those approaches, from time to time there are episodes of violence and aggression, and there are times when we still do have to use seclusion. We do not generally use restraint in the inpatient setting, but yes, from time to time you still do use seclusion. And staff are not precluded in any way from using seclusion. If that is what is required to maintain the safe environment for the consumers and themselves, they are able to utilise that. But, on the whole, evidence tells us that we are much better placed if we utilise the alternative approaches.

MR WALL: Is there a special section or rooms within the mental health unit for—

Dr Brown: There is a seclusion suite. Yes, two separate—

MR WALL: Okay. And they are both fully operational?

Dr Brown: I would have to take advice from—yes. I indicated before there was some damage previously, but it has clearly been rectified.

MR WALL: Turning to the staff that are working in that facility, I assume there are a number that have ended up on workers comp leave as a result of some of these incidents. What is being done to facilitate their return to work?

Dr Brown: Again, I would need to go to management in terms of the specifics of that. There have been some incidents where there has been injury to staff. I am just looking at Ms George to see whether she actually has any detail that she is able to provide. We can certainly take that question on notice.

Mr Corbell: Yes, we will take it on notice, Mr Wall.

MR WALL: Okay.

THE CHAIR: Just a supplementary—

MR WALL: Just a couple of quick questions which will probably be taken on notice. It was the number of staff that are currently on workers compensation from that unit and how many staff have been recruited either permanently or temporarily to cover that.

Dr Brown: Sorry, could you repeat the last one?

MR WALL: The number of staff that have been recruited either permanently or temporarily to cover that shortfall. Thanks.

Mr Corbell: Yes, we will take those on notice. Thank you, Mr Wall.

THE CHAIR: While still in the area of mental health, there is an adult mental health day service that commenced at Belconnen Community Health Centre in July. I understand that is an interim measure until the UC public hospital is established. Can you tell us a little bit more about that service and the work that it is doing, please?

Mr Corbell: Ms Fitzharris did ask me about this earlier and I did outline the details of—

THE CHAIR: Very good. And then can you tell me about the process of the plans for the secure mental health unit?

Mr Corbell: Work on that facility is underway. The site has now been cleared of the old Quamby facility, except those parts of the old Quamby facility which are still in use by Corrective Services for weekend detention. The weekend detention capability there has been physically separated from the balance and the site cleared for more adult secure mental health.

In terms of next steps, there are two things. First of all, we have to look at finalised discussions and decisions on the model of care. The model of care involves both finalisation of how that will be delivered here, but, for the very small number of people who will need further accommodation in a very secure facility, that will need to be delivered in the New South Wales context, so there are ongoing discussions with New South Wales forensic mental health services to ensure that is in place, because there will be a small number of people who need high security accommodation that is not suitable for this facility.

Finally, in terms of construction, as I have said, demolition has occurred; construction will commence this year.

THE CHAIR: And when do you expect it to be operational, minister?

Mr Corbell: Completion of works in late 2016.

THE CHAIR: Thank you. Substantive question, Ms Fitzharris.

MS FITZHARRIS: I wanted to ask, minister, about the healthy weight action plan and progress towards that. I think you noted it in your recent ministerial statement as a priority.

Mr Corbell: This is a priority. Lifestyle-related illness is a growing burden on the health system and it is having a detrimental impact on far too many people in our community, so the government have a very comprehensive agenda to tackle this issue. Obviously we have made election commitments around refocusing health promotion

moneys onto active lifestyles and healthy weight. We have got a comprehensive policy framework in place. The government have provided funding for 13 projects in two previous rounds through our healthy Canberra grants program—over $550,000, for example, to the National Heart Foundation to deliver the live lighter campaign.

We have also partnered with ACT Medicare Local, and I was pleased to be with them at a recent launch for the connect up for kids program, which is providing support and information to GPs to work with parents and kids about healthy weight and tackling problems early in relation to kids who are in an unhealthy weight range, or heading in that direction, and we are going to continue to focus on this.

There is funding, for example, for Indigenous organisations to improve health and wellbeing for Indigenous kids, and we have provided $450,000 in that area as well, and it is all part of the towards zero growth strategy. Towards zero growth recognises that we must halt the increase in obesity in the adult and child population. If we do not, the impacts of diabetes, cardiovascular disease and a whole range of other illnesses are only going to continue. We need to connect that up with other related government policy settings. Measures such as how we utilise land and transport planning to enable people to have active transport choices, projects like improving bus services, projects like capital metro are all about providing choices for people that enable them to have active transport more readily available where walking or cycling is more likely to be part of the transport journey rather than simply being car dependent.

This is a long-term strategy. It is not going to be achieved in three or four years. It is a 10, 15, 20-year approach. By putting in place those types of policies, whether it is on transport, land use planning, health promotion, these are all responses that help us achieve that objective, and we need to remain consistent in our approach on that. It is as much about the physical environment as it is about what people eat and how much exercise they get, and bringing that complete picture together is very, very important.

MS FITZHARRIS: Thanks. Have you been able to quantify the costs of obesity to the health system?

Mr Corbell: Dr Kelly might have something.

Dr Kelly: The minister has answered all of the easy questions.

Mr Corbell: That is my prerogative.

Dr Kelly: Yes, indeed, minister. So the answer is that it is very difficult. We can quantify, and we have attempted to quantify, the very direct costs of obesity in terms of, for example, the types of new arrangements we have to make in the hospital and related services to cater for large people. Mr Carmody might be able to answer a bit more—to pass it on again—about that in relation to, for example, lift infrastructure, the infrastructure that is required to lift patients from beds and so forth when you are dealing with the very high end of the obesity spectrum.

But the cost to the health system is much broader than that, and obesity in itself is a risk factor for diabetes, as mentioned by the minister, but there is also cardiovascular disease and some types of cancer. So there is a component of all of the treatment

options in terms of health services provision which is related to obesity.

That is actually quite a tricky question for a health economist to answer. We are looking to answer that question. I will not be able to provide that this year, but by next year I will be able to.

MS FITZHARRIS: Great. I will look forward to that next year. Thank you.

THE CHAIR: When it comes to obesity, there was that NHMRC systematic review of clinical treatment of obesity which indicated that bariatric surgery was the only means to achieve an outcome which was sustainable. What has been done about bariatric surgery in the ACT?

Dr Brown: Government made provision in the 2014-15 budget to commence bariatric surgery here in the ACT. We have not as yet got that service up and running. We are negotiating currently with surgeons who are trained and able to undertake bariatric surgery. But it is very important that we do not leap to the conclusion that bariatric surgery is the only solution or indeed the best solution. It is one option, but it needs to be seen as part of a spectrum of treatment options, and for that reason access to bariatric surgery will be via the Obesity Management Service that was set up last year, operating out of Belconnen Community Health Centre. That is a multidisciplinary approach to working with people who have a BMI, I think, of over 40, which is the current criteria for access.

Mr Corbell: And clearly the issue is to have a range of policy responses that avoid the circumstance where people end up morbidly obese, because then the interventions become more complex, more expensive and more difficult, and we know that there are just so many other responses that can assist people and prevent them from ending up in those circumstances.

Dr Kelly: May I add, Dr Bourke, that we are talking about a major issue here. Sixty-three per cent of the ACT population is either overweight or obese, and a small proportion are in the area that could benefit from—indeed it may the only benefit that could be given to those people—bariatric surgery. But I think we need to concentrate on preventative measures that the minister has already outlined in terms of stopping people getting to that point. That is definitely the most cost-effective way of dealing with it from a government's point of view and definitely the best outcome for the people of the ACT.

THE CHAIR: I certainly agree with the concept of active travel and building a society which has less obesity developing, but the thrust of the NHMRC report was that there were not any other medical treatments which were effective.

Mr Corbell: Yes, I think Dr Kelly certainly agrees with that.

MS LAWDER: Supplementary question.

THE CHAIR: Ms Lawder.

MS LAWDER: Are you able to tell me how many patients have been seen by the

Obesity Management Service and is there a waiting list? How many people are on the waiting list and how long might they wait?

Mr Corbell: You would have to put that on notice, Ms Lawder.

Dr Brown: I will have to take that on notice.

MS LAWDER: We have had some constituent correspondence that they have been put on the waiting list but will not be seen for some time, so are you able to give us an indication of the staffing levels? Are all the positions currently filled and fully staffed?

Mr Corbell: Yes, we are happy to provide that detail.

MS LAWDER: Thank you.

THE CHAIR: Any substantive question, Ms Lawder?

MS LAWDER: Is the cancer centre fully operational now?

Mr Corbell: Yes.

MS LAWDER: And are all the staff positions completely filled?

Mr Corbell: There is inevitably some level of normal turnover, but the staffing complement is funded to the level that the government was anticipating.

MS LAWDER: It is funded to the level that it is funded at.

Mr Corbell: Can I say to you absolutely that some vacancies have not occurred through natural attrition and turnover? No, I cannot say that.

MS LAWDER: After the damage caused by the flooding last year, are there any ongoing consequences still to be fixed up? Or is everything completely—

Mr Corbell: No, not in terms of the physical operation of the building. There are outstanding contractual matters that have to be resolved with the contractors involved, and insurance claims and so on that have to be settled.

MS LAWDER: And what was the final cost to Health of the delay in the opening of the cancer centre?

Dr Brown: There was no specific cost in relation to the delay because the services continued in their old setting. There obviously was a cost in terms of the remediation of the damage, and that, as the minister referred to, has been a matter that we have been dealing with, with the insurance company and the relevant contractor.

MS LAWDER: Do you think the full amount will be paid by the insurer or will there be any impact on the Health budget as a result?

Mr Corbell: My advice is that we have made provision for what we anticipate will be the payout in terms of insurance. The advice to me is very clear that responsibility rests with the contractor, so we are pursuing that matter through our insurers and their insurers.

THE CHAIR: Before I adjourn, I would like to acknowledge you, Dr Brown. On behalf of the committee I would like to thank you for your service to the territory.

I also remind members that the committee has resolved that supplementary questions are to be lodged with the committee office within four business days of receipt of the proof transcript from this hearing. The committee asks that the minister respond within 10 working days of the receipt of those supplementary questions. Answers to questions taken on notice today are to be provided five business days after this hearing, with day one being the first business day after the question was taken. The committee's hearing for today is adjourned.

The committee adjourned at 5.01 pm.