LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING, COMMUNITY AND SOCIAL SERVICES

(Reference: Annual and financial reports 2014-2015)

Members:

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

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 12 NOVEMBER 2015

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

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

The Assembly has authorised the recording, broadcasting and re-broadcasting of these proceedings.

All witnesses making submissions or giving evidence to committees of the Legislative Assembly for the ACT are protected by parliamentary privilege.

"Parliamentary privilege" means the special rights and immunities which belong to the Assembly, its committees and its members. These rights and immunities enable committees to operate effectively, and enable those involved in committee processes to do so without obstruction, or fear of prosecution.

Witnesses must tell the truth: giving false or misleading evidence will be treated as a serious matter, and may be considered a contempt of the Assembly.

While the Committee prefers to hear all evidence in public, it may take evidence in-camera if requested. Confidential evidence will be recorded and kept securely. It is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly; but any decision to publish or present in-camera evidence will not be taken without consulting with the person who gave the evidence.

Amended 20 May 2013

The committee met at 9.00 am.

Appearances:

Gentleman, Mr Mick, Minister for Planning, Minister for Roads and Parking, Minister for Workplace Safety and Industrial Relations, Minister for Children and Young People and Minister for Ageing

Community Services Directorate
Chapman, Ms Sue, Director-General
Sheehan, Ms Maureen, Executive Director, Service Strategy and Community Building
Hubbard, Mr Ian, Senior Director, Finance and Budget, Service Strategy and Community Building
Manikis, Mr Nic, Director, Community Participation Group, Service Strategy and Community Building
Wyles, Mr Paul, Director, Early Intervention and Prevention Services, Office for Children, Youth and Family Support
Collis, Dr Mark, Executive Director, Office for Children, Youth and Family Support

THE CHAIR: Good morning 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 2014-15. Today the committee will be examining the following components of the Community Services Directorate annual report: children and young people, early intervention services, ageing, and youth engagement.

Minister and officials, could I confirm that you have read the privileges card lying on the table in front of you?

Mr Gentleman: Yes; correct. Thank you, Mr Chair.

THE CHAIR: And that you understand the privilege implications of the statement?

Mr Gentleman: Indeed.

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

Mr Gentleman: Yes. Thank you for the opportunity to be here today to talk about my portfolio responsibilities as Minister for Children and Young People and Minister for Ageing. 2014-15 was a year of quite a bit of change across the portfolio of children and young people as we continue to step up for vulnerable children, young people and families.

These changes have the aim of providing more seamless tailored support for Canberrans. For example, the integration of the statutory services project, combined with the functions of care and protection and youth justice to provide a better service response to children, young people and families involved with the statutory system,

was launched on 1 July this year. In January this year, the government launched a step up for our kids, which is designed to keep families together, stem the rate of children and young people entering care, and help those in care to lead better lives.

During the reporting period we carried out a significant amount of proprietary work to enable the new services under a step up for our kids to be implemented from January next year. This has included legislative changes and carrying out tender processes. A step up for our kids will build on what we have learned during the successful first year of Melaleuca Place and its operation.

The government is also refreshing the model of services at child and family centres. The centres are making a significant difference in the lives of children and their families. Parents have reported that programs such as the circle of security have strengthened their relationship with their children and made them more confident as parents.

Through the youth engagement portfolio, we deliver initiatives such as the Youth InterACT grants, which provided 17 grants to young people or services supporting young people in 2014-15. In addition, we continue to promote and award Youth InterACT scholarships for young people to attend learning, sporting, personal development and career development opportunities. In the period 2014-15, 30 Youth InterACT scholarships were awarded to young people.

In the ACT we have a range of ways in which young people can have their say on issues that are important to them on an ongoing basis. This includes the Youth Advisory Council, which not only provides me with valuable advice related to young people but also supports the development of young people as leaders. The council's 15 members are aged between 12 and 25 years and are drawn from a wide range of backgrounds that represent our broader community, including gender balance, disabilities and representation from Aboriginal and Torres Strait Islander and culturally linguistic and diverse backgrounds.

Turning to the portfolio of ageing, the ACT government's commitment to seniors in the ACT is demonstrated through the grants programs, the ACT seniors card program and promotion of positive ageing through events such as the annual Seniors Week. In the past year we also carried out extensive consultations, including through the second older persons assembly and the ACT ministerial mature age workers roundtable, to develop the ACT active ageing framework for 2015-18 and associated action plan.

I would like to take this opportunity to thank all of the staff of the Community Services Directorate. The front-line staff work with some of Canberra's most vulnerable people in very difficult and complex circumstances. I thank them for their dedication and commitment. We stand ready for questions from the committee.

THE CHAIR: Thank you, minister. You mentioned the launch of Melaleuca Place in your opening. Could you tell us a bit more about the centre. For instance, what sorts of responses come from users and stakeholders?

Mr Gentleman: Melaleuca Place has come forward as a very successful enterprise for the ACT, looking at early intervention to assist families before they reach the

vulnerable stage. We launched it last year; it was one of my first tasks as Minister for Children and Young People. It was quite an exciting time to launch it, but also quite an emotional time for me to listen to the advocates for early intervention.

We had two speakers at the launch, Dr Louise Newman and Judy Atkinson, the latter an Indigenous person supporting intervention and support for Indigenous families. I recall quite vividly the speech from Louise Newman on how important it is to look at assisting young people at risk or vulnerable from previous trauma that they have had in their lives. She described some of the events that occur with these young people when they do not have the same sort of upbringing that perhaps you and I have had with families that are cohesive and loving. It really does change the way young people grow up. It affects their ability to mingle with other people, of course, and it affects their ability to learn. And there is actually a physical change to the brain, which I was quite surprised about.

Melaleuca has been going very well. We have dealt with quite a number of families, and we have some experts in the field that are outreaching. Most recently, we launched the garden at Melaleuca, which is a physical opportunity for kids to play in sandcastles and pump a water pump whilst the people at Melaleuca are talking to the kids and involving them in getting better, if you like. I might ask directorate officials to give you some more instances. I call on Paul Wyles.

Mr Wyles: We are very proud of the achievements of Melaleuca Place in a very short time. When we were given the project, we looked at best practice services in Victoria, New South Wales and Queensland, and in a very small way we have been able to develop a service of excellence. Part of the reason for that is that we have been able to recruit highly skilled and trained staff and support them with additional training and development. We have a multidisciplinary team, which really helps. It means that many of the services will be provided in house. On the team we have social workers, psychologists, a part-time occupational therapist, a speech therapist and a child and adolescent psychiatrist. That means that we can provide a suite of services on site.

The other thing we have been keen to do is place this service in the suite of services across the ACT. We are aware that it is really important to educate particularly those who are in the child's support network, be it the family, the carer or the teacher if the child is of school age. The staff do a fair bit of outreach to families' homes and to schools, and they do a lot of education about what is trauma, how it comes about and what can be helpful in terms of managing those children.

We have done some initial surveying to get feedback. We see that most of the children, through the intensive therapy they receive, improve on a range of developmental measures, and that the carers and families feel incredibly supported by the therapists. I think it is important to note that although there have been only a relatively small number of children, 27 over the 15-month period that the service has been open, all those families have actively engaged with the therapists; there have been no dropouts, if you like. And 40 per cent of those children are of Aboriginal or Torres Strait Islander descent.

Ms Chapman: I would like to add that one of the really important things about Melaleuca Place and what we are learning through the work that the experts there are

doing is that we are taking that learning into other aspects of our service delivery. With our step up for kids program, which talks about every child having a therapeutic assessment, we are actually learning from the Melaleuca Place work that they are doing. So we are increasing the competence and the skill sets of broader staff outside of Melaleuca Place per se to be able to work with children and young people. Our therapeutic assessors that we have recruited for the step up program have learned a lot from Melaleuca. Melaleuca is, as Paul says, a centre of excellence, we believe, and we are providing information and skill development into education services and into health, because we are running seminars and so on. So it is not just the place; it has a ripple effect right across our service system.

THE CHAIR: With a new program and a new initiative, minister, there are always questions asked about the assessment of effectiveness and efficiency within a particular environment. Given the very small numbers of children—I think it is 26?

Mr Wyles: Twenty-seven.

THE CHAIR: With the 27 that have been cared for there, the absolute need for a facility like this, and the richness of the qualitative evidence that has already come to the committee, is there any really meaningful quantitative data that can come out to support the work of this place? Or is this really something that we have to do, something that we are going to learn from, and something where we can just rely on the richness of that qualitative experience?

Mr Gentleman: Melaleuca Place is at the very beginning of helping these children that we see at risk, so it will be some time, I think, before we see definite data. But we can provide some information on where it has occurred in other jurisdictions.

Dr Collis: The service model that was developed around Melaleuca is about fairly long-term involvement with children whose experience of trauma has been quite severe and where the impact of that trauma is quite severe. We are looking at getting the support to the neediest children.

Consequently, the 27 young people who have been involved have been involved over the course of a period of time. As Mr Wyles was suggesting, the fact that we have had no dropouts is really quite astounding. For a start, it is a good early indicator, and it is a really astounding thing given the nature of where we are targeting this service, to the neediest children.

However, there are going to be a very specific assessment and evaluation of the effectiveness of the service. We are just about to enter that as our first cohort of children start leaving the program and stepping into broader community support. Those assessments will be specifically behavioural so that we will be able to track what the gains have been, and we will follow them up over time so that we can see the degree of tenacity of those gains as we move forward. We are at the point now where we are just about to embark on some significant post-testing which will allow us to answer very specifically questions on effectiveness.

As Mr Wyles suggested, this is part of a constellation of programs which include the therapeutic assessors, which is about getting in early when children come into care,

about early advice, early support. So we will also be evaluating as best we can the whole system and how moving to a therapeutically informed system will move the whole system. We would be expecting, for example, that we would be able to be more successful at reunifying families if we get a good therapeutic assessment in earlier. We would be expecting that we would be getting better outcomes—educational, health, social and relationship outcomes—more broadly in the system for kids in out of home care.

That broader piece of work is being encapsulated under the step up for kids outcomes framework that we are currently constructing. We have a skeleton of that, and we are going to be working with service providers and other important stakeholders to populate that broader thing.

In terms of Melaleuca Place specifically, absolutely, we started our first round of post-testing to do that. We should be able to start to report on the effectiveness in the next six months, I would say.

THE CHAIR: Did I hear right that Melaleuca Place has been modelled on facilities in other states or is this something that has particularly involved the ACT?

Dr Collis: The development of this was incredibly thorough in that the group that oversaw the development were experts. Louise Newmann and experts from all over Australia came to help us devise this model, including significant people who were providers of like services in other jurisdictions. What we have been able to develop at Melaleuca would not look exactly like other places in Australia. It would, however, be harvesting what has worked in those places and putting it together. What I can say is that the feedback we are getting from those experts coming in now means that we seem to have achieved going to the next level of quality in terms of the provision of a trauma recovery centre.

We absolutely have learned from experience across Australia and the research. There was a significant research paper. The service model which is on the internet now serves as a base. I have had numerous requests to get links to the service model, and that service model in fact formed the basis of our therapeutic assessment model. We did not have to go and do that work again because fundamentally we had done the work about what the current state of quality service provisions was in this area. At the moment we think we have situated this at the very leading edge of quality in this area. Yes, it looks a bit like some others but it looks a bit different to them.

Mr Wyles: One of the differences—and I think this is a great achievement—was when we took advice from other jurisdictions. One of the problems or barriers they had was access to child psychiatry for those children who may need mental health assessment and access into that mental health system. Having a child psychiatrist on staff a day a week has made a tremendous difference.

Dr McAndrew on staff has been incredibly flexible in, I suppose, bringing to the team an ability to work within the model. Most psychiatrists will not, as part of their standard role, do home visits but Dr McAndrew is doing those with our therapist. She is going to schools with our therapist. That is a really substantial achievement, to have a doctor on staff who can do outreach work with our staff and who knows the model.

Just on the outcomes—and we see outcomes as really important—there are a range of psychological and developmental assessments that we do as children enter the program and then, as Dr Collis says, as they leave the program. That will give us some tangible data of those improvements over time.

This is an intensive therapeutic model. The advice we took, particularly from the Australian Childhood Foundation in Victoria, was that you can either do this quickly or you can do it well, and if you do it well it will take time. In terms of a reasonably intensive therapeutic service, children need to be engaged over a 12-month to two-year period. That is why the numbers coming in are limited, but we hope that because it is a best practice model and we are putting in place the resources to work effectively with these children we will see those improved outcomes.

I think the other thing that we considered closely was the work by Professor Eileen Baldry from the University of New South Wales who has done some cost-benefit analysis over the lifespan of complex clients. Her evidence with real clients in New South Wales would indicate that you spend a little more before children are 10 or 12 and you can actually save substantial amounts in terms of what those children without intervention would develop, in terms of hospital admissions or police callouts or ambulance callouts et cetera. It is a very tangible piece of evidence that spending upfront in early intervention will have effects that are positive later down the track.

Mr Gentleman: Whilst we have also talked about, I suppose, the level of professionalism that we have had and professional people we have had at Melaleuca I mention, too, Rach Armstrong, who is a local singer in the ACT. She is a 16-year-old young woman who has been helping us with events at Melaleuca Place. She was there at the opening and then later on for the garden opening as well. She has just been unearthed on Triple J. She is doing a fantastic job and it is great to have her on side when we are doing those events as well.

THE CHAIR: A supplementary, Ms Fitzharris.

MS FITZHARRIS: Are you able to tell me what the experience is like at Melaleuca Place? Do children and their families come in for a couple of hours in the morning or is it residential at all?

Mr Wyles: No. It is a closed referral system. The children are referred by child protection services. These are children typically who may have been removed from home and placed in kinship or foster care or there may be concerns that the child is at risk in their current living arrangements.

Over the first six weeks to three months there is a fairly thorough assessment of the children, and that will take place, if children are of school age, in the classroom as well. There will be a lot of outreach in terms of home visiting, in terms of school visiting by the therapist. And then as the therapist builds trust with the child and the carers, or the family, they will start coming in to provide service. Every presentation will be quite different. It may be a couple of times a week for some children or it may be just once a week.

There is a range of therapeutic interventions. I suppose when people think about counselling in adults, that is fairly limited in this situation, although we would do some of that with parents or carers. There are things like having a therapeutic garden where therapists can work alongside children as they play, speak to children in that environment. Speech therapists are really critical. When we visited a service at Seaforth in Sydney, which was a residential service, they could show us how intensive speech therapy for children of a particularly young age can have a dramatic effect on their development. So we want to really place children at the end of that therapeutic intervention in the best place in terms of their schooling particularly.

I think the other thing we want to do is make sure that we are providing carers with the information and the support they need to be able to effectively care for the children, and that will have a flow-on effect, hopefully, in terms of stabilising those placements so that the children do not fall out of those placements or there is not a breakdown.

MS FITZHARRIS: It may be multiple children from one family. Is that the situation?

Mr Wyles: Yes. In some cases there are sibling groups. We take a fairly family focused approach. If children are in care the children that are in care may also be involved in discussions about the impact of trauma on the child and how best to respond so that you are really working with the whole support network of that child to educate them and support them.

MS FITZHARRIS: It is from birth to 12 years old. From 12 years old what services are available in this area?

Mr Wyles: There is a range of, I suppose, broader services that would be brought to bear, whether they are youth services or the child risk assessment unit at the hospital. For adolescents I suppose there are different sorts of therapeutic approaches.

MS LAWDER: You mentioned a multidisciplinary staff team and I heard you talk about a child psychiatrist and a speech therapist. Can you tell me what other disciplines work there, and how many FTEs there are?

Mr Wyles: In total it is 4.5 FTEs but I think there are seven staff on site—two social workers, two psychologists, one part-time speech therapist and one part-time occupational therapist and one part-time child psychiatrist.

THE CHAIR: Mr Wall.

MR WALL: Minister, if you turn to youth justice in the annual report, page 112, it outlines that there were a total of 170 clients under the youth justice system for the reporting period. Are they individual cases or if someone came in early in the year and then returned under a different order does that count as two?

Mr Gentleman: I will ask Dr Collis to give you those details.

Dr Collis: First of all could you say the question again?

MR WALL: The annual report shows at point b on page 112 that there were 170 community youth justice clients for the reporting year. Are they individuals or if someone came through the system early in the year and then returned under a different order are they—

Dr Collis: They are individuals.

MR WALL: How many of those individuals were held in detention at the Bimberi detention centre?

Dr Collis: The numbers of people in Bimberi over the year? I would need to find the data I can. It would be a small proportion of those—

MR WALL: I was hoping you would be able to provide a breakdown of the difference between the numbers who spent time in detention and those that spent time under supervision orders.

Dr Collis: I will be able to provide that for you.

MR WALL: Maybe an easier one while you are looking for that is: how many young people are currently in your care at Bimberi?

Dr Collis: Seven.

MR WALL: That has been a stable number or has it been fluctuating much lately?

Dr Collis: It has fluctuated between about five and 12 in the past 12 months.

MR WALL: I will give you a moment while you are looking for that.

Mr Gentleman: I will say too that whilst the numbers are low it is a good result to have those very low numbers. We feel that we might be getting to a position where we might not have any more reduction. There may be a core of young people who come through who are not able to be assisted as much as previously. So we are doing our very best at Bimberi to work with through care and other opportunities to assist those people in Bimberi at the moment to live better lives afterwards. There has been quite a bit of success with the Bendora through care unit in training up young people to take jobs.

In fact, two visits ago I was able to meet with a young person who was just about to exit Bendora. He had been training to do a job as a bricklayer and he was due to start the very next day with a company in Sydney as a bricklayer and he was very happy with the way his life had turned around. So it is a good result I think. We need to keep up that work, yes.

Dr Collis: I have those figures on sentence detention in Bimberi. Over the course of the year it was 13. That is individual cases. I would like to take on notice the total number of young people who have been on remand but I will get back to you.

MR WALL: They were sentenced individuals?

Dr Collis: Yes those are sentenced individuals. That is correct.

MR WALL: Is there a cost breakdown that you can give? You have got in point e an average investment per youth services client. Is there a differential between those that have spent time in detention on a, say, per day basis against those on supervision orders?

Dr Collis: I will defer to Ian Hubbard for that. My understanding is that is an average across the service.

Mr Hubbard: Can you ask me the question again sorry?

MR WALL: Yes. On page 113 of volume 2, in point e you have got "average investment per youth services client". Are you able to give a further breakdown of what the average investment or cost was per client that spent time as a sentenced individual or the difference between the average cost per sentence against supervision order?

Mr Hubbard: I will have to get you that detail. I will find out how we actually got that number.

MR WALL: That would be great. While we have got you at the table I am struggling to work out the correlation between point b, the estimated number of clients through the reporting year, and point e, the cost per client. My simple arithmetic was: if I times the average investment per client, which is at 35,420, by the 170 clients you have a year and then—

Mr Hubbard: Hang on, what was the first bit of that?

MR WALL: I am just trying to work out the correlation between point b and point e. Point e gives you an average cost per client that you have helped through the year. Point b is the number.

Mr Hubbard: Fair enough.

MR WALL: If I times point e by point b—170 clients times the cost per head and then divide it by what you are actually budgeting on, which was 315—I do not get to an average cost per client of $25,000. I get a cost of about $19,000.

Mr Hubbard: I think the maths will be closer to the total amount that we have as a budget for youth clients. Youth justice clients would be 170 by 35,000. And because we expected to have more clients in the original target, if you multiply 315 by 25,000—that would be the reason. The reason is essentially the drop of almost 50 per cent in youth justice clients. I will get you the actual maths to figure out what that is or just do them myself. I will see if I get close to it, but I will get you that before the end of the session.

MR WALL: The 170 times 35 clients is around $6 million; 315 at 25,000 is almost $8 million.

Mr Hubbard: Yes. I will see what the—

MR WALL: I am just a little curious as to how that has come about.

Mr Hubbard: I will get you the exact figures.

MR WALL: And also, with the additional cost per client, part of that is going to be attributed to just having fewer young people coming through the system, but it also makes a note of workers compensation. What is the breakdown? How much is workers compensation toward that figure?

Mr Hubbard: I am not sure workers compensation will affect that particularly. I will see if it gets added into that specific youth services budget, but the workers comp figure for that whole output is in the order of about 2.4 million. That was the increase in premium that we received—a significant increase in premium that we received—as an agency from Comcare.

MR WALL: So is 2.4 the cost or the increase?

Mr Hubbard: That was the increase. That was the addition to the budget. It was about 5.7 for the whole of CSD as an increase.

MR WALL: This is probably speaking broader than just this output class, but is that as a result of an increase in claims?

Mr Hubbard: Remarkably enough, our performance has improved, particularly over the last couple of years, in workers comp and our claims history. When you are calculating workers comp, there is a four-year tail. There is a combination of reasons why the premium went up. One is that, as you probably have read in the paper, Comcare has increased its premiums across the board to all agencies significantly, probably in the order of 50 per cent to 60 per cent this year. And also the other part of our calculation of the premiums specifically for CSD is shaking out that four-year tail. We did have some significant claims four years ago. My expectation is that next year, given that Comcare will not raise their premium for covering their own costs, our performance premium will actually go down quite significantly, because our claims performance is very good at the moment.

Dr Collis: Mr Wall, further to your questions before, we are attempting to get the uncleansed data round individual clients. You will appreciate that that takes checking and we do not do that for a survey, but we do have some data. The average per day number of young people in Bimberi for the reporting year was 9.5.

THE CHAIR: Minister, how many beds do you have at Bimberi? What is the capacity?

Dr Collis: The number of beds is 40. Capacity is another issue, because there are requirements around segregation that would make that a floating figure. The physical

capacity of Bimberi Youth Justice Centre is 40 beds.

THE CHAIR: You have got a facility that is built to accommodate 40 young people. You have got an average population of five, six or maybe seven in there. Is it time, minister, to reconsider the role of Bimberi and whether there is an alternative facility or whether an alternative option is needed, given that you have a significant facility with a lot of capital costs tied up in it and the operating costs in relation to a facility of that size? Has there been any policy work done to consider what alternatives there might be?

Mr Gentleman: I think we need to have that physical capacity within Bimberi. There are a couple of pressures that we see coming up in other systems. For example, AMC is growing quite rapidly in its population due to events in society at the moment. We know that the ice scourge is affecting population numbers at AMC. Justices are doing more sentencing than ever before. And, of course, children of those people sometimes tend to go down similar lines. So we want to go through that early intervention process to assist those families as much as possible. But we still need the physical capacity. The cost differs, of course. You need to provide the level of security that is necessary and the level of support for the individuals that are there at the moment. It would be an interesting test to look at what the difference in cost would be if we were to look at a smaller operation, for example.

THE CHAIR: Thank you.

Ms Chapman: Chair, I just want to go back to Mr Wall's question, touching on our workers compensation. As Mr Hubbard said, part of our premium increases is because of Comcare increasing their premiums, and we do have a tail. But in CSD we have put a huge amount of effort into managing staff risks and, if people do suffer an injury, working with them very quickly, bringing them back to work as soon as we possibly can, not letting them fall off the edge of the cliff, as it were. And we are doing a lot of preventative work in terms of focusing on the health and wellbeing of our staff overall. We do training in manual lifting and those kinds of things. We do work on people's mental health, managing stress and dealing with their day-to-day work. And I would like to read this into the record: in July 2014 we had 140 workers compensation cases; in June 2015 we had 120; and at the end of September this year we had 110. We are really working on that front end to bring them down, which will help with our premiums going forward. When the rolling four years starts to pick that up, our premiums should come down. And this is a cost CSD—

MR WALL: That is the whole directorate?

Ms Chapman: That is exactly right. In relation to the other issue, in terms of the increase in the premium, Mr Hubbard talked about the whole of CSD getting an increase of about 5.2, I think. That was allocated out to our various divisions through a particular formula. That is why, in the children and young people space in Dr Collis's division, they got an impact of about 2.1, because of the number and staff and so on. We got a big bill and we have allocated that bill out to the individual divisions based on their headcount.

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Minister, obviously the reporting covers up to 1 July, but the new structure, Child and Youth Protection Services, came into place on 1 July. Are you able to give us an update on how that has gone?

Mr Gentleman: Yes. It is progressing well. The integration and alignment of care and protection services and youth justice have provided a more streamlined service response to children and young people. It has also allowed the child and youth protection service to introduce single case management into their system; it helps, with that, to sustain relationships with children, young people and their families where that is important and intervention is required at the same time.

So there is now more of a regional approach, providing increased opportunities for the office for children, young people and family support to work more effectively with the community and sector partners. I will ask directorate officials to give you a bit more detail on that.

Dr Collis: Thank you for the question. This has been an enormous internal reform that has been driven for two fundamental reasons. One is to prepare the government workforce for step up for our kids and the changes that will be coming there. But it also afforded the opportunity for the first end-through-end design of a child protection system. I know from going to national forums how envious other jurisdictions are that we have had the impetus to do that. And it has largely been able to happen in a way that has addressed the advice that has been provided in the public advocate reports and in previous inquiries in the area.

Up front we invested very heavily into a changed management approach straightaway. We brought staff along into this process. The aim of integrating the services was to design a system which was designed from the child and family point of view. We wanted to remove unnecessary referrals, barriers and whatever. We wanted to maintain consistency. We wanted to have a capability to develop relationships locally, so we want to somehow regionally manage our workforce so that they can develop relationships with schools, health centres, childcare centres and agencies and people can talk to people. We wanted to maximise that.

The other thing is that reducing the system from so many referral points into basically an intake function and a protection function—it is slightly more complicated than that—means that our workers have responsibility for the whole issue. That is really important for us. The work that they start they get to finish with families. That is a major goal in developing the single service.

We are the first fully integrated youth justice and child protection service in Australia, and we are now having visits to look at our service. We are very young, though. We started that process on 1 July, when we moved everyone into the teams. We did not disrupt cases: we are migrating family relationships with our workers naturally; we are taking natural times to populate the regional aspect, and that is moving on. We have invested very heavily in the process and systems to allow people to know their work. The integrated management system that is there was created before we turned the whole system on, and we invested very strongly in the training component there; all our cases workers received the equivalent of about nine days worth of training over

the lead-up in that final 12 months.

We have done a 100-day review of the work from the team leader point of view. We have taken time out for the team leaders and our managers to sit there and say, "How did the first 100 days go?" The anecdotal feedback is that people can see the sense in the system. We have been delivering pulse surveys all the way along. We know that people are feeling confident that they can deliver the change, but we also know that they are feeling under pressure for all of the change that is happening around that. So we know we need to moderate, where we need to moderate and where we need to consolidate.

At this point of the program we are in what we call the consolidation phase. We are giving it six months to consolidate. We have moved the service from 7 o'clock in the morning at the front end to taking child concern reports from 7 o'clock in the morning to 7 o'clock in the evening service. We have just recently reviewed that. The staff are telling us very positive things about that, and our objective data around that is very positive as well.

MS FITZHARRIS: Can I ask what it was prior?

Dr Collis: Sorry?

MS FITZHARRIS: What time it was before?

Dr Collis: Prior to that it was a nine to five service with after-hours provision. Now it is seven to seven with after-hours provision.

What we did in the analysis of our work in setting up the integrated statutory service is look at the workflow. We discovered that there were bumps in our workflow at different times in the day. For example, when hospitals change shifts in the morning is a critical time. When teachers actually leave school usually is a critical time. So we felt that it was more appropriate to have a service. Our staff voluntarily agreed to take different shifts: some start at seven and finish early; some start at 10 and go through. And so forth. There is always someone there to answer the phone between those hours, to do the work for the next day. It seems that we have now deployed our resources much more efficiently in addressing the child concern reports as a consequence of that. We have been able to set the day up much earlier so that when the case management staff come in there is work there that has already been processed.

So early signs are really positive, but it is at consolidation level. People are still learning new roles. We are hoping to see this benefit realised in the next 12 months.

MS FITZHARRIS: Thank you. How many staff in the area, in this division? How many staff are being—

Dr Collis: There are approximately 382 in the—

MS FITZHARRIS: Approximately!

Dr Collis: Depending on whether we are doing headcounts or full-time equivalents.

MS FITZHARRIS: Or FTE. Yes.

Dr Collis: We have about 165 in regard to specifically front-line activity.

Mr Gentleman: While Dr Collis mentioned that during the process there was quite a bit of pressure on staff, we know from the feedback from the surveys that staff morale is really good; they have told us that whilst the pressure is there, they are quite excited about the changes.

MS FITZHARRIS: Because they can see that they will have an effect?

Mr Gentleman: Yes, indeed—deliver a better outcome.

MS FITZHARRIS: And the integrated management system—when did that start getting rolled out?

Dr Collis: The integrated management system has been rolled out in Bimberi Youth Justice Centre for quite a while—at the beginning of last year, in fact. The integrated management system for Bimberi, which was the first of our integrated management systems, was rolled out in 2014. We took a view at that time to wait till it was complete before we rolled it out and turned the switch on for that. We changed our view when it came to the child protection integrated management service, on the basis, out of experience, that we figured we could turn on parts of the system.

The integrated management system is designed around the client journey. It is about the experience of intake and what you do with it. Then it moves into case management. Then it moves into supporting processes around case management and then how you move to permanency. So it has a workflow. We actually turned on the aspect to do with intake in January 2014; then we went live totally in the end part of September 2014, when we were totally live in that space.

MS FITZHARRIS: It says in the annual report that the IMS is a quality assurance system. It is not just an IT system, for example. Can you just explain a little more what it is?

Dr Collis: The IT component of it is probably a latecomer. It is actually a quality assurance system. It goes from a view of risk and compliance and looks at what the Children and Young People Act requires us to do and how to do it. It then creates the policy framework that sits under that, and from that policy framework comes practice guidance for individual workers. It is a process by which we ensure a direct line of sight between what the workers are doing and what they are required to do under the Children and Young People Act.

Built into this are a compliance register and an internal auditing process, so we audit what we do. The fact is that, as you do the policies and practice guidelines, you also start inputting other things like best practice. Whilst the act might require a certain way of framing a decision, within how that is framed there are a range of best practice approaches to doing that, so we will be able to input that best practice at that point in time.

The integrated management system is hosted on our knowledge portal. Our workers have access to this. They do not have to wade through pages and pages of practice guidance notes and whatever. When they turn their screen on, the knowledge pool is there. They can go straight to the area. If it is for emergency action, procedure or something that a worker needs to have guidance around they can go straight in, check the procedure or practice and make sure they are complying with what they need to comply with. The knowledge pool also allows us to host a whole lot of practice tools—for instance, risk management tools. This allows us to make sure that our decisions are consistent and framed in an evidence-based way.

MS LAWDER: I want to go back to the table that Mr Wall, I think, was referring to on pages 112 to 114 of volume 2. It talks about the workers compensation contribution to the total cost, which I think you said was a $2.4 million increase. At the very top of that table, the total cost and the government payment for outputs were above target. It says that was due to both the workers comp premium plus increases in foster care and out of home care costs. I guess it is a terminology thing, but foster care is not mentioned anywhere else in this table. Can you quantify that for me? Is the remaining difference due to foster care and out of home care being calculated separately? Can you give me the two amounts? Do you understand what I am asking?

Mr Hubbard: Yes. Thanks very much for that question. The difference between those, as you pointed out, is in the area of approximately $2 million. The big part of that is obviously the workers compensation premium. When you are looking at the details in foster care and out of home care costs, we are using that term really to say that there was some increase in not the payments to those two things but the cost associated with the service delivery in that area of out of home care and foster care. It is not actually an increase in a foster care payment, if you know what I mean. It is more a category of expenditure rather than a payment made to a foster carer or per out of home care child. It actually captures a group of expenditure.

MS LAWDER: So there has not been an increase in the payments?

Mr Hubbard: No. That is right.

MS LAWDER: Does the increase relate to items k, l and m in that table on pages 114 and 115?

Mr Hubbard: Yes; that represents the number of kids actually coming in—the increase in demand in that year. Overall, when you look at the entire output, part of the pressure of the increase in the cost is related to the increased demand.

MS LAWDER: A bit higher up on page 114—and you have just mentioned this—it says in item i:

> … the Integrated Management System (IMS) leading to more effective risk assessments and risk management practices. For children and young people this means the right service is being provided at the right time and fewer families being drawn into the statutory child protection system.

However, k, l and m have shown an increase. Can you talk me through that?

Dr Collis: Yes, I can, Ms Lawder. The number of children in out of home care is driven by two things: how long children are staying in care as well as how many children are coming into care. Over recent years the number of children coming into care has remained relatively stable. As to the length of time young people are staying in care or leaving care, staying in care has increased and leaving care has decreased.

MS LAWDER: How does that relate to the 11 per cent increase at item k then?

Dr Collis: The 11 per cent—a number of those children will be in the care of the director-general, maybe living at home or in other situations, but there will be parental responsibility. That means that, whilst we are continuing to bring people into care at roughly the same level, we are not moving people out of care. Each year we will want to move people to permanency, back home, and equalise that balancing act. That is what the step up is attempting to do—to both cut the inflow and increase the permanency arrangement. The largest contributor to that number would be moving young people out of foster care or kinship care into a permanent arrangement.

Mr Gentleman: You can also see, Ms Lawder, in the notes that it is a point of time measure. Those numbers can fluctuate daily. That increase is shown in the notes as emergency action is taken to support the safety of those children.

MS LAWDER: Items l and m showed an increase. It would appear, on a very basic analysis, that the increase in l may solely be due to the increase in m. The numbers are similar—about 6,000 more out of home care days used by Aboriginal and Torres Strait Islander children and an increase, roughly, of 6,000 in out of home care in total. Why would that be? Why has there been a recent increase in the number of Aboriginal and Torres Strait Islander children and young people requiring out of home care?

Dr Collis: There are a number of possible explanations for that. The community are discussing right now what is driving children to come into out of home care and, specifically, what is driving Aboriginal and Torres Strait Islander children and young people to be in out of home care. Our trend line in this is still roughly the same. About 25 per cent of all kids in out of home care are Aboriginal or Torres Strait Islander children. This increase is within that general trend, if you like. We have not seen a particular spike in this data.

MS LAWDER: It is an 11 per cent increase.

Dr Collis: In days, yes.

MS LAWDER: In the directorate you do not have an understanding of why that is the case? You are saying the community is having discussions, but what is the directorate's view?

Ms Chapman: The directorate does have some views. As you know, it is a very complex area. We think that some of it is related to the broader community's awareness and unacceptance of things like DV. If a community member knows of a family where DV is happening they might have previously said, "That's a private

matter; we shouldn't get involved," but now the government, the community, the world at large are saying—

Mr Gentleman: The justice system—

Ms Chapman: The justice system is saying, "Not good enough." We know that magistrates in town are taking a much stronger view about the perpetrators of DV. That can have an influence on whether children are reported who might not have been, or families have been reported who might not normally have been reported. One of the other things that the Aboriginal community is talking to us about is the increase in the use of ice and how that is impacting on families. If parents who are supposed to be looking after and protecting young children have a serious ice addiction—and we know the kinds of outcomes from there—people are saying, "We need to tell somebody about this." I think there is a combination of factors, but those are two of the drivers.

We have not changed our thresholds in terms of what is legislatively permitted and what our processes are. All of those technical things have stayed the same. Our threshold has not suddenly gone up and we are saying, "If you've got a pile of garbage in your front yard, suddenly the child is at risk." That is not what is happening. There are very complex community things happening, I think, that are influencing at least notifications as a starting point. Then if you have more notifications you do more appraisals, and you see more of what families are going through.

MS LAWDER: The last one is about the number of permanency placements. You have a target of 20 to an actual of 21, which is good. However, I guess the really crude measure does not appear to be keeping pace with the increases. Can you talk a bit about how the new changes to the Children and Young People Act will help to make adoption and permanency easier and quicker for families?

Mr Gentleman: Sure. Adoption is quite a lengthy process. Of course, the original parents have to give permission for adoption, so you have got to go through those processes, and then you have to ensure that it is the right place for that permanency for the child. And then you need adoptive parents that are prepared to take on that responsibility, so it is a quite important responsibility for adopted children. I will go to the director to give you more information.

Dr Collis: As you would be aware, the recent legislative amendments laid a framework for reducing the time that children are required to be in a stable placement before enduring parental responsibility could be considered. That is the framework that we wanted to operate on as we procured the new systems to benefit from more children getting to permanent arrangements more often.

In the context of the whole step up for our kids, the aim is to reduce the number of kids coming into care in the first place. When we talk about permanency, we also talk about investment in the family environment, the birth family. We are investing very heavily in strengthening the high risk area by intensively supporting children being able to stay with their birth families and, when that cannot happen, making the decision very clearly to move to a permanent arrangement. There will be more

certainty in the decision-making about permanency by the time you get to that and there will be less bureaucratic red tape in terms of having to wait for two years of stable placement for an enduring parental responsibility to be considered for the children.

I guess within that, in procuring the continuum of care, which is the service related to the provision of all forms of care—kinship, foster care and intensive-based care—we are giving one organisation, one agency, the capacity to work straightaway. We are encouraging that by setting up that procurement for them to look at the recruitment of more foster carers who want long-term arrangements. We are encouraging them to move toward permanent arrangements, which are enduring parental responsibility or adoption—whichever is appropriate.

MS LAWDER: Of that 21 that were achieved, can you tell me how many were EPRs and how many were adoptions?

Dr Collis: I believe seven were adoptions and 14 were EPRs.

MS LAWDER: I hear from families who are willing to adopt and who are finding it quite lengthy, perhaps unnecessarily lengthy. In instances where birth parents will not give permission, what is the process? What can happen for those parents? A birth parent may be patently unable to care adequately for a child.

Dr Collis: Sure.

MS LAWDER: They may have found a supportive, loving, permanent home. Is there some way to work through that process?

Dr Collis: Yes. In regard to adoptions, of course, in the ACT, as in nearly all jurisdictions, we only have open adoptions now. "Open adoption" is the term meaning that the children should expect to have contact with their birth family through their lives—I say "should expect"; that does not necessarily mean that it will happen, because there are all sorts of circumstances where that might not be desired by people—and adoption is appropriate for the caring community, for children. Clearly Aboriginal and Torres Strait Islander children are not considered in regard to adoption. The other even larger group is the kinship care group, which is over half our population.

MS LAWDER: Perhaps we could leave those aside.

Dr Collis: So they are with enduring parental responsibility.

MS LAWDER: Perhaps we will leave those aside.

Dr Collis: In adoption or enduring parental responsibility, it is possible to dispense with the parental rights of the birth family. That is a process that is a court-based process where we go into the court and make a decision to dispense. We work very hard for that not to happen. That is the worst possible option, given that if it is adoptions, we are talking about open adoptions; and if it is enduring parental responsibility, children will have contact with their birth family. We attempt to work

very strongly with the birth family to make that decision.

In many ways, Ms Lawder, there is an opportunity here. This is about how we can change some culture and understandings both in our community and in our workforce and, early on in the proceedings, keep alive an option for a birth mum or a birth family to know that adoption or enduring parental responsibility is a responsible decision to make and is a sign of good parenting and being a good mum and good dad. That is about an early opportunity to make sure we do not discount that.

I think it is true that we need to move more and more to make sure that that narrative holds. There are all sorts of reasons why, in the community, that story has changed over time. Clearly, there is the stolen generation, the forced adoptions, for which as a nation we have apologised. However, we need to acknowledge, moving forward, that there is a place for permanency and there is a place for parents to make difficult and responsible decisions about who should care for their child. We should not shut those possibilities down early, and that is, hopefully, what we are going to be working on. The consequence of not getting that process right—so we move to either an EPR or an adoption basis—is that all of these orders can be contested again.

One of the things that I know from talking to carers is that it is in the back of their minds, and with an enduring parental responsibility they are not only taking on children and developing their family but developing a relationship with this other family as well, and it is for life. We aim to give some reassurance to them that we will support them through that process. If it goes wrong and it is contested, it could, for instance, be contested in a family law court jurisdiction, which is exceedingly expensive and exceedingly disruptive and so forth. So getting it wrong is a significant legacy. We have not seen that in our jurisdiction, and we are really fortunate with the work that we have done around this. It is an emerging trend in other jurisdictions, including New South Wales, that these orders are being contested.

What we can do is signal to the community, and I will be really thrilled that we have a bipartisan signal in the legislation that permanency is important for children's stability, is important for children. We need to signal that that is what we are going to do. At a practice level we need to make sure we get that work right—that we do not shut down these permanency options early in the process; that we keep them alive and keep talking through that; and that we give the organisation that is best placed to pursue those conversations, that is, the organisation that will be looking after the whole continuum of care, the tools and capabilities to deliver. We as government need to then provide the framework of support, which will include potentially some legal support around those processes for those people moving forward.

That is what we can do. The new system, and that is what I have described there, is what the intent and actuality of the new system of step up for our kids is trying to deliver.

Mr Gentleman: Can I add that you will see, through these processes and also through the early intervention processes and support processes, that there is a distinct change in the way that the directorate and staff are working with children and families; it is now child focused, and focused on the outcomes for the child. That is a change from quite a while ago.

MS LAWDER: Thank you.

Ms Chapman: Chair, could I just add one more thing in terms of some data for Ms Lawder. As at the beginning of October, we had two applications for local adoption orders in the ACT.

THE CHAIR: Supplementary?

MS FITZHARRIS: Thank you. I believe it is National Adoption Awareness Week. Obviously Deborra-Lee Furness is the driver of a particular charity and had quite a bit of publicity this week around the people who perhaps cannot have their own families and would like to add to their families. Previously the campaign had been about overseas adoption, but, from my observation, this week she was talking about Australian children. In the annual report, you note that there is a case study on foster carers as well. Could you just talk to us a bit about this side of the adoption story for people who are looking to either foster children or add to or grow their own families, and what sort of involvement you have with people on that side?

Mr Gentleman: Yes. I can give you some personal views on events that I have attended with service providers in the territory on adoption and foster caring. One of the most interesting ones, very similar to the experience that we had at Melaleuca Place, was with professionals talking to people about how trauma informed responses are superior, in that when Marymead was doing theirs last year for possible foster parents and adoptive parents an expert told us about the way that young children who have been involved in trauma behave quite differently from other young children. Indeed, this expert went into quite a bit of detail about a particular child—the outcomes of that child's trauma; how it behaved, even with loving adoptive parents, quite differently from other children in its groups at school et cetera.

It was a really good learning experience for me, but certainly for those parents who are thinking of taking on that role. They provide all the love and care that they can, but, gee, sometimes it is just very difficult for those young people. But the evidence is that they can recuperate and they can have really good outcomes later on in life.

Dr Collis: I will just clarify, Ms Fitzharris, the question of what we do to support parents. It is really important for us to understand that the carers are at the heart of the system, to understand that relationship between the primary carer and the child and to understand the motivations for different carers. There are carers whose interest is in short-term and emergency care, there are carers who are interested in doing short-term emergency care but are open potentially to longer-term care arrangements, and there are carers who have made the decision for a whole lot of other reasons that this is a way that they want to build their family.

I was with a foster mum just recently who was celebrating her enduring parental responsibility of her children. She described that experience as as significant as the birth of children. For her, it was a completion of her family.

I just want to make the obvious statement overall that in that space is probably the rawest of emotions for everyone, because we are talking about attaching to children,

to families, and we are talking in that space of disruption to that attachment. I was talking to a training group of foster carers and kinship carers yesterday and thanked them for being there for the training but also for opening up their hearts. You cannot attach to a child without opening your heart up to a child to be able to make that attachment and that bonding experience. Then in this space you may have to disrupt that attachment.

In terms of practicalities, we keep active a pool of carers who nominate that they would like to be permanent carers and move into a permanent arrangement. We work with those people to determine, obviously, suitability but, beyond that, what are their goals, the conditions under which they would like to commence their caring and who with. Many people might well have a preference for age of child or they will be fitting this in with other siblings in the family. So we talk through that and work out their capabilities, their motivations and their interests and then we attempt to match the suitable circumstances to those carers.

It can be very fraught because sometimes children who have come through the out of home care system are experiencing a period of uncertainty while we work out issues to do with family preservation, reunification and those matters, so we need to be really sure that those matters are resolved and we are in a position where we can be pretty sure the match is right.

Anecdotally, most of our permanent carers seem to be carers who have taken on shorter term commitments but who make longer term commitments to children after that. That would be not surprising in terms of how it works out. We also provide support after the permanency arrangement. Under the new system, the therapeutic assessment, we would be preparing the family for the children but also offering services into the future for advice around things that they might not understand or whatever. We also follow through to assist with future life story work around the child.

MS FITZHARRIS: Thank you. As a quick follow-up there, does the ACT government have any role in the issue of overseas adoptions or is it solely with the commonwealth?

Mr Gentleman: It is the commonwealth.

Ms Chapman: We do the actual work for the commonwealth jurisdiction.

Mr Gentleman: We do.

MS FITZHARRIS: So the usual arrangement then?

Ms Chapman: It is commonwealth legislation.

MS FITZHARRIS: Thank you.

Mr Gentleman: Just before we go to the next question, we have Mr Hubbard back with the answer to the previous detailed question.

Mr Hubbard: Mr Wall, this is really addressing the question you raised about the

calculation for how the number of community youth justice clients relates to the average youth services client. The similarity between the youth justice clients and the youth service clients leads to a bit of confusion about whether there is a direct correlation between the two. In fact, youth justice clients are a subset of the overall youth services clients, so unfortunately we cannot use 315 as the number to divide into the total number, but I was just going to give you the total group. If you look at the original target, instead of being 315, the total population that we use in the calculation is 527, and that includes, in addition to youth justice clients, young people at the Youth Justice Centre and also clients that are in turnaround to make up the 527.

So the total budget for youth service clients is $3,276,334 and then we divide that by the 527 population and that is where you get the $25,192. When you move over to the actual, where we had youth justice clients being 170—so it is a significant reduction in the number of youth justice clients—the total pool when you include the Bimberi young people and the turnaround young people is 367 young people in that youth services group. The budget for that year—what we use is a quarterly snapshot to get the number—is $12,999,171, divided by 367, which gives you the $35,420. I apologise for the confusion. They are pretty close in those two titles. When I first looked at it I thought "maths error" but it is actually a population error.

MR WALL: Thank you.

THE CHAIR: Minister, just to finish off before we go to morning tea, on page 16 under strategic plan goal 3, "A Productive Life", it is reported that 36 young people were able to remain in education, employment or training through supported accommodation. How long can young people remain in this supported environment, minister? What is the average?

Mr Gentleman: Very good question. I will ask the directorate staff.

Ms Chapman: I am not sure of the question. The length of time that young people can stay connected to the youth service?

Mr Gentleman: Supported environment.

THE CHAIR: Yes, within the supported accommodation facility as referred to on page 17, the second dot point. Maybe you could talk a bit more about those facilities.

Ms Chapman: Sorry, chair. We will have to look at that more closely. We will come back to you after morning tea if that is all right—to make sure we are talking about the right thing.

THE CHAIR: Okay. We will break for morning tea now and come back in 15 minutes.

Sitting suspended from 10.28 to 10.46 am.

THE CHAIR: Ministers and officials, we shall resume. I think we are now on to early intervention services. I think we have probably touched on some of that anyway.

Mr Gentleman: Indeed. Thank you, Mr Chair. Before we do go back, we have an answer in regard to—

Ms Chapman: Dot point No 2 on page 17. It actually relates to a Housing sponsored initiative under the "Youth" heading. It is Our Place, which is a youth integrated education accommodation service, and you will find the detail of that service on page 110 of volume 1. It is written this way; it is kind of a shorthand headline response to the strategic goals that we have in our plan. It probably should have talked a little bit more about who they are working with. If you look on page 110, it provides medium-term supported accommodation to young people aged 16 to 21 who are at risk of homelessness and who are studying or employed. That dot point is a takeout of that piece of information.

THE CHAIR: And that is a Housing initiative?

Ms Chapman: It is a Housing initiative for young people, yes.

THE CHAIR: Thank you. We might turn, minister, to the circle of security program that you talked a little bit about before. Could you talk us through a little bit more about how that works, particularly when a child's parents are perhaps not in a stable relationship or even perhaps when one parent does not have contact with the child?

Mr Gentleman: Yes. Circle security is a relationship-based early intervention program offered through the child and family centres. It enhances attachment security between parents and children from birth to eight years of age. To support the program expansion to all three of the child and family centres, we are doing that through the implementation of the step up for our kids and, of course, with the child and family centre staff as well. They began training for that at the beginning of this year. The program is now offered in both the group format and with individual families through case management. I will ask directorate officials to give you more detail on how the program is working.

Mr Wyles: We are really pleased that the American trainers for circle of security were in Canberra in January, and most of our staff out at child and family centres attended that five-day training. Following that we have run six of those eight-week groups across the territory, including one in the early childhood school at Isabella Plains. We are really interested to see how we could engage parents where they felt most comfortable. This is a group that is really based around attachment and helps parents reflect on their own childhood and their own parenting and attachment style. It uses video and it uses group discussions.

Because the group works specifically with parents, we have also been keen to support parents who otherwise would not be able to attend that group because of their caring responsibilities for their children. So we have used some money out of our emergency childcare budget to provide child care for those parents so they can attend the eight weeks without having to worry about the care of their children.

This is an evidence-based group, and certainly the feedback we have had from people is that they feel very supported in that and they feel more confident as parents at the end of that program. There is a 20-week program we are also exploring. We have one

staff member trained in that and we have just had the other staff member attend training in Brisbane. We will be able to offer that longer term or intensive program to parents who perhaps need a little bit more.

Dr Collis: Just to note that this is part of a suite of intensive parenting offers that sit in the strengthening high risk domain of the strategy. So among some of the strategies we want to achieve through the step up for our kids is to have connection with families who do not necessarily find accessing services easy and who need intensive support to get in early to keep children out of the need for a statutory response.

This is one of a constellation, rather than parents as teachers and so forth. This is one of the systems we are building upon. I think we may have addressed this at the estimates committee earlier in the year. We are hoping to have a network of these capabilities to move across that are relevant to the needs of families at a particular time.

We have ones that might be relevant to mums who are going to give birth in a little while and we will be able to develop those parenting programs there. This one is for the early years children. It needs to be seen in the broader constellation of that investment in those intensive parenting courses.

Mr Wyles: We were really pleased that in one of the groups that ran at west Belconnen over half of the participants were fathers, so we are really keen that we are engaging that group too. Partly that is probably because of the type of group it is—that is, it can be seen as educational and less sort of intense. That is an area we are keen to continue to engage in.

THE CHAIR: How are people selected for this program, or is it self-selected?

Mr Wyles: We advertise the program through child and family centres and a lot of the participants will come through the intake in the child and family centres. Through the one that the Tuggeranong Child and Family Centre ran at Isabella Plains, we talked to the school about what the program was and they assisted in putting forward people who would attend. Other parents will have had contact with either child and family centre programs or partner programs in the past, and they will be referrals through, for example, UnitingCare Kippax or Belconnen Community Service.

THE CHAIR: You mentioned it was an evidence-based program. What is the nature of that evidence?

Mr Wyles: The evidence really is about a suite of evidence around attachment and the importance of the early attachment.

THE CHAIR: Perhaps you could just remind us how you define "attachment"?

Mr Wyles: Attachment really is about how children attach to a significant caregiver, usually a parent. There is some evidence that for some children and parents that attachment does not happen well for a range of reasons. That might be related to the parents' own experiences as children or experiences as adults. It is really important in a sense to make people aware of what attachment is and how they can repair

attachments. Usually as children grow what we see is that for parents where the attachment is not good they find it difficult to manage children's behaviours.

This group really helps parents understand what attachment is and things that can support attachment. A lot of those are things through practical experiences—getting children to play, parents playing with children and parents reading to children. As that attachment builds it allows parents to have more confidence in the way they manage and respond to their children.

THE CHAIR: Does that actually go to what I was talking about before where parents may have separated? Do you have a lot of separated parents and parents without care of the child in this program?

Mr Wyles: There would be some single parents, some separated parents and some parents, in fact, parenting in blended family situations who attend those groups.

THE CHAIR: And they find this helpful?

Mr Wyles: They find it is helpful. They find they are more confident and have a better understanding of their children. Sometimes this is also about changing roles as perhaps one parent returns to work and the main caring responsibilities may fall to the other parent. It gives them some confidence in that space.

THE CHAIR: Thank you. Mr Wall.

MR WALL: If I could ask about the child and family centres, how many staff are involved in operating those centres?

Mr Gentleman: Staff numbers, Mr Wyles.

Mr Wyles: I think it is probably important to say that we did some redesign work at the end of last year, and it was important in talking to our staff and our partners to conceptualise the child and family centres as more than just Community Service Directorate staff in three buildings across Canberra. Although that is part of it, we have a range of community partners whose staff operate every day from our centres. Those community organisations include Relationships Australia, the Domestic Violence Crisis Service, the Smith Family and in some cases some legal advice services and women's information services. The Health Directorate have a number of staff in our centres, including maternal and child health, women's health, counselling and nursing. Community Services Directorate staff are seven in each centre plus a team leader and a manager plus a reception staff. There are 10 effective CSD staff in each centre but then you will get Relationships Australia in the centres several days a week.

MR WALL: So the NGOs like Relationships Australia, or whoever it might be, get free space to engage?

Mr Wyles: That is right, and there are then activities that happen outside the centres. We are linked closely with local schools particularly. So there are groups that occur in schools or there might be case work. One of our core programs, parents as teachers, is

a sustained home visiting program so our staff are working in people's homes.

MR WALL: Are the NGOs that come in selected by Community Services Directorate or do the organisations approach you and say, "We'd like to be part of it"? How has that collaboration come about?

Dr Collis: The real success of CFCs is the way that they have been embedded and owned by their own communities. I think the west Belconnen rollout of the blueprint initiative is an example of how the CFCs are the centre of engaging with the local community service providers about where the need is and how they come in. In reality partners will often come to CFCs. We think the CFCs are a great universal provider to deliver services, like the match nurses we talked about from Health. It is a much more child friendly and supportive kind of environment.

Since we have looked at the redesign work into the CFCs, one of the things we have said we would like to see the CFCs develop is a capability of developing local area governance—that is, groups that can meet and determine what is the nature and balance and need of services in that community that we should be trying to shape the partnerships around. So that is part of the service.

The short answer to that question is that many people come with a shared mission to say, "This would be a great way to deliver services," and other times it is about CFC staff working with the local community and inviting people into the service.

Ms Chapman: Mark touched on, for example, the local network trial out at west Belconnen. One of the things about the human service blueprint that we are working under which you have heard about in previous hearings is to make sure the whole service system works together. Part of the mandate that we have is to find partners, whether they are other government directorates like Health or education or with the non-government sector, to provide the services in a streamlined, joined up, cross-cutting way. There is a group that oversights the human service blueprint and we have representatives on that from the sector from other government agencies. Part of their role is to look for ways that we can bring other providers into the service system in that joined up way.

As Dr Collis says, the CFCs form a really good place to start that work, but a lot of it is done out in the community by the providers themselves. We know about their work; we can refer people who come into a CFC or to the gateway or to Housing. "In your community there are these other service providers. Here are some contact details." I think it is really important to see the CFCs and the ripple effect that they have as part of that continuum of service under the human service blueprint so that we are providing human services in the broadest sense in a joined up way in those communities.

Mr Gentleman: If you look at some of those regional partnerships, if you like—west Belconnen is a really good example—some of those partners are Communities@Work, UnitingCare Kippax, Belconnen Community Service, Gugan Gulwan, ACT library and strengthen the arts. They are groups that are within the region as well.

Mr Wyles: I was just going to say that in the redesign we are really keen to preserve

the role of our intake service. Within each of the three child and family centres there is an intake worker operating during business hours and they will see all comers. So it is a real local service where anyone can wander in and get some advice, some direction. Although we are specifically targeting programs for children and families it is not uncommon for us, at west Belconnen, to be directing people to Foodbank at UnitingCare Kippax or programs that UnitingCare Kippax or BCS run in that space. It is really a one-stop shop, a go-to place that people can be directed in the local community.

MR WALL: How many families are currently accessing these services or these service centres?

Dr Collis: In the last reporting period, on page 286, strategic objective 3, the actual result was 1,675.

MR WALL: What is the capacity that the centres have?

Dr Collis: Capacity is a difficult construct in this basically and in fact you are an access point. You are providing some service directly. You are linking other service provision. Anyone who walks through the door will get access to the intake service which will provide that direction. There will be individual programs. We talked about some, for instance circle of security. There will need to be a wait for that to come in. I cannot directly say there is a number that is a capacity number for these. What I can say is that they are very well utilised and the response that comes back from the community is that they really value the work that happens in there. We are working in a high degree of capacity.

MS FITZHARRIS: Could I add that my local child and family centre was just that, a real hub, particularly when our children were very young. It continues to be. We recently had a morning tea during Anti-Poverty Week at which a number of community service providers in Gungahlin, of which the Gungahlin Child and Family Centre was one—and I believe their 10-year anniversary is coming up too—attended.

Mr Wyles: On 25 November there will be a celebration for the 10 years at Gungahlin Child and Family Centre, which is a significant milestone.

MS FITZHARRIS: If I could add that during the break I was reflecting on the series of hearings we have had, through you, minister, with other officials and the extraordinary reform work we talked about in terms of NDIS firstly, then the blueprint and now all the work in the child and youth sector as well. It is an extraordinary amount of reform work and each time it has come back to having the client and the community at its heart. Congratulations. It has obviously been a very big couple of years.

I ask about the children and young people's commitment for this year. Could you talk us through how the commitment came about and the consultations that were involved? Minister, what are the key things that you took out of it about what the commitment will do for children and young people?

Mr Gentleman: Thanks very much. The commitment is an important process for

government. There was quite extensive consultation undertaken in development of the commitment and we had over 1,500 children, young people and community agencies as well as government stakeholders providing feedback in the first phase of the consultation. Of those who provided their age, over a third, or 38 per cent, were under 25 years. So that is a good result.

The second consultation phase focused on seeking feedback on the draft commitment to ensure that it actually resonated with the community, especially among the target audience, those aged from birth to 25 years, and also key stakeholders and participants from the first round of consultations so that we could ensure that those ongoing contributions were still valid.

The children and young person's task force of course will continue to oversee the implementation, promotion and dissemination of the commitment both across government and to the broader ACT community, but I will go to directorate officials to give you their personal reflections on how that worked through.

Ms Chapman: Mr Wyles led it.

Mr Wyles: It is probably worth letting the committee know that the minister is launching the commitment on 4 December at Namadgi School. Invites are going out for that as we speak. Just going back, the commitment replaces what was the children's plan and the youth plan. I think it was prior to Minister Gentleman. Minister Burch had indicated she thought it would be useful to bring those two things together and it makes sense in the way we are looking at bringing children and youth services together as well and to have a high level document that picked up a number of government initiatives and that was right spaced. So that is where we started.

There were two phases to the consultation, as the minister has said. In the first phase we used three approaches. We used an online survey through time to talk, a tailored survey which used child friendly language to try and really pick up that group of children and get their feedback and targeted sessions for community groups, particularly some where there might be some difficulty engaging. We really sought to perhaps just push it out to people who might not normally respond to online surveys. As the minister said, we got 1,500 people participating and a third of those were under 25.

In the second consultation phase we then went back with some of that information and in a sense tested it with the community. We provided further surveying of individuals and we invited individuals to participate in the final phase of consultation through a whole-of-government and community message. We modified a survey and we targeted young people in both Bimberi and the Alexander Maconochie Centre. We also engaged the Youth Coalition to do a specific focus group with some of their stakeholders. It was a very thorough consultation. We have the commitment but we will wait for the minister to launch it and then you will see it in all its glory.

Dr Collis: What we can say is that the commitment is going to be reportable. We are going to use the framework of the picture for children and young people, which is now a document some years old, and, as I say, we are again the only jurisdiction to have a document that comes out every year which looks at, tracks and monitors the

wellbeing of children and young people in our community. We brought the commitment together to align with the children and young people.

Mr Gentleman: That is right.

Mr Wyles: The committee will probably be familiar with this document and we can provide copies if they have not got it. The minister launched this a couple of weeks ago at Children's Week. This is our fifth year of publishing this data which brings together government data around children and young people and parents and indicates through a series of arrows how we are tracking in that space. This has an outcomes framework at the front which is broken into three areas: children, families and communities. And there is data against those three areas.

The children and young people task force across government, which includes Community Services, Health and education representatives, police and Corrective Services, are reviewing both the data sets and the outcomes framework and, as Dr Collis said, will link the outcomes framework to the commitment which will allow some annual reporting as this comes out and will inform the ministerial statement annually for the commitment.

Mr Gentleman: Interestingly, the launch of the *Picture of ACT's children and young people* was at, as you have heard, the Children's Week event at the National Museum and it was a very exciting day. We had some very important people there to help launch it. Of course the theatre was full of young people from schools, particularly Turner Primary School who gave some vocal renditions for us, and a new song which we all moved our hands in coordination with. I was able to highlight that I was a student at Ainslie Primary School. There was always a bit of competition between Turner and Ainslie, and in this particular instance Turner certainly won the competition.

MS FITZHARRIS: Thanks for looking into that.

THE CHAIR: Ms Lawder.

MS LAWDER: I have one question on the contracts area. It is in volume two, page 272. I did not realise KPMG are involved in the delivery of early intervention services. Can you tell me what KPMG do in that area?

Ms Chapman: I can probably answer that question without looking at it if we are talking about early intervention. When we were looking at services in the disability area because we are moving to the NDIS, you might remember that the government announced that they were getting out of providing services in the Therapy ACT space and the specialist disability space.

One of the other areas that the ACT government was moving away from was the provision of early intervention services in schools. So we had to find what was going to be the replacement for that when the government withdrew their early intervention services for children who might have had perceptions of developmental delay or whatever. Disability ACT and education hired KPMG to do a review, to report on what was possible, to consult people, to find out what people were looking for, what

were the needs and so on. I think you will find that it relates to that early intervention, to prepare us for what it should look like into the future.

As a result of that piece of work, even though this is Minister Burch's area, there were a number, I think about 30, of providers that came into the ACT. Some of them were already here but they expanded their work to provide early intervention services, in a sense not beyond the school gate, although some of them still do because we have given them premises there.

MS LAWDER: If you are able to answer, it is on page 272, did the work take place before a contract was signed?

Ms Chapman: I am just looking. That I cannot answer because I was not responsible for the contract, or that piece of work. I would have to—

Mr Gentleman: I will say that where there are questions on other portfolios or close portfolios I am happy to take the question on notice and go to that minister and ask for—

MS LAWDER: It is perhaps not clear from this but it does say early intervention services.

Mr Gentleman: We will take that on notice and get back to you.

MS LAWDER: It just looks like the contract was signed after the work had already been completed, which is interesting. I was looking also in the outcome area here—and you referred to it earlier when you answered Mr Wall's question about the number of families that were supported—but in relation to services provider it talks about parenting and information available online through parenting fact sheets, home visits, parenting advice and support services. Are you able to provide a breakdown of how many home visits, how many and what type of community development activities and community education activities? Do you keep track of the accessing of the fact sheets online? Do you have figures and statistics about that sort of thing?

Mr Wyles: The online parenting fact sheets are through the ACT ParentLink website. We are reviewing and refreshing that currently, and we have actually got some figures. I do not have them at hand but we could provide those on notice. People may have seen those parenting tip sheets—there are about 150 of them—that cover everything from bringing a baby home from hospital, toddler training, families dealing with grief and loss, dealing with a new school, starting school, those sorts of things. They are at a range of sites across the ACT. You may see them in GP waiting rooms, pharmacies, some schools, health clinics et cetera. The review will look at usage in some detail but we certainly have some evidence around access of the parenting website.

We can describe the range of programs out of child and family centres. In terms of numbers of home visits we could do some work to get that off the database, if that is what you wanted to. A number of groups are in centre but as I say, for groups like parents as teachers, there is sustained home visiting, from pre-birth up to the age of three. Effectively the worker is visiting weekly, fortnightly or monthly over a sustained period. We could take that on notice and get some—

MS LAWDER: In terms of an indicator, the number of families is an important measure, but there is a number of other—

Mr Wyles: I think you are right, Ms Lawder. For some of those, they will be one-off brief contacts, and some information or a parenting fact sheet will be enough; for others, there will be some intensive involvement over a period of time.

MS LAWDER: How do you assess and adapt, if necessary, your fact sheets? What is your process for review? Is it a regular thing? Is it based solely on feedback? What sort of process do you go through?

Mr Wyles: With the ParentLink website and fact sheets, I suppose we are mindful that that has not been reviewed over a long period of time. We are keen to have conversations with a range of groups. I spoke recently to the new Medicare Local Capital Health Network. We are keen to see what practice nurses and GPs find helpful both on the website and in the fact sheets, so that we can refresh and refine those. Given that the fact sheets are all online on the website, we probably need to reduce the number of hard-copy ones but also look at different uses of technology, including apps. We have seen some parenting apps with advice about getting children to sleep, et cetera, or dealing with children's anxiety, that might be quite useful to put on the website.

MS LAWDER: Is that like a raising children website or that sort of thing?

Mr Wyles: Yes. And links to other key websites are important.

MS LAWDER: Are the fact sheets available in languages other than English?

Mr Wyles: They are not. There is a standard sort of block at the back of the fact sheets which allows people to access interpreters; but no, they are not, unfortunately.

MS LAWDER: Thank you.

Mr Gentleman: Mr Chairman, we have an answer for you on the KPMG question.

Ms Chapman: Ms Lawder, KPMG was already in contract with education; they were doing some work on personal care. We used the contract they were already in contract with to expand it and do the extra piece of work.

MS LAWDER: Thank you.

THE CHAIR: Minister, I want to go to the evaluation of the child, youth and family services program. There is a note that you are going to identify areas for improvement to strengthen the service system. What areas are you looking at and what proposals do you have for strengthening the system?

Mr Gentleman: It is working well, but needs some extra work for the future. It has been well supported in funding through the cabinet process. I will just go to directorate officials.

Ms Chapman: I am happy to make a start on the conversation. The child, youth and family services program was reviewed by the Institute of Child Protection Studies at the Australian Catholic University. They collaborated with both the CSD and the key stakeholders who provide those programs. There was a high-level evaluation report prepared. The aim of the review was to look at the processes that we follow, not so much specific individual programs. But because there were changes made to the child, youth and family services program, we wanted to see if it had been successfully implemented in the manner we intended.

When we did that review, they made a number of recommendations. Some of it had gone well, according to the reviewers, and as designed. They made some recommendations about a central data information system, which we all appreciate we really need to have, and we are certainly working on that particular recommendation.

Another thing that became obvious, because the human service blueprint was being initiated, is that we needed to look at the programs to ensure that they aligned with that human service architecture. Some programs may have looked a certain way 10 years ago, but because we were changing the approach that we were taking, there were some recommendations about doing that alignment, not only with the human service blueprint but with the out of home care strategy that was coming to the fore. As Dr Collis has talked about, there are some intensive services that sit in that program that we want to align with the strengthening high-risk families part of our service provision.

The other recommendation that they made, which we are also working on, was improving the coordination of our child, youth and family gateway. The child, youth and family gateway is now working with what we are calling the human service gateway, including first point, the gateway, and some information from disability, the NDIS and so on. The advice that they gave us was to make this gateway align with other gateways. We are working on that at the moment. That is really the outcome of the review.

Mr Wyles: It is probably worth adding that we have commenced that recommendation around a client database. It is called "info exchange". It is an off-the-shelf database that we are adapting. That is being rolled out to the child, youth and family support providers and we are really pleased that there is capacity in that database to interface with the system in Housing ACT. That will allow, over time, some efficiencies and some information exchange in terms of referrals et cetera.

MR WALL: I have nothing further in this area.

MS LAWDER: I am happy to move to ageing.

THE CHAIR: We shall move to ageing.

Dr Collis: Could I just add some information to answer a question Mr Wall asked before the morning tea break about the numbers of young people in Bimberi—that number of 170. I have just been informed of that. Of the 170 young people on community-based orders, 68 served a period of remand across that year and 14 served

a sentence period of detention. That varies from my response, where I said 13 people were sentenced. I am saying 14 now because we are quoting from different counting rules. One of the people sentenced was sentenced in the previous financial year and was not counted in the 14.

MR WALL: And it overlapped?

Dr Collis: Yes, it overlapped. So the answer is 68 with a period of remand and 40 with a period of imprisonment over that time.

THE CHAIR: We shall move on to ageing and youth engagement. I will kick off with a question. Minister, perhaps you would like to comment on how an integrated public transport system such as capital metro could improve the ability of older people to maintain social networks and independently access services.

Mr Gentleman: Indeed. Transport is key to allowing people to age actively, to ensure that they can get across the city in a timely manner and get the correct services. As you know, I launched the light rail master plan just the week before last, which shows light rail travelling right across the ACT in a 25-year framework. Each time a light rail corridor gets activated, that frees up other transport systems, such as our bus system, to better service those living in the suburbs. That will mean, for example, that when the Gungahlin line is completed to the city, or even during the process, there will be more buses available to service other parts of the city. It is not our intention at all to lessen the number of buses; in fact, we intend to increase the number of bus services at the same time as introducing light rail. Interestingly, we also have other services for older people across the city at the moment. There is the community bus service, which provides services for older people, who can ring up and make an appointment to use the community bus. I think that will service older persons as they age across the ACT. There is always plenty of demand, though, and there are always older persons who would like more travel options. That is what we are trying to supply for them.

MR WALL: I am curious how you, as the minister who has responsibility for only a part of this output class, balance against the competing priorities of another minister.

Mr Gentleman: I use it as my priority for sure. In that output class, I do as much as I possibly can to help. A lot of the work that I do is policy work, of course, but there are some direct interventions and availabilities for me to work with older people across the ACT. I have had a series of workshops on active ageing and workshops on the mature age workforce and what we can do there. And, of course, we have direct work with groups like COTA and other bodies in the ACT.

MR WALL: What about the youth component?

Mr Gentleman: With respect to?

MR WALL: This output class. You are the minister responsible for youth engagement. The reason I ask the question is that we have the bizarre situation where output 3.1 incorporates women, youth, ageing and multicultural affairs. Aboriginal and Torres Strait Islander affairs falls under this output class. You have two ministers

responsible for one small output class of a department. Obviously there are competing priorities for both of you. How does that get managed across what is such a diverse and important scope of work the Community Services Directorate does?

Mr Gentleman: It is a very simple answer. We work with a whole-of-government approach to all of the services that we provide. Each time there is a priority, whole-of-government decisions are made in regard to those priorities. Each minister will argue quite strongly for their particular slice of portfolios. Indeed, when it comes to budget cabinet, you will see very furtive arguments for particular slices of finance for particular areas.

MR WALL: Enjoy your cabinet budget, minister; we do not see it.

Mr Gentleman: I know. It will be reported to you, though, later on. It is about whole-of-government responses and ensuring that we get the best outcomes for the whole of the community.

MR WALL: Whilst we are in this space, what work have you done over the past year with the Youth Advisory Council?

Mr Gentleman: That is a good question. I thought we were in active ageing, but anyway.

MR WALL: It is youth engagement as well.

Mr Gentleman: Thank you, Mr Wall. The council provides core strategic advice to the territory and the government. The council also provides a link to me and the local community and it is an opportunity for young people to learn about areas such as community leadership and that. The consultation in response was to the issues paper addressing alcohol-related harm, being one of the works that have been achieved by the youth council—and also in response to the mental health perspectives of young people 12 to 25 in the ACT. That was released by YouthCo in the ACT. There is also the work done by them with media partners; a lot of work has been done with 2XX.

MR WALL: Have you sought any specific advice or comment from the Youth Advisory Council?

Mr Gentleman: Yes; we do regularly. In particular, planning is a good way that we sought their advice. As you are aware, during the statement of planning intent workshops, we held workshops with a number of different groups across the territory—with community councils, stakeholders in industry and directorate officials. But also we had a particular night set for young people in the territory. It was the biggest attendance of all of those workshops; we had 100 young people to talk about planning for the future of the ACT. The evening was very successful. They workshopped ideas on how they would like to see planning for the territory in the future, how they would like to live. They gave us great examples of denser living but still having opportunity to enjoy urban open space. Better transport options were a key focus in that too. I would like to congratulate the group that attended on that night. I use them as an example each time on community consultation, on how good consultation can be. Of course, those young people will be the people paying for the

changes in the future and living in that future Canberra.

MR WALL: On the youth engagement team, since it has come into the community relations output class, how is the efficacy going? How effective has the team been and what is the current make-up of the staffing profile for the team?

Mr Manikis: The youth engagement unit is part of the Community Participation Group now. The main work has been around the youth grants scholarships that are administered by the youth engagement unit as well providing support to the Youth Advisory Council and the youth awards. There are a series of programs that are administered. The work has been ongoing and quite consistent. There are three positions that are dedicated to that work out of the group but—

MR WALL: Dedicated to the youth—

Mr Manikis: Attached to youth engagement. However, in the Community Participation Group, as we have said in previous hearings, where there is a program that needs work, like National Youth Week or whatever, those three positions are supplemented by other areas of the Community Participation Group and there is more resourcing. So, depending on what time of the year it is and where the work is, the youth engagement unit would have an expansion of resources to undertake an event, management or awards assessments. In the context of the Community Participation Group, the youth engagement work seems to be going very well.

MR WALL: What portion of the community relations team's budget is attributed to the youth engagement work?

Mr Manikis: I do not have that with me but I can get that on notice for you.

MR WALL: Thank you.

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Minister, I have got a couple of questions on the ageing aspects of this output class. In particular, do you know how many grandparents have weekday responsibilities caring for grandchildren? I seem to come across more and more.

Mr Gentleman: Yes. There are a number and what is occurring now, with the current demographic of working families, is a bit more pressure in getting grandparents to assist in childminding and that sort of thing while both parents go off to work. I will ask Ms Sheehan to give you some more information there.

Ms Chapman: Sorry, minister. She has come up to answer the other question. I do not think she can answer the grandparents question.

Mr Manikis: The question is: how many grandparents there would be—

MS FITZHARRIS: Do we know?

Mr Manikis: I do not have that figure with me. I do not think that figure is around. I

do not think it is something that would be a census question. We can look around but I can say that this is the second year that we have put an emphasis on Grandparents Week. The ACT government thinks it is very important that we highlight the importance of the role that grandparents play. It is not just in the mainstream. We are talking about in the CALD communities as well as the Aboriginal and Torres Strait Islander communities in particular. Grandparents deserve at least a highlight throughout the year of their efforts. Grandparents Week has been something that seniors clubs have partnered with the Office for Ageing on, to help promote and assist, and that seems to go very well.

MS FITZHARRIS: Great. We were having a discussion earlier about the child and family centres. I know that in Gungahlin, for example, there is not a seniors centre as such, although one is developing in Ngunnawal through Communities@Work. Are there any programs that are able to be made available through the child and family centres, for example, or are they already?

Mr Manikis: I am not aware that there are any specifically for grandparents, but we are aware that there is an interest. We have had approaches, particularly from the CALD community, for centres. We do have some programs happening in the Theo Notaras Multicultural Centre. The Chinese community in particular use that centre for their intergenerational programs. Certainly in Flynn and other places further afield we have had approaches and we will be looking at something like that down the track.

Mr Gentleman: I can say too that on some of the personal visits I have had to older persons accommodation—I will use IRT in Belconnen as a really good example—they have said that they see an opportunity for a childminding centre not too far away so that they can go and visit with the children and pick them up before and after childminding. I have not worked up a process yet to take to cabinet but I am certainly interested in taking an opportunity to look in a planning sense and also in a government decision-making sense at where we can co-locate childcare centres with the availability for grandparents to help out.

MS FITZHARRIS: Thank you.

Ms Chapman: Ms Fitzharris, on the question about grandparents, in the back of my head I knew that I had seen something about grandparent playgroups. The Playgroup Association here in the ACT organises those for grandparents.

MS FITZHARRIS: Great. Just one final question on ACT Seniors E-News: there is a monthly newsletter that goes out, which it says is currently distributed to 500 people, but I think there are probably more than 500 seniors across Canberra. Do you have plans to reach out more broadly or does, for example, COTA do that through their network as well?

Mr Manikis: We call for contributions from relevant organisations around Canberra. Seniors E-News is well received. It is a monthly newsletter. I can get something on notice for you as to the distribution list. I am aware that it does have a significant distribution. Whether it is individuals or organisations, I will need to just check that.

MS FITZHARRIS: Thank you.

THE CHAIR: Ms Lawder.

MS LAWDER: A supplementary.

THE CHAIR: Of course.

MS LAWDER: On Grandparents Week and the partnership with the senior citizens clubs et cetera: are the Grandparents Week activities aimed at the members of those clubs or at the broader community?

Mr Gentleman: It is aimed at the broader community, but they are sort of first contact, if you like. They provide us with the easiest way to communicate with the broader community.

MS LAWDER: I found it interesting because I am a grandparent many times over, but, apart from these hearings, I have never heard anything about Grandparents Week.

Mr Manikis: This is the second year that we have held it.

MS LAWDER: I know, because we spoke about it last year.

Mr Manikis: We did; that is right. Our partners are the four seniors clubs as a starting point. Each seniors club, because of the demographic of their membership, would—

MS LAWDER: It is aimed largely at perhaps retired people, people who are no longer working full time, rather than grandparents per se.

Mr Gentleman: They tend to have links as well with people who are still working. For example, just the other day we launched the ACT Seniors Card and the directory. Mr Doszpot was there as well. A number of people in the room were still working. A number had reduced their working hours, though. This is another topic for discussion in regard to transitioning into a mature age workforce. Even though they tend to be seniors clubs, they do provide a lot of connection to people who are still in the workforce.

MS LAWDER: Do you have any figures on the number of participants in the activities?

Mr Manikis: No, we do not have any of those figures at this point, but going forward we will—

MS LAWDER: When you say support, was that financial support that was given to those?

Mr Manikis: We do provide a little bit of money.

MS LAWDER: And you expect a report back from them about that engagement?

Mr Manikis: We do, yes, and we will get some figures this time around. However, I

must say that our desire at the end of the day is to make sure that we promote this to the broader community. We cannot do it out of the Office for Ageing in terms of putting on the activities, so our seniors clubs are natural partners for us in the first instance. Depending on our resources, we will make sure that in the future there is the mainstream impact.

MS LAWDER: I have a supplementary on the E-News. It says it is available both online and in hard copy. How many hard copy newsletters do you send out?

Mr Manikis: If you are looking for a number, I can get that for you.

MS LAWDER: Great. Thanks.

Mr Manikis: We send hard copies to the nursing homes and the seniors clubs, but it is essentially on the website.

MS LAWDER: But you can take that on notice—how many you send out?

Mr Manikis: Yes, I will take that on notice.

MS LAWDER: Thank you. And to my question: I am interested in older women's housing and what engagement or involvement your area has in that.

Mr Gentleman: Ms Sheehan will be able to answer that question.

Ms Sheehan: Thank you for that question. As the committee heard from the minister, through her working with a lot of homelessness organisations that have been identified and also through her role as the Minister for Women, a lot of older women experience extreme housing stress, particularly if there has been a separation in a relationship, they have been in private rental and they are no longer employed. They find it very difficult to meet those rental payments.

The way that the ACT government has been trying to address this is by working with community housing organisations as a starting point. CHC Affordable Housing has a really lovely shared arrangement, which is called Betty Searle House, which was constructed originally as part of the older women's boarding program but now is an affordable rental. It is a very large property so, although it is a group share arrangement, there are many common spaces and plenty of opportunities for women to have some private space as well.

In addition to that, the YWCA off its own bat has become a registered community housing provider and has just constructed its first property directed to supporting older women with housing affordability issues. Housing ACT, which is heavily targeted to low income people, as the committee is aware, has a very high proportion of its properties—I think about a third—for older people, and waiting times for older people are relatively lower than waiting times in the more general housing waiting list. That does give an opportunity for older people and older women to have access to high quality housing.

I would like to point out that under the nation building program over 432 properties

were constructed right around the ACT, most of those being six-star energy efficiency older persons properties. That was a very successful program because it enabled older people to downsize into properties that met their needs, and those properties that they vacated were available for families more generally.

MS LAWDER: Thank you for that. On an ongoing basis, I understand that it is largely within the Housing ACT portfolio, but how is your directorate, your output area, involved in housing for older people, especially older women? What involvement do you have, if any?

Mr Gentleman: I think it is more, again, a whole-of-government exercise. There are opportunities through Health, through Housing, through Community Services, and in some instances through JACS, to assist older women in the ACT. Ms Sheehan has given you a really good example of how that works in the housing portfolio. Each different portfolio has a different way of working, but it is certainly part of the focus for government.

Ms Chapman: Could I add, Ms Lawder, that the roundtables and the older persons assembly, which the minister hosts, provide some good input into policy decision making of those other agencies, because it is a whole-of-government approach. The ageing policy area sits with Minister Gentleman, but the implementation of a lot of that potentially sits outside this particular portfolio. Information that we get from those kinds of consultations and policy initiatives that are happening elsewhere around the country get fed into decision making across the government.

Ms Sheehan: I would add there that it is a good example of the way in which the community participation group works as a whole, because of course the Ministerial Advisory Council on Women looks at issues of housing affordability and so on for older women and the youth engagement area is also looking at areas of assistance for young people, young women, who are in need of housing assistance. As Ms Chapman was saying, it is an opportunity for us to look right across the portfolio area at issues for women and issues for older women.

MS LAWDER: Thank you.

THE CHAIR: Mr Doszpot, would you like a question?

MR DOSZPOT: I would. Could I just get a little bit of a clarification? Are you not allowing me to ask supplementaries?

THE CHAIR: Mr Doszpot, you are a visitor to the committee and—

MR DOSZPOT: With respect, I am just asking—

THE CHAIR: We can either discuss this now or you can ask some questions. If you want to ask some questions, I would just get on with it, if I were you.

MR DOSZPOT: Thank you. Minister, further to Mr Manikis's explanation of the 500 newsletters that go out electronically and other areas that receive it in a written format, you are probably aware of the Canberra Seniors Centre, which has 500 members and

is straining at the seams, so to speak. It is in dire need of upgraded facilities and a lot of work has been going on over the last few years. Can you explain to me your role in what is happening to the Canberra senior citizens centre?

Mr Gentleman: I have been a strong advocate for the centre and for the centre getting an opportunity to expand in a relocation program. I have visited the centre a number of times now and have met with centre directors. The centre, as you know, was constructed about 50 years ago, and it now requires substantial refurbishment and upgrade. You have probably visited it yourself, Mr Doszpot. It is a series of buildings that have been joined together over the years, which provide different ceiling levels and quite a burrow, if you like, of different rooms. It is quite a large building at the moment. In that sense it is available for service, but there are a lot of other things that really do need work. There is not a lot of car space at the rear of the centre. There is quite a bit of parking across the road, but then you have to cross a road to get there. The government has worked with the centre to look at the building and property that is managed by the club. The lease over the land is concessional and has the ability to deal with those constrained environments—a concessional lease, if you like.

The Ministerial Advisory Council on Ageing undertook a review of the club as a whole in the follow-up to the review in 2005. The focus of that review was to look at all of the four clubs, but they looked particularly at the Canberra Club. In consultation with representatives of the club, it was confirmed in the findings that Turner needed quite a bit of work and, in fact, replacement was probably the better option due to the growing demand for their services. They have been working with the Economic Development Directorate to look at an opportunity to build a new building for the Canberra senior citizens club at Dickson. There is an opportunity there and a piece of land that the Chief Minister has looked at. My understanding is that those consultations are ongoing.

MR DOSZPOT: Has that site been confirmed with a legitimate offer to the Canberra senior citizens for them to take up that option?

Mr Gentleman: That is my understanding. That work has been done with EDD, though, so I have not actually been involved in the allocation of a parcel of land. I am certainly at this stage able to assist as much as I can to—

MR DOSZPOT: I am sure the Canberra senior citizens would be very glad to hear you say that because they are in urgent need of confirmation that the Dickson site is still on the drawing board and there is no change to that. They have had no clarification of that, and they have been trying to get some information. This has been dragging on for quite some time. Are you aware that apparently from the Chief Minister's area there has been information that the Canberra Seniors Centre management, or the group, have been offered that Dickson site and that they have rejected it? It seems that the Chief Minister's office is under the impression that negotiations had ended, basically. This is hearsay, but it is apparently fairly strong hearsay. Can you check into that?

Mr Gentleman: Certainly. It is in direct contradiction to the information that I have. I have been provided with information from Chief Minister's directorate that that work is ongoing for the Dickson relocation. The only comment I could make in regard to

rejecting it is that certainly on a visit that I had to the Canberra senior citizens club there was a view put to me that they did not really want to move to Dickson. That is the only thing that I can think of. The rest of the work is—

MR DOSZPOT: As I understand it, there has been no formal rejection. I would like it on record that there has been no formal rejection by the Canberra senior citizens. They are concerned about the fact that that seems to be the information that is current within the government.

Mr Gentleman: No, it is not the case. The Chief Minister's office has provided me with information saying that their intention is to work at the Dickson site as quickly as possible. I will ask them to continue that negotiation with the club and see how quickly we can get them there.

MR DOSZPOT: This has been going on for quite a while. Can you give us an indication as to the time lines that senior citizens are looking at in getting to the next stage, and obviously to a working stage of a working plan, so they can move into something that they require? You will take that on notice?

Mr Gentleman: It will have to be constructed, of course. There will be a budget allocation, a cabinet decision, I would imagine. It will be some time. I will certainly take that on notice. I will talk to the Chief Minister's office and see if we can provide some time lines for you.

MR DOSZPOT: The information we had was that in the 2015-16 budget $200,000 had been allocated to the design of the replacement centre and that was set to be completed by December 2015. Do you have any idea when the design process will be completed by?

Mr Gentleman: The information I have is that the budget appropriated $650,000 for design and feasibility for the relocation of the Canberra senior citizens centre, with an object to identify and select a suitable site and to commence preliminary design work associated with that. That was in the 2013-14 budget.

MR DOSZPOT: How much of that has been spent?

Mr Gentleman: I do not have that with me, but I will certainly find out and come back to you, Mr Doszpot.

MR DOSZPOT: Obviously the design of the replacement centre is the smaller amount—$200,000. I would like to know how much of that has been spent. The December deadline is approaching very rapidly. Is that still on the boil? Is consultation still taking place with the Canberra senior citizens centre on this and, if so, who is doing the consultation?

Mr Gentleman: The information I have from CMTEDD is that consultation is continuing. They are leading that; the economic development directorate will be leading that consultation.

MR DOSZPOT: I am glad to hear you say that there is a whole-of-government

approach, which I have heard here a number of times today. I get the impression that that seems to be a euphemism for 'it's not in my area and I don't really care'. I appreciate what you have just said. If you could take it on board for the senior citizens, I think it would be a step forward.

Mr Gentleman: Certainly. I am sorry you have that impression of a whole-of-government approach. It is quite important I think that government works together through all of its portfolios and all of its ministers—and indeed all of its directorates—to provide the best opportunities for Canberrans. Whether it is with senior citizens or youth engagement, as we have talked about earlier, a whole-of-government approach is the best approach. Rather than divide and have silos—as we have had with previous governments—when you seek a whole-of-government approach to particular aspects of policy there is a much better chance of getting the best outcomes, because they get to talk to each other all the time and, therefore, provide information across directorates.

MR DOSZPOT: I do not disagree with you. If a whole-of-government approach is one of interaction between various ministers, I fully support it. I must admit the evidence of that is rather lacking. Thank you.

Mr Gentleman: Mr Chair, we wish to provide a further answer.

Ms Sheehan: Mr Wall, your question was: what are the resources allocated to the youth engagement area? The answer is that we have a notional allocation across the whole budget of $380,000. Of course, as Mr Manikis was describing, all of the resources of the community participation group at any time could be working on something to do with youth engagement.

MR WALL: That includes the staffing costs; is that correct? There are three staff associated with that area?

Ms Sheehan: That is right, yes.

THE CHAIR: Minister, in the brief amount of time we have left, could you tell us what community relations has been doing to minimise the risk of elder abuse in our community? I refer particularly to the section on page 79 of the annual report, where it says the community participation group has been responsible for coordinating a program. Can you tell us a bit more about that program in the few moments that we have left?

Mr Gentleman: I will. Just before I pass over to Mr Manikis, I have had some conversations with older people in the community recently about elder abuse and the implications for them. I was particularly dismayed about the amount of financial pressure that they have received—elder abuse in a financial sense. Sometimes it has even been family members that have pressured older people to make decisions that are not best for them but indeed best for others in that process. It is quite disturbing. I will ask Mr Manikis to give you some detail on what we have been doing. I think this is a piece of work that will grow. It is certainly something that we probably need to deal with across government as well—I am sorry, Mr Doszpot. There are several areas where we would need to provide some support for older people.

Mr Manikis: Certainly older people here in the ACT are entitled to feel safe and to live without fear of intimidation. That is a given. They certainly have the right to dignity, respect, security and to be provided with the necessary support and assistance when required. We are an inclusive community and certainly abuse would not be tolerated or go unnoticed. That is our starting line.

We have worked closely with COTA this year. They have done some surveys as well. We have also maintained the abuse prevention and referral information line. We have had 102 calls so far from January to September from people who are concerned, or reporting elder abuse, or wishing to gain further information for referrals. We also have an elder abuse prevention working group which is looking at ways that we can promote the unacceptability and support measures for addressing this issue.

Certainly throughout the reporting period we have developed an elder abuse prevention campaign, which involved the promotion of world elder abuse day on 15 June this year. We have raised awareness through social media, we have done some website promotion and also on world elder abuse day we had some stalls at regional shopping centres and information stands. It is interesting that as a result of those information activities at the shopping centres there was a spike in the number of calls that we received on the hotline. Whilst 102 calls may not reflect absolutely every single instance of abuse in this town, it is something that we need to work a little bit harder at, in terms of promoting where people can get assistance, and probably work a little bit harder with the services that are out there. We will be doing that through the elder abuse prevention working group, and working with COTA as well.

THE CHAIR: Thank you, minister, and officials. I remind the committee that supplementary questions are to be lodged with the committee secretary within four business days of the receipt of the proof transcript of this hearing. The committee asks that ministers respond within 10 working days of the receipt of those supplementary questions. Answers to questions taken on notice today are to be provided within five business days after the hearing, with day one being the first business day after the question was taken. The committee's hearing for this morning is adjourned.

Meeting suspended from 12.04 to 1.04 pm.

Appearances:

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

Health Directorate
- Feely, Ms Nicole, Director-General
- Thompson, Mr Ian, Deputy Director-General, Canberra Hospital and Health Services
- Kelly, Dr Paul, Chief Health Officer and Deputy Director-General, Population Health Division
- Carmody, Mr Paul, Deputy Director-General, Health Planning and Infrastructure
- O'Donoughue, Mr Ross, Executive Director, Policy and Government Relations
- Croome, Ms Veronica, Chief Nurse
- Lamb, Ms Denise, Executive Director, Cancer, Ambulatory and Community Health Support
- Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Service
- Centenera, Ms Liesl, Acting Executive Director, People Strategy and Services Branch

THE CHAIR: Good afternoon everyone and welcome to our last public hearing of the Standing Committee on Health, Ageing, Community and Social Services inquiry into financial and annual reports for 2014-15. This afternoon the committee will be examining the 2014-15 ACT Health Directorate annual report. Minister and officials, can I confirm that you have read the privileges card lying on the table in front of you?

Mr Corbell: Yes, thank you, Mr Chairman.

THE CHAIR: Do you understand the privilege implications of the statement?

Mr Corbell: Yes, thank you.

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

Mr Corbell: Thank you very much, Dr Bourke, and your colleagues on the committee for the opportunity to appear before you all this afternoon. I do have a brief opening statement I would like to make. The ACT Health Directorate is a critical service delivery function of the government, and each year we see increases in the number of people seeking care and support from our health system. Despite this ongoing demand, in the 2014-15 financial year over 11,800 people were removed from our elective surgery waiting list; 100 per cent of urgent, 95 per cent of semi-urgent and 99 per cent of non-urgent radiotherapy patients commenced treatment within standard time frames; and our two emergency departments saw 130,000 people present for care.

That is around 360 people each and every day looking for and needing emergency care. This alone is an increase of around an additional 15 people every day from the 12-month period prior. ACT Health also met this increase in demand while still

maintaining a did-not-wait rate of 5.2 per cent across the two years of 2013-14 and 2014-15.

Furthermore, ACT public hospitals achieved an average bed occupancy rate of 85 per cent in 2014-15, an improvement on the 90 per cent reported in the year prior. ACT Health saw 100 per cent of emergency dental clients within 24 hours and achieved well below the national rate in the decay missing or filed teeth indexes at ages six years and 12 years. The directorate also met its response in its target for the aged care assessment team of two days to assess the needs of clients for patients in public hospitals. Public mental health services were effective in providing care to mental health clients with only six per cent of clients returning to hospital within 28 days of discharge from the acute psychiatric unit.

Indigenous Canberrans' immunisation rate at 90.5 per cent indicates a very high level of investment in public health services to minimise the incidents of vaccine-preventable disease amongst this disadvantaged population in our community. Overall, as members would know, Canberrans continue to enjoy the highest life expectancy of any jurisdiction in the country.

These are good achievements, but our health system also faces challenges. We know that this financial year, the one indeed we are in now, sees more growth and more demand being placed on our public health services. That is why the government will continue to invest heavily in service delivery and infrastructure to meet these current and future challenges.

Right now the health infrastructure program has completed a number of comprehensive and significant projects. These include major projects such as the Canberra Region Cancer Centre, the Centenary Hospital for Women and Children, two new walk-in centres and expansions to the emergency department and the intensive care unit. Over the next year the government will fund the opening of more inpatient beds, more outpatient services in cancer, women, youth and children services, and other outpatient clinics will also be expanded. There will be more funding for people affected by suicide and mental health and for suicide prevention awareness and research.

Whilst concerns about the health system are an essential part of improving service delivery, we continue to see compliments continuing to outweigh the number of complaints received when it comes to the delivery of health services. Indeed, in 2014-15 there were 300 per cent more compliments than there were complaints about our health system, and that speaks to the very effective and professional work of all of the staff within ACT Health and the service that they seek to provide each and every day. Thank you very much, Mr Chair. I and my officials are very happy to try and answer your questions.

THE CHAIR: Thank you very much, minister. We might start with the University of Canberra in my electorate of Ginninderra. That has a specific rehabilitation focus. Could you please outline the types of services that will be offered at the hospital and provide an update of where the project is at?

Mr Corbell: Thank you very much, Mr Chairman. In terms of where the project is at,

the directorate has been successful first of all in receiving a development approval for the reference design for that project. That was received in the last week or so. We are currently in the process of finalising our assessment of preferred bidders for the project, and I expect an announcement on that will be made very shortly. In terms of the service delivery that will be provided, the key services will include rehabilitation, adult mental health and aged care as well as a range of other clinical training, teaching and research functions.

Clearly, what is most important about this project is that it is a purpose-built outpatient and subacute capability that is designed to shift the emphasis away from Canberra Hospital when it comes to subacute care, provide a range of inpatient services, particularly in areas such as mental health in a subacute setting, as well as purpose-built, modern facilities for rehabilitation for a range of conditions. This is a really important investment. We expect construction to commence early next year and, as I say, the contract is expected to be awarded late this year.

THE CHAIR: There could be some public confusion, minister, about UCPH's role when it is described as a subacute hospital. It has been suggested it might be clearer to call it a rehabilitation hospital, but that probably detracts from the richness of what you have talked about with adult mental health care and aged care and its teaching role. Perhaps you would like to comment on that.

Mr Corbell: I do not have any specific comments to make about that, Dr Bourke. Nomenclature is something that I think you can get very hung up on. The fact is that it is a public hospital facility. It is not a tertiary treatment hospital but it is, nevertheless, a public hospital. The government is certainly very happy with the terms in which the new project is going to be described.

THE CHAIR: Are you able to give us some more detail about how this investment in the University of Canberra public hospital will help relieve the pressure on parts of the health system?

Mr Corbell: It will be of assistance in terms of the relocation of a range of functions that currently occur at the Canberra Hospital site in particular but also at some other health facility sites around the city, such as Brian Hennessey house, in terms of either freeing up capacity at those sites or allowing those sites to be vacated because of their age and the need to provide more modern and contemporary facilities. It is about making sure that we keep non-tertiary functions away from that acute tertiary care setting, which is such a critical and primary role of the Canberra Hospital.

MR HANSON: Could I have a supplementary?

THE CHAIR: No. We will work down the row and then we will get to you, Mr Hanson. Mr Wall.

MR WALL: Minister, last year's health budget was $1.195 billion. The budget for 2018-19 is forecast to be $1.412 billion, an increase of $217 million. Previous health ministers and previous Chief Ministers have stated that this level of growth is unsustainable. What is your take on it?

Mr Corbell: It is the case that we have to constrain growth in the budget because of the significant pressures that health service delivery puts on public finances, and we are no different from any other jurisdiction in that respect. We have to make sure that the dollars we spend are spent in a way that improves access to service, improves efficiency and improves timeliness. My focus as minister is to look at how we can, within our existing budget and within the existing growth envelope that is provided for, utilise the finance available to improve access, improve timeliness and improve service delivery. That is the primary focus for me as minister.

MR WALL: How are those outcomes going to be achieved?

Mr Corbell: It is not for me today to make policy announcements, but what I can say is that since becoming minister and in close coordination with my director-general, we have been looking at how we can achieve just that. The government will be making further announcements about that in due course.

MR WALL: What work has been done to inform what the options are?

Mr Corbell: The government has commissioned a range of reviews around the budgetary position of ACT Health as well as around our performance in a couple of key areas, such as access to emergency care through emergency departments, as well as assessments of infrastructure need and overall demand going forward. All of these pieces of analysis will inform the government's policy in this area.

MR WALL: To what extent has, through that analysis, the cost of providing services in the ACT been compared to other jurisdictions such as New South Wales over the border, and what are some of the reasons attributed to why health services continue to be more expensive in the ACT than they are in neighbouring jurisdictions?

Mr Corbell: There is a range of factors at play; some are more effectively within the government's control and others less so. For example, issues associated with the terms and conditions of employment of senior doctors, visiting medical officers, staff specialists and other health staff have historically been higher in the ACT than they have been in other jurisdictions. The government is not in the business of wanting to achieve a cut to the real wages of nurses, doctors or other health staff, so clearly that is a factor that is less easy to control. But there are other factors—

MR WALL: Just on that point, minister, to what extent of the cost differentials between jurisdictions do you attribute staffing costs?

Mr Corbell: I do not have a percentage figure. If you want something more specific in percentage terms then I am happy to try and get that to you. But the point I am simply making is that that is a cost factor which is more difficult to control. In relation to other factors, obviously we do have a longer length of stay on average for people who are admitted to our hospital service system than in other jurisdictions. That means the capacity to meet demand due to bed availability is not as strong. To the extent that we can improve our performance around length of stay, that means we can improve the efficient operation of our hospital system and it means that more people are able to get the care they need in a timely manner, particularly people coming through, for example, from the emergency department. Issues like that that are much

more within the government's control, and we are looking very closely at those factors.

A number of other things drive the cost base here in the ACT that are worth observing: first of all, of our GP numbers, particularly our bulk-billing rate, continues to be quite low compared to the national average. That does have an impact on people's decision about whether or not to seek care, primary healthcare in particular, or whether they wait until it becomes more acute and rely on the hospital system. There are issues around our scale, economies of scale. We run one hospital ourselves and we contract out the service delivery from another, so we do not have the benefits of the economies of scale of larger jurisdictions. There are factors like that that are also at play.

MR WALL: In order to achieve greater service capability and efficiency, as you said earlier, ultimately there is going to need to be some savings made in other areas to help do that. What are the areas that are being looked at to gain the additional capacity that is required in the health system?

Mr Corbell: Again, I am not in a position to make policy announcements today, but the government will be spelling out its reform agenda in this respect in due course.

MS LAWDER: A supplementary.

MR WALL: Ms Lawder.

MS LAWDER: On the budget, I note that the value of leave earned exceeds leave taken. It is covered on page 117 and 118 of the annual report. And annual leave consumption was lower than anticipated, at $3.3 million. Firstly, is this good for staff morale and performance? What plans do you have to manage this? Where do you see it going in the current year, for example?

Mr Corbell: I will ask Ms Feely to deal with that.

Ms Feely: Leave management, as I look to my staff here, is a key element of one of the reform agendas we are looking at through ACT Health. Every deputy director-general going down to ED level has been asked to prepare a leave reduction plan to make sure that people take leave, to ensure that we eradicate, remove or reduce the issues of tiredness and those sorts of health issues that come to fruition when people are tired and because they have not taken their leave. Yet also it is important that we look at these issues to reduce the cost burden on the health system, because it becomes a large liability. The plan is, over the next 12 months, that leave balances will be reduced, as far as possible, to the 200-hour base level.

Each area is looking and working constructively with me on that, and I say that genuinely; everybody is trying to take it on board. We do not really have many down periods in the hospital sector, but we will use those down periods wherever we can to minimise requirement for backfill. But there is now a proactive move to encourage people to take as much leave as possible. And where there are excessive leave balances, leave plans will be put in place to make sure that leave is reduced as far as possible.

MS LAWDER: Do you deem people to be on leave? Have you and will you?

Ms Feely: At this stage, the discussions are, as I understand it, moving forward in a collaborative way. We have not moved to the deeming state yet. I will look at that again by Christmas.

MS LAWDER: Some people say that staffing levels or workload demands mean that they cannot, or feel like they cannot, take leave.

Ms Feely: There is probably a difference between the feeling and "cannot". There would be some critical areas in the health service where the ability to find backfill will be challenging; I might defer to Mr Thompson to answer that in more detail. But again, through the conversations we are having with all our staff who have excess leave, we are trying to remove that concept of "we feel we cannot take leave". However, we do not want to get caught in a trap where the backfill is actually removing the financial benefit that will come from a reduction in leave strategy. That is why, if we work together and try and work it out through the ups and downs of operational requirements, we are hoping that we do not need to get to the deeming side. I will ask Mr Thompson to talk in more detail.

Mr Thompson: I very much echo the director-general's comments. There are staff who feel as though they cannot take leave but the actuality is that in most cases I think it is not the case. We have the ability to backfill people going on leave in a number of different ways, and we have used them—even, for example, with senior doctors, looking to get locums in to cover their period of leave so that they are able to reduce their leave balances. With our nursing staffing, we are able to recruit more nurses on a temporary basis, even right through to agency nursing if it is necessary, in order to ensure that there is a safe workplace. We have got lots of different strategies we can use. To date, however, we have not had to use those to a large extent. It is about negotiation with the staff and ensuring that we have leave plans that cover, as far as possible, the coming 12 months, so that everyone's leave is scheduled well in advance and everyone has some certainty about when they can take their leave.

MS LAWDER: Do you survey people on having a feeling of whether they can or should be able to take leave? And do you look at the correlation between sick leave taken and people who have not taken any personal leave? Is there any correlation?

Mr Thompson: There is not a strong correlation on the latter point, and in most instances I would not say that there is evidence that sick leave is up in substitution for annual leave. We do not survey as such. This is a discussion that happens with local managers. The structure of what we do in the process is that we have leave planning at the local level; that then rolls up to an organisational level; and if there are areas where the leave planning indicates that there is a low take-up of annual leave, that is where we will get in more detail.

MR HANSON: Can I have a supplementary?

THE CHAIR: No, Mr Hanson. Ms Fitzharris.

MS FITZHARRIS: Minister, can I ask about the emergency department. The annual report notes that there has been an increase in patients presenting by comparison to the previous year. I noted that the expansion of the emergency department is well underway. Can you give us an update on that expansion and what additional services the expansion will enable? It is very brief—on page 55 under the heading "Emergency Department".

Mr Corbell: The expansion of the emergency department means an increase in capacity in terms of bed numbers of around 30 per cent. It will add an extra thousand square metres or so of floor space to the ED. This is being delivered through the construction, first of all, of a series of modular units at the existing facade, the western facade, of the emergency department. That will allow us additional space, and it will also allow the redevelopment to be staged in such a way as to allow the emergency department to continue to operate.

There will be up to nine more acute beds for people with severe conditions; around three for patients with less severe conditions; three more beds in the emergency medicine unit; two designated paediatric consultant rooms; two additional resuscitation bays, particularly important for the effective functioning of the ED; and a complete rebuild of the mental health short-stay unit.

I am particularly keen to see that mental health short-stay unit in place. People who present to the emergency department often—it is not infrequent, I should say—present with mental health conditions. They need to be cared for in the short term in the ED; they need a suitable and safe facility to do that, and one which is contemporary, up to date and respectful. The existing facility is aged, it is out of date, and it does not meet contemporary standards and it needs to. I am particularly pleased that that is underway.

The refurbishment is at stage 1. That is due to be completed by the end of this year. Stage 1 is the emergency medicine unit and the mental health short-stay unit. The final completion of stage 1 and the subsequent stages will be late next year. The total cost of the project is just under $24 million.

MS FITZHARRIS: How many beds in total will that take the ED up to?

Mr Corbell: The total number of beds? I do not have that in front of me, so I may have to take that on notice, Ms Fitzharris. We will come back to you shortly on that.

MS FITZHARRIS: And are the dedicated paediatric beds in the new dedicated paediatric part of the ED?

Mr Corbell: Yes. We are keen to have a separate assessment area and a sort of sub-waiting for parents and children. Obviously the types of circumstances the ED deals with can sometimes be traumatic, or at the very least confronting, in terms of people's behaviours and conditions, and that is particularly hard for kids. Having a separate sub-waiting area and assessment area for parents, with their younger children, in particular, I am sure will be of great benefit to those families.

MS FITZHARRIS: Are you able to provide the numbers on the number of paediatric

patients that come through the ED?

Mr Corbell: Yes; I can take that on notice.

MR HANSON: Can I have a supplementary?

THE CHAIR: Mr Hanson, we will get to you shortly. Ms Lawder.

MS LAWDER: While we are on the emergency department, there is an article from 23 June this year saying that Canberra's hospital emergency department wait times are among the worst in the country. I note that in the AIHW statistics for emergency department care the ACT has had a slower rate of increase in emergency department presentations compared to the Australian average, again in the past two years. If we have had a slower rate of increase in emergency department presentations compared to other jurisdictions, why haven't our ED services improved faster than in some other states and territories?

Mr Corbell: There is no doubt that we need to be doing better when it comes to timeliness, particularly for certain categories of patients presenting for care at the emergency department.

Obviously it is worth highlighting that we meet the national benchmarks, the so-called NEATs, for category 1 and category 2 patients. For category 1, 100 per cent seen immediately—that is obviously resuscitation——we are achieving that. We are just under achievement for category 2: the target is 80 per cent; the result for the reporting year we are dealing with is 78 per cent. So we are very close to meeting that target. But when it comes to category 3 and category 4, we are not meeting those targets. We do meet the target in relation to category 5.

So there is work to be done. As minister, I consider it a priority that we invest more time and effort into getting the processes, procedures and resources right to improve performance in this area. I am confident that that can be done. The government will be talking more about what steps it believes can be taken to work with and support the work of our doctors and nurses in the ED to improve timeliness when it comes to service delivery.

MS LAWDER: It is very challenging in the emergency department; I cannot even begin to imagine what it is like. I have only been there as a patient or a parent; it must be extremely difficult for staff.

Mr Corbell: It is a challenging care environment, but the people who work in emergency departments do it because they enjoy it. They enjoy the challenge; they enjoy the purpose of that work. Whilst we do well in categories 1, 2 and 5, we need to do better in categories 3 and 4, and that is the area that we are very focused on.

MS LAWDER: Overall only 61 per cent of ED presentations are seen on time compared to the national average of 75 per cent. Why is that?

Mr Corbell: For category 3?

MS LAWDER: Overall 61 per cent of all ED presentations. Are you saying it is category 3 that is affecting the overall figure?

Mr Corbell: There are a range of factors at play that are preventing us from meeting these targets. There are issues around the capacity to move patients through the hospital from the ED into other parts of the hospital where they need to be admitted. Getting people through the ED promptly is critically driven by the availability of beds and the availability of all the other processes that need to be in place to allow that patient to be moved into another part of the hospital in a timely manner. That is what prevents us meeting those targets currently, and that is very much the focus of the analysis and the actions that the government is currently working on.

MS LAWDER: That has potentially answered my next question: why do ACT emergency department patients at the 90th percentile wait about an hour longer than the national average? Is it about availability elsewhere in the hospital?

Mr Corbell: In part. There are also factors within the ED itself, in terms of workflow and how decision making occurs around treatment. That needs to be strengthened. The government has commissioned a very detailed analysis of the workflow within the ED that will assist us in identifying those points. Then we will use that analysis to work with our clinicians, our nurses and other key staff to improve patient flow and improve the time frames around decision making that affect how long people spend in the ED.

MS LAWDER: Based on what you have seen so far, do you think, for the year we are currently in, those types of figures are going to improve?

Mr Corbell: The government has only recently completed this work and is yet to make a final decision. I will be putting some recommendations about that to my colleagues in due course but I expect that the government will be able to set out a very clear agenda for service improvement in the ED during this financial year.

THE CHAIR: A supplementary, Ms Fitzharris.

Mr Corbell: Chair, just before you go to Ms Fitzharris, with your indulgence, Ms Fitzharris asked me for the number of paediatric presentations to the ED. The advice I have hot off the presses is that for patients aged 16 or less for the 2014-15 year it is 29,952 paediatric presentations, or 23 per cent of the total.

MS FITZHARRIS: Minister, I ask a supplementary from Ms Lawder's question around services in the ED. I am thinking of my experience in ED. Does that include things like blood tests and x-rays? Is that what you mean by services within the ED or is that services apart from those?

Mr Corbell: All of those things can potentially add delay. If there is a need for tests, if there is a need for scans or imaging, that can mean the person in the ED spends longer in the ED. The trick is to make sure they do not spend any longer than they need to, to have those tests and scans and other requirements undertaken. Timely decision-making around when those tests are requested, making sure that that is communicated efficiently and the assessments can be made, all mean that people will

get a more timely level of service delivery. There is a whole range.

It is a very complex picture of decisions that have to be taken by treating doctors or nurses, and it is not about what decisions they are taking but how those are communicated. The doctor might say, "The person needs imaging," but that may not be communicated for another half an hour, for example. That leads to delay, and if that becomes a frequent or regular approach to managing those sorts of requests, which it has, that adds time to the length of time someone spends in the ED and it means fewer people can be seen within the time frames.

It is a whole matrix of decision-making that needs to be sharpened up, and I am confident that can be done. Until recently we had not undertaken the level of analysis that we have now on these matters to get full visibility on where we can improve service delivery.

THE CHAIR: Mr Hanson.

MR HANSON: Going back to the University of Canberra public hospital, minister, that was an initiative, I believe, taken to the last election and you are delivering on that promise from the last election. Is that correct?

Mr Corbell: I beg your pardon?

MR HANSON: The University of Canberra public hospital represents a commitment by Labor at the last election and you are fulfilling that election commitment?

Mr Corbell: We certainly made clear that the development of a subacute facility at UC was part of our agenda, yes.

MR HANSON: Why were no costings submitted to Treasury for that? You took it to the election and said that was part of your commitment. Why were there no costings submitted to Treasury either for capital costs or for ongoing costs?

Mr Corbell: I am not privy to those processes. I was not the minister at the time.

MR HANSON: What are the capital costs of the University of Canberra public hospital and what are the ongoing costs?

Mr Corbell: The government has made provision for the capital and recurrent costs of the project—they are reflected in the overall quantum of the budget—but the government has also made the decision that those capital costs and indeed their recurrent costs are not for publication at this time. The reason for that is the commercial sensitivities surrounding the procurement process for the UC project. Once the contract is awarded the government will disclose those details.

MR HANSON: You think it is reasonable to announce an open commitment, announce a policy three years ago, but still the public has no idea what the capital and ongoing costs are?

Mr Corbell: I do not think it is reasonable that the taxpayers' position is

compromised by disclosing to the market what the territory is prepared to pay ahead of a competitive process. It is a bit like if you are going to auction something and you tell everyone what price you are prepared to accept. It means you do not get value for money.

THE CHAIR: Minister, can you tell me what sorts of employment contracts nurses coming out of, for instance, the University of Canberra are offered when they are employed at the Canberra Hospital?

Mr Corbell: Sorry, I missed the first part of the question.

THE CHAIR: I am interested in what sorts of employment contracts the nurses are offered when they come out of the University of Canberra and are employed at the Canberra Hospital.

Mr Corbell: I ask the Chief Nurse to assist you on that.

THE CHAIR: Excellent.

Mr Corbell: While we are waiting for Ms Croome, Ms Fitzharris asked about the total number of beds as a result of the ED expansion. They will deliver up to 21 additional beds. The total number of beds in the ED will increase from 54 to 75.

Ms Croome: Thanks very much for the question. The University of Canberra new graduates are offered the same employment contract as any new graduate from across Australia who applies for a position, and that is a 12-month contract. There is very good reason that we do that—and it is actually in line with every other state and territory in Australia—and the reason we do it is that we ran the very likely risk that if we did not offer 12-month contracts all new graduate nurses who were employed would choose to stay on. While that is not a bad thing, it means that all of our positions become consumed by nurses who have continuing employment so that we would eventually run out of opportunities to offer positions to new graduate nurses. The considered view of all chief nurses across Australia is that it is far better to offer a 12-month program of facilitative clinical practice that prepares the new graduate nurse for opportunities elsewhere than to run out of places altogether.

One of the things that the University of Canberra are doing, and other universities as well of course, is increasing the number of student placements on the basis that there is a predicted shortfall, ultimately, in relation to the health workforce. With the numbers of students who are graduating, that number of positions are being requested and we cannot meet that as a small jurisdiction. In fact, neither can the larger jurisdictions, for that matter. Twelve months is a great opportunity for them to get a transition to practise, to get the skills that prepare them for re-employment at Canberra Hospital—and we certainly do re-employ them after 12 months if we have the positions to do so and they have demonstrated their worth—but in terms of the greater good we are preparing them for opportunities wherever they choose.

THE CHAIR: And how do you manage the issues that arise for worker health in regard to these forms of precarious employment where people are on a contract not knowing whether they are going to have a job in 12 months time or not?

Ms Croome: It is interesting because we would have thought that may have an impact on the number of applicants applying to Canberra Hospital and Health Services. In fact it has had the opposite. We had more applications this year than we had any other year. The nurses seem to be very accepting of the fact that they have 12 months employment—and that is a good thing—and if they work hard and they demonstrate that they are good clinicians and they are giving something back to the health team, we snap them up at the end of their 12-month contract and offer them employment on a permanent basis. It certainly has not had an impact on the number of applicants, and that would be the same across Australia.

THE CHAIR: I appreciate that but my question was really about how you manage potential health impacts, particularly mental health impacts, for workers who are on contracts of that nature? Alternatively, your answer may be that you do not think there are.

Ms Croome: I am sorry; I missed that last bit.

THE CHAIR: Alternatively you may think that there are not any.

Ms Croome: I could not categorically say that there were not, but I have not seen any. It is a good question, and it is food for thought and I will certainly look into that. I do not believe that there are mental health issues as a result of offering 12-month contracts to new graduate nurses and midwives. As I said, it is now across Australia. I am not saying that that is something that we will always do. It is a short-term strategy to deal at the moment with large numbers of new graduate nurses that we are trying to help find employment, and we may reverse that strategy to ongoing employment if and when the need arises. But I will certainly take on board your comments and your question about the impacts on the mental health of new graduate nurses and we will look into that.

THE CHAIR: Mr Wall.

MR WALL: Minister, what is being done to improve emergency waiting times at TCH?

Mr Corbell: The conversation in the questions I was asked earlier, particularly by Ms Lawder I think, points to the processes that the government has put in place. I simply refer you to that earlier series of question and my answers.

MR WALL: Why does TCH continue to have a longer duration of wait times at their emergency department when compared to Calvary?

Mr Corbell: There are some differences between the types of matters that are dealt with at TCH compared to Calvary. I think it is important to point that out. Critical trauma, for example, is going to arrive at the Canberra Hospital. It is not going to arrive at Calvary ED. Aeromedical retrieval and other critical trauma are going to arrive at the Canberra Hospital. There are significant differences, and that does impact on overall levels of demand. But in terms of the other issues at play, I have discussed a number of those in response to Ms Lawder's questions. I simply reiterate those

points.

MR WALL: It seems interesting. I love the data that the department puts up online. If you have a look at the app at the moment, Calvary is currently treating 31 patients in the emergency department and TCH has got 35. They are treating a similar number of cases. Yet in the last four hours 90 per cent of patients in the Calvary emergency department were seen within 68 minutes but those at Woden were waiting for 102 minutes. Similar numbers are being treated.

Mr Corbell: But you do not know what their acuity is.

MR WALL: But one is a far more well-equipped hospital to deal with that level of—

Mr Corbell: But that is not the point. I think you miss the point. You do not know how sick those people are just by referring to the numbers. The point to be made is that the sickest people will be coming to the Canberra Hospital ED, not to Calvary. That impacts on the demands, the workload and the other issues at play at Canberra Hospital ED.

MR WALL: Have the number of presentations in the ACT's emergency departments been consistent with what is happening nationally?

Mr Corbell: I have some of those figures. In what respect? Total numbers? Growth?

MR WALL: Growth would be a good measure. A number of states and territories have made great improvements in the waiting times in their emergency departments. What levels of growth have they been experiencing in comparison to the ACT and—

Mr Corbell: In terms of comparison with other jurisdictions I would have to take that on notice, but in relation to our growth rates the five-year growth rate in presentations at our ED is 15.8 per cent. Over the same period the population grew by around eight per cent. So presentations are growing faster than the overall level of population.

MR WALL: What is that attributed to, if we are having more people coming into our emergency departments disproportionate to the population growth?

Mr Corbell: Again, I referred to a number of these matters in my answers to Ms Lawder's questions. The first is access is to primary health care. That is a factor. We do have lower bulk-billing rates than other jurisdictions. That does have an impact on people's willingness to seek care earlier or their propensity to rely on the public hospital service because they know it is going to be charged to Medicare rather than potentially being out of pocket by seeking care from their GP. That is a factor.

There is no doubt that Canberrans actually love the access and care they receive from the Canberra Hospital. They do select it more than we see in other jurisdictions. So that is a factor. But then there are other factors at play as well. I refer you, again, to the issues I highlighted to Ms Lawder.

MR WALL: Minister, was there a change in emergency department presentations, in the figures, when the walk-in clinic was moved from TCH campus?

Mr Corbell: I would have to take that on notice. Coming back to your earlier question, it is worth adding that changes in the presentation rate are also driven by issues in terms of population and health more broadly in the community. We know that, first of all, we have got an ageing community; the more people you have that are elderly, the greater the number of times that cohort of people seek care and need care because of their age. A rapidly increasing ageing population will seek more care than the same number of people who are younger. That has an impact on presentations.

The other issue at play would have to be lifestyle-related disease. This intersects with age to a significant degree, but not universally. The increases in the presentation of healthcare related incidents that are driven by obesity and related diseases like diabetes, heart conditions and a range of other problems like that are certainly increasing in our population as well. That is why the government is focused very strongly on prevention, to reduce those demands on our health system and improve people's wellbeing by our healthy weight initiative, the whole-of-government healthy weight initiative, and the broad range of programs that are in place to respond to that change in people's health status that sees far too many Canberrans overweight or obese—over a quarter of our population, if I recall correctly. That is a significant factor that has to be addressed.

MR WALL: Just looking at the annual report, on page 48, table 12 shows a really good comparison of the number of patients seen or the percentage of patients seen on time by triage category. For triage category 5, Calvary has seen 91 per cent on time and TCH 81, yet the peer group average—my understanding is that that is comparing apples with apples; it is similar type hospitals—

Mr Corbell: Sorry, which page are you on, Mr Wall?

MR WALL: Page 48.

Mr Corbell: Thank you very much. Sorry; I interrupted you.

MR WALL: That is okay. As I was saying, in triage category 5, TCH is seeing 81 per cent of patients on time for 2013-14 and Calvary 91 per cent, which is meeting the national peer group average of 91 per cent. There is a comparison there, particularly in the peer group, showing what similar hospitals are capable of doing on average. Why do we continue to be trailing when it comes to TCH?

Mr Corbell: Again, I refer you to the issues that I addressed at some length in response to Ms Lawder's questions. But let me be very clear. As health minister, I am not in the business of making excuses for the issues with timeliness and access for certain category types at the emergency department. I want to see those problems fixed. That is why I have worked closely with my DG and the directorate as a whole on developing new strategies to address them, to address these deficiencies. I believe they can be addressed. The advice to me and the government is very clear on this point. It will need a concerted effort, led by our clinicians, our nurses and other health staff, but I am confident it can be done and I will be making further announcements about that in due course.

MR WALL: Further to that, table 12 only has the figures up to 2013-14. This being the new report for the year 2014-15, why is the reporting year's data not in there?

Mr Corbell: Sorry, could you just clarify your question, Mr Wall?

MR WALL: Just looking at table number 12, we have got the financial years 2010-11, 2011-12, 2012-13 and 2013-14, but there is no 2014-15.

THE CHAIR: Isn't that presented in the table above, minister?

MR WALL: Or is that extrapolated out above?

Mr Corbell: You do have the 2014-15 year performance for—

MR WALL: Is that just extrapolated out in a different format in table 11?

Mr Corbell: I would imagine that probably the difference between the two is that we may not have the peer group average for the most recent financial year.

MR WALL: Okay.

Mr Corbell: I would imagine that is probably the reason why it is presented in a slightly different format. Clearly, we do have the performance data for our own hospitals, both individually and collectively, and we do have the overall national average, so we report on that.

MR WALL: Thanks.

MS FITZHARRIS: On page 48 it refers to the health pathways that you launched on 13 April this year. Could you tell us a bit more about that project?

Mr Corbell: Health pathways was a project that was funded through what is now the public health network, the previous Medicare Local. Health pathways was about establishing clearer, up-to-date, contemporary referral pathways for GPs when it came to the referral of their patients to specialists for the assessment and treatment of certain conditions. The establishment of health pathways allows GPs to access online, contemporary, up-to-date referral guidelines for a whole range of conditions. It allows for those conditions to be drilled down into and reminds the GP how they should go about making that referral and the types of questions they need to be asking—who is available to take the referral, not just within the ACT but in the broader region. That was done in partnership with the then Medicare Local and the broader region. It is a voluntary piece of information, if you like, or access to a database, that GPs can take up to improve their referral practice and to make sure it is contemporary and best practice. It is a good initiative and ACT Health is supportive of it.

MS FITZHARRIS: Did it come about because there was a view that there were too many referrals, not enough referrals or referrals to the wrong specialists?

Mr Corbell: I think the key issue was that some GPs dealt with referrals more often than others in terms of specific matters. The objective was to have a more consistent

referral framework in place that GPs were collectively seeking to adhere to. It was about improving knowledge gaps for those GPs where those existed and making sure that information was kept up to date for those GPs in relation to referrals. For example, access to specialists, who is treating and who is available in terms of specialist assessment, does change, and sometimes it is a challenge for a GP practice to keep all that up to date. Health pathways is delivered by what is now the PHN, the public health network, and they do that work. They keep the information up to date; they keep the referral guidelines up to date. That takes pressure off the GP, saving them from having to do that themselves on top of everything else they have to do, and it makes sure that referral pathways remain contemporary and best practice.

MS FITZHARRIS: I know it is early days, but do you know what the take-up by GPs has been?

Mr Corbell: It is not a service that is delivered directly by ACT Health; it is delivered by the PHN. We would have to get some information from PHN for you.

MS FITZHARRIS: Thank you. Apart from the change in the name, has there been any change in the type of service or the type of partnership ACT Health has with the network?

Mr Corbell: No, not here in the ACT. We have been fortunate that the older Medicare Local was successful in the tender process to become the new public health network, so all of the existing infrastructures simply shifted over. That is good for us. In other parts of the region around us, there have been changes in who is in control of the activities of the previous Medicare locals, now known as the public health networks. For example, that has occurred in the region immediately around us. That means building new connections in collaboration with those new organisations. That is well and truly underway. And from day to day we maintain a very good relationship with our PHN.

MS FITZHARRIS: Are they all fully funded by the commonwealth—the networks?

Mr Corbell: Yes. We will collaborate with them on specific projects or activities, but their base funding is commonwealth funding.

MS FITZHARRIS: Thank you.

THE CHAIR: Ms Lawder.

MS LAWDER: Thanks. I have a quick supplementary before I move to my substantive question. On health pathways, does that referral pathway also address some of the Auditor-General's recommendations for the GEHU about the issues about referring it to specialists there? Or have you not yet addressed those?

Mr Corbell: The government has put in place a comprehensive response to the Auditor-General's report into gastroenterology and hepatology. But health pathways is—it may be a related issue, but it is not directly related.

MS LAWDER: We will wait for that. I want to move on and talk about the Canberra

Hospital tower project. What is the status of that?

Mr Corbell: Tower block?

MS LAWDER: Tower block, yes.

Mr Corbell: Building 1 or building 2/3?

MS LAWDER: What is the status of that project?

Mr Corbell: The government is completing an assessment around demand that will inform our decision making about new health infrastructure. That information will inform the government's decision making about the future of work in relation to building 2/3, which is the site of a proposed or possible second tower block at the Canberra Hospital.

MS LAWDER: So it is not permanently shelved?

Mr Corbell: No. The government's position is that, obviously, infrastructure should meet demand. As I have indicated at previous public hearings, the government has requested that further work be done on the business case in relation to that infrastructure, particularly in regard to our analysis of demand, the utilisation of the existing infrastructure, condition audits of the existing infrastructure, and all of those issues currently being finalised by ACT Health in conjunction with the treasury.

MS LAWDER: How much has been spent on the tower block project to date?

Mr Corbell: I would have to take that on notice, but I am happy to provide a figure for you.

MS LAWDER: Thanks.

THE CHAIR: Is that work within the Canberra Hospital master plan study or is it a separate piece of work?

Mr Corbell: That is a separate piece of work.

MS LAWDER: Related to that, with the master plan, last year there was $524,000 spent on the multistorey car park which opened in 2011. What was that money spent on last year?

Mr Corbell: Are you referencing a particular point in the annual report?

MS LAWDER: Pages 204 and 205, the capital works table. It says that $524,000 was spent on the multistorey car park.

Mr Corbell: This is at table 52?

MS LAWDER: Yes.

Mr Corbell: I am just trying to find that for you. Is this page—

MS LAWDER: Page 205, about halfway down.

Mr Corbell: Could you could just point me to the part of the table you are referring to?

MR WALL: The 10th point up from the bottom on 205.

Mr Corbell: Thank you very much.

MS LAWDER: "Completed Projects", under "New Multistorey Car Park TCH".

Mr Corbell: Mr Carmody?

MS LAWDER: I just wondered, given that it opened a few years ago, what the money has been spent on.

Mr Carmody: Just looking at that table, looking at the numbers, I would be fairly confident in saying that it is probably the financial completion of the project. If you look at previous years, there were some big chunky expenditures, tens of millions of dollars. That $500,000—that is what I would be guessing it is, but I can certainly come back and confirm that.

MS LAWDER: It is now complete? There will be no more money spent?

Mr Carmody: Correct. On the car park, it is correct; it is complete, and the expenditure has been paid out. There is a new project coming down the track to go onto that project, which is the installation of a photovoltaic electricity supply system, but that will be a future new work.

MS LAWDER: Was the car park project on track budget-wise?

Mr Carmody: Yes.

MS LAWDER: It was not overspent?

Mr Carmody: Not that I am aware of, no.

MR WALL: Can I ask a quick question on that? The annual report has got the original project value at $29 million. You have the revised project value at 42.7. What was the reason for such a substantial cost change?

Mr Carmody: I would have to take that question on notice. I do not know.

MR WALL: Can you honestly say that it was delivered on budget when it has changed from 29 million to 42?

Mr Carmody: To the best of my knowledge, yes.

MR WALL: Okay.

MR HANSON: I can give you the answer, if you like. The original plan for the car park was at the northern end of the campus and they had to move it to the Hindmarsh end of the campus. The scope of the project changed from one end of the campus to the other, and that in part was the reason for the increase in costs. It blew out to 45 million and then got reduced to 43 million. If that helps?

THE CHAIR: Thank you. Mr Hanson.

MR HANSON: Back to the University of Canberra public hospital, minister: the original number of inpatient beds was going to be 200. That is now 140. In the design of the hospital, is the footprint going to allow capacity for growth?

Mr Carmody: As you would be aware, the site for the UCPH, as we regularly refer to it, is quite a large site for the facility that is being provided on it. If it was decided that it needed to be expanded, there would be every opportunity to do that.

MR HANSON: Given that the original scope was for 200, it is not being built with the services to build that capacity? It is just going to be that if we need to build it in the future, we will?

Mr Corbell: I think we have to be clear. The original scope was up to 200. The government has determined what the bed mix is between overnight places and day places for day treatment, and that is reflected in the physical fabric of the reference design. Obviously within the physical fabric of the reference design—if you wanted to increase the number of overnight places there would be the potential to do that within the physical fabric to some degree, but it would mean a reallocation between overnight and day treatment areas.

MR HANSON: In terms of the modelling that you have been doing for demand to look at where that is tracking, you have been looking at infrastructure, so the University of Canberra public hospital. There was a body of work done. There was a committee hearing and there was a study into the future Canberra Hospital options. There was a lot of demographic work done that then laid out where the growth was going to occur. The government said back in 2012 that there were going to be 200 new beds at Calvary and 200 beds at the University of Canberra public hospital in terms of inpatient beds. Has something changed in the modelling or has something changed in the plan? When was the decision taken not to do that?

Mr Corbell: You mean in relation to UCPH?

MR HANSON: UCPH and also Calvary, I guess, to an extent.

Mr Corbell: I am not familiar with what you are referring to in relation to Calvary, but in relation to UCPH, in the final documents the specification around capacity was up to 200 beds. The government took further advice, particularly from experts, in relation to contemporary rehabilitation treatment. That led to a change in the mix of treatment spaces between overnight and day treatment spaces. The overall capacity is actually well over 200 in terms of treatment spaces but, based on the advice we have

received about the mix of how many people you need admitted and the number of people you treat without needing to admit for an overnight stay, that has informed the final design of the facility.

MR HANSON: I remember that in 2007 in a committee here you said that after cutting the number of beds in the jail the jail would have capacity in its current configuration for 25 years, and I think everybody understands that that has not been the case. But we are not repeating history here where you have cut the number of beds at the hospital and then said it is going to have sufficient capacity? What is your evidence for that? Can you demonstrate that it is going to have sufficient capacity?

Mr Corbell: The facts are very clear that UCPH has a capacity to treat over 200 people a day. I know you want to keep litigating this argument about overnight stays versus people who stay for less than an overnight stay, but what I am focused on—and I think it is what the community is focused on—is how many people can actually get the treatment they need. The capacity of the UCPH in that respect is unchanged from what the government initially committed to.

MR HANSON: I think what the community is also interested in is whether the government is building infrastructure that is going to be full the day it opens, as we have seen with a number of construction projects. I am just trying to get the evidence that says that you are not going to open the University of Canberra public hospital with 140 inpatient beds and find that is not sufficient and come back to retrofit and rebuild, which can be problematic.

Mr Corbell: The government has released all of the analysis it has received on this issue. It is publicly available. I tabled it in the Assembly earlier this year. I encourage you to go back and have a look at that, because it is all—

MR HANSON: No—

Mr Corbell: Hang on; let me answer your question. It is all on the public record. Let me also be very clear. The total capacity is over 200 in terms of treatment spaces to accommodate people on a day-to-day basis at UCPH.

MR HANSON: I will just go back to that point—

Mr Corbell: You can have an argument about whether they should all be capable of being admitted overnight, but this is not a tertiary treatment hospital, and not everyone needs to be admitted overnight. So you have then a decision to make about your mix of the capacity that you need to provide for people who are admitted overnight versus people who are admitted for less than a full 24-hour period. That is essentially what this argument is about.

MR HANSON: Sure. I am making another point—

Mr Corbell: What I would say to you—

MR HANSON: I am asking another question, minister.

Mr Corbell: What I would say to you, Mr Hanson, through you, Mr Chairman, is that I think Canberrans want to know that when they need care, they are able to get care. If you only need treatment for six hours during a day, it is pretty silly to put you into an overnight bed. There are other ways of managing that demand.

MR HANSON: The studies that were released that you referred to were really based on existing bed numbers and existing capacity and existing demand. The point I am going to is that you referenced a range of studies that you had done to anticipate demand. It may be that 140 beds is the right number for today. The point I am getting to is that if you are building infrastructure you should build capacity for the future. Where is the evidence that you have aligned the capacity of the University of Canberra public hospital with the demographic analysis and demand studies that you have done?

Mr Corbell: I will ask Ms Feely to elaborate a little on this issue for you, recognising that the analysis the government has undertaken in relation to overall health infrastructure requirements is yet to be considered by the government as a whole. I am not in a position to reveal all of that at this point in time, but Ms Feely can give you some sense of the work that has been undertaken.

Ms Feely: Putting it also in the context of the ED and population growth, as a team we are going back to what I call the fundamental basics in relation to models of care. For example, we were reviewing our population projections under 1.3 and are now doing the work to move to 1.4. We are looking at every element of our clinical delivery. The new facilities that are coming online will be the subject of extensive work in relation to the models of care and how we transfer people. It is about the right place concept.

We are going to make sure that people who are in the tertiary beds need to be there and that, with a model of care approach, we are moving as many people out of the system from a tertiary context into rehab or non-tertiary centres. In doing so, we are going to be working very closely with a lot of our private hospitals. We are looking at the ACT as a whole in relation to what facilities we have to make sure that everyone in the ACT and its region can get timely access to services.

I hope that answers your question. We do need to update our population figures. The team sitting over there are the ones who are doing the work to upgrade and update our population figures, because that is actually one of the key drivers for us to determine what will be coming to the ACT and from the region to 2030.

MR HANSON: I think that was last done in 2006 in a substantive way. Clearly, the demand has been different from the projections.

Ms Feely: Yes. That was my concern when I first got here and looked at that. We needed to update this as a fundamental tool for us to start working out forward plans.

MR HANSON: Have you looked at what, I suppose, went wrong? I am not trying to be critical. Did you look at what the difference was between the projections that then did not match the reality? It seems the reality exceeded the projections. Did you look to see what that discrepancy was so that it can be factored into those studies this time?

Mr Corbell: We are simply drawing on the most contemporary modelling capability to make these assessments. Obviously those capabilities change over time and the assumptions that underpin them change over time. That can have an impact on the numbers. Mr Thompson can elaborate.

Mr Thompson: The last modelling was done in 2012. We have recently undertaken an exercise to look at what the model projected would be our activity and our demand, and what the actuality was. It was actually very close. The actual was slightly under the modelled prediction in terms of demand projections. So we have got quite a high degree of confidence in the accuracy of the projections.

MR HANSON: Are you projecting out to a certain date to inform this infrastructure build? I assume that you would want to be going out a decade or more.

Mr Thompson: Yes. The update that the director-general has just been talking about is looking to 2030, so we will have more than a decade's forward projection.

MR WALL: Which population are we looking at? Is it just the ACT's?

Ms Feely: It is ACT, but we also need to take into account the region, because a lot of the people that come in to use the facilities in the ACT are not ACT residents. Again, as we are looking at our models of care, our pathways and all our clinical pathways, we are actually making sure that we take into account the wider region. We have a responsibility to deal with people who are not just ACT residents, although the HAAS is focused on ACT, and regional New South Wales data are required.

MR HANSON: What was the number of overnight bed admissions? It was about 30 per cent. Is that consistent?

Mr Thompson: Bed days taken up is 24 per cent, but the actual number of admissions is a bit lower than that. That reflects the fact that there is generally a higher acuity of New South Wales patients.

MR HANSON: Is that a reduction, the 24?

Mr Thompson: It is a slight reduction. It is a very slight reduction over the last five years. The bed number has been very stable over that time.

MR HANSON: I beg your indulgence, Mr Chair: the use of the private system—you referred to that—are you able to expand on what you are looking at? I am encouraged to hear that that is happening, but can you explain how you are looking to incorporate the private system into your planning?

Ms Feely: It is early stages yet. There is no time frame here. For example, in relation to joints—and you can jump in here if you wish—we are working at making sure that at public sector rates we can use the private hospital facilities at John James to put as many of the joints as possible through the private system so that public patients are being treated in a very timely manner.

MR HANSON: That is already happening, is it?

Ms Feely: Yes, but that is the sort of concept of trying to break the walls down by saying that as an ACT health system—

MR HANSON: You have purchased beds and purchased facilities?

Ms Feely: Yes. The issue is always going to come down to cost and availability of clinicians. For example, we are having a meeting next Tuesday night, I think it is, where I have called on all CEOs, key leaders, whether it be consumers, private hospitals or universities, to come coming together to talk about how we can work more cohesively as one ACT health system. The sort of discussion I want to put on the table is to understand very carefully and clearly what is the excess capacity in the private system and then, with them and other people here, to look at whether or not there are opportunities for us to utilise the private hospital system at public sector rates—it is not going to be any more expensive—to actually increase access for the people of the ACT and the region.

So far the discussions have been very positive. It may not be the right expression, but ACT Health only needs to break some of the barriers down in relation to how we have traditionally worked and start looking at the system as a whole, rather than just a public sector system. And I am very encouraged by the positive feedback that I have had from the chief executives of the private hospitals who are very willing to look at options with us.

THE CHAIR: Members, we are going to stop acute services there and move to the next output class, mental health, justice health and alcohol and drug services. Minister, on page 64 of the annual report it refers to a new initiative to undertake the early identification and treatment of children presenting with emerging illnesses and disorders. What sorts of emerging mental health illnesses and disorders are we talking about, and can the committee hear some more about that, please?

Ms Bracher: If you could repeat the page number so that I have got the exact—

THE CHAIR: Page 64 of the annual report.

Ms Bracher: Thank you. With regard to the question that you asked around emerging mental illnesses—they are emerging and there is no diagnostic group that we could describe in that group—it is children who present with anxiety disorders, a differential diagnosis with learning difficulties, early signs of depression. And we want to work with schools very closely to highlight those children and provide the children and their families with as much support as possible.

THE CHAIR: Given that they are emerging mental health disorders, what sort of treatment are you providing and how do you know what sort of treatment you should be providing if you are not sure what they are?

Ms Bracher: The child and adolescent psychiatrists try very hard to use non-medication modalities of care. That is really around family support, family dynamics, behaviour modification. There are a lot of psychological therapies that go on in that

space. And family therapy is by far a large component of the care. Child and adolescent clinicians also work very closely with teachers to support the teachers and carers to support the child in place.

THE CHAIR: You mentioned you are working with schools.

Ms Bracher: That is right.

THE CHAIR: Government and non-government schools?

Ms Bracher: At this point in time we are working very closely with the education directorate within the ACT government but certainly children that attend non-government schools have exactly the same access to our Child and Adolescent Mental Health Service as any other child in the ACT.

THE CHAIR: This initiative also talks about "in-reach to primary health services targeting children". What does that mean?

Ms Bracher: In-reach into primary schools is what that means.

THE CHAIR: So it is not primary health services, because that is what it actually says in the report?

Ms Bracher: I am sorry; that must be a typographical error.

THE CHAIR: The primary schools, which is what we just talked about effectively?

Ms Bracher: That is right.

THE CHAIR: A supplementary, Ms Fitzharris.

MS FITZHARRIS: Would you be able to give us a little more detail about the work that you are doing with the directorate and in schools as well?

Ms Bracher: That is actually an initiative in the 2015-16 mental health growth package. We are working with schools to have two senior clinicians in place and liaising in the schools to do that work.

MS FITZHARRIS: Two across the city?

Ms Bracher: Yes.

MS FITZHARRIS: And they will work with the existing counsellors in schools?

Ms Bracher: That is right. It is to provide an escalation point for the counsellors that are already embedded within the school staffing system.

MS FITZHARRIS: And is it usually to come in and treat children once they have been diagnosed as having an emerging mental health issue or is there a preventative aspect to the work as well?

Ms Bracher: We are very clearly targeting a preventative function with those staff. Two clinicians cannot treat all of the children in the ACT. Part of the role is also around advocacy and facilitation into our Child and Adolescent Mental Health Service if the children need to enter into secondary and tertiary level care.

MS FITZHARRIS: Do you have any sense of the trends—I am sure you do—and what are the trends in child mental health in terms of the types of conditions you are seeing, the age of children, the gender of children?

Ms Bracher: Over the last few years we have been trying to move our interventions into that early intervention space and we are finding that younger and younger children and their families are needing support from our child and adolescent service. We have enhanced our perinatal service for just that reason for families with very young children, and this initiative is really around focusing on primary school aged children as well.

THE CHAIR: The new bill that came in, the Mental Health (Treatment and Care) Amendment Bill 2014, required some training for staff. Could you give us some detail about what that sort of training involved?

Ms Bracher: There will be a large component of training for different groups of people that use the Mental Health Act and come under the Mental Health (Treatment and Care) Act. Obviously the psychiatrists who have a high-level role in implementing the Mental Health Act will have very targeted training, and we have already started that, on supported decision-making in particular.

Our mental health officers, who are also delegates of the Chief Psychiatrist under the Mental Health Act, will have a higher level of training; then there will be a second tier of training, if you like, for our general mental health clinicians and the health professionals that work across the health system. In the emergency department we are working with the Capital Health Network around training for GPs.

We are working with the Ambulance Service and the police service around the training that police officers and ambulance officers will need with regard to the new act. And then there will be some very general information sessions for community organisations and the public around the new provisions in the Mental Health Act.

MS FITZHARRIS: Can you tell us when the detail will be available about that new initiative?

Ms Bracher: The one in the schools or the Mental Health Act?

MS FITZHARRIS: The one in the schools.

Ms Bracher: We can provide that to you now. We are developing that service. We have recruited the staff for that service. The appropriation was available from 1 October. We have staff in place and they are developing the guidelines and the model of care, if you like, with the schools currently.

MS FITZHARRIS: Potentially for the 2016 school year you will see that rolling out in schools, you hope?

Ms Bracher: Yes. That is our anticipation. There will be some preliminary background documentation and work with the schools, and pathways and clarification, but absolutely.

MR WALL: What changes or steps have been taken in a health sense to cope with the additional number of prisoners that the AMC is going to be able to handle?

Ms Bracher: We provide two big services at the AMC through our justice health service. One is a primary care service, which is a GP-led service, and a community nurse-led service as well. We have put some additional resources into that team to support the nurses to do all of the induction assessments for the increasing numbers and increasing clinics. We have also worked closely with Corrective Services to do some satellite clinics within the prison environment so that not all of the detainees need to come to the health centre for health care.

The second team that we have out there is our forensic mental health team, and they are a secondary referral team. Not all of the detainees at the prison see our forensic mental health service. But two years ago we increased the staffing profile of the forensic mental health team and we are certainly looking to increase that further and work closely with Corrective Services around the role of the custodial staff in providing wellbeing, care for the detainees and our role in providing secondary level mental health services.

MR WALL: Will there be any expansion of the services that are offered as additional accommodation comes on line at the AMC?

Ms Bracher: Expansion in terms of numbers ultimately to deal with a growing population out there?

MR WALL: Yes, in beds and cells that are being constructed.

Ms Bracher: That is right.

MR WALL: What additional health services are going to need to be provided to complement—

Ms Bracher: As part of this year's mental health community growth budget, in the 2015-16 budget there is provision for an additional eight FTEs, I think it is, in our justice health service, with an increasing number in 2016-17. That was modelled on the additional beds in 2015-16 and then 2016-17 that Corrective Services gave us for their planning.

MR WALL: I do not know if this is a question best directed to you or to corrections but has any work or assessment been done as to whether it is more cost effective to provide a broader range of health services—be it dentistry or x-ray, ultrasound and the like—at the prison site versus transportation to TCH or another facility?

Ms Bracher: We did some of that analysis at the commissioning of the Alexander Maconochie Centre and then about 18 months after the centre opened when we had some numbers around how many people were being transferred. The decision we took at that time and the advice that we provided to the Minister for Health at that time was for a community equivalent service in the prison and transferring people into the tertiary sector should they need it. The primary rationale for that was the expertise that would be needed to provide higher level skills like radiology in a community setting and the economies of scale around that.

We also looked at, at the time, providing 24-hour health care—inpatient care at the prison—and we very clearly, in collaboration with Corrective Services, came to the view that we could not staff an inpatient health service at the prison because the numbers of people with each diagnosis would be very small and we could not guarantee the skill required for staff.

MR WALL: The other question I have is about the statement in the annual report on page 61 through to page 62 under the banner of services provided by the divisions. It lists "Adult Mental Health Services", "ACT-Wide Mental Health Services" and then a number of areas. I have a couple of questions as to why certain services are listed under "Justice Health Services". One is "Perinatal Mental Health". Why is that categorised as a justice health service?

Ms Bracher: I think that there has been an editing error here. There should be another highlighted heading, for our Child and Adolescent Mental Health Service, and that should be that purple colour. All of those areas—"CAMHS", "Dialectical Behaviour Therapy Program" and "Perinatal Mental Health"—are part of our CAMH service.

MR WALL: That makes sense.

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Minister, I know that in this year's budget there was an announcement for a community mental health team in the Gungahlin health centre; we covered it in estimates as well. I was wondering if you could give us any further detail about that team—whether there has been any recruitment, what they will be doing.

Ms Bracher: The team was established in August this year and we have a consultant psychiatrist out there now, a full-time psychiatrist. We have recruited our team leader for that team and we have a number of the staff, the mental health clinicians, already recruited, but we are in the process of recruiting the full team.

MS FITZHARRIS: How many people will make up the team when it is fully—

Ms Bracher: It will be about eight or nine full-time equivalents.

MS FITZHARRIS: How will people access the service? Will they be walk-ins, referrals, a mobile service across the region?

Ms Bracher: We have modelled that team on the referral process for all of our

community mental health teams so that the processes are the same. All of those methods that you have suggested—walk-in or referral through our crisis team, transfer and referral out of our inpatient units—are all ways that people from the Gungahlin region can access it. GPs as well.

MS FITZHARRIS: What is the connection with child and adolescent mental health? Is this primarily for adults, the team in that centre?

Ms Bracher: That is correct; it is an adult mental health service.

MS FITZHARRIS: Will it have it relationships with the other community sector providers? I am particularly thinking of Common Ground now being in Gungahlin where there is a particular connection there.

Ms Bracher: That is right. For any people that are living in Common Ground that need our secondary mental health service, that will be the team that provides the care there. We have worked very closely with the Common Ground management team for us to be embedded in their service and for them to be embedded within ours.

MS FITZHARRIS: When do you expect the team to be fully staffed?

Ms Bracher: Certainly in the next few months. Probably somebody will leave and we will need to recruit that vacancy.

MS FITZHARRIS: But are the services starting to become available in the centre now?

Ms Bracher: That is correct. For the record, I think it is important to note that when Gungahlin health centre opened a number of years ago, we provided secondary level mental health services from there. They were outreach from the Belconnen mental health team, but this is now an independent team in its own right.

MS FITZHARRIS: And the hours of the day that the team is available?

Ms Bracher: Standard business hours—8.30 till five-ish.

MS FITZHARRIS: Is that the opening hours of the centre?

Ms Bracher: I believe so.

MS FITZHARRIS: I think it opens earlier in the morning for pathology, but possibly that is only for pathology.

Ms Bracher: Okay.

THE CHAIR: Ms Lawder.

MS LAWDER: I will pass to Mrs Jones in the interests of time.

THE CHAIR: Mrs Jones.

MRS JONES: There have been various reports around the traps about assertions of gaps and a lack of qualified mental health nurses in our system. Do you have a statistic on that on a monthly basis or an average statistic? How is that statistic collected within the directorate?

Ms Bracher: We provide monthly data to the Chief Nurse around our vacancy rates across our division. That is discussed in the DCC, the directorate consultative committee. So we report those there.

MRS JONES: Could they be provided for the last two years on notice to the committee?

Mr Corbell: I will take the question on notice, Mrs Jones, and clarify whether or not we can provide that.

MRS JONES: Okay. Also, the assertion is that the shortage might be 17 full-time equivalents in general terms a lot of the time. I know we have had conversations before about the difficulty of attracting staff into this area. There are a couple of things about that that I think the community is probably quite interested in. One is what is being done to recruit and maintain our mental health nurses within the ACT. Secondly, how is the risk associated with the use of qualified nurses who are not mental health nurses only—those whose profession is nursing rather than mental health nursing—being managed? Also, is there a confidence that when the new unit is built we will be able to staff it?

Ms Bracher: I might have to ask you to repeat some of the questions, but in relation to the first one with regard to recruitment, with our HR area we are working through a recruitment package to bring on line a number of staff that are across all of the discipline groups, including mental health nursing, so that we are looking to recruit nationally and potentially internationally for key staff. We work very closely with the universities. We have a post-doctorate nursing program, a registrar training program and a psychology internship program within our division that are around supporting the development of higher level mental health skills. As part of the workforce development for the secure mental health unit, we have eight or 10 scholarships for forensic mental health care, which are for nurses and psychologists in that space. We are about to offer some scholarships to our support staff that are at a certificate IV level, at the—

MRS JONES: To push them up?

Ms Bracher: Yes, to push them into mental health care and alcohol and drug care at the cert IV level. That is what we are doing about recruiting and growing our own staff in that space.

MRS JONES: The next bit was about managing the risks of the not specifically mental health trained staff that are regularly in our mental health units and systems.

Ms Bracher: A proportion of our staff do not have specific mental health skills. We do have training programs and orientation programs that are quite clearly around

supporting staff in those spaces. Particularly in the inpatient areas, we do PART with our staff, which is around aggression and response to aggression and violence in the workplace.

MRS JONES: Just on that, are there, nonetheless, staff in the facility who have not done that training when you are using nursing services to fill gaps and so on?

Ms Bracher: Are there some staff that have not done that training? There probably are in terms of their cycling into and onboarding through our service.

MRS JONES: Do you have a limit to the number of those people on per shift?

Ms Bracher: We try very hard to roster our shifts so that the skill mix is good.

MRS JONES: Is there a number that you work with, a percentage?

Ms Bracher: No. We do not have a number.

MRS JONES: And the final part of the question was: are you feeling confident or do you have some assurance that the new unit will be staffed appropriately?

Ms Bracher: Some of the initiatives that I described earlier are clearly directed at bringing into the ACT highly skilled clinicians to work in our service generally and specifically in the secure mental health unit when it opens.

MRS JONES: Are you tracking the outcomes of those things to know that you are going to have enough? Or is it just that you are generally pushing in that direction and we are hoping that we get there?

Ms Bracher: We are poised, if you like, to do a recruitment process around those key staff. We obviously do not want to bring them on board too soon before the unit—

MRS JONES: But I meant the result of the actions you outlined that you are taking to increase the pool. Are you measuring the results of that, or will the results just be measured by the recruitment outcome?

Ms Bracher: There will be some recruitment outcome measures. With regard to your specific question about outcomes of training those staff, we are not specifically measuring that, other than to—

MRS JONES: With scholarships, for example?

Ms Bracher: Other than to say that if somebody does a scholarship program through Griffith University, for example, we are assuming they will come to us with post-graduate skills.

MRS JONES: Yes, but that is based in the ACT. So you assume they will come into the system here?

Ms Bracher: Yes.

THE CHAIR: Mr Hanson, a question?

MR HANSON: Minister, yesterday, or whenever it was—it is a bit of blur, is it not?—we had some conversation about ice with your Attorney-General's hat on, and we said that we would come back and revisit this with your health hat on in terms of what specific actions the Health Directorate is taking to combat the scourge of ice. Can I invite you to outline that for the committee?

Mr Corbell: Thanks, Mr Hanson. And as I indicated in my earlier answer to you during the justice A-G's portfolio, the government's response on issues related to the use of crystal methamphetamine is very much a health-focused response, recognising it is first and foremost a drug addiction and, therefore, a health response matter. I provided some advice to you earlier about the $800,000 in additional funding for drug and treatment support services. Overall, I can indicate that we provide funding to the level of $17.2 million for drug treatment and support services across the board in the ACT, including for information; education; counselling; support and case management; withdrawal rehabilitation, both residential and non-residential; peer support; pharmacotherapy; sobering up; and police and court drug diversion.

In terms of the additional boost in funding of that $800,000, ATODA received $115,000 to increase its capacity and assist services to ensure interventions are accessible for those people experiencing problems with methamphetamine or crystal methamphetamine use. The balance of $95,000 each has been allocated to six non-government organisations to increase their capacity to treat patients and reduce their waiting times. CAHMA will receive $115,000 for the ongoing work they are doing with the excellent naloxone program which is helping to save people's lives.

Whilst the total number of people using methamphetamine is relatively unchanged, what has happened is that the use of methamphetamine has shifted to this crystalline form, or ice as it is known, and that is presenting some particular challenges. According to the national household drug survey, the shift in use from the powdered form of the drug to the purer crystalline form has been 50.4 per cent in 2013 from 21.7 per cent in 2010. In the ACT the number of people reporting recent use of methamphetamine for non-medical purposes increased to 2.2 per cent in 2013 from 1.1 per cent in 2010.

MR HANSON: Just on the $800,000, when I looked at the breakdown of that, I could not see much, if anything, that was specifically targeting ice; it seemed to be generic drug and alcohol. Some of it was specifically targeted towards opioids, but in terms of education, research and treatment specifically for ice, how much of that $800,000 was for that?

Mr Corbell: There was funding for programs to provide support for people with drug addiction. Those NGOs are dealing with an increased number of people presenting with ice-related matters, so the funding to them allows them to meet that demand. We are not saying to them, "You can only use this money in relation to ice." We are increasing their overall capacity, but what they are experiencing on the ground is an increased number of people presenting with ice-related addiction problems. Therefore, this gives them the capacity to deal with that problem.

MR HANSON: Sure, but a chunk of that money was for naloxone, for example, which is for opioids, is it not?

Mr Corbell: Naloxone is for opioids, but we are seeing multiple drug use. Opioids are being used sometimes by users to counter the impact or the effects of ice use. With that comes an increased risk of overdose, and, therefore, the use of naloxone is helping to address that problem. These are co-related drug-use issues.

MR HANSON: So your methodology is to give it to the organisations and let them work out what the priorities might be. More globally, though, are you looking at any education programs, community awareness programs or prevention strategies that are specifically targeting ice?

Mr Corbell: We are engaged with the national strategy work in relation to ice use. Our position, though, has been that we have expressed some reservation about some of the awareness campaigns that have been run, particularly by the commonwealth, because we believe there are risks associated with drawing attention to the use of the drug and encouraging more people who might otherwise not do so to experiment with the drug through such campaigns. We approach those types of matters quite cautiously, and we have provided—

MR HANSON: How have you come to that view? Is there research around that?

Mr Corbell: Yes, there is. The national task force has engaged with a broad range of academics in this space. There are mixed views on this question, but there is certainly plenty of public commentary from academics and others in this space who believe that education campaigns do have to be careful in the way they present drug use. Their intent is good, but if the result is to either glorify or identify this type of drug taking as a form of behaviour that is designed to draw attention or to act in some sort of rebellious manner, it could be counterproductive. Our position has been that those are issues that have to be taken into account. We are not against the strategies that are in place, but we do stress caution about glorifying or inadvertently promoting the availability of the drug to people who may not otherwise access it.

Sitting suspended from 2.51 to 3.10 pm.

THE CHAIR: We will recommence and look at outputs 1.3, 1.4, 1.5 and 1.6, public health services, cancer services, rehabilitation, aged and community care, followed by early intervention and prevention. We will start with public health, minister, and talk about the Aboriginal and Torres Strait Islander health unit. What is its relationship with the multicultural health policy unit within policy and government relations?

Mr O'Donoughue: Thank you for the question, Dr Bourke. I have two discrete units within policy and government relations, one of which deals with multicultural health policy issues and the other with Aboriginal and Torres Strait Islander health policy issues.

In the sense of the relationship between them, we have identified in the branch generally that one of the ways we work is to be champions and advocates for a

particular issue across the whole portfolio, and both of these teams I guess are working in that modality. The Aboriginal and Torres Strait Islander health unit has been very successful in trying to make Aboriginal and Torres Strait Islander health everybody's business. Since they came on board fairly recently, the multicultural team have taken that same approach. One of the tangible successes that they can demonstrate is a dramatic increase in the use of interpreting services in the health directorate since the time that they have been on board. There is no other congruent relationship between the teams other than that synergy of a similar way of working.

THE CHAIR: How many Indigenous staff are within the Aboriginal and Torres Strait Islander health unit?

Mr O'Donoughue: We have just recruited our manager, which makes it a total complement of four staff members, of whom two are Torres Strait Islanders.

THE CHAIR: Is the manager position an identified position?

Mr O'Donoughue: No, it is not. There is no position, Dr Bourke.

THE CHAIR: Why not?

Mr O'Donoughue: Why not? There is a tension between designated positions and the necessary skill set that is required for a senior position. With a limited pool of people that can be recruited in the ACT, one always has to balance that tension. We are going to identify a position within our team, but not necessarily the manager position. The manager is at a SOGB level. We think perhaps a SOGC level would be the appropriate place within our structure to have a designated position.

THE CHAIR: Minister, how is the directorate going with its Indigenous employment strategy since last we spoke?

Mr Corbell: I will refer you to the director-general.

Ms Feely: And I might defer to Liesl Centenera, who is head of HR, if that is all right, minister?

Mr Corbell: Of course.

Ms Centenera: With our Aboriginal and Torres Strait Islander employment strategies we have been doing a lot of work in the traineeship space, particularly because the Chief Minister, Treasury and Economic Development Directorate launched their traineeship program. They had not done one before and, given that we have had experience bringing a traineeship on in the past in the Aboriginal and Torres Strait Islander context, we have been helping them out. We have had 14 trainees commence across the service, which has been really fantastic, and we have had one in particular in ACT Health, in addition to our own traineeship program.

We have been looking at the completion rates for not just trainees but other Aboriginal and Torres Strait Islander programs and for Aboriginal and Torres Strait Islander employment generally. Completion of temporary placements and progression

into other career pathways has not been as successful as we would like, so one of the things that we have been looking at in particular is support mechanisms. One is around cultural competency training and also in relation to mentors and buddies, both provided by Aboriginal and Torres Strait Islander employees within the directorate, as well as people who are not Aboriginal and Torres Strait Islanders. We came upon the idea that Aboriginal and Torres Strait Islander staff should have one or both in order to get a holistic, I suppose, experience and understanding of the directorate and the support that they can have.

We are hoping that by providing some more tailored career pathway advice, and by that extra support, we will grow the staff into creating that larger pool, so that they can progress into senior roles, which I know has been a focus certainly of the Aboriginal and Torres Strait Islander Elected Body and other interest groups in this field.

The Ngunnawal Bush Healing Farm and other Aboriginal and Torres Strait Islander-specific projects also produce other opportunities for increased employment for Aboriginal and Torres Strait Islanders, though they will not be direct employees of ACT Health. We will be monitoring that, watching that space very closely in the upcoming year.

THE CHAIR: Within the area of recruitment, are you advertising positions available looking for people within that Indigenous-specific media?

Ms Centenera: There has been a renewed focus on doing that. One of the things that we are finding is that we are not hitting target. We are not necessarily identifying the types of positions. Our timing seems to be out in terms of when we go out to market and attracting a suitable field of Aboriginal and Torres Strait Islander candidates for identified positions.

The trend in the commonwealth recently has been to identify what they call special measures positions as a whole, against a range of classifications. That is something certainly that we will be looking into as a next step. Defence, I think, had an ad in the paper last weekend. We will probably be looking to do the same thing, to try to get that sweep, to see if we can have more success when we go for a range of jobs rather than identifying single positions and crossing our fingers.

We do work with particular Aboriginal and Torres Strait Islander centres to identify candidates—if you like, doing our own headhunting—but it has not seemed to work to date. I am hoping that going for a broader approach will gain us better success in that recruitment.

THE CHAIR: Are you utilising Indigenous people within your advertising or, indeed, promoting the fact that Health welcomes diversity?

Ms Centenera: We are trying to do that. We have had certain contacts that have felt a bit overexposed, I have to admit, because the numbers are not large in ACT Health, and that has been an issue across ACT government, I think.

Another way that we have been trying to indicate that we are a diverse workplace is

through the reconciliation action plan, of which we have just done our next iteration. It was only done last July. We have included in it things such as having rooms that have Aboriginal and Torres Strait Islander names. We have put in more flags, more artwork—having those other aspects of the workplace, reflecting our diversity and that we are a welcoming workplace.

We have acknowledgement to country as a regular part of our general meeting. Again, it is to encourage that feel, encourage the thinking and keep at front of mind that we have Aboriginal and Torres Strait Islander employment and inclusion as a particular focus for ACT Health.

THE CHAIR: How do you convey the message to the Aboriginal and Torres Strait Islander community that Health needs Aboriginal and Torres Strait Islander employees to do its job?

Ms Centenera: It is a continuing dialogue with particular groups and with employees. It is not just a cultural issue with Aboriginal and Torres Strait Islanders. Generally, especially with Canberra being such a small place, word of mouth works here, spreading that message and spreading a positive message amongst staff as well. It is definitely working with those groups and we are gaining the expertise of our representative on the elected body and others that can keep informing what we are doing in this regard.

THE CHAIR: Do you do any auditing of Health Directorate staff as to their attitudes to diversity or indeed Aboriginal and Torres Strait Islander people?

Ms Centenera: No. I will have to take that on board. We are very active in identification. We go out once a year to update details. We really want to know the numbers of Aboriginal and Torres Strait Islanders and what they need. We obviously keep a very close eye on our employment figures. We have several committees within ACT Health at executive level and expanding down to lower levels, but an audit is something that we will certainly have to think about.

THE CHAIR: Within the respect, equity and diversity framework, there is an opportunity perhaps to consider what people's attitudes are and whether more work is required.

Ms Centenera: Certainly we do that in that we have a three-yearly culture survey. It is out at the moment and it closes at the end of November. As part of that, and every year as part of our reporting for the commissioner for public administration workforce profile, we do have to put in quite extensive figures around employment attitudes, people who have completed our cultural competency training and the like. That further step to an audit of those particular things: I will have a think about that. I would not think I would get it to the audit stage.

THE CHAIR: Thank you.

MR WALL: Minister or the director of staff, has the department of health or government more broadly been undertaking many polling or public surveys in regard to health this month?

Mr Corbell: Not that we know of.

MR WALL: I had a constituent contact me who was contacted in regard to a survey that asked a number of questions around the last 12 months: had they visited the emergency department, dentist, GP, specialist; in the last four weeks had they visited a nurse, optometrist, chiro? That is not one of yours?

Mr Corbell: No.

MR WALL: There you go. That is all right.

Mr Corbell: The advice I have is it could be a private health insurance research activity.

MR WALL: Okay. That is all right. It is always worth asking.

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Is there any progress under the healthy weight initiative?

Mr Corbell: Healthy weight is led at a whole-of-government level by chief minister's directorate, but to the extent that ACT Health plays a critical role in that I am sure the Chief Health Officer can assist.

MS FITZHARRIS: Food and beverage marketing is a consultation that is being led by Health?

Mr Corbell: Yes.

MS FITZHARRIS: It has still got a week or so to run, so I suppose there is not much you can tell us at this stage. Are you able to tell us how many people have contributed to that consultation yet or not?

Dr Kelly: Thank you for the question, Ms Fitzharris. As the minister mentioned, the healthy weight initiative is being led out of the Chief Minister's department and was announced just over two years ago by the then Chief Minister and health minister. The Chief Minister is the lead on this, and many of his staff. The way that the initiative works is that it is truly a whole-of-government plan. Under the original plan, there were six specific clusters of groups led by different directorates, and Health continues to lead three of those clusters.

In the plan 19 specific tasks were put forward as work that those clusters could do across government. Whilst each of the clusters was led by a particular directorate, there remains strong engagement across the government in those things. It has grown a lot since then. Part of the plan was to put out an annual report, so the Chief Minister has put out the first of the annual reports. The 2014-15 report has been made public and that shows how the range of initiatives has been working.

One of the six groups being led by Health is what we call the food environment

cluster. That has a series of tasks, one of which was to look at the issue of advertising of—let us not beat around the bush—junk food and drink, aimed at children, and how the ACT government may be able to influence that part of the food environment. Minister Corbell announced that opening last month and, as you say, there is another week or so go on that. Bear with me a moment; I do have some figures, if I can find them, to tell you about how that is going.

MS FITZHARRIS: The Mr Broccoli and Ms Pear, I think. Are they—

Dr Kelly: Yes. They have been at Gungahlin shopping centre. Did you bump into them?

MS FITZHARRIS: I did.

Dr Kelly: There was a lot of selfies apparently.

MS FITZHARRIS: Are they owned by ACT Health?

Dr Kelly: Yes, they are owned by ACT Health, and they are wheeled out from time to time. I am just struggling to find that one at the moment, but I will find it. The way that we have been running the consultation, as I am looking for that and trying to do two things at once, is that we have had a range of—here it is. We had a range of mechanisms whereby people could actually intersect and give their views. We are looking for a very wide community conversation about this issue because with anything that the government does in that space there are trade-offs one way and the other.

MS FITZHARRIS: Yes.

Dr Kelly: There is a specific survey on time to talk, and as of yesterday we had had 114 online surveys completed. We have a series of postcards that we are putting out in some of those community events that you mentioned at various shopping centres around town and in other places. We have had 204 of those filled out; that is an opportunity for people to put their ideas down, with free postage back to us. There has been a social media component to it. There have been 82 comments back to us around that matter through various ways, through email or via Twitter and Facebook. We have had a specific forum organised by the Canberra Business Chamber, with Glenn Keys and Robyn Hendry. Robyn Hendry organised that; they had a facilitator and invited people to come to talk from a business point of view. That was very interesting.

MS FITZHARRIS: Are you able to share anything that came out of that roundtable?

Dr Kelly: There was a lot of engagement more broadly about the issue, the issue being the wide and sort of pervasive availability of junk food and drink, particularly at places where children congregate. There were some very specific questions and answers about advertising of the same. In an audit run by the Heart Foundation a year or two ago we found that that advertising was extraordinarily pervasive and persuasive. Business came through with a number of challenges. One was to look at issues of the pester power of children at the cash register in stores. Whereas some of

the larger supermarkets could provide a checkout that was free of junk food and drink, that would be very difficult for the smaller supermarkets. These are the sorts of things that came from there. But they came with a range of options; the Business council will collate that and give it to the consultation. We have also had quite a lot of articles in the media. Last night we had a meeting with supporting organisations. We have also had a community forum.

MS FITZHARRIS: Sorry, did you say 34 sporting organisations?

Dr Kelly: No: with supporting organisations and also a community forum. We had non-government organisations, including the Multicultural Council, who came to that.

MS FITZHARRIS: Are you getting feedback directly from children?

Dr Kelly: I do not know how many of those postcards might be from children, but that would be terrific, yes.

MS FITZHARRIS: You might be able to tell by the content.

Dr Kelly: We would certainly like to hear from them. I think there is pester power in both directions.

MS FITZHARRIS: Yes. You were talking about population modelling. Obviously the trends that you see for obesity in the future are severe, and there is a lot of work going into that now in terms of population modelling. What assumptions do you make about the current policy having an effect and in 20 years, hopefully, seeing fewer people with obesity? Are you able to factor that into the modelling?

Dr Kelly: That is certainly our aim. In fact, the aim of the healthy weight action plan is rather modest: it is zero growth; it is actually to reverse the upward trend in both children and adults. Some of the trends that have been thought through by people more skilled in this area than I am in the academic sphere are quite alarming. Professor Boyd Swinburne, who was here a couple of weeks ago and gave an excellent talk at our healthy Canberra forum and then later gave some talks on the media, firmly believes that we are heading for 80 per cent of the adult population being obese if we do not do anything about it. Some of the World Health Organisation global figures on that are equally disturbing.

So the ACT is not alone in that; we are part of a global trend which includes the whole of Australia. But really we should be doing much better. When you think about where we live, what we have in terms of the availability of physical activity spaces and that we are a highly employed and well-educated population, we should have lower rates of obesity than the rest of the world. That is really what we are trying to achieve.

In terms of our own modelling, we believe that it is continuing to increase. We are doing work now in preparation for the Chief Health Officer's report next year. One of my roles every two years is to bring out such a report, and that will tell the story more fully over the last couple of years.

MS FITZHARRIS: For the coming year, are there any specific milestones in the ACT Health aspect of the healthy weight initiative that you are feeding in?

Dr Kelly: We are continuing to do the monitoring that we need to do in our survey program. There is one of those in the field at the moment, but I do not think that was the one you were referring to, Mr Wall; I cannot remember those particular questions being there. But the general health survey is there, so that will be measuring that. There are a range of those activities. But we are looking to increase our population reach on a number of our programs, particularly the ones we are doing in schools. Our very popular ride and walk to school program, which we believe will be proven to be successful, is currently being rolled out in collaboration with the Physical Activity Foundation in over 50 schools, and we are looking to have that in every school. That is what we are aiming for.

Similarly, our fresh tastes program, which is more on the nutrition side, is looking at healthy food options—in the school environment, in the canteen, but more broadly than that, with curriculum developments, school barbies and so forth. We are looking to roll those out right across the sector as well. They are some of the exciting things that we have been funded to do and are looking to scale up to the population to cover all of the kids.

MR WALL: Supplementary, if I could, chair?

THE CHAIR: Sure.

MR WALL: There has been quite a lot of discussion and a number of announcements by the government on junk food advertising and trying to restrict access, particularly restricting kids from purchasing these things. We are seeing healthy options put into school canteens and a recent announcement of the government to ban junk food advertising on buses. It seems that there is a lot being done to restrict access to or awareness of that product offering. What is being done to educate the population, particularly the adult population, who really are the ones who largely control the eating habits of children and also their own habits? What is being done to educate the bulk of the population about healthy eating choices rather than simply restricting advertising options?

Mr Corbell: The answer to that is: a lot. This area, though, does not tend to get a lot of attention, from the media or otherwise, because banning things or prohibiting certain things always seems to make a better story from a journalist's perspective. But, for example, the government is funding work through Nutrition Australia to provide a dedicated nutrition education service for families. That includes both telephone-based information and also in-house workshops or demonstrations where nutritionists are available to give advice to families on how they can structure healthy eating choices that are affordable and easy to do. That is obviously one of the key issues with junk food: it is the easy choice; you pay a small amount of money and get a meal.

MR WALL: I think as a city we are reasonably well off.

Mr Corbell: Yes, indeed.

MR WALL: Affluence is a positive for the city, but also—

Mr Corbell: It can be a negative too; that is right. So there is that work that is being done with nutritionists. Elements of that program and the like are also being rolled out in schools in terms of education in the school setting. So there is quite a bit of work happening in that space as well. I would be happy to get you a more comprehensive list, but there are quite a number of programs that have been deployed to promote healthy eating choices, and in particular to support parents in terms of information and advice on how they can provide good alternatives to that junk food purchase.

MR WALL: I guess there are two parts to it, minister. Obviously, having the programs or the information available is one thing, but informing the average family that it is available and that they can go and find it or access these services is another.

Mr Corbell: Yes.

MR WALL: From feedback I get and from my own experience, it is probably an area where the information system is being let down. What is being done to address that?

Mr Corbell: This is a challenge. The government runs a very broad range of programs, but not everyone is aware of them. Certainly the government is looking at how it can improve its communication strategies overall, to reach more people, to tell them what the ACT government is doing in terms of services, facilities and so on. That is led at a whole-of-government level by the Chief Minister, Treasury and Economic Development Directorate. They are completely restructuring the way we go about our information provision to households in terms of regular newsletters into homes so that people see those regularly from the government telling them what services and programs are going to be available, what projects are being undertaken and so on.

But it is also looking at online media and the more traditional media in trying to get the message out. We look at all those channels. A strengthening of that approach is ongoing, both at the whole-of-government level and at the Health level, in terms of a consumer-focused strategy to reach more people. We are very cognisant of that. People have busy lives; they are not there anxiously waiting to see the public notices section of the paper.

MR WALL: Absolutely, which is why I am saying it is—

Mr Corbell: Yes.

MR WALL: What else has been done to target it?

Dr Kelly: May I add a couple of specific programs, minister?

Mr Corbell: Yes; thanks.

Dr Kelly: Within my own area, we have a program called good habits for life, which is a locally developed program. This had input from children as well as parents in terms of asking what are the key messages that need to get out there to help people to

make the right choice, the healthy choice. That was locally developed. It is a social marketing campaign. It is extensively using social media, but also using more traditional media. It was launched in November 2014, and 10,982 people had accessed the website up to June 2015. That has been spurred along by adverts on the television and radio and in newspapers and other media. Every time we do that there is an increase in the social media.

The other one we are funding, through our healthy grants program, is for the Heart Foundation to run their own social media. It is the toxic fat one. You have probably seen those advertisements. It is a highly successful program out of Western Australia. We have adopted that, as have several other states. This is a bit more in your face than the traditional kind of health promotion messages, saying, "This could be you; you need to do something, and you need to do something because it is influencing your children."

Both of those campaigns have that similar message: you are influencing your children now; you can influence them in different ways by taking on these other ways of doing it. They are just a couple of things that we are currently doing.

MS FITZHARRIS: Is there an agreed national definition of junk food? Is it in the space of the national food labelling debate?

Dr Kelly: It is an interesting one. We are guided by the National Health and Medical Research Council dietary guidelines. Everything we do is based on that very well-respected guideline, which is itself based on over 30,000 research articles in relation to nutrition. Through that, we have come up with a traffic light system—"we" being the ACT, nationally and all the other jurisdictions—green being definitely not junk, red being definitely junk, and orange being towards junk but you could use it sometimes. That is one of the ways that we address it.

Out of those same guidelines comes the healthy plate, which got a bit of news recently around the bacon issues. That also is quite clear. Things that are not on the plate essentially are junk, and things that are on the plate in their different criteria are in the healthy category to a greater or lesser extent.

That is the sort of guidance that we use. But it is interesting to see what is out there. There are a lot of other ways of saying things that are confusing for people. My role and my staff's role are to decrease that confusion.

MS FITZHARRIS: Thank you.

THE CHAIR: Ms Lawder.

MS LAWDER: I want to continue a conversation we had during estimates about smoking outside health facilities, especially, but not limited to, the Canberra Hospital at Woden. I continue to see people standing on the footpath every night on my way home. Can you outline some of the measures that you are taking to progress the no smoking zones?

Mr Corbell: When it comes to the specifics of Canberra Hospital, I will ask

Mr Thompson in a moment to outline those. But more generally I just make the observation that the government is currently consulting on legislative options to strengthen our legal capacity to prohibit smoking in a range of public areas. That includes areas of public land that may, for example, fall outside the Canberra Hospital campus but are still immediately adjacent to but not technically part of the Canberra Hospital lease. They are public land.

Similarly we are looking at issues around public areas that have a high level of use. That might be playgrounds, bus interchanges and other public transport facilities, public playing fields, swimming pools and other facilities like that. The government is currently consulting on options around that. That consultation is ongoing at this time.

But it is my intention at the conclusion of that consultation to take into account the feedback and to develop a model that allows the territory to deal with smoking in some of those public places that have become prohibited in terms of smoking in other jurisdictions but have not yet been able to be dealt with.

Mr Thompson: Very much leading on from the minister's comments, we have arrangements where smoking is prohibited on the campus but of course off the campus that is a public space and we are not able to prohibit smoking under the current legislative framework there. However, we have got various security patrols and warning processes put in place for anyone caught smoking on the campus, and there is an encouraging, steady decline in the number of cautions that we give to people. We believe that is working.

One thing we have monitored and will continue to monitor in particular with people who are smoking on the fringes, so to speak, is—and frequently those staff who are smoking are on a paid break and under our employment arrangements they are required to remain on campus during a paid break—where we identify that there are situations where staff are leaving the campus on a paid break for smoking or any other reason then we inform the managers and remind them of their obligations. That is the most active thing that we are able to do but we have to recognise currently that in public spaces if someone smokes that is their choice.

MS LAWDER: Do you clear away the crates?

Mr Thompson: We do that on a regular basis. The frequency that they return is a little frustrating but we do clear them away on a regular basis.

THE CHAIR: Mr Hanson, a question.

MR HANSON: Are we still on public health?

THE CHAIR: We are.

MR HANSON: The healthy Canberra grants that you have as a program—the $2 million, is that right?—to provide grants to organisations that are trying to raise awareness to combat obesity, smoking and so on, what is the process for making grants and evaluating them? Is that done year by year or can people put in for a grant for a protracted period?

Mr Corbell: There is a regular call for proposals, on a yearly basis. Dr Kelly can give you some detail on that.

Dr Kelly: Thank you for the question. Yes we do have a healthy Canberra grants program, and it is $2.2 million annually. A few years ago we changed the way that the grants were given on the basis that we had received feedback from various sources that a large number of very small grants for a short period probably was not the best way to go in terms of strategic outcomes and the best bang for your buck in terms of population health outcomes. We had some consultation about that with the non-government sector and came up with a program which really encourages people to put in for larger grants for a longer period, up to three years. And 80 per cent of that funding goes to that type of grant.

We have also reserved, again based on consultation we had, an innovation round, which is essentially open all year round. The first one is only once a year and then three times a year with small grants given up to the value of $15,000—show us your innovative ideas or what might lead to one of those larger grant applications in the future.

MR HANSON: And do you have an evaluation of those programs?

Dr Kelly: Yes.

MR HANSON: Do you have an allocation within that $2.2 million towards targeting smoking, towards targeting alcohol or towards targeting obesity, or is it depending on the merit of the program? How do you stop it all becoming obesity or all becoming smoking?

Dr Kelly: That is a very good point. Part of that strategic alignment was to look at the big risk factors for disease that we are really looking to influence. Clearly, as has been mentioned in answers to other questions, the issues of obesity, poor diet, low physical activity—all of these things are really important. People were encouraged to put in grants around that. But that does not preclude issues of alcohol and smoking as well. If you add all those five risk factors together, that is about 80 per cent of our disease burden that is hitting our hospitals. The minister mentioned earlier some of those drivers for what is happening in clinical service, the need for more clinical services at the moment.

The specific answer to your question of whether there is a particular quota, for example, within that round is no there is not; it is based on merit. They are extremely popular. In the last round we had there were grants in the order of $14.68 million put forward to us, and we allocated just under $2 million for that round—a seven to one need versus availability.

MR HANSON: And in terms of a whole-of-government strategy, are other directorates running similar programs? For example, if someone had a program that wanted to look at the reboot of the school curriculum or something that was happening about kids diets in schools, are you running that grant program on behalf of the whole of government or is there a similar grant program running out of the chief

minister's directorate or within education?

Dr Kelly: This is a specific Health one. Of course one of the other ticks that the grant applicants get would be for working across government, in a way, but what other government directorates have in terms of grant programs I am not really in a position to answer.

MR HANSON: But how do you then synchronise what has happened? If this is a whole-of-government strategy, or it is meant to be, but you are unaware of what other directorates are doing with big chunks of money for grants then how do you synchronise that whole-of-government approach? How do you stop someone getting—

Dr Kelly: Multiple things?

MR HANSON: multiple things? Going to the earlier point that we want to balance the response to smoking, alcohol and so on, how do you then monitor that that balance is a whole-of-government approach, not just a Health approach?

Dr Kelly: It is a very good point. I make the point that the health promotion grants program is a Health function, and we have aligned it with that whole-of-government approach to obesity. As I mentioned before, not all of that money goes to obesity prevention initiatives. There were several in the last round that are around alcohol and smoking, particularly in pregnancy for example. That is one point.

Through the healthy weight initiative we meet very regularly. Virtually weekly I am in discussions—actually, more frequently than that—with chief minister's department, and one of my staff or I would be meeting in one of these cluster groups on a regular basis, probably every couple of weeks. We have a great awareness, much better than before the start of that program, about what is happening in other directorates. But your specific question about who has grants for what, I cannot answer.

THE CHAIR: I have a supplementary. Dr Kelly, on your grant application form do you ask whether applicants have applied for grants either from other directorates or from other places like the NHMRC, the Institute of Health and Welfare or indeed even from private sources?

Dr Kelly: I have to take that one on notice.

MR HANSON: I would have thought that the biggest area of coordination would be with education because a lot of the programs are targeting kids and the access to kids when they are at school in terms of both exercise and diet. I know there are a number of programs, really good programs as well, that go into schools and do things. Is there any thought to then saying, "Let's combine it," or, "Let's coordinate it better"? I am aware of a number of programs that sort of intersect between the two. It might be not directly Health and it might not be directly education. There is a risk it gets lost or duplicated.

Dr Kelly: It is a very good point, and the whole-of-government approach was really aimed at trying to fix that problem, if it indeed existed beforehand. The original plan

was to work in schools. One thing which was identified was: how do we increase physical activity for children? And it was exactly the point you are making. There are a whole lot of private providers, often, or non-government organisations that will come very regularly to schools and to individual principals, or indeed the education directorate, to offer their solution, shall I say. And it is confusing.

Through that work it has been recognised that the sport and recreation area in the directorate; I am not sure which one that is—

MR HANSON: The minister is Mr Rattenbury.

Dr Kelly: Yes, the economic development directorate. They took it on board to actually create an IT solution to that. Now there is something that school principals or individual teachers or the education directorate can go to and say, "Here's a list of the things that are out there. This is the type of thing that various organisations provide. If you are looking for this sort of thing in your school, this is the list of five people you might want to talk to."

Those sorts of things are happening—and I have seen that quite a lot—where education will say, "We've really got a problem here," and somewhere else in government, because of this mechanism of meeting, can say, "We can help you with that." My role really is, as a technical adviser, to say, "That's a good solution in terms of the health output or the health outcome."

THE CHAIR: We move to cancer services now. Minister, on page 243 of the Health annual report it mentions that Clare Holland House is part of the ACT specialist palliative care service. Could you comment to the committee on the current inpatient capacity and demand for beds at Clare Holland House? Looking to future demand is there any concern that, given our ageing population, this demand will outstrip supply?

Mr Corbell: I have a general observation first, and then I will ask Ms Lamb to give you some more detail. The general observation is that increasingly palliative care will need to be provided in settings other than a hospice. The reason for that is simply an ageing population and the fact that it is very difficult to sustain hospice care alone as the only response for palliative care services for end of life.

The government is very focused on supporting other forms of palliative care as well. We do that closely in conjunction with our stakeholders, including the palliative care NGOs, and we have increased funding for palliative care options outside the hospice, in-home care and other options. We are going to need to continue to pursue those strategies because there are limits on what a hospice facility can provide in terms of capacity.

Ms Lamb might be able to elaborate a bit on demand at the hospice and other options that are being pursued.

Ms Lamb: Certainly. From the perspective of my service, we provide palliative care services at the Canberra Hospital and within our outpatient services. Clare Holland House inpatient services and community-based services are run by Calvary Health Care, and we work in partnership with them to ensure that the community can access

the appropriate place for palliative care.

The particular question was in regard to?

THE CHAIR: Future demand versus current supply.

Ms Lamb: I need to pass on that.

Mr O'Donoughue: Thanks for the question, Dr Bourke. The government released the palliative care services plan for 2013-17 in October 2013. That plan and its technical appendix do some calculations about demand and projected demand. As the minister has indicated, it also has an emphasis on alternative ways of delivering palliative care services to supplement the inpatient beds that are provided by Clare Holland House and TCH.

A recent initiative, which is part of the 2015-16 budget, is the end-of-life care at home budget initiative. The government allocated $2.428 million to that initiative, which incorporates the expansion of Clare Holland House's community specialist palliative care service. That includes out-of-home-based palliative care and a proof of concept study by the centre of palliative care research about palliative care in the home.

We have also very recently engaged a consultant to develop and finalise a model of palliative care. This was one of the recommendations in the palliative care services plan, that a further model of care be derived. The principle of that model of care will be again to seek a balance in the role delineation between the various arms of the service. A lot of palliative care services can be delivered by general practice, for example, and by the residential aged-care sector. If you get the balance right between that type of service, the inpatient service and the home-based services, it is our feeling that the demand going forward can be managed, although there will need to be at some point an expansion of inpatient beds as well.

I guess the other trend that the minister was also alluding to is that overwhelmingly people would prefer, in most circumstances, to manage their palliation period at home, as far as possible. In general terms, people only spend a really short period of time in a hospice environment towards the end of life.

THE CHAIR: Minister, on page 75 of the annual report it states:

> Referrals for palliative care to the Community Care Nursing Service are expected to rise in response to the increased need for primary palliative care services for the ACT community.

Furthermore, it states that this will place pressure on the existing capacity of community nursing. What is the plan to manage that pressure on community nursing?

Mr Corbell: As Mr O'Donoughue said, that is why we are expanding our capacity in that area for in-home palliative care capability.

THE CHAIR: There has been no consideration of establishing another inpatient facility on the north side, perhaps in my electorate of Ginninderra, to relieve future

pressure on Clare Holland House and provide families and friends with a location more accessible at such a critical time?

Mr O'Donoughue: That has not been canvassed to date, Dr Bourke. I guess there is always the problem of critical mass in terms of the expertise required and the staffing profile that is required to manage a specialist service such as a hospice. There would be a real question about whether the territory was physically capable of managing the resources for two such services in a small jurisdiction.

THE CHAIR: Mr Wall.

MR WALL: Minister, I refer you to page 229 where there is the chart for this output class. It mainly relates to the breast screen program. Line b shows that there was a 10 per cent reduction in the target for screens completed as a result of the new information system being introduced in 2014. Why would a new information system be the reason for a 10 per cent reduction in the number of screens carried out?

Ms Lamb: The introduction of the breast screen information system was one component of the reduction in it. The reason is that when you introduce a new system you actually need to allow time for the staff within the service to make sure the system is working appropriately and that we have a quality care continuum. For that period, you reduce the number of appointments available during that time so that you can introduce a system safely. That was done through the period of December.

MR WALL: So the number of appointments was reduced whilst staff were brought up to speed on how to use the new system? It was not an issue in sending out reminders or notices, but in staff inputting the data at the other end.

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Minister, I want to ask about the role of the nurse care coordinator within the division of cancer around providing support to paediatric oncology patients. Are you able to talk to us about that?

Mr Corbell: If you could ask a question, Ms Fitzharris, we will do our best.

MS FITZHARRIS: How long has that role been in place, and what is the role in general of a nurse care coordinator? In particular, what is it in the paediatric oncology area?

Ms Lamb: ACT Health funds a group of care coordinators across all ranges of tumour streams, as well as specific age groups. We have an adolescent and young adult nurse care coordinator who generally works with children from 12 upwards. We do not do the very young children. Their care is mainly provided through the paediatric service and in conjunction with the Children's Hospital in Sydney. They will coordinate that young child's care.

The role of the nurse care coordinator is, as it says, to actually help and assist in the coordination of care. When somebody is diagnosed and then treated for cancer, there are a myriad of places they need to be and people they need to see. The care

coordinator role is there to help navigate the path through the system and provide them with information around a particular cancer type, or tumour type, and support them in how they can best get the care that they need.

MS FITZHARRIS: Is that one position that is filled most of every day, or is it a number of nurse care coordinators?

Ms Lamb: We have, I think—I am not exactly sure—just over 10 FTE nurse care coordinators. I can get that number for you. They are a combination of full-time and part-time positions across the different tumour streams. We have a breast care coordinator—a full-time position covers that—whereas we have other coordinators that have a couple of tumour streams that are smaller.

MS FITZHARRIS: For children under 12, is there a similar position that you are aware of in the paediatric stream that is able to provide that coordination or navigation point?

Ms Lamb: I am not aware that there is a specific position. I would have to refer to the paediatric area for that. However, thankfully, our numbers are very small, so it would not justify a full-time position. You would need to have a position that was identified to support those families.

MS FITZHARRIS: What does "small" mean—that the number of children is very small? How small is small in our population as a whole?

Ms Lamb: We would have to take that on notice.

MS FITZHARRIS: Thank you.

THE CHAIR: Ms Lawder.

MS LAWDER: I will pass to Mr Hanson.

THE CHAIR: Mr Hanson.

MR HANSON: I had a tour of the new building the other day—thank you, minister, and staff. It is very impressive. I appreciated that. I also had the chance to have a look at some of the other areas while I was at it. I look forward to seeing some of those areas come on line, particularly the ED expansion and so on. It was nice to see a new building, and I am sure it is a good place for your patients.

I suppose this goes a little to the point where you were talking about the integration of the private system, where the gaps may be in service provision, and where you can synchronise the two. Because of the economies of scale, there are some treatments that just cannot occur in the ACT so people are going elsewhere for treatment. I guess this new facility now affords us, potentially, the capacity to grow and target particular treatment areas. Have you had a look at whether, be it in cancer or elsewhere, there is a migration of patients out of Canberra going to look at specific treatments in New South Wales? It is always very difficult. I know that paediatric cancer is a particular area here where you have been able to say, because of the expansion in cancer

services, "We can now offer this facility so that people do not need to go to Sydney anymore." Is that a body of work that you are looking at?

Ms Feely: Access is one of the key issues we need to look at. As part of the review of all the pathways and models of care, the sort of work we will be doing with the business intelligence unit, which tracks all of these flows, is work I want to undertake in the next six months. That is exactly the issue. It is about identifying not only where our patients are coming from but also where they are going if we cannot treat them here. Then we will need to prepare a business case in relation to all of the surrounding issues—the cost of maintaining the service here and how we are going to staff it and then take back to government a case as to whether or not it is preferable that we do it here, or what the alternatives are.

In terms of assuming people are leaving the ACT because we do not provide a service, there does come a time, I think, when we cannot be all things to everybody. It is about the best care in the right place. If we can provide that here in a cost-effective and appropriately staffed-up way, it would be a matter that I would take back to the minister. If not, it would be a matter that, again, I would discuss with the minister as to what we need to do to facilitate access to ACT community services that may be provided, whether it be in Melbourne, Sydney or wherever. I hope that answers the question.

MR HANSON: It does.

Ms Feely: It is part of the model of care—

MR HANSON: But digging down on that, there have been particular services from time to time that have become more visible. I remember that in relation to diabetes a lot of patients were going to Sydney because they were not happy with the service here. I understand that that has been rectified. How are you going to then map it, because they are essentially the people who are not accessing the health services? When people access public health, you can identify them and say, "There was a delay in their treatment; they've waited a year," or whatever it might be. But for those patients that look at the ACT health system and say, "No, I'm not going to get treatment here, either private or public," and go somewhere else, how do you track that?

Ms Feely: In a general sense, we are going to be looking at not only the population and models of care but also disease modalities—again, to look at the concept of access to the best possible care for the people of the ACT community. Again, we have to step back and say, "You look at trends, you look at what has been developing and you look at the population as a whole." We will be making some decisions in relation to whether, if we do not provide that service, we should. Then we will be looking at the information that is available around the country in terms of where people are being treated for that sort of disease.

It is a complex issue, but if we are to provide a suite of services to our community that actually meets the needs of our community we are stepping back and looking at what we are providing and how we are providing it and making sure it meets those needs. Where it cannot, for a number of reasons, whether it be cost or proper servicing—the

ability to have clinicians who have the particular skill that is required—that is a matter for discussion as to what we do in those processes. It is population; it is disease; it is multiple care; it is staffing—there are a whole complex range of issues. Does that answer your question?

MR HANSON: It does. I am glad that work is ongoing. When do you anticipate having a model where you can actually make some recommendations to the minister and say, "These are the areas where we think an increase in capacity would be of merit"?

Ms Feely: We have started the work now. We have a clinical services plan and we are stepping back and reviewing every element of that. I would be hoping that within six months we would have a good draft. I would hope by the end of this financial year to be in a position to say we are more confident about where we sit. That will all depend on the modelling that is coming through from my fantastic team over here, looking at staffing profiles and all those issues. If we do not have this done within this time next year I will be horrified. I am looking at a six-month process. In addition to that, we will be looking at the way we operate across the board. We have to look at staffing profiles and how we deliver multiple care across the board.

MR HANSON: You have got cooperation happening from the private sector to help with that process?

Ms Feely: We are starting that. Again, if we take access as a key determinant of our ability to deliver—making sure we all have access—it is critical that we have them at the table. We are starting that process literally next Tuesday night, I think. We have called them all together and we are going to say, "Let's talk about how we can actually open up the access issues across the ACT." That is part of what will come into our review of the clinical services framework in relation to pathways and who is doing what and where we are going to focus resources around the system. It is a multifaceted matrix approach, but I think it is very doable here given our size. The beauty of it is that we also have the scope. So I think there is a lot of opportunity for us to work constructively.

MR HANSON: I am really encouraged to hear that is happening. My only comment would be: it has taken so long. That is a good thing that is happening.

Ms Feely: Everyone says it is a challenge, but everyone is focused on it, and we are up to it, yes. Again, yes, we have listened, and if there is a reason why people cannot access things here, I would like it to be because it has been considered and rejected on the basis of a proper assessment as distinct from things just falling through the cracks. We will not get it perfect, but we are starting the process again. A lot of it has to be about innovation, the use of technology and understanding our population very well.

MR HANSON: Do the advances in technology help? Are there things you can do now that you could not do before?

Ms Feely: I have to say that I am still a counting on my fingers type technology person. I try to use computer screens thinking I can swipe them, but they are not an iPad. I might hand over to Ian on that.

Mr Thompson: It does to a degree. For consultations, transfer of information and non-direct contact type activities, technology actually does help a lot: we can transfer information a lot more readily; we can undertake videoconferencing and the like to provide input and elements of the care. The primary barrier currently is when it involves a procedure or something that requires direct examination of patients; that is where the barrier currently sits. Technology has made the other aspects a lot easier.

THE CHAIR: We might stop there and move to rehabilitation, aged and community care. Minister, I am told that waiting times for the community health intake line can be quite lengthy. For instance, I heard the case of a consumer waiting seven minutes for their call to be answered and three minutes for their inquiry to be dealt with. I am told that the average mobile phone charges roughly $1 a minute, so this would amount to $10 for a call. This is the only access point for making appointments at community health centres. Could this rather large cost be a disincentive to accessing health services?

Mr Corbell: I will ask Ms Lamb if she can help you with that.

Ms Lamb: I am sorry; could you please repeat the question?

THE CHAIR: Of course. I have heard that waiting times for the community health intake line can be quite lengthy. For instance, I have heard the case of a consumer who waited seven minutes for their call to be answered and then was on the line for three minutes when they were there. Given that I am told that the average mobile call charge could be $1 a minute, this would amount to a $10 call. As that is the only access point for making appointments to community health centres, would this be a rather large cost disincentive to accessing health services?

Ms Lamb: Certainly we have a process where we can monitor the time that it takes to answer calls and then, on wait times, will transfer through to our other services. We monitor that on a monthly basis. If we are identifying that the wait times are extending out, we look at what has happened over that period. At times, unfortunately, if we have staff off sick, there is a tendency for that time to be a bit longer. We are looking at improving our systems so that people have the option of requesting a call back from the community health intake service.

The other issue that occurred this year is that we have moved the dental health appointments into the community health intake service. That has increased our calls into that area significantly. We have recently increased the staffing levels to ensure that that does not impact on that wait time.

THE CHAIR: How many calls are we talking about a day?

Ms Lamb: I would have to take that on notice.

THE CHAIR: Apart from a call-back service, have you investigated any other technological solutions—like toll-free numbers, perhaps?

Ms Lamb: Yes. We are looking at how we can look at our intake services generally

across the board and get the best solution. There is work being done with regard to looking at solutions.

THE CHAIR: What about internet booking services? Is there any sort of opportunity there?

Ms Lamb: We are working with our health information officer in regard to appropriate solutions that can open the options of how people book into services. For instance, with breast screening, we are looking at the option of people being able to go online and book for breast screening services rather than having to call up.

THE CHAIR: That would be a service which is reasonably consistently the same time.

Ms Lamb: Sorry?

THE CHAIR: That would be about the same time for each service there.

Ms Lamb: Yes.

THE CHAIR: So you would be able to book that reasonably easily.

Ms Lamb: Yes.

THE CHAIR: Thank you. Mr Wall.

MR WALL: I will defer to the other end of the table.

THE CHAIR: We will go to Ms Fitzharris. Ms Fitzharris, you are next.

MS FITZHARRIS: Thank you. Within this output class, obviously it sounds a lot like the services that are going to be provided at the new public hospital at the UC campus. What plans are in place for planning around this output class in terms of how it will look when it is delivered through a dedicated facility?

Mr Corbell: In relation to planning and the model of care for UCPH?

MS FITZHARRIS: Yes.

Mr Thompson: We have developed quite a detailed model of care that is currently out for community consultation in relation to the services and we are currently seeking feedback on that. The intention, broadly speaking, is that within the University of Canberra public hospital we will have three broad groups of services. We will have the mental health inpatient services; we will have the rehabilitation and other subacute inpatient services; and then we will have the day programs in the outpatient services.

The emphasis in developing that model of care is to look at models of care that are easily accessible and that minimise the extent to which people will require inpatient care, based on the principles (1) that people usually prefer not to be in hospital and

(2) that for things like rehabilitation and the activities of daily living, the more people can return to their normal routines the more effective the rehabilitation can be. We have a model of care that is looking very much at how we can enable speedy recovery and good access for people using the services.

The new hospital and the rehabilitation and aged-care services will integrate with our other community-based nursing services as well as with the acute hospital services at both Canberra Hospital and Calvary hospital to manage referrals and transfers from the acute hospitals to the new hospital as well as home-based care that complements the centre-based care.

MS FITZHARRIS: Do you have yet a profile of the staff that will be at the new hospital or will this come out of the model of care consultation that you will be doing?

Mr Thompson: Yes. It is coming out. We want to complete the model of care before we get a detailed staffing profile. So yes; that is a work in progress at the moment.

MS FITZHARRIS: With the location on the University of Canberra campus, what discussions are underway with the University of Canberra in terms of the courses that they offer, and do you have any insight into what they may be planning to do in the future as a result of the hospital being located there, through their academic programs?

Mr Thompson: We have what is called a collaboration committee that we have established with the University of Canberra to look at that, adjust those issues. They have obviously got their current nursing and allied health services, some of the functions of which are expected to be transferred into the hospital itself in the space that we are providing for the university as well as being integrated with the service delivery and the education and research opportunities provided there. We are also looking potentially at more innovative approaches in terms of looking at not just the way we can relate to the University of Canberra around the health courses but finance, IT courses and so forth.

MS FTIZHARRIS: Leadership training.

Mr Thompson: Leadership training. That is part of the discussion that we are currently undertaking with the collaboration committee.

Ms Feely: I have met Stephen Parker, the UC executive on these issues; he had the dean of research, the dean of medicine, Stephen and also their dean of development for the university. We have discussed particularly those issues about how we can have a closer collaboration, being Canberra focused, being Canberra based and using the skills that we have here.

MS FTIZHARRIS: Will that be around teaching and courses as well as research?

Ms Feely: Yes, opening up again. We have met them. I would like to start a discussion about how we can better collaborate on a number of fronts—and have exactly the same conversations with the ANU and the John Curtin School of Medical Research in relation to research, training, education, leadership, management training

and a number of issues.

THE CHAIR: Ms Lawder.

MS LAWDER: On page 230 of the annual report, under output 1.5, it has the strategic priorities for rehabilitation, aged and community care. The first one says:

> … ensuring that older persons in hospital wait an appropriate time for access to … assessment by the Aged Care Assessment Team …

What is an appropriate time, please?

Mr Corbell: There is a performance measure for that.

Mr Thompson: Two days is the performance that we achieve, and that is within the guidelines. That is below the expectations given to us by the federal government.

MS LAWDER: Below expectations?

Ms Feely: I think it is three to five days, isn't it?

MS LAWDER: So better than expectation?

Mr Thompson: Shorter.

MS LAWDER: When does that timing start? Two days from admission? From what?

Mr Thompson: It is from the request. A lot of people are admitted as an acute patient; they require treatment and management of a condition and a period of time to understand whether or not residential or aged care is a likely outcome for them. It is only after it is clear that residential aged care is a likely or appropriate outcome that we request the ACAT assessment. There is no point assessing someone who is very acutely unwell if they are going to be a lot better over the next couple of days.

MS LAWDER: So there is a Canberra-based ACAT team?

Mr Thompson: We employ the ACAT team and we receive some funding from the federal government for that purpose.

MS LAWDER: How long is it from the time the assessment takes place to when you get the assessment?

Mr Thompson: Two days is the time it takes to be assessed—in other words, for an assessment to be made. The process is a relatively straightforward process for reaching an outcome of the assessment, immediately after the assessment. There is an administrative paperwork element, but it is not a material—

MS LAWDER: Perhaps I am thinking of the time from when they leave the hospital. What is that average time?

Mr Thompson: That can vary quite considerably and this is something that is to a large degree out of our control. The residential aged care sector is managed and funded through the federal government, and they control the process for allocating places. We undertake the assessments. We have discharge planners, social workers and particular dedicated staff to look at residential aged care placements. We work with the patients to assist them and their families to identify aged care places and to make the applications, but we cannot control the availability or the decision-making of the aged care services themselves in terms of when they will get a place.

MS LAWDER: And are the rehabilitation places ACT run or federal?

Ms Thompson: We run a lot of rehabilitation services, both inpatient and community based. There are private rehabilitation hospital services as well that we work closely with, with people who have private health insurance and interested in being transferred to those services.

MS LAWDER: Some will go from hospital to rehab and then to aged care. What are the vacancies for rehab places?

Ms Thompson: That is a very dynamic situation. People can have relatively short lengths of stay within the rehab units. That changes all the time. It is not the same as residential aged care, which is effectively someone's home and with much longer lengths of stay.

MS LAWDER: So you do not publish those figures?

Mr Thompson: The occupancy within our rehab services is typically 95 per cent to 100 per cent. They are always full. I do not have the information about the private sector services.

MS LAWDER: Thanks.

THE CHAIR: Mr Hanson.

MR HANSON: On community health centres, Belconnen is relatively new and it seems to have capacity. Gungahlin is new; I am not sure where it sits in terms of capacity. There has been some talk about expansion, relocation, of the Phillip centre. How is it going in terms of its capacity? I would imagine the demographics are changing around that area. It is probably more of an ageing population, so there might be less demand for services. I am interested generally in that demographic work that you are doing. I imagine that the services required change based on evolving demographics. Are you responding to that? With each of the health centres, where are we at in terms of need for expansion, or have you got additional capacity?

Ms Feely: Just to continue on from the discussion, the actual role of the community is critical in relation to how we want to approach the delivery of services. If I could put it tactfully, we want to change the conversation so that everything is not about TCH. TCH is the tertiary hospital and we need to start looking at how we devolve as much as possible back out to the private sector and the community sector, getting as many services as possible delivered out through existing services, the community health

centres, so maybe looking at what they actually deliver.

On that note, in relation to your specific questions, I will ask Denise to update you as to how they are looking. Part of the thing we are going to look at is what services are being delivered out there and whether we can co-locate, for example, some pathology or radiology—all of those sorts of things—to change the nature of the service that can be delivered out in existing facilities.

MR HANSON: Some of that has happened already, has it not?

Ms Feely: It is starting to, yes. We just want to re-emphasise and look at all that.

Ms Lamb: The Phillip Community Health Centre is certainly well occupied and well utilised. The rooms are on the whole fully booked with a range of different services—child health, adolescent health, community nursing services and mental health. Breastscreen also has a screening program. With the expansion of Tuggeranong, there was the ability to move some services to Tuggeranong to ensure that we could expand services, and also from the perspective of Village Creek a lot of the rehabilitation services are able to be there. Phillip is an area that is well utilised at this point.

MR HANSON: Sure. What about Civic? Are there any plans to do anything to that health centre?

Mr Corbell: In the longer term, the building on the corner of Alinga Street and Moore Street is identified for redevelopment, so the government will need to make a decision about the future location of a city health centre. There is adequate time to do that and that process will be worked through in the coming period.

MR HANSON: You said there is adequate time. What is the time line on that in terms of redevelopment?

Mr Corbell: No 2 Moore Street has been identified as part of the government's commitments in relation to asset recycling, given the age of the facility. Those commitments need to be met by the year 2020, so that is the time frame we are looking at for decision-making and identifying an alternative site.

MR HANSON: When you sort of mapped the ACT, are you comfortable that, although expansion may be required in some areas and reduction in some, the health centres are broadly appropriately located?

Mr Thompson: The short answer is yes. We have looked at the demographics and the distribution. If you think of the geography, we have got the health centres at Tuggeranong, at Phillip, in the city, at Dickson, in Belconnen and Gungahlin, so they are quite well distributed across the city. Broadly speaking, I think they are appropriately located.

MR HANSON: With the growth in Gungahlin that is anticipated, is there enough space there to expand if required? It is certainly smaller than Belconnen, isn't it, at the moment?

Mr Thompson: It is a smaller health centre. It is still not full, so we have still got some capacity to expand services there. One of the aspects of the health services is that we have got different roles for different health services. Gungahlin was built with the expectation that it would be a smaller community-type health centre, without the same range of services available at the bigger centres like Belconnen or Civic. It was built from that perspective.

MR HANSON: We will be retired, maybe, but in the view of where it sits in 20 years time as Gungahlin continues to grow, is it thought that it will always stay as a smaller one or is there going to be a need for it to match the sort of services required in Belconnen in the much longer term?

Ms Feely: A bit of a side sort of discussion is actually working with CSD and education in relation to looking at the community need. If we start to talk about any new facilities, what I am trying to do with the other director-generals is say, "Let us identify what we need as a community there before we start talking about expanding just health facilities," and see what that will look like on that journey of discussion. But I think it is the best utilisation of a centre and having a one-stop shop as much as we possibly can. Of course, that is not a discussion we have had in detail with government yet, but that is what we are talking about at a directorate DDG level, which I think is quite exciting as a concept.

In relation to that particular health service, I would not be rushing to advise the minister to expand until we have a better understanding of what the future needs of the community in any area will be, and then looking at how we can bring services together.

MR HANSON: In terms of taking services out of TCH, are you thinking that with, say, dialysis or whatever it might be—I think there is a lot of that happening in Belconnen; I do not know if you have it somewhere else—the idea is to get people off the TCH campus and you will just transfer that to Belconnen, or is it about trying to spread it out across the community?

Ms Feely: No. It is about the right care at the right place. A tertiary hospital, I would hope, is the last place anybody wants to be, even though when you get there you will get looked after with the best care. When you start utilising tertiary level funded beds and services, which are far more expensive than what can be delivered in the community, that to me is the efficiency economic argument combined with the best way to deliver services to the community that we need to take time to look at.

So we utilise the tertiary level beds and services for the tertiary level requirements, and where we can either utilise existing infrastructure or make recommendations to government about new forms of infrastructure or whatever, we do that at the appropriate cost level.

We were talking about the efficient price before. An issue for us is that, because everyone comes to TCH and beds are being used by all levels and not just the tertiary or more particularly the quaternary beds, we need to get the funding models right for particular beds. Again, my preference would be, working with the team, to look at where we can deliver services in the community, not necessarily ourselves but

through NGOs or partners, in partnership with others. That is something we want to look at progressively over the next few months.

MR HANSON: So it is a big body of work.

Ms Feely: Yes, it is.

MR HANSON: A lot of it seems to be interconnected, so you are not trying to do it in isolation. When do you think that that matures to a point where you are able to integrate all those various aspects to start making recommendations to government, whether they agree with it or not, as a body of work?

Mr Corbell: The key task, first and foremost, Mr Hanson, is in relation to what we need to do to improve access, particularly at the tertiary level, because that is where the real pressure is. ED, elective surgery and a range of other areas are where there is significant pressure, and that is where the bulk of our money goes in terms of service delivery. We need to get better, more efficient use of the taxpayers' investment in that part of the health system. That is really the primary focus at this point in time.

Obviously the analysis is, as you commented, looking more broadly across the system in terms of community-based care as well. But in the immediate term—and by that I mean over the next six months or so—the focus of the government is on the tertiary level care and the redesign of systems and processes to meet the challenges we face in relation to access at the moment.

THE CHAIR: We will stop there, Mr Hanson, and move on to early intervention and prevention. Minister, has the ACT had success in preventing the fall in immunisation rates that has occurred across Australia in recent years?

Mr Corbell: Our performance on immunisation rates, Dr Bourke, continues to be strong. We continue to achieve a high childhood immunisation rate. All three cohorts that are measured nationally remain above the national average. In relation to cohort 1 compared to the Australian average of 91.32. For cohort 2, which is 24 months of age to 27 months of age, we sit at 91.41, compared to the Australian rate of 89.16. And for cohort 3, 60 months to 63 months of age, we sit at 93.18 per cent, compared to the Australian rate of 92.25.

That is a good outcome and highlights the ongoing level of effort being put into maintaining our high immunisation rates and at the same time the fact that as a population, as a community, parents understand very well the importance of immunisation.

THE CHAIR: You have been sending out letters to parents or guardians to remind them that their child is overdue for immunisation if that has not happened. How effective has that been, minister?

Mr Corbell: I might ask Dr Kelly if he can help with that question.

Dr Kelly: As the minister has pointed out, unlike some parts of Australia, particularly the northern rivers area of New South Wales but also some inner city areas in our

major cities, at the moment we have a very good uptake of immunisation.

There are still people that for various reasons—their busy lives or so forth preclude them from reaching the targets. Those numbers that the minister mentioned are very narrow in time, so this is absolutely every single immunisation at that point in a timely fashion, that three-month period. Sometimes it can be a week later and they become then a part of the statistic of not being immunised. That is when the reminder letters come into play. We do that regularly and we pick up most of the rest of the people through that process. We do not really have an issue of conscientious objection so much in the ACT. There are certain people that make that decision, but it is a very small number.

THE CHAIR: Letters are a bit old-school. Why aren't you using SMSs or emails?

Dr Kelly: I think communicating with parents would probably be a more holistic way of saying that. We use whatever way we can. We rely really on the Australian childhood immunisation register. That is where the information gets put through by the people that provide the immunisations, which are mostly general practice or our own maternal and child health nurses. That goes into the national register, and the register is part of the reminder component as well as us.

MR WALL: What is the proportion of the population that is not able to be immunised? Obviously 100 per cent is never going to be achieved but herd immunity is the key objective.

Dr Kelly: That is right. Herd immunity as a concept is a really important one to keep in mind. Kids are being immunised for their own protection but it is that proportion of the population that is being immunised that really is also important. And where effective herd immunity is based on the numbers—it depends on the actual organism—using measles as an example, we have to reach 95 per cent to make sure we have got absolute herd immunity in the community. It is related to how infectious the agent is. That is what we are aiming for.

As I mentioned before, those figures that the minister gave, for example for the 12 to 15-month age group, show that almost 93 per cent are immunised on time, fully immunised. That would include their measles vaccine. I imagine—I do not have those figures totally off the top of my head—most of the rest would be covered in the next three to six months. And then there are a small proportion of people that, for medical reasons, cannot have vaccinations, because some of them contain egg product, for example. If there is a true allergy to those things, that is contraindicated. You are right; we will never reach 100 per cent but we can reach over 95 per cent.

MR WALL: Over 95 per cent is ultimately where we should be?

Dr Kelly: Yes.

MR WALL: Does the directorate have access to the data on what the immunisation rate is just past that window? You said some people might be a couple of days late and become part of that statistic. Do you track what the actual immunisation rate is beyond that?

Dr Kelly: We follow up all of the ones that have not reached the target, and we aim to find out whether they are unable to have that vaccination, whether they refuse the vaccination or whether it is just because they have not quite got around to it. As part of that follow-up, we get the information back in to say that, if they have had it, they have had it.

MR WALL: To what extent within the ACT do we have—and I hate the term—conscientious objectors?

Dr Kelly: There are some people, for very specific religious beliefs or beliefs of their own on the way that they want to raise their children, that are in that category. But we are very different from some of what I would call problem areas in relation to that. As I mentioned, the Northern Rivers of New South Wales is one of the big areas of concern, where their immunisation rates are well below third-world rates. They are very much at risk of outbreaks of the infectious diseases we have not really seen in Australia for a long time. Some inner parts of our major cities, Melbourne and Sydney in particular, are also in that category. But that is not a big issue for us.

THE CHAIR: Mr Hanson.

MR HANSON: On the issue of immunisation within pharmacies—that seems to be a growing trend—where are we at with that in the ACT?

Mr Corbell: Work is continuing to implement that model here. I have given my in-principle agreement to establish a framework that allows pharmacists to provide certain immunisation services. The model has been proven safe and effective in other places around the country, and I see no reason why it should not potentially be available here in the ACT. We need to work with the medical profession on it. Obviously this is a key base service that GPs are able to provide.

So it is important to their business model. But at the end of the day it is desirable that access to immunisation be as broad as possible, and if the model can be delivered through a pharmacy, which clearly it has been demonstrated it can be, I think we need to talk about that seriously and get agreement on how we can implement it.

MR HANSON: In terms of GPs, there are obviously issues in terms of bulk-billing, costs and so on. Do you know what the per capita number is at the moment? I think we were at about 70 a few years ago.

Mr Corbell: On GP numbers?

MR HANSON: Do you know where that is at?

Mr Corbell: Certainly the most recent data I have seen confirms that we remain below the national average, particularly on bulk-billing rate. It always astounds me that places like the North Shore of Sydney have a better bulk-billing rate than the ACT. I am not sure I have those. That remains remain a genuine concern.

MR HANSON: I have seen the costs but I have not seen the per capita numbers and

trends lately. You have got some in there?

Mr Corbell: Our headcount was in 2013-14, which is the most recent reporting period for the report on government services from the Productivity Commission. Our headcount was 466 GPs, down from 470 in the previous years—a very modest downward movement. In terms of GP numbers per capita, we sit at 72½ per 100,000 population. The national average is 99.5 per 100,000.

MR HANSON: And is that an FTE number, because we have got a higher sort of—

Mr Corbell: That figure is full-time workforce equivalent number.

MR HANSON: I know there are a lot of older GPs and a number of female GPs who are only working part time.

Mr Corbell: The 466 is the total headcount. The full-time workforce equivalent number is 277.

MR HANSON: Would it be possible on notice to get the numbers over the last five, six or seven years, just as a trend, to see whether we are flat-lining or whether we are going slightly down or slightly up—where that is actually heading?

Mr Corbell: I have to take that on notice.

MR HANSON: If you could, that would be good. In terms of what you are doing about it—I know that there are jurisdictional issues in terms of the feds as well—given the bulk-billing problem, the per capita problem and so on, are you doing anything to fix it?

Mr Corbell: We have a range of programs in place to support capability development for GP practices. For example, we have run quite a successful grants program for GP practices that allows them to secure finance and help with the costs of expansion of their facilities so that they can actually accommodate additional doctors, because one of the key barriers to practices choosing to try and engage additional practitioners is the up-front costs of the extra facilities.

MR HANSON: Is that still running? I know there was money in the budget a few years ago.

Mr Corbell: It has now ceased but a significant amount of money has been spent.

MR HANSON: There was $12 million, I think, in the budget a few years ago.

Mr Corbell: For example, earlier this year I had the opportunity to go to the Wattle Street practice in O'Connor where they took advantage of that to leverage additional finance so that they could provide additional physical space to accommodate additional GPs and also additional allied health practitioners. That is a great example of how that program has worked in practice to remove some barriers. That program has been effective. The funding has been utilised. Obviously it was about capital provisions. It was always going to be a one-off mechanism.

We continue to fund the after-hours locum medical service to the tune of $1.2 million per annum to provide access to GP services that way. We also support GPs to provide care to vulnerable and hard-to-reach populations and provide 100 per cent bulk-billing, for example for Aboriginal and Torres Strait Islander people and also people who are refugees in our community—the very vulnerable. We provide direct funding to GP services to provide bulk-billing services there.

We have a range of interventions in place but clearly this continues to be a challenge for the territory.

THE CHAIR: I have some questions in this area that I would like to ask. Minister, I want to ask about the first smiles program, which is in this output class, 1.6, early intervention and prevention, if you could get someone to tell us a little more about it please. I understand it is an early intervention program focusing on caries in young children.

Mr Corbell: I think I will have to take it on notice, Dr Bourke. I am sorry.

THE CHAIR: I will get some other questions in so that I can get some more details in the answer. Who in your dental team is delivering the program? How often is it delivered? What are the messages they are delivering? What are the outcome measures you are using to assess the success or otherwise of the program?

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

THE CHAIR: Mr Wall, a question?

MR WALL: I will defer to Mr Hanson.

THE CHAIR: Ms Lawder?

MS LAWDER: Thank you; Mr Hanson.

THE CHAIR: Back to you, Mr Hanson.

MR HANSON: About a year ago a new home doctor service started operating in the ACT. It was a group that came up from Sydney. I think it is actually Kristina Kenneally's husband that runs it. I cannot remember the name of it, but it made a bit of a splash when it arrived, I remember, because they were going to be doing a bulk-billing home service. Has that had any impact? Are you aware of that service and how it has been operating?

Mr Corbell: I recall the announcement when it was made public.

MR HANSON: The company's face is Ben Kenneally. Sounds right?

Mr Corbell: Could be the same bloke. But I have not received any advice as to its activity or whether it has made any overall impact.

MR HANSON: I am just wondering because it is after-hours and in-home services bulk billing, and it was announced that this might be something that would make an impact, but you have not—

Mr Corbell: No; I do not have any specific advice.

MR HANSON: You have not had any engagement with them at all?

Mr Corbell: No, not to my knowledge.

MR HANSON: When it comes to GP services, the division of GPs has evolved into its new structure. Who do you seek and get advice from? Is it the AMA?

Mr Corbell: I think there are two key areas. Obviously the AMA is a key advocacy organisation industrially and a policy perspective for doctors. I meet with the AMA, and there is a range of issues that they raise. In terms of service delivery and broader issues around policy, the Capital Health Network are a particularly important source of engagement for the government because they are representing and working with general practice in terms of service delivery in the community, identifying gaps and identifying opportunities for strengthening service delivery at the primary health care level. Capital Healthcare Network is another important source of advice.

MR HANSON: Have you had any discussions—

Mr Corbell: We also have in-house GP advice capability. A professor of general practice reports directly to the D-G, and there is also a GP adviser as well.

MR HANSON: Have you had any recent conversations with Winnunga Nimmityjah Aboriginal Health Service?

Mr Corbell: Yes, I meet with Winnunga quite regularly.

MR HANSON: Because they are, I think, looking to expand. They are treating more people than they potentially have capacity for, as I understand it.

Mr Corbell: I am certainly aware Winnunga have a range of projects in train to increase their capacity. My approach on that is that I am very willing to work constructively with Winnunga on all of their proposals and identify the best way forward for each of those. I feel that we as a government have a very constructive relationship with Winnunga.

THE CHAIR: Minister, looking at immunisation rates for Aboriginal and Torres Strait Islander children, strategic objective 14 on page 45, the indication is that your 2014-15 results have exceeded your target, although you acknowledge that in many categories immunisation rates for Aboriginal and Torres Strait Islander children are lower than the general population. How do these results compare with other jurisdictions?

Mr Corbell: I can give you a comparison against the coverage rate nationally, Dr Bourke. I do not have a breakdown on a state and territory basis but, again, in

those three cohorts I mentioned—I will not outline the criteria for each of those cohorts—in cohort 1, we sit at 92.91 per cent, with the Australian rate at 87.7, approximately; in cohort 2, in the ACT, 84.25, with Australia at 86.75, so slightly below the coverage rate in cohort 2; and in cohort 3, for the ACT rate, 94.31, with the Australian rate 93.48. So it is slightly better in two of those cohorts, and slightly behind on the other one.

THE CHAIR: What are you doing to achieve the success rates that you have managed to achieve?

Mr Corbell: I think the point we would make in relation to these figures is that it is a very small cohort overall in terms of total numbers.

THE CHAIR: Probably about 100 kids in each one.

Mr Corbell: The movements in and out of families and changes in the number of people physically present in the territory and factors like that can see data fluctuate significantly in percentage terms.

THE CHAIR: I presume there is a reasonable amount of coordination with Winnunga as well?

Mr Corbell: Yes; Winnunga would be a key service provider for this population.

THE CHAIR: There are no further questions.

Mr Corbell: Mr Chairman, before we conclude, to answer a question that was taken on notice earlier in relation to phone calls from the community health intake line, a question was asked about the volume of calls. For level 1, calls handled for the year 2014-15 were 119,125, a 29 per cent increase from the previous year. For level 2, calls handled totalled 12,896, a more modest two per cent increase from the previous year.

THE CHAIR: Level 1 and level 2 calls?

Mr Corbell: I would have to defer to somebody else.

Mr Thompson: Level 1 is the initial contact; level 2 provides further clinical placement, so it is for those for whom further information is required or discussion is required about what the appropriate services are. They get transferred to level 2 rather than simply being managed in level 1. That is why there is such a difference between the two numbers.

THE CHAIR: I think it was a 29 per cent increase, you mentioned, minister. That is probably due to the transfer of the mental health program over to that area?

Mr Corbell: I would have to get some advice on the reasons.

THE CHAIR: Before we adjourn I remind the committee that supplementary questions are to be lodged with the committee secretary within four business days of

receiving 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 within five business days after this hearing, with day one being the first business day after the question was taken. This brings us to the end of this committee's hearings for annual and financial reports 2014-15.

The committee adjourned at 4.59 pm.