LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2018-2019

(Reference: Appropriation Bill 2018-2019 and Appropriation (Office of the Legislative Assembly) Bill 2018-2019)

Members:

MR A WALL (Chair)
MS T CHEYNE (Deputy Chair)
MS C LE COUTEUR
MS E LEE
MS S ORR

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 21 JUNE 2018

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

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 20 May 2013

The committee met at 9.30 am.

Appearances:

Rattenbury, Mr Shane, Minister for Climate Change and Sustainability, Minister for Justice, Consumer Affairs and Road Safety, Minister for Corrections and Minister for Mental Health

Health Directorate
De'Ath, Mr Michael, Interim Director-General
Vivian, Mr Trevor, Chief Finance Officer
Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
Shuhyta, Ms Amber, Director, Mental Health Policy Unit

THE CHAIR: Good morning, and welcome to day five. Today we are looking at the Health Directorate and budget statement C. I trust everyone is familiar with and aware of the privilege statement that is in front of you?

Mr De'Ath: Yes.

THE CHAIR: Minister, we have been trying to avoid opening statements this year. You are not going to break the trend?

Mr Rattenbury: No, I am very happy to go straight to the things you are interested in.

THE CHAIR: Minister, of the $195 million budgeted in 2018-19 for output class 1.2, how much of that is dedicated to justice health? I am referring to page 12.

Mr Rattenbury: Give us a couple of minutes and we will come back to you on that one.

THE CHAIR: How does that compare to the estimated outcome of expenditure for justice health in 2017-18?

Mr Rattenbury: Again, we will take it on notice, but within five minutes.

THE CHAIR: Whilst you are looking for that, how many employees by head count and FTE are currently dedicated to the justice health portion of the output class?

Ms Bracher: Justice health services within ACT Health comprises the Dhulwa mental health unit, the services out of the prison—primary care and the forensic mental health services—and the forensic mental health services across the community as well. So it is a broad group of people: nurses, doctors and allied health staff. The total budgeted FTE is in the order of 100 to 120 staff. I have to take on notice the breakdown.

THE CHAIR: Can I have a breakdown of how many are in each stream of the output class, given that it is quite a broad capture?

Ms Bracher: Yes.

THE CHAIR: Is the funding in the budget for the Winnunga model of care at the AMC included in the funding for output class 1, or is that funded from elsewhere?

Ms Bracher: The funding for the Winnunga model of care will be through the mental health policy area, the policy area of ACT Health. As to where it has been allocated within the budget, the CFO would have to answer that question.

Mr Vivian: I will have to take that question on notice.

MR MILLIGAN: In relation to funding provided to Winnunga for services—I am referring to page 18 of budget statement C—there is $797,000 allocated for 2018-19 and $814,000 for 2019-20 to provide a model of care. What is the model of care that will be provided? Has there been some sort of agreement with Winnunga in relation to that?

Mr Rattenbury: This arises from the recommendation in the Moss review that we have a dedicated Aboriginal health provider, and the Moss review specifically named Winnunga. The government has funded that, and are currently finalising the details of the exact model of care with Winnunga. Obviously a degree of care is being taken in making sure we get that right.

The government obviously retains the overall duty of care to our detainees and any clients of our health services. At the same time we are obviously very keen to have this partnership with Winnunga. They have expressed a view to me that they are keen to make sure they build it up in a way that is carefully thought through and sustainable. So we are just working through the details of getting that right.

MR MILLIGAN: What will their presence be at AMC? Have you had that discussion? Will it be five days a week or seven days a week?

Mr Rattenbury: That is part of ongoing discussions.

MR MILLIGAN: Will the model of care be provided for all detainees or is it Indigenous-specific?

Mr Rattenbury: I expect that to be finalised as we go through the details. The discussion so far has been that it will be available to all detainees. Equally, Indigenous detainees will not be expected to attend the Winnunga service; they will be free to choose. If they prefer to remain being treated by ACT Health staff they will have that freedom as well. We will essentially be operating a choice model for detainees.

MR MILLIGAN: Will Winnunga be working with ACT Health on cultural awareness so ACT Health can also provide services to Indigenous in much the same way as Winnunga?

Mr Rattenbury: ACT Health already has cultural awareness training in various forms through its system. But an inevitable exchange of understanding and capability and

culture awareness will go on by having the two services operating side by side. I would like to think that over time the level of integration will increase, the partnership will grow even stronger and there will be knowledge and capability transference between both agencies.

MR MILLIGAN: So potentially there could be a difference between Winnunga and ACT Health? I am trying to ascertain what ACT Health cannot provide that Winnunga can? Is it mainly cultural awareness?

Mr Rattenbury: Different people would have a different answer to your question, Mr Milligan. Clearly Mr Moss identified in his report that he saw advantages. Winnunga make the case very strongly that their model of care is particularly suitable for Indigenous detainees. Often the people who are in custody see Winnunga before they go to custody and see Winnunga when they come out of custody. Having that continuity of care whilst they are in the AMC is a particularly attractive feature that ACT Health cannot offer because they are not seeing them before and afterwards.

MR MILLIGAN: Potentially Winnunga could integrate their operation of systems into AMC and use their recording of detainees and past history?

Mr Rattenbury: One of the important elements of this partnership will be information sharing. Winnunga have their own systems, and they will bring that to their treatment of care. But if they are operating a service, for example, from 9 am to 5 pm, there will need to be handover because AMC will have responsibility for other times. They are the important details that are being worked on at the moment.

MRS DUNNE: I presume that there is thinking going on about how Winnunga will integrate with the other services. That will also include the methadone program, I am presuming?

Mr Rattenbury: Yes.

MRS DUNNE: Is it envisaged that Winnunga will participate in the methadone program, the actual administration of methadone?

Ms Bracher: The discussions that we have been having with Winnunga to this point are that they will be providing all of the care that the particular detainees that they are seeing need. That would include the methadone program for the detainee needing that.

MRS DUNNE: You have introduced a new methadone dispensing system at the AMC, the idose system. Has that rollout been completed?

Ms Bracher: It has.

MRS DUNNE: What have you learned from that? Is it a more effective system? Is it a quicker system, a slower system? How does it work?

Ms Bracher: We have learned a lot from implementing the project. Clinically, idose is a much safer way of administering medication. The identification of a detainee and their prescribed dose are far more accurate through the electronic system. We have

learned a lot in terms of implementing that in a prison environment, which is different from an ordinary clinic environment. We have learned a lot, yes.

MRS DUNNE: It has been put to me that it may be quite resource intensive. Is that the case?

Ms Bracher: It is actually the opposite, Mrs Dunne. We have been able to free up nursing time to do nursing clinics out of the prison through implementing idose. The manual counting of all of the medications that was required prior to idose was an extraordinary use of nursing time. It was an appropriate use of nursing time in the absence of an electronic system, but it was an extraordinary time commitment.

THE CHAIR: You mentioned that prisoners at the AMC will have choice in their health service provider. Will they be able to go between ACT Health's provided services and Winnunga's services on a daily basis depending on what their need is?

Mr Rattenbury: Potentially, yes. We do not intend to constrain their participation.

Ms Bracher: ACT Health and Winnunga, in our discussions, have been very clear that the choice remains with the detainee. We have also been very mindful of the activity that can happen in any system of doctor shopping. There will have to be very clear communication between Winnunga and justice health services with regard to who the primary treating team is at any given point in time. Corrections also need to know that information for the safe running of the prison.

THE CHAIR: Will information within patient records be shared between the two providers to ensure that there is no doubling up or crossing over?

Ms Bracher: Absolutely, with the consent of the detainee, other than risk information; risk information we share.

THE CHAIR: You have just mentioned that Winnunga will be providing a methadone service. How will both the existing health services and corrections themselves ensure that no one detainee is managing to double dip on the methadone program? You know the incidents that have resulted in a couple of deaths at the AMC. A big part of the illicit culture there is stockpiling of methadone. How are we going to safeguard against that or any other pharmaceuticals being prescribed more than once?

Ms Bracher: For any health care, including methadone, the two clinical teams will have to be absolutely certain who the treating team is. Both Winnunga and justice health have given a commitment to each other not to take on care if the detainee is being treated by the other team. That includes for methadone.

Mr Rattenbury: Mr Wall, you just made a passing remark about the causal basis of at least two deaths in the AMC. I do not believe that was accurate.

THE CHAIR: It was a contributing factor but not the—

Mr Rattenbury: I just need to put on the record that we do not accept quite the

assertion, though I do not think you intended to make a particular assertion.

THE CHAIR: Not to that extent, but certainly it is a significant concern that someone might go from one program to the other.

Mr Rattenbury: I agree with that point, yes. That is fair point.

THE CHAIR: Be it methadone or be it any other form of medication.

Ms Bracher: In relation to the other point you made in terms of diversion, we have a very tight system, which Winnunga will have to be part of, with corrections to communicate who is on the methadone program and who is not on the methadone program. Corrections have a very important role in monitoring and managing the diversion, just as the justice health team do. That will not change with Winnunga being in there.

MS CHEYNE: I note on the accountability indicators page that on arrival at both AMC and Bimberi, detainees get an assessment within 24 hours. That is a 100 per cent target that is seemingly easily met. Are you able to talk me through why that is a target, why it is important for that to be a target, what happens with it being met, and whether any conditions have occurred which might affect it being met this year? I assume no, given that it is still 100 per cent, but I am just keen to know.

Ms Bracher: In both Bimberi and the AMC, the two pieces of legislation—the Corrections Management Act and the Children and Young People Act—have within that legislation a requirement that all detainees or young people at Bimberi are seen within 24 hours and have medical assessment within 24 hours. That is a duty of care that the state is obliged to provide to anybody who is detained within care. The two accountability indicators that you see there are really a monitoring of our regulatory requirements in both of those domains.

At the AMC, we have a very organised process with corrections where the detainees all enter an admissions area. Our health staff, both forensic mental health and the primary care team, are in the admissions area with corrections to undertake that health assessment. That is a screening assessment at that point in time. It is about risk; it is about making sure that any health conditions that the detainee might have continue to be managed in the prison. Corrections also do their intake process at that point in time.

At Bimberi we have a slightly different process, but nonetheless we are notified of any young people being detained at Bimberi, and we see those young people, as well, within 24 hours.

MRS DUNNE: In those accountability indicators, could somebody talk me through accountability indicator g, the percentage of clients on opioid treatment with management plans? Why is that not 100 per cent? There is a footnote, but could somebody talk me through why that is not 100 per cent? That is on page 16.

Ms Bracher: That is an indicator that relates to our alcohol and drug service out at building 7. The reason for having an opiate treatment plan is obvious at some level, but it is really around ensuring that each person on our opiate treatment service

program in the community has a key worker; has that key worker assessment, the key worker usually being a nurse; and then has a full assessment by an addictions physician to monitor and—

MRS DUNNE: These are people in the community; these are not people in the AMC?

Ms Bracher: That is correct.

MRS DUNNE: Sorry; because of their proximity, I thought that they were inmates. Perhaps it needs to be clearer.

Ms Bracher: The reason that it is not 100 per cent is that sometimes we see the patients in the community in collaboration with their GPs, and the management plan might be there.

MRS DUNNE: I had a basic misunderstanding of that. It was probably just the proximity in the list. I was assuming that it was corrections health rather than wider community health. Thank you for that.

Ms Bracher: Those indicators relate to the division that I manage.

MRS DUNNE: Sorry. Perhaps the labelling could be a little better so that people do not make rookie mistakes like that.

Mr Rattenbury: Yes, sure.

MS LE COUTEUR: Budget paper 3, page 116 has more money for mental health care for older Canberrans which is, basically, what I am interested in. I have got a number of questions: basically, what is happening, how is the service being expanded? I suppose that is the summary of the questions.

Ms Bracher: Thank you for the question. Our older persons mental health service is a community-based service. We provide in-reach into aged care facilities, we treat people in their homes and there is some clinic-based work. We have psychiatrists and mental health clinicians in that service. This initiative here is the continuation of some growth money that we received two years ago and that was extended for a further year last year.

With the outcomes that we have been able to deliver through that program, government has provided ongoing recurrent funding. This particular funding includes a nurse practitioner that we are currently recruiting so that they can do extended scope nursing care in the community for older people. This initiative also includes about three staff—three-point number of staff—who are part of our intensive treatment team. They provide care in aged care facilities, in-reach care in aged care facilities, so that people can age in place but still receive their specialised psychiatry and mental health care.

It is really aimed at, like many of our assertive treatment teams, keeping people as well as possible in the community where they live, whether that is in an aged care facility or in their home, and to stop the need for a hospital admission. We have had

some really fantastic data out of this team so far over the past two years in terms of the number of people they have been able to keep out of hospital and out of the aged care unit at Calvary.

MS LE COUTEUR: Particularly, how is dementia being treated as part of this? Is it going to be a high-priority needs group? I am aware from my own experience that most nursing homes these days seem to have dementia units, wards, wings—whatever they are called. Are you going in and helping the residents there?

Ms Bracher: With regard to dementia being a complex scenario for older people, we provide the mental health, the psychiatric care. Dementia, by definition, is not necessarily a psychiatric condition, an illness. It is an ageing process. We do work very carefully with people and very closely with people and the services for people who might have dementia and a mental illness. It is a multi-disciplinary approach, if I can say that. The dementia care actually comes from the staff in the aged care facility, with in-reach from a geriatrician, mostly.

MS LE COUTEUR: You would not get involved just because somebody has dementia?

Ms Bracher: No.

MS LE COUTEUR: It would only be if they had dementia and something else?

Ms Bracher: A mental illness.

MS LE COUTEUR: It may, of course, for many patients with dementia, be incredibly hard to determine.

Ms Bracher: Older person psychiatry is a sub-specialty area of psychiatry for that very reason. It is a complicated area and a highly specialised area, and they do work very carefully and very closely with geriatricians for that reason.

MS LE COUTEUR: I note that the ACT has been having difficulty recruiting enough psychiatrists. Given that you said aged care psychiatry is an even more specialised area, have we got sufficient clinicians? Can we recruit them?

Ms Bracher: Generally we have a workforce shortage in psychiatry. There is no secret about that. We had discussions in this forum previously. With older persons psychiatry, we do have a number of psychiatrists who have been with our service for a long time—very experienced psychiatrists. We are fortunate in older persons psychiatry. Could we use more? Yes. We are recruiting for older persons psychiatrists as well. But we do have some very experienced older persons psychiatrists currently on board with us.

MS ORR: On the same page, 116—and Ms Le Couteur has noted the services for older Canberrans—there are also services for younger Canberrans. I am going to note that in this budget there is quite an extensive range of mental health initiatives. Can you just run me through those for younger Canberrans? We are not missing out on any age group? Also, those who are not old or young, what are we doing for them?

Ms Bracher: The initiative related to the younger Canberrans is for our CAMHS. It is an assertive outreach service. There are 5.6 FTE, I think, in that initiative. It is really around assertive treatment in a similar way to what the older persons assertive treatment service is. That model already exists in the adult domain. Our community mental health teams do a lot of home visiting for the adult domain. With this initiative we will be able to provide that service for adolescents from 12 to 18-year-olds. That is really around supporting families, supporting the child to stay within the family unit with their illness, supporting families to learn how to manage a child with a mental illness and a young person with a mental illness in the family unit and to prevent hospital admission. It will also be a very important component of early discharge or support after an admission to hospital for those families and those young people.

MS ORR: There has been quite a focus on providing more mental health beds at the hospital, in the wards. But it sounds like there is a quite a focus, from what you have just said, on supporting families to keep kids out of those areas. Can you run through a little more, I guess, the treatment perspective for why one might be better than the other or when one is more appropriate than the other?

Ms Bracher: What we are trying to do in our child and adolescent mental health service is also build a step model of care. And that step model of care goes across all the age domains in mental health. And we do that quite deliberately. With mental health care, people should get the care at the right place for them at the right time of their illness, acknowledging that mental illness can be a fluctuating illness, fluctuating between ill health and better health. For the person to receive the care in the right place for them is really important. Primary care and GP-provided care and community sector care is a really important broad base for children and families receiving mental health care.

In the event that the risk or the complexity of their care increases we need to have a different service system and that is where the secondary community-based services like our child and adolescent clinic-based services and now this assertive treatment service and our crisis teams in the community come into play, all with the intention of being able to support people where they are and improve their health where they are.

In the event that the risk is too high for the young person to stay in the community we choose an admission, in consultation with the family. We advise that that is the safest place for the young person to be at that point in time. But we do that with the intent of stabilising the young person, managing the risk at that point in time—not completely eliminating the risk but managing the risk with the family—and then supporting the young person to go back into that family unit to live as normal a life as they can within their family unit, supported and managed.

MS ORR: The focus is very much on making sure they get the treatment they need when they need it but with a view to making sure they can live within the wider community and manage that?

Ms Bracher: Yes, for young people to certainly be able to participate in school and all those other really important developmental things that children need to do to grow into being an adult.

MS ORR: And what role will the office for mental health take in supporting, I guess, both these initiatives we have been talking about plus the others?

Ms Bracher: I think it is fair to say that that will come into view over time but Amber might like to speak more specifically on this.

Ms Shuhyta: I acknowledge the privilege statement. I understand the question was: what role would the office for mental health play in increasing supports for young people? Is that it?

MS ORR: Yes, and I guess more broadly some of the other initiatives that we are taking within the mental health area.

Ms Shuhyta: The office for mental health really acknowledges that the importance of good mental health for Canberrans requires a coordinated approach across the service system, across government, across different agencies and really is being established to provide that leadership and integration for the number of mental health initiatives happening in Canberra.

If we are looking at young people in particular there are a range of specialist services from Ms Bracher's area but there are also a number of community services that Health fund. There are a number of initiatives that Education is rolling out and there are a number of initiatives in the justice reinvestment space. There are a number of initiatives in the primary health space through the Capital Health Network and, with the amount of work that is going on to increase supports for people across the age span, there is a lot of good work going on. The gap is around leadership and coordination of those services.

We have a fuller understanding of what is happening and what could be happening better. We have a better understanding and a better coordination of services, coordination of those agencies delivering services, pulling together, not duplicating services, filling the gaps, working well together, creating a seamless service system. The office for mental health is a great addition to the service system to really provide that leadership and coordination.

MS ORR: I note that the office is taking a little longer than expected to get up and running. Is that because it has been bringing everything together?

Mr Rattenbury: There have been a number of things going on. We have had an extensive process of community consultation and that has been a fine balance. Some people actually wanted us to take longer, do more consultation. Others were saying get on with it. That has been a bit of a balancing act.

The other part of it is that is has gone through a full cabinet process. I think for me that was quite important because one of the key outcomes of that cabinet process was a whole-of-government sign-off on a remit for the coordinator-general and the office for mental health. Cabinet agreed it would be a coordinator-general and all ministers agreed that they would have a remit to operate across other government agencies. Again, putting a cabinet process in adds time but ultimately it will produce a better

outcome because there is now a whole-of-government acceptance that the coordinator-general has to be able to talk to Education, to justice, to various government agencies and make sure that we are coordinating those mental health efforts more thoroughly.

MS ORR: Was that need for coordination across the directorates something that came out of the consultation?

Mr Rattenbury: I think one of the key bits of feedback we get from the community is a sense that it can be hard to navigate your way through the system and there is a lack of linking up of some things. For example, how do school counsellors and school psychologists working in the education system relate to ACT Health services, these kinds of questions. They are the things we want to make sure are as seamless as possible.

MS ORR: Now that the office is established what are the priorities in the short term?

Mr Rattenbury: In the short term we already have a number of staff on board and they are working to raise awareness of the office, build those linkages with other agencies, find out where people are committing resources—those sorts of questions that we were just reflecting on.

We are in the process of recruiting the coordinator-general. That is a national search to find the right person. We need to find someone with the right mix of skills and the right ability to drive change, be a change leader. And when they come on board they will produce a detailed work plan within 100 days of taking up the position.

MS ORR: Maybe by annual reports?

Mr Rattenbury: We can certainly have a further discussion by annual reports but work is already going on and the team are getting going with that.

MS CHEYNE: Talking about the step up, step down model of care, I note that we have that facility on the north side, which I have been able to tour a few times. It is excellent. But also the budget commits to establishing one on the south side, which I know has been called for for a long time. It will help in terms of students' travel, getting to school and things like that. In terms of the initiative, when do you expect that facility to be actually up and running with the money that is committed across the forward estimates?

Ms Shuhyta: Thanks for that question. I just clarify that there are three step up, step down facilities already existing. There is the north side adult step up, step down. There is also a step up, step down for younger people based in Kambah. There is also a youth step up, step down and a child and adolescent step up, step down.

Those three services run as partnerships with mental health, justice health, drug and alcohol services and some NGOs that are running those services. There will be a fourth step up, step down added with the south side community step up, step down in the budget paper. There is a schedule of works around designing and securing the appropriate facility. At the same time that that is happening, we will be running a

procurement process for a suitable NGO to partner with to provide the psychosocial supports in that service.

In respect of the exact date, I am not sure if the schedule has finalised when that building will be ready and the partnership ready to go. But definitely that work is underway and developing.

MS CHEYNE: As a ballpark, is it 18 months, 24 months, five years?

Ms Shuhyta: We are going to market now for a design team.

MS CHEYNE: Yes.

Ms Shuhyta: In terms of the ballpark—please take it as a ballpark—

MS CHEYNE: Yes, I will not hold you to it.

Ms Shuhyta: The second half of 2020 will be when that is looking like coming online. When we have a consultant team on board they would be able to firm up that program of works, once we start through the design process.

MS CHEYNE: It is just for adults?

Ms Shuhyta: It is an adult—

MS CHEYNE: Are we also looking at one in the future, perhaps a south side facility for adolescents?

Ms Shuhyta: We do not have those plans on the planning horizon.

Mr Rattenbury: We do have the one at Kambah that Ms Shuhyta referred to.

MS CHEYNE: Yes.

Ms Shuhyta: Yes, and it has been flagged with us by the NGO that runs our adolescent step up, step down around looking at, into the future, what our strategies are to create a more centralised facility or program that enables student travel, as you mentioned, for the south side.

MS CHEYNE: So it is on your radar—

Ms Shuhyta: It is in the initial discussions, but nothing has been secured, as in a plan.

MRS DUNNE: Just on the money in the budget, you mentioned a figure of five point something FTEs in this brochure. Will those staff be dedicated to adolescent mental health or will they just be an addition the existing CAMHS establishment?

Ms Bracher: They will be part of the CAMHS program area, but they will be very clearly recruited to be a team that does that outreach service.

MRS DUNNE: So they are part of the establishment but they are, at the same time, dedicated to children and adolescents. What sorts of hours will that be operating if there is only 5.7, or whatever the number is?

Ms Bracher: CAMHS is all dedicated to children and adolescents, other than the perinatal service, which focuses on women as well. The hours that that outreach service will be looking to provide care is seven days a week, possibly into the early evening. We need to finalise that model of care, but into the early evening. Crisis care after hours will be through our crisis team and the usual emergency services that the mental health service use.

Part of our thinking is really around supporting families—acknowledging the huge generalisation here—that tend to be at home with their children in the evenings and not during the day. Part of it is really around targeting support for the child and young person and to give the family the capacity to continue to engage in the other components of their life as well.

MS LEE: I am happy to continue with mental health. I have a couple of follow-up questions. Ms Bracher, you talked quite a bit about adolescents. On page 116 of budget paper 3 you have specific outreach programs for young Canberrans from 12 to 18. We know that there has been anecdotal evidence at least to suggest that mental health issues are impacting younger and younger children. What role will the office of mental health have in looking at the needs of those younger and younger children?

Ms Shuhyta: The office of mental health, as I discussed before, will provide that oversight across the lifespan and across the service system. It will aim to have a broader understanding of the needs of the young person age group, not just having the focus on what specialty services are being run through mental health, justice health, drug and alcohol services but also around the interfaces that young people have with our NGO supports, with education, with justice, with housing.

So it is looking for a true early intervention approach. We need to look beyond just people needing health treatment for all illness. We need to look at how we pull together a cross-government approach to improve a range of different services and a range of different supports to meet a range of different needs. The office of mental health will be having that as a key priority in the work plan that it develops.

There is work underway already to establish what the evaluation framework for the office will be, so what success will look like. Improving mental health for young Canberrans is a big part of that.

Mr Rattenbury: Just on that, Ms Lee, there are already obviously a number of programs in place. Particularly for those under 12; they tend to be operated through Education. This is programs like KidsMatters and other things like that. You may have seen earlier in the year that we have just funded Menslink to establish new programs, as you have reflected on.

There is at least an anecdotal, if not more substantive, observation that younger and younger people are presenting with mental health conditions. So we have rolled a new program with Menslink. They put that proposition to us to say, I think in a very

confronting way, that they are seeing young men—10 and 11-years-old—presenting with quite serious concerns.

MS LEE: Minister, you earlier talked about being on a nationwide hunt for a coordinator-general. I know that Ms Orr gave her view. She hoped that by annual reports hearings we will have some answer. Do you have a time frame on when the coordinator-general might be in place?

Mr Rattenbury: As soon as we can practically get it done.

MS LEE: So shall I pin my hopes, as Ms Orr did, on annual reports, that there might be some—

Mr Rattenbury: I am not sure that I would drag them before the annual reports hearings in the first bit of their term. But we will see how that goes.

MS LEE: It would be a good initiation.

Mr Rattenbury: I would like them to stay once we get them.

MS LEE: Do you have the figure for the salary of the coordinator-general?

Mr Rattenbury: Yes, I will defer to the director-general on that.

Mr De'Ath: The role is a very senior role. It is graded at a 3.7. I am sorry, I do not have the exact salary figures, but that is one of our most senior deputy classification roles. Just to support the minister's comment before, that recruitment is well underway. We have an executive search consultant on board. We have met with that person to take a detailed brief. He is underway with that process. We will be moving that process through as quickly as we possibly can, but as comprehensively as we can as well, so as not to compromise the quality of a good candidate.

MS LEE: In terms of the additional staffing for the office, I know that we sort of threw a couple of FTEs around. Can you confirm for me exactly the structure in terms of the staffing and how many will be qualified? I acknowledge that you have acknowledged that there is a shortage of psychiatrists. Can you give a bit of a structure for FTEs and staff?

Mr Rattenbury: We might have to provide that to you on notice so you have that full detail.

MS LEE: That would be great, thank you. We would appreciate that.

Mr De'Ath: Acknowledging that it is still being finalised and some components of it as well.

MS LEE: Yes, I understand. Thank you. The consultants: is the pronunciation Synergia?

Mr Rattenbury: Synergia, yes.

MS LEE: Synergia recommended that the office of mental health and wellbeing be independent of ACT Health. That is not the direction you have taken. Why is that?

Mr Rattenbury: I did reflect on this quite a bit. We canvassed a number of possible models. We could have gone for a full legislative model. We thought about whether it perhaps should sit in the central agency—so over at Chief Ministers—or whether sitting with ACT Health was the best.

I really did reflect on this quite a bit. I ultimately formed a view that Health is obviously the primary contact point for much of the mental health work. But I go back to my early comments about needing that whole-of-government perspective. I think having a sponsoring agency is actually very helpful.

Having our sponsoring director-general, who is at the table for the strategic board within government and who can help the coordinator-general navigate I think will be advantageous. Equally, though, the coordinator-general and the office will have the ability to undertake any report they want to. As I mentioned earlier, they now have a whole-of-government remit. They are free to go and talk to anybody they want to.

I feel we struck the right balance there of providing an adequate level of support by giving them the independence and freedom to report directly to me as the minister. They will appear before estimates and other committees. They have that freedom to commission any report they want to.

Mr De'Ath: Yes, just to add to that, Ms Lee, having had direct experience with the Office of the Coordinator-General for Family Safety I think we have learned a lot about how to work this sort of model. That, I think we would all acknowledge, has been very successful to date in terms of how that role integrates across government and, in line with what the minister has just said, supported by a director-general or across directors-general. I think that it has been particularly successful. We see similar success arising out of the model that has been applied here now.

MS LEE: Minister, in an article in the *Canberra Times* on 3 June you said that the office of mental health and wellbeing will not be part of the ACT Health policy agency. Is that still the case?

Mr Rattenbury: Correct, yes.

MS LEE: It is confirmed?

Mr Rattenbury: Yes, if I put it in org chart terms, they will sit outside the policy unit and they will have a direct line to the director-general.

MRS DUNNE: I have seen a copy of the current consultation on the org chart for the new health structure and the office for mental health does not appear on it anywhere. Where will it appear?

Mr De'Ath: Thank you for your question, Mrs Dunne. That is quite simply because at the point that org chart was put out the office—

MRS DUNNE: 7 June?

Mr De'Ath: The office had not been announced at that point.

MRS DUNNE: Okay. So where will it fit?

Mr De'Ath: The office of the coordinator-general will report directly to the Director-General. It will sit along to the side.

MRS DUNNE: Okay, right. So the coordinator-general reporting to Minister Rattenbury and to the Director-General?

Mr De'Ath: Correct.

MRS DUNNE: Great, okay. Thank you.

MS ORR: I want to focus on some of the other budgetary announcements and the accommodation services. I have a few books open here. Page 116 talks about more mental health accommodation. Can you run me through what that funding will be providing?

Mr Rattenbury: This is one of the bits of the budget that has been very well received by the community sector particularly. There are three main components to this. In no particular order, the first is an upgrade of the extended care unit at Brian Hennessy Rehabilitation Centre. This will be a secure facility or a locked facility to help people transition back into the community. That is targeted at people who have a higher level of acute need.

The second is the step up, step down facility on the south side, which we discussed a little bit before. I will not go into more detail on that. The third is three community-based mental health accommodation facilities. These are designed to be houses that accommodate up to five clients and a carer on a 24-hour basis. This is targeted at people who have an enduring mental health condition but who exhibit a degree of independence.

If we just put them out into the community, perhaps into a government home by themselves, they probably would not go okay and might end up being readmitted or end up involved in the justice system. We want them to have as much independence as they can. It is designed to be that point between the two of being in a facility or being by themselves, but having the ability to live in the community but with a degree of support.

MS ORR: Are any of those targeted at specific age groups or will they be for all age groups?

Ms Bracher: Adults.

Mr Rattenbury: Adults.

MS ORR: Adults, thank you.

Ms Bracher: Over 18s, but certainly adults.

MS LEE: Is there a gender divide there?

Ms Bracher: We are not anticipating that, no.

MRS DUNNE: I have a quick comment rather than a question on that budget item. I found the presentation of that in the budget papers much more helpful than just about any other, because you have the combination of the recurrent and the capital in the one place, rather than flipping backwards and forwards. I compliment you on that.

Mr Rattenbury: Yes, thank you. I will let treasury know. For the first of those three houses, we are starting consultation this Saturday in Florey. ACT Housing have written to the neighbours already. As a member for Ginninderra, Mrs Dunne, you might be interested in this one.

MRS DUNNE: It is not Berne Place, is it?

Mr Rattenbury: I do not know.

MRS DUNNE: It is not in Berne Place?

Ms Bracher: No.

MRS DUNNE: Right; good.

Mr Rattenbury: That is getting underway this Saturday. They are intended to be houses in the community.

MS ORR: That raises a good question: will they be located across Canberra? You have indicated that the first one will be in Belconnen.

Mr Rattenbury: Yes.

MS ORR: Are you locating them across Canberra to provide people with support within their local community? Is that the intention?

Ms Bracher: Absolutely across Canberra. We are anticipating three houses that loosely relate to our community mental health teams. Community mental health care will be provided through our current public health services. The people will—we are anticipating—all be eligible for an NDIS package so that they will receive their care and support. Many of those people will require 24/7 care. The design of those homes means they will have capacity for a live-in carer, if that is required. Does that answer your question? Was there another bit? I cannot remember, sorry.

MS ORR: What I was trying to get at more is this: as this is seen as a support service for people who are not quite ready to go back into the community—but you do not want to be stepping them up to a higher or I guess a more removed level of care—how

do you intend to manage how they interact with the community so that they can be rehabilitated and go back out there?

Ms Bracher: Could I confirm that these houses are for people who are ready to be in the community. They are ready to be in the community with a level of care and support, like any person with a long-term illness or disability who is able to live within the community.

The people that are not quite ready to live independently in the community may be the people that we admit to the step up, step down facility. In that step model of care, we provide an increasing level of care. The homes with Housing ACT are intended to be a home for people for as long as they need to live in there or want to live in there.

MS ORR: The accommodation packages fit quite nicely within the step up, step down program?

Mr Rattenbury: That is the way we have tried to design it, yes.

MRS DUNNE: Could I ask some more questions about the office for mental health? There is $2.9 million over four years for the core staff. What other budget is allocated to the office for mental health?

Mr Rattenbury: Within that money, Mrs Dunne, there will be I expect some latitude for expenditure by the office for seeking research and other things. Certainly once they are up and running, I anticipate they may also come forward with further budget bids to support any work they want to do.

MRS DUNNE: So the office for mental health will not have control of the mental health budget?

Mr Rattenbury: No. It has been part of the research. There are different models in different jurisdictions. Some of the mental health commissions have been full commissioning agencies. They spend the whole mental health budget. We in the ACT opted not to go down that path.

MRS DUNNE: So who has control of the mental health budget in the ACT?

Mr Rattenbury: Ultimately I do, I suppose.

MRS DUNNE: Ultimately you do, you suppose?

Mr Rattenbury: Well, I—

MRS DUNNE: Sorry, how do—

Mr Rattenbury: I am trying to anticipate the question you are about to ask me, which is why I put a caveat in it. You know, it is—

MRS DUNNE: Do you have control of the mental health budget?

Mr Rattenbury: I do not want to get too philosophical. The Assembly does, then the cabinet, then the minister, then the Director-General and then the staff who apply it day to day.

MRS DUNNE: As the Minister for Mental Health, you have control of the mental health budget?

Mr Rattenbury: I think the answer to your question is yes, but I am not sure what you are trying to ask me.

MRS DUNNE: I am trying to ask who the decision maker is about the expenditure related to the mental health budget. Is it you or the Minister for Health and Wellbeing?

Mr Rattenbury: It is me.

MRS DUNNE: It is you? You have control of the—

Mr Rattenbury: Yes. Now I understand.

MRS DUNNE: You have control of the $200-odd million in the health budget which is mental health?

Mr Rattenbury: Yes.

MRS DUNNE: Is that also the case for corrections, health, drug and alcohol—all of those items in that output class?

Mr Rattenbury: No, not—

MRS DUNNE: You have control of that budget?

Mr Rattenbury: When it comes to mental health, justice health, and alcohol and drug services division, there is an administrative arrangements split. I have mental health and justice health; Minister Fitzharris has responsibility for alcohol and drug services.

MRS DUNNE: You have responsibility for alcohol and drug services in the prison.

Mr Rattenbury: No, Minister Fitzharris does.

MRS DUNNE: But what about in the prison?

Mr Rattenbury: That would be covered by justice health.

MRS DUNNE: That would be covered by justice health. But you have full autonomy within the cabinet arrangement for the mental health budget and the corrections health budget?

Mr Rattenbury: Yes.

MRS DUNNE: Thank you.

MS ORR: In relation to the $1.3 million to expand counselling services for headspace, for children and young people, can you just run me through what that has to cover, please?

Ms Shuhyta: The increased funding to headspace will occur in conjunction with the commonwealth funding for headspace in Canberra. ACT Health is adding to the headspace funds so that we can provide more clinical services and reduce wait lists for people needing to access headspace services.

This year we have already funded increased services in headspace through the ACT budget. We had a focus, and we will continue this focus with the ongoing years of funding, to really target those people who have contacted headspace requiring help, requiring assistance, right there and then. Instead of having to be on an extended waitlist for lengthy services, we have provided a brief solution service for people before they sit on a long waitlist.

People may need some brief therapy sessions to help them manage the situation or crisis they may be in, for the immediate family and personal needs that they may be experiencing, for the immediate stress reduction strategies and problem-solving strategies that they might require. That would then open up space for longer term sessions for people requiring a step up of care.

MS ORR: The budget also has funding for the ACT mental health recovery college trial. Can you run me through what that actually is?

Ms Shuhyta: The recovery college is an innovative mental health initiative that is rolled out in a number of places around the country. The ACT has not had one before. It takes an educational approach to mental health outcomes: providing psycho-education around goal setting, stress management, sleep hygiene, engaging in employment initiatives, health. There is a range of different psycho-educational programs that do not require health treatment to have successful mental health outcomes.

It will be an addition to the mental health system. It will not be looking to duplicate or replace anything else that currently exists in the mental health system; it is looking to be an innovative addition to the system.

Mr Rattenbury: One of the figures that is out there is an estimate that 65 per cent of people who experience mental ill health do not access support services. One of the views around the recovery college is that it will appeal to some of that 65 per cent, that people who are currently not getting supported and who could go better in their lives will access that sort of support. That is the point Ms Shuhyta is making around providing a different type of care and support.

MS ORR: So it is getting to that 65 per cent who would not necessarily interact but who might, in a particular area, need a bit more support?

Mr Rattenbury: Some of the other 35 per cent might go as well if they find it right,

but there is a sense that it will start to access some of those other people as well.

MS ORR: Who is going to be coordinating the trial?

Mr Rattenbury: The Mental Health Community Coalition are our partners on that one. It has been co-designed. They designed it up from the ground themselves. There has already been funding in a previous budget where they went out and worked with the community. They designed it, and now we are funding it. I feel very optimistic; that one has a real sense of community buy-in.

MS LE COUTEUR: How will the 65 per cent find out about it? It sounds like a great idea, but how are you going to get your clientele to appreciate its virtues?

Ms Shuhyta: That is part of the outcome indicators that we will be looking at and evaluating on this trial: whether the access has increased. This is an adjunct to the service system. There is a range of different things we are looking at in terms of access, and information and awareness campaigns, through the establishment of the college. The community coalition, in a tripartite agreement with CIT and ACT Health, will be working to establish that, and have access as part of the things that we are evaluating. How are we getting the word out? How we are getting people to know that this is another place where they can access mental health support?

THE CHAIR: We will adjourn there. If there are any other questions in these output classes for Minister Rattenbury, I would encourage members to put them in on notice.

Mr Rattenbury: There is just the one.

THE CHAIR: Just the one.

Mr Rattenbury: There were also your questions at the start, Mr Wall.

THE CHAIR: Yes, if you can get those back. The committee asks that they be returned to the committee secretary with five days, day one being tomorrow.

Hearing suspended from 10.30 to 10.47 am.

Appearances:

Fitzharris, Ms Meegan, Minister for Health and Wellbeing, Minister for Transport and City Services and Minister for Higher Education, Training and Research

Health Directorate
De'Ath, Mr Michael, Interim Director-General
Doran, Ms Karen, Deputy Director-General, Corporate
Kelly, Dr Paul, Chief Health Officer and Deputy Director-General, Population Health Protection and Prevention
Bone, Mr Chris, Deputy Director-General, Canberra Hospital and Health Services
Vivian, Mr Trevor, Chief Finance Officer
Mooney, Mr Colm, Executive Director, Health Infrastructure Services
O'Halloran, Mr Peter, Chief Information Officer
Hammat, Ms Janine, Executive Director, People and Culture
Dykgraaf, Mr Mark, Chief of Clinical Operations, Canberra Hospital and Health Services
Chatham, Ms Elizabeth, Executive Director, Women, Youth and Children, Canberra Hospital and Health Services
Talaulikar, Dr Girish, Executive Director, Medicine, Canberra Hospital and Health Services
Chamberlain, Ms Jodie, Executive Director, Territory-wide Services Redesign
Fletcher, Dr Jeffrey, Acting Chief Medical Officer
Kohlhagen, Ms Linda, Executive Director, Commissioning, University of Canberra Public Hospital
Brady, Ms Vanessa, Executive Director, University of Canberra Public Hospital and Canberra Hospital and Health Services Program

THE CHAIR: We now we have Minister Fitzharris to continue with the balance of output class 1—health and community care—and the committee's examination of budget statement C. I will defer my first question to Mrs Dunne.

MRS DUNNE: Minister, I am going to ask some questions about something I realise I do not ask questions about often enough in estimates or annual reports hearings: Calvary Hospital. You said a couple of times recently that it is a priority for you to finalise a new service agreement, however it is described. It has a name but I cannot remember what it is. When does the current service agreement expire?

Ms Fitzharris: The Calvary network agreement?

MRS DUNNE: That is what it is called, thank you.

Ms Fitzharris: It does not.

MRS DUNNE: It is just a rolling agreement?

Ms Fitzharris: That is right. Within that there are annual performance agreements. I will ask some officials to talk in more detail about what they are. More recently the chair of Calvary and I made an announcement about how we progress a more modern

Calvary network agreement. That is something we are collectively working on. I have been working with the board chair on that for some time.

MRS DUNNE: That is Mr Watkins, not Mr Bowles?

Ms Fitzharris: That is right. Mr Watkins is the chair of the Little Company of Mary board under which Calvary sits. Calvary's presence in the ACT includes the delivery of public health services at Calvary Bruce, and Clare Holland House but also private services at both John James and Calvary private.

MRS DUNNE: But they are not part of the service-wide agreement?

Ms Fitzharris: No, they are not. They are our partners in delivering public health care both at Calvary and Clare Holland House. Within that agreement there is recognition that we can work better together and do more together. It is an essential part of the ACT government progressing a territory-wide health services approach. It has been a very constructive time working with Calvary. In this calendar year some very positive progress has been made with Calvary on a number of specific issues as well as more broadly on our shared future. That obviously includes territory-wide health services planning as well as the government's commitments around providing more hospital facilities on the north side.

MRS DUNNE: What is the quantum of the contract on an annual basis with Calvary?

Ms Doran: Our arrangement with Calvary operates under the Calvary network agreement and is formalised on a yearly basis in the performance plan. In 2017-18 the quantum of funding was $205 million. We are in the process of negotiating the performance plan for 2018-19.

While it will remain an annual basis, we are looking at formalising a rolling annual plan within a three-year forward planning structure to provide more certainty to Calvary and to the budget but also to facilitate better longer term planning of service provision. That process has not been finalised, but the quantum of funding will be of the order of the 2017-18 funding with some indexation.

MRS DUNNE: Minister, you said you have had discussions with Mr Watkins, the chair of the LMC board. Is there a negotiating team under that?

Ms Fitzharris: Yes.

MRS DUNNE: Are the parties on both sides of the negotiating team identified?

Ms Fitzharris: Yes. I recently wrote to the chair with a framework for what the discussions will include. There are established teams from both ACT government as well as the Little Company of Mary.

MRS DUNNE: Are you aware that Ms Gallagher started work at Calvary hospital this week?

Ms Fitzharris: Yes.

MRS DUNNE: Is she part of that negotiating team?

Ms Fitzharris: Not to my knowledge at this point but considering she only commenced on, I believe, Monday of this week, that is a matter for the Little Company of Mary.

MRS DUNNE: Would you concede that, if Ms Gallagher became part of that negotiating team, there might be conflicts of interest?

Ms Fitzharris: I think that is a matter for Calvary and for Ms Gallagher, and I would leave that to them. She is a private citizen and they are a separate organisation, and that is really a question for them to consider at this point. If she becomes part of that team we can have further discussions with Calvary about it.

MRS DUNNE: Ms Gallagher is in the employ of the Little Company of Mary or Calvary?

Ms Fitzharris: Yes.

MRS DUNNE: Not ACT Health?

Ms Fitzharris: That is right, yes.

MRS DUNNE: What is your understanding of her role as a service design liaison person?

Ms Fitzharris: Exactly what I believe the title suggests.

MRS DUNNE: I do not know what that suggests.

Ms Fitzharris: I think that is really a question for Calvary but it is certainly one that—

MRS DUNNE: Is there anyone from Calvary here?

Ms Fitzharris: No.

MRS DUNNE: They are the largest single contractor?

Ms Fitzharris: Yes they are.

MRS DUNNE: They used to come to estimates but they do not come anymore?

Ms Fitzharris: Not in my time in the Assembly, including sitting on the estimates committee.

MRS DUNNE: In relation to the annual performance plan and the wider agreement, what are the accountability indicators and are they being regularly met?

Ms Doran: Under the existing performance plan yes, there are accountability indicators and they are regularly monitored. We have a monthly meeting under the Calvary network agreement. There is an established Calvary network committee with representation, obviously from Calvary and from ACT Health, and that is a process where we do look at the performance outcomes against financial performance and activity level indicators as well as infrastructure capital spending. There is a quite formal government process around all that.

MRS DUNNE: This may be a question that you can take on notice. What are the performance measures in that agreement?

Ms Doran: I will take that on notice if I could but I will also indicate that, going forward, with the new performance agreement we are looking to develop an activity-based funding model. We are actually looking at reviewing the way in which we strike those performance indicators and monitor them going forward. I am very happy to provide what existed last year.

MRS DUNNE: I understand that that would be what existed in this current year. Is ACT Health currently happy with Calvary hospital and whether it is meeting its performance measures?

Ms Doran: There is a very good relationship now between Calvary and ACT Health and we have much more open and transparent discussions around these issues. There have been some issues in the more recent past—

MRS DUNNE: They were touched on by the Auditor-General?

Ms Doran: That is right. But over the past six to 12 months there have been changes of personnel on both sides and concerted efforts on both sides to address those issues. I think now I could say that it is a very good relationship and we are very happy with how Calvary is performing and is willing to discuss issues. When there are issues with performance we are able to work through them together.

MRS DUNNE: There have been issues with performance?

Ms Doran: Again they are more in the past. I think there is a need for flexibility in managing any form of performance agreement. We set targets with our best estimates and best intents at the start of the year, and circumstance can affect the ability to deliver against those targets both at Calvary and at TCH. Our new relationship has allowed us to have more open discussions about how we manage performance and respond to performance challenges over the year.

Mr De'Ath: If I could add—and I acknowledge the privilege statement—we are in regular dialogue with Calvary. I am probably talking to Mr Bowles on a weekly basis. There are many conversations at an operational level. I have to say my observation is that this is shaping up very well in the true sense of partnership, as a major provider, and I think that bodes well for how we navigate the various challenges we all have in the demands that are on our health system.

Ms Fitzharris: I think we have spoken a lot and will continue to speak a lot about a

territory-wide health services approach. There are some examples of that which have significantly improved. More recently the budget announcement around hospital in the home is an example but right across the board, in terms of working with Calvary, there has been a significant improvement strategically, operationally and in relations in the past six to 12 months. We are very committed to continuing that. From my point of view, as the ACT health minister, we need to make the most of the full range of public health facilities and staff that we possibly can right across the territory.

MRS DUNNE: On the subject of making the most of our resources, I noticed that somewhere in here there is a rollover of something like $1 million, just over $1 million, in medical imaging from Calvary. What was the cause of that?

Ms Doran: That is page?

MRS DUNNE: Page 23.

Ms Doran: That is a timing issue on the ability to get in place the purchasing orders for some imaging equipment. It is something that is going ahead. It has just not been able to be finalised by 30 June and is rolling into the new financial year.

MRS DUNNE: What is being purchased for $1 million or just over $1 million?

Ms Doran: That I would have to take on notice, the specifics of it.

MRS DUNNE: On the subject of making the most of our available resources, there was investment four or five years ago in a stand-alone intensive care unit at Calvary. How much of that is operational? Is it fully operational? Are all the beds operational?

Ms Fitzharris: I do not know if anyone can talk to that previous investment before my time. I am not—

MRS DUNNE: I am not asking about the investment. I am asking: now that it is built, is it fully operational?

Ms Fitzharris: We might have to take that on notice.

MS ORR: I note in the budget that there is actually quite a large investment in Calvary hospital. Can you run us through what that is going to cover?

Ms Fitzharris: Certainly. In addition to the budget announcement, I would like to also highlight the work that is currently underway and due to be completed shortly on expanding the maternity capacity at Calvary hospital, and most particularly upgrading the facility. But also in this budget there is funding to both relocate and improve the mental health facilities at Calvary and also to expand the emergency department reasonably significantly, which was a commitment that the Labor Party made at the last election and one we are very pleased to be delivering on. That work will get under way and will be completed in September next year. I do not know if anyone would like to add some further detail. No.

MS ORR: Taking this Canberra-wide approach to the health network, will Calvary

hospital be impacted by the opening of the UCH, given that they are in such close proximity to each other?

Ms Fitzharris: One of the reasons we have been able to progress the work around the expansion of the ED and the refurbishment of the mental health ward was that a ward has been relocated from Calvary to UCH, and that has been part of the planning since day one. As of Saturday, with the opening of the University of Canberra Hospital, staff have transferred from Calvary to ACT Health to work in the facility and we have been talking with a number of the staff there. Over the course of the past week we have had a number of functions there. The feedback to me has been that it has been a very smooth transition and that brings all the rehabilitation services across Canberra into one purpose-built facility. Do you want to add to that?

Mr Bone: I acknowledge the privilege statement. Calvary hospital has one ward which was a rehab ward. It fits into the philosophy of the rehabilitation being provided at the University of Canberra Hospital. That would create capacity at Calvary for us to work with them in terms of how we utilise those clinical spaces.

MS ORR: Minister, you mentioned in previous conversations that there would be more work undertaken for a north side scoping study. Having a north side electorate, that is of particular interest. Could you run me through what you are going to be looking at or what you hope to achieve through that?

Mr De'Ath: I will probably hand it to Karen but, suffice to say, just to open, there is some pretty comprehensive planning going on at the moment. We have just commenced some pretty serious discussions with our partners around this. We are going to be working pretty intensively on that over the next few months. I will let Karen run through the detail of that.

Ms Doran: The north side hospital scoping study is at an early stage of considering options for delineation of service provision across the territory and exploring the issue of where demand is relative to the different regions within the territory and getting our infrastructure positioned in the best locations to meet that demand. It is running in parallel with our territory-wide services framework and some service demand modelling work that we are doing that is then informing really the demand need across the territory. This will then feed into a scoping study on the infrastructure needs, both in terms of location or siting and the scope of services that are delivered at those different sites. While it is a project in its own right, it is also a project that is very necessarily integrated with other infrastructure projects such as the SPIRE.

Ms Fitzharris: I was just going to add that it is important to note it is about expanded hospital services on the north side. We are open to a range of options there but, as I have said previously, obviously we have an existing health precinct on the north side, in the Bruce area, with both Calvary public, Calvary private and a range of other services available in the Calvary precinct. We have UCH and considerable investment from the government on the University of Canberra campus as well as private investment through both the University of Canberra and their partners. We also have CIT located in the precinct and their health services are located at the CIT Bruce campus as well. It is about expanding service capacity on the north side.

That precinct is really coming to life and I think the connection between all the institutions that are very closely aligned in what is quite a small distance from one another is something that is part of this broader work.

Mr De'Ath: If I could just add, I think this goes to the comments made earlier about the strength and nature of the partnerships with partners and not just with the Little Company of Mary and Calvary. Can I say that I have had quite lengthy discussions with some of our university partners.

When you consider the fact that we have some of the best universities in the country, if not the world, here in Canberra and we have a teaching hospital, we have a medical school, we have research facilities happening in different places and we are bringing parties to the table to consider a really strengthened way forward, to consider all the elements of evidence that we have and any new information coming to light—these are big decisions for government to make going forward, particularly on the infrastructure spend. We absolutely want to take a comprehensive and considered approach to getting the advice to government absolutely right in the first instance.

MS ORR: It sounds like it is quite a big piece of work and something that you would obviously want to take time to do thoroughly but, given that, is there a time line that you are working to for the study?

Mr De'Ath: We already have a lot of good information. It is not as if they are starting from ground zero here, but in terms of timing, Karen maybe has more comments.

Ms Doran: The study phase of the project will play out over the next nine to 12 months. These are complex projects, and they do have stages in their evolution in the context of the 2019-20 budget. Some options would be put to government in terms of that initial scoping and the decision made as to how and if it is taken forward. But in terms of time lines, that will only become clearer as some of the options and then the detailed designs are further developed.

MRS DUNNE: Is this an overall infrastructure study or is it a study about the need, or otherwise, for health infrastructure on the north side?

Ms Fitzharris: I would say they are all connected. And the territory-wide health services planning, the demand forecasting and the infrastructure requirements we need—that includes hospital requirements and community health related requirements—are all part of the same overall strategic approach. Each one is necessarily broken down into different projects.

MRS DUNNE: I ask the question because if you say you are going to have a north side health infrastructure study, it begs the question: what are you going to do about the south side? Mr Wall is going to start asking what you are going to build in his electorate.

Ms Fitzharris: That is a fair question.

MRS DUNNE: And considering that Woden is the geographic centre of Canberra, we might risk spreading ourselves too thinly, putting a bit of stuff here and a bit of stuff

there.

Ms Fitzharris: You can be very assured that the directorate is very focused on it being a territory-wide approach. This particular project is about the north side, but it is intimately connected to the service planning, the infrastructure planning and the demand modelling underway.

MRS DUNNE: I think you run the risk of Mr Wall asking you for some health services in Lanyon.

Ms Fitzharris: It also includes—

THE CHAIR: The deep south is under-serviced.

Ms Fitzharris: In terms of understanding what a city of our size needs—it services our city but, importantly, services a broader region as well, particularly in terms of health care needs in the New South Wales region—this is the most important health care hub for a region that is growing as well as for a city that is growing.

In terms of how we provide the right type of care in the right place at the right time, it is also very important to think about people being able to access primary care services, community-based services and hospital-based services. That is, again, all part of the thinking around infrastructure. It is not necessarily just hospital infrastructure; it includes community health infrastructure, the walk-in centres and support to GPs. We are just about to finalise a round of grants the government made available through last year's budget to GPs to support them with their infrastructure requirements and other requirements they might need to increase bulk-billing. There was a particular focus on that in your part of the city, Mr Wall.

MS LE COUTEUR: On Tuesday afternoon, in your role as minister for higher education, you said that the CIT Campus in Woden is no longer needed. In the context of infrastructure planning—you can probably guess what I am about to say.

Ms Fitzharris: Yes.

MS LE COUTEUR: It is very close to Canberra Hospital, and Canberra Hospital appears to be short on space, you would have to say. Can I just suggest—

MRS DUNNE: It is a big site.

MS LE COUTEUR: It is a big site, but it has a lot of things on it. The obvious option for expansion would be to use that space, which clearly is redundant for its current uses, and, very close, the townhouses in between, some of which probably could, I imagine, be acquired if that was the desire of the government—

Ms Fitzharris: That is not currently being planned.

MS LE COUTEUR: I am sure it is not, but I would imagine—

Ms Fitzharris: I would welcome your visit to all of those residents.

MRS DUNNE: It may be outside the standing orders to ask the minister to announce policy.

MS LE COUTEUR: I was not inquiring; I was just saying that there is a possibility that some of those would be available if there were an issue of how good the connection between was. I note that there is a decent walkway already, because I walk up there sometimes. It is crossing the road that is the issue.

Ms Fitzharris: That is a great question. Obviously, part of the government's consideration is about other activities happening and other plans the government has for precincts around the city. That includes Woden, obviously. A couple of decisions around the Woden town centre recently, which you are well aware of, were to not proceed with the expansion of the Woden Cemetery, and also, as I said on Tuesday, to make sure that the CIT Woden site remains a community facility.

What that means, given its proximity to Woden town centre and Canberra Hospital, and the government's investment in light rail in Woden, is that it is timely for the government to consider the precinct as a whole and, further to that, make sure that it remains a community facility in that precinct. We also want to retain the same levels of open space in the area, particularly now that we have decided not to proceed with the expansion of Woden Cemetery.

MS ORR: Going back to the Calvary precinct, it might be a silly question, but why does UCH have such a specific focus on rehabilitation?

Ms Fitzharris: We would be very happy to talk about that particular question. Linda Kohlhagen would love to come up and chat about this. Could I add, going back to my other portfolio on higher education, and mentioning the presence of higher education on Canberra's south side the other day, that there is a presence at Canberra Hospital already from ANU. But we are very keen, in reflecting on the ACT government's greatest partnership with the higher education sector, particularly the universities, that it is in the health area. There is considerable work we can do, both in my role as the health minister but also under the Vice-Chancellors Forum, to have a very specific discussion with our education institutions about how we can further collaborate to build and to do even more with our health partnership with our universities between ANU; UC; potentially, to some extent, UNSW; and CIT. And ACU as well; they play an important role in the skilling of, particularly, nurses and paramedics.

We are very active in considering what we do with the universities, specifically as it relates to health. That is another consideration in terms of a presence, and an increased presence, of universities, at the Canberra Hospital particularly, as we look at how we develop SPIRE and what role ANU and UC in particular can play in that.

Ms Kohlhagen: I think the question was around what role UCH plays within the health sector.

MS ORR: Yes, particularly given that it has a focus on rehabilitation, just how that fits.

Ms Kohlhagen: It was a very deliberate decision to create a facility that is dedicated to rehabilitation and that includes mental health rehab as well. That is consistent with models around the country where rehab plays an important part in what we call the continuum of health care. It has a role when people who might have had a serious illness, injury or trauma no longer need acute care but need recovery facilities and need to undertake activities still in a 24-hour health care or day services. It looks quite different from what you might see in an acute setting.

There were 3,500 people who went to the facility on the weekend. I know there were a number of people in this room who went. It looks quite different to an acute hospital. Attached to each of the inpatient units we have gymnasiums, which are significantly tailor built for the types of patient cohort that we have within the units. We have activities and daily living facilities. There are bathrooms where patients can practise, kitchens and laundries. The idea of rehab, whether it is mental health rehab or your more traditional rehab, is to work with people and their families and carers so they can develop and enhance their skills to return to community living safely and successfully. The model of care looks very different in a rehab hospital. People get out of bed; they get dressed in their normal clothes; if possible, they go and have breakfast, lunch and dinner in a communal dining room.

It has quite a different model of care, and the environment, the workforce and the way we structure how we deliver care are very much suited to a rehab setting as well.

MS ORR: How many patients will the new hospital take?

Ms Kohlhagen: It has been designed for a full capacity at 140 overnighters, but we will not open all the beds on day one. We will also run day programs in both the rehab and mental health rehab areas, and they can take up to a total of 75 people for a day session. That is where they will receive meals as well as the tailored therapy programs. Then we will have a number of different outpatient clinics as well. So there could be hundreds of patients coming to a range of different services.

MS ORR: You said it will be rehabilitation services. What does that cover?

Ms Kohlhagen: The way we have designed the inpatient care for mental health rehabilitation means people could stay anywhere from three to 12 months. In the inpatient units in the general rehab we have structured the wards so they are slightly different. There is a neurological ward, and that will have people who might have had a stroke and have to go through the recovery phase. It could also include people who might have neurological conditions such as MS, motor neurone disease, Guillain-Barre syndrome. The length of stay in those units could be four to six weeks. If you unfortunately have something like a brain or spinal cord injury you may be in hospital three to six months.

We will also have a general rehab for people who have had significant operations or spent a long time in the hospital and need time to recover and to regain their strength. That also might include people who have had bad care accidents and have broken quite a lot of bones. We will also have an older person's rehab unit for people who need certain types of health care related to an ageing process.

MS ORR: I guess a big part of this will be patients transferring from Calvary or Woden hospitals. How will they be informed of the transfer and the reason for movement from one hospital to another?

Ms Kohlhagen: Firstly, we will take people from Calvary and Canberra hospitals, and they transfer between the different units as we speak as well. We will also take a small number of people who might be transferred from acute hospitals in Sydney, so the tertiary specialised units, say, for brain injury and spinal cord patients. There is also a small cohort of people who might come directly from a community, such as an amputee who goes home for their wounds to recover and are then admitted to learn how to walk on their prosthesis.

In preparation for the establishment of the University of Canberra Hospital we created what we call a CHASERS team—we love our acronyms in rehab. The CHASERS is the Canberra Hospital Acute Subacute Early Rehabilitation Service and is a team made of the rehab physicians, registrars and nurses and they work with the clinicians when someone is in the acute hospital or in an acute ward. They work with the patient and their family to talk about what rehab is the different options. You do not always need to have overnight rehab; you could go to a day program or you could go to a sessional program.

Moving towards the transition to the new facility there will be lots of posters and letters. We have a welcome to rehab book that has just been published that explains what rehab is about and what the different clinicians do.

We have blank pages at the back where people can write down the names of their physio, their doctor, their nurse. It talks about the rehab process: what to bring into a rehab ward, like wear good shoes, comfortable clothes et cetera. Clinicians will work with the families and the individual to ease that transition from one facility to another.

MS ORR: There has been quite a bit of discussion on a Canberra-wide focus for health services. How does the rehabilitation hospital fit within that Canberra-wide network? What are the benefits of a specialised service for the whole network?

Ms Kohlhagen: That is reflected in the type of workforce we can employ within the facility. It is very targeted to meeting the needs of the rehab client. The environment hopefully will enhance the outcomes for patients and the experience of the patient and their families. An acute unit is a very busy environment; you do not have access to a lot of what we call the activity of daily living environments and gyms, so hopefully there will eventually be better patient outcomes.

As we have talked about, people can be admitted to this facility from a wide range of hospitals. GPs and specialists can refer to the psychiatrists, the rehab physicians and the geriatricians who will be working on the site.

Ms Fitzharris: It is important to note that this purpose-built facility brings into one location services that were provided across seven existing locations. Another important aspect, going back to our partnerships with universities, is that the University of Canberra has a significant presence in the hospital. Over 70 staff are transferring to be in the hospital, and that is a key part of the new hospital.

Ms Kohlhagen: Throughout the development of the University of Canberra Hospital there has been quite a lot of work around developing a collaboration deed and collaboration plans that will underpin how we deliver a range of health-related services. One of those is around student education.

One of the wonderful things that happened on Saturday when people were walking through the facility was that we had graduates of the University of Canberra who are now working within our workforce. Our service takes a lot of students, but this is an opportunity to enhance not only the total number of students we might have but also the training opportunities for students as well as our clinicians and academics.

The collaboration deed has three separate working parties that will underpin the service enhancements. Student education is one of those. The second one is around workforce: how we can increase the opportunities and the skills and capabilities of staff employed within ACT Health to undertake things like research, student education or to look at what sort of workforce we need into the future to meet the needs of the community going forward.

We already have quite a number of student placements. We support nursing students, physios, OTs, speech pathologists, dieticians, pharmacy, exercise physiologists—I am sure I have forgotten some. We also have medical students from other universities, and there were even some discussions last week around the opportunities with ANU and UC with us around doing very collaborative work in that area.

The third pillar is around research. We have a small research project we are currently doing with the university looking at patient outcomes and experience. That involves the clinicians who work in my division as well as academics from the schools of nursing, physio and OT as well.

Ms Fitzharris: Chair, opening a new hospital is no small feat, so I want to put on the record our thanks to ACT Health and particularly Linda and the team she has been leading, which includes people from right across ACT Health and also Calvary. A new hospital is a very significant milestone for the city. After such thoughtful and detailed work over a very long time I know they cannot wait to start receiving patients in just a couple of weeks.

MS CHEYNE: Minister, you have spoken about the upgrade of the maternity ward at Calvary hospital. Over the past six months there has been quite a bit of media about demand for maternity services and staffing right across the territory. While I appreciate that Calvary is one part of that, are there other things we are doing territory wide to address that demand?

Ms Fitzharris: Yes. I am very well aware of the growing demand for maternity services and considerable work is underway, including on the service side. Under territory-wide health services, a speciality service plan is being developed for maternity which has some features to help address the demand.

Funding that has come from investment in both Calvary and Canberra hospitals in this year's budget has increased the inpatient postnatal beds by around about 23 per cent,

so that is a considerable increase. It is something we have been discussing at length, particularly this year, and I will hand over to both Chris Bone and Liz Chatham to talk you through it.

Mr Bone: One of the concepts currently on the table is to create a single point of entry. That will enable a woman starting their pregnancy and registering with ACT Health to contact the central point and then go to a hospital close to them so they can have a conversation with a midwife about the model of care they wish to choose. The models of care are consistent across Calvary and TCH, and models of care are available in the greater regional as well.

It is at that conversation at the local facility close to where the woman lives that she will engage with the midwives and the broader team. As a result of that conversation we will then allocate her ongoing care to a facility closer to where she lives so she will get the right care at the right place.

Doing that across the territory and the region enables us to get better utilisation of both our very valuable human resources and also our infrastructure so we can share the load across both the territory and the region.

THE CHAIR: Budget paper 3 shows that $3.5 million that was originally planned for the expansion works for Centenary hospital has been rolled over to 2019-20. What is the reason for the delay in that funding coming forward?

Ms Fitzharris: It is the timing of the project. It continues to be on track for its implementation date.

THE CHAIR: But what caused the delay?

Ms Doran: It is not a delay. As we work through these complex projects we refine the profiling of the capital requirements over time and we look to reflect that in each subsequent budget. It is really just a reprofiling of moneys.

THE CHAIR: When is completion of works scheduled?

Ms Doran: There are various phases to the Centenary project, so to answer that in more detail I will have to take that on notice.

MRS DUNNE: I would like to follow up on the Centenary building project and the child and adolescent mental health facility as well. Where is that at?

Ms Fitzharris: It is part of that project, yes.

MRS DUNNE: Yes, I know, but what is the timing on that?

Ms Fitzharris: The same as the full timing that we will get back to you on, yes.

MRS DUNNE: I wanted to make sure that that was in it.

Ms Fitzharris: Yes.

MS LE COUTEUR: I am going back to maternity. I understand that the situation is that there is a birth centre and a birth suite. They used to be managed separately and they are now managed—

Ms Fitzharris: At Centenary?

MS LE COUTEUR: At Centenary, yes.

MRS DUNNE: At Centenary, yes.

MS LE COUTEUR: The birth centre and the birth suite were managed separately and they are now being managed together. Can you tell me more about that and why you are doing this?

Ms Chatham: Thank you for your question. We are currently doing a governance review of the nursing and midwifery structure within the Centenary Hospital for Women and Children. One of the suggestions has been that we merge the leadership, as has just been said. But that is currently going through due process. It is out for consultation. What it will look like finally has not been decided. I think we have had 123 responses to the consultation process. We will be considering the feedback that we have received and whether that recommendation does or does not go ahead.

MS LE COUTEUR: Who are you consulting with?

Ms Chatham: We have consulted widely with staff, but also with ANMF. We have spoken to the Friends of the Birth Centres as well.

MS LE COUTEUR: I guess that that is the only way in which you are contacting the users of the centre.

Ms Chatham: We have met with the Friends of the Birth Centres, yes.

MS LE COUTEUR: That is the only way that you are—

Ms Chatham: Yes.

MS LE COUTEUR: Are they supportive?

Ms Chatham: Within the consultation with them, they were more concerned about that continuity of care model being maintained. Certainly, there is no intention to change the continuity of care model. In fact, we are looking at ways to increase and grow the continuity of care model at the hospital. Obviously, it gives women a high satisfaction in their birth experience. We actually have another project just looking at that: how we can grow the continuity of care, the model of care within the service.

Ms Fitzharris: That is available at both hospitals?

Ms Chatham: Yes, which is also available at Calvary

Ms Fitzharris: It is important to note that that is available at Calvary as well.

MS LE COUTEUR: On that note, the other maternity-related question is about having births at home, with midwives at home.

Ms Chatham: Yes.

MS LE COUTEUR: My understanding is that that is only available to women who are within 20 minutes of the Canberra Hospital. Given that, as the minister has just said, birthing support is available at Calvary, why can't the women of north Canberra also have this option?

Ms Chatham: This, as you know, is a pilot project—

MS LE COUTEUR: Yes.

Ms Chatham: and we are midway through the project at the moment. We have had 13 births to date. We have a very narrow 20-minute catchment for women to access that service. That has been based on the time it takes for an ambulance to be dispatched and get back to the Canberra Hospital.

MS LE COUTEUR: Yes, but still—

Ms Chatham: Later on, when we have done the pilot and it has been evaluated properly, I think that will be a model of care for Calvary hospital to consider whether they want to move into to provide home births.

MS LE COUTEUR: It would seem reasonable for the women of north Canberra to have equal options.

Ms Chatham: Yes.

Ms Fitzharris: Yes, I agree. I agree and I certainly think the most important thing was to get the home birth pilot underway. Those were some of the constraints that were part of being able to start that.

Ms Chatham: But the satisfaction with the model is very high for the women who have experienced it.

MS LE COUTEUR: That was my next question. Obviously, there have not been any significantly negative events?

Ms Chatham: We have had 13 babies being born within that project and we have had no transfers into hospital.

MS LE COUTEUR: Great.

Ms Chatham: Of mothers or babies.

MS LE COUTEUR: Congratulations!

Ms Chatham: Thank you.

MS LEE: What are the wait times for admission to the birthing centre?

Ms Chatham: Women book into the hospital then they are allocated to the birth centre if there is space in the birth centre. Each midwife takes 40 women a year. We allocate women per staff member. Women might have to wait for a few weeks to find out whether they are actually being accepted into the birth centre. Usually by about 15 or 16 weeks they will know whether they have a place in the birth centre.

MS LEE: Has the birthing centre to any extent or at any time been used for postnatal accommodation?

Ms Chatham: It is. It is a deliberate strategy and it is part of our escalation policy that when we are at capacity in our birth suite, we actually move beds and use beds that are available within the birth centre. We only use the beds if they are free. There is minimal impact or no impact on women who are in the birth centre when we do that because they run at about a 30 per cent occupancy in that area.

MS LEE: That must have a direct impact on the wait times for women trying to get in?

Ms Chatham: No, because they come in to birth. When a woman comes into the birth centre she comes in with her midwife. That would not impact on any wait time for having entry into their program.

MRS DUNNE: I would like to follow up on those questions, which are roughly in the same area I was thinking of asking questions on. Ms Chatham, you seem to be indicating that the birth centre runs at about 30 per cent occupancy. That would mean that anyone who qualifies—and there are qualifications on access to the birth centre—would get in. But from looking at some of the social media commentary it has been indicated to me, both through social media and directly, that there are people who are waiting and who meet the criteria but have been told that there is no room for them at the birth centre.

Ms Chatham: I think there is a confusion there, Mrs Dunne, around occupancy. It talks about overnight stay, people coming in and having a birth in the birth centre, compared to capacity in the actual program. The capacity in the program is related directly to how many midwives are in the program. They are allowed to care for 40 each over the year. Once they are allocated their 40 women, the program is full. The actual capacity or the actual bed occupancy, the 30 per cent that you were talking to, refers to how—

MRS DUNNE: You used the figure.

Ms Chatham: I used the figure. The occupancy of 30 per cent which I referred to is not the program; it is the use of the beds in that space. At any time over the year, they have no more than a third of their beds used by people in their program. If you wanted—

MRS DUNNE: Where are the other people in the program? You are saying that a third of the people in the program use beds in the birth centre?

Ms Chatham: No. I am saying that—

MRS DUNNE: Okay, what is it you are saying?

THE CHAIR: So a third of the beds in the birth centre are used for the program?

Ms Chatham: Yes.

Ms Fitzharris: Yes, but at any given time—

THE CHAIR: So the other 70 per cent of the occupancy is made up by—

Ms Chatham: Nothing. That space is only used 30 per cent of the time. Many of the women in the CMP program, the continuity of care program, actually birth in the birthing centre. In the program, where they birth will depend on what happens in the course of their pregnancy. About two-thirds of the women will birth in the birth centre because everything goes fine and they can have their low-risk birth there. But there is another group that will go and have a caesarean section or will have to be induced, and those women are still in the continuity of care program but actually birth in the birth suite.

Ms Fitzharris: There are the physical locations and then there are the different programs.

MRS DUNNE: So the continuity of care program is not entirely dependent upon access to the birth centre.

Ms Chatham: Not at all.

MRS DUNNE: Because not everybody in the continuity of care program has their baby in the birth centre.

Ms Chatham: That is right.

MRS DUNNE: Even though they have to meet a whole lot of criteria along the way, of being pretty much low-risk pregnancies.

Ms Chatham: We have two continuity of care programs. One is the low-risk program, which is known as the Canberra midwifery program. That is a low-risk program for women with quite strict criteria who are looking for very much a drug-free birth and a natural birth. That is one model of care we have for continuity. The other continuity of care model we have is called the catch program, which is a high and mixed model of care.

So women can have any sort of birth that they want. They might be having an elected caesarean section or they may have a very complicated twin delivery, but they are also

allocated to their own midwife, who follows them through the antenatal period, birthing and postnatal. They are both incredibly popular models of care. If we were growing one tomorrow, we would grow the high-risk or medium-risk one, because that is the client group which we have more of within our hospital.

MRS DUNNE: I am just trying to get down to the issue of demand. I have been told that there is a waitlist to get into the birth centre continuity of care midwifery program, the low-risk one.

Ms Chatham: The low risk one? There are a very small number of women who do not receive a place in the low-risk model of care. There is actually capacity in the Calvary model of care, their low-risk model of care, at the moment.

MRS DUNNE: But I am talking about the women's and children's hospital.

Ms Chatham: Yes. We have about three to four women per month who do not get on the program.

THE CHAIR: That is three to four women that qualify with a low-risk pregnancy?

Ms Chatham: Yes.

Ms Fitzharris: The point about there being capacity in Calvary is a very important one. It means that there is capacity in our city, in public health services. It is really important that we improve that where we can so that that is evenly spread across the city in terms of both the service and the location that women can access.

In terms of the feedback around why perhaps women were not choosing Calvary, overwhelmingly the feedback was that it was a slightly more dated facility compared to the beautiful facility at Centenary. I think we will start to see some of that shift.

From my point of view, where you have extra capacity here and increased demand on capacity over here, you must do everything you can to make sure that we are making the most of our facilities and the staff who work in them, to make sure that women and their families can get access to high quality care in a high quality facility. I think it is fair to say that the quality of the facility is like this, and we will balance that out in the next month.

Mr De'Ath: As Mr Bone mentioned earlier, we are taking a very structured approach to that. We have a responsibly within ACT Health to keep the Canberra public well informed about the facilities available to them. This does not just relate to maternity services. Over time, people have seen the icon of the Canberra Hospital, and that is the point where a lot of people go. On a range of different services, we need to do better to educate people about where they can go to access different parts of the health system.

Ms Chatham: I had the opportunity in January to speak to 99 northern women who had chosen to have their babies at the Centenary Hospital for Women and Children. They gave me five very clear reasons why they were choosing our hospital over Calvary hospital.

The first was the facility. The facility at Woden is amazing; it is a fantastic facility. It has primarily private rooms with ensuites, which will not be available at Calvary until we do the renovation. There were another group of women who just did not know that Calvary was a public hospital. They would drive past and did not recognise or were not aware that it was a public hospital. If they did know it was a public hospital, they did not know that it did birthing services. They thought that, public that it was, birthing did not occur there or, if they did do birthing services, they did not know the capacity of the services at Calvary: that if you had any level of comorbidity or complications during your pregnancy, you must come to the Woden hospital. And there was another group of people that were concerned that it was a Catholic hospital.

Mr De'Ath: Being victims of our own success is a good problem to have, but it does mean we have to rethink how we educate people.

Ms Chatham: And that was the same for GPs. There was a very similar understanding in the GP sector, and we spent quite a lot of time re-educating GPs about two years ago.

MRS DUNNE: Could I just follow up on the question about capacity? You said, Ms Chatham, that three to four people a month did not get into the program. Is that because the midwives had a fully allocated case load?

Ms Chatham: That is right.

MRS DUNNE: It is about staff resources, not bed resources or not resources in the birthing centre itself?

Ms Chatham: It is about staff resources, but it is not that we do not have enough staff. We have staff allocated to that service. We often do not have it fully staffed, because attracting midwives into that program is quite difficult. The program requires a certain type of midwife, who has to be available 24/7. We would like them to work more than 0.6 so that they are available to provide that continuity of care. It is not very family friendly, and often our midwives have children or have families.

Attracting and keeping midwives in that model of care is quite difficult. This has been identified across Australia as an issue in maintaining midwives working in that model of care. While it provides great satisfaction to the midwives as well, I would suggest—they have great satisfaction in providing that care—and also to women, it is difficult to find staff who want to work there for many years. They might work there for a while and then want to step out of it. It also requires the midwife to be quite skilled. We would not want to put a brand-new midwife into that model of care, or if we did, we would do it in a very supported way.

Ms Fitzharris: We are continuing to work on that.

MRS DUNNE: I understand the point about it being more obstetrician hours than regular nurse hours where people would work shifts or something like that.

Ms Chatham: It is.

MS CHEYNE: Could we cast our minds back to what you were talking about before? That is something you are looking at doing; when do you expect that we will have this model, this kind of centralised—

Mr Bone: At the start I said it was a concept we have been discussing with Calvary. We still have to consult with other bodies. We would like to do it as soon as possible but we do need to go for—

MS CHEYNE: You have to get it right.

Mr Bone: Get it right and get the consultation right.

Ms Fitzharris: Importantly, there is some detailed work to do and conversations to have with other stakeholders, particularly over the next month to six weeks, about how this could best be implemented and supported—both the services and getting the structure of it right. That coincides with the work that is underway at Calvary as well. When that opens, there will be women that will already be patients at Calvary due to have their babies. They will have signed up, if they are going to have their baby in July, in about November last year. They will be some of the first women in Canberra having their babies and being on the ward in this new facility. It is purposely aligned to that.

MS CHEYNE: Minister, I have heard you mention in some speeches specialty service plans. What are they, and does maternity specifically have one? Is that what the plans' purpose is?

Ms Fitzharris: Jodie Chamberlain can talk to you about specialty service plans, which are set underneath the territory-wide health services plan.

Mr De'Ath: Jodie will speak to it. It is an exciting story and a huge piece of work.

MS CHEYNE: Yes, I hear it mentioned.

Ms Fitzharris: Good.

Mr De'Ath: That is a good thing.

MS CHEYNE: But I kind of glaze over when I hear it. If it is being mentioned a lot, maybe I should pay more attention.

Ms Chamberlain: Specialty service plans are really a stocktake or a road map of the specialty services we provide at present. There are about 46 different specialties that we provide in the health service. In consultation with Canberra Hospital staff and also with Calvary hospital staff, we have been able to articulate what those services actually are and what is provided in the different jurisdictions. It is not new information; it is actually what our staff currently do. They already have this information, whether it be in a model of care, a procedure or a policy that they have within their specialty, but we have collapsed it into a single format document that is now available for each specialty.

Ms Fitzharris: In fact, we anticipated getting a question about specialty services. We have some examples of what they look like that we can provide to the committee so that you can see what one looks like.

MS CHEYNE: Is this public?

Ms Fitzharris: Yes.

MS CHEYNE: Are these things all online?

Ms Chamberlain: They are still in draft. They are not available online at the moment. We have collated this information, and an important part of that was actually determining what would be the framework of the document and what it would look like.

The specialty service plan describes the actual context of what the specialty is and what is provided. It also includes the models of care, which are more about the patient journey and what happens to the patient while they are actually in the hospital, and in the community. These specialty service plans look at it from the point of view of preventive health, care in the community and care in the hospital. They really give that whole continuum of care view.

The plan that you have been provided with there is the haematology specialty service plan. You will see within the plan some data in terms of what activities or services are provided at the moment, and that is in the inpatient sector and in the outpatient sector. You can look at it by volume—what are the most common procedures or reasons for admission to the hospital. You can also look at where we are providing services to, whether that is north Canberra, south Canberra or other regions, including southern New South Wales, and also whether there are interstate or overseas visitors to Canberra at the time that are admitted to hospital for a particular reason.

With these documents, because we have arrived at a format that is a bit different from when we started this project back in December, we will be doing some more consultation over the next eight weeks, and going back to Canberra Hospital and Calvary hospital staff to say, "This is the information you gave us, and this is what it looks like now. Is there anything else you want to add or any changes you might like to make to the information that has been provided previously?" We will also be validating the data and the projections that we have included for each specialty group.

You will notice at the back there is a section called "NGOs". We have done some consultation with the GP sector. I have a GP as part of the territory-wide services redesign team who has done some consultation with GPs to articulate what services are available in the GP sector and how that then has different entry points into community health services or into the hospital sector.

An important part of community service is those services provided by NGOs. Where there are specific NGOs that relate to a specialty—in haematology that has been quite visible, with the Leukaemia Foundation, the Cancer Council and the Haemophilia Foundation—it acknowledges that a lot of NGOs provide support or advocacy

services that are not able to link quite clearly to a particular specialty, which is why we have done a section at the top of that to describe that there are a massive range of services available in the community. These documents will go out, as I said, for the next eight weeks. We will then go through an endorsement process and then they will be finalised.

MS CHEYNE: With the endorsement process, who will endorse?

Ms Chamberlain: Internally to Canberra Hospital and Calvary hospital, the executive staff look at them and accept that that is an accurate reflection of what their specialty provides.

MS CHEYNE: How do you make sure that this plan is live and engaged with, rather than: "Awesome plan; put it in a drawer"?

Ms Chamberlain: "Pop it on the wall," yes. If you look at pages 9 and 10, the information that we collected from staff there refers to current service challenges and projections through for the next 10 years. This is just one element of the planning that occurs in health services.

We look there at some of the suggestions that our staff have made in terms of where there is a possibility to look at service improvement, whether that be in workforce, infrastructure or some business cases that may be required. It is then looked at against quality indicators and the financial funding that is available. The executives at the hospital work with the senior specialists to say, "These are our priorities within our specialty or within our division." It then goes through a governance process in the hospital, for the hospital executive to determine what the directions and priorities for the hospital are in the coming year and the forward years.

Mr De'Ath: While it is an exciting development, it sits in the context of bringing absolute coherence and clarity to our health system. We have talked about maternity; we have talked about service demand and planning infrastructure needs involving some of our tertiary providers in this sort of planning. It is about having our clinicians and other important staff groups involved in the thinking about how we take things forward. We have some examples across Australia at the moment of where we have not had the adequate engagement of people who know about the business in planning how the business should go forward. This is a really critical step in a broader picture of absolute clarity about how we go forward with the system, and educating the public, as we mentioned before, about what it is that we do.

Ms Fitzharris: From my point of view, we have talked a lot about territory-wide health services and trying to build the understanding of exactly what that means. That is why, just in case we got asked about specialty service plans today, we brought along a copy to demonstrate that, under a broad framework for a city of our size, we simply must make the best of the locations we have, and especially the staffing expertise that we have, with clinicians and other staff, and with our stakeholder organisations that also deliver some of the services on our behalf.

Intensively, within the hospital setting, it is about making sure that this happens. I wanted to be able to fully demonstrate to the committee that underneath that there is

an extensive amount of work. If you contemplate that there are 46 of these plans that have been developed, it really gives you an indication of territory-wide health services, and the incredible amount of detail and engagement that have gone on underneath this to make the most of the expertise and the facilities we have in the ACT to provide better health care to Canberrans.

MS CHEYNE: It is not just for acute; it is for—

Ms Chamberlain: No, it looks at the community sector, and the preventive health area as well. I think it will be a great education document. People who work in hospitals tend to think about hospitals and what happens there, whereas this will provide information from that pre-admission to post-admission phase, and what supports are available in the community.

MS CHEYNE: Once these are endorsed, are they going to be public?

Ms Chamberlain: We have not looked at that in terms of whether they would be put on the website. They would certainly be available, but they would perhaps need to be condensed and maybe looked at from a different perspective. We could maybe make a more user-friendly model.

MS CHEYNE: You say that people in the hospital might just think about the hospital rather than the whole service. Sometimes I think the community would think about just the place or the building, rather than the whole thing.

Ms Chamberlain: Yes, absolutely.

Ms Fitzharris: Again, more broadly, the territory-wide health services framework sits over the top of the service plans. The really detailed work is in the specialty service plans, but there is a draft framework which we launched late last year, and sitting alongside that there is a territory-wide health services advisory group, which has representatives of the hospitals and a number of different stakeholder organisations like Health Care Consumers, Capital Health Network, academics and a couple of community organisations. They are soon to finalise the framework, and that will again give a broader picture of what the whole health system is seeking to deliver. The draft framework is available publicly, and you will see the final one shortly.

Mr De'Ath: I have mentioned a couple of times having a considered approach. Getting the feedback and seriously listening to people about what they tell us about what sits in these documents is critically important. We have had a pretty intensive focus on that; hence the shape of things as they are going forward in their current machination.

MS LE COUTEUR: I probably should have asked this as a supplementary when we talked about infrastructure planning, but one of the things that is happening with the new hospital in Bruce is that the Canberra Hospital's hydrotherapy pool appears to be closing. I have been contacted by a number of residents close to the existing facility whose basic question is: why is it being closed and how can they access what they need, a hydrotherapy pool, close by and at a reasonable price?

Ms Fitzharris: Certainly that has come about. I would say that there are going to be a lot of people who live near Belconnen who are delighted, but I certainly understand that that is the case. There has been a proposal put to the government from Arthritis ACT which we are considering at the moment in terms of being able to support them to provide more access to hydrotherapy pools, but it is certainly the case that there has been a plan for a number of years to move the hydrotherapy service to the University of Canberra Hospital. Some of the work that we will discuss with Arthritis ACT is around access to hydrotherapy pools.

I think it is important to note that the hydrotherapy service is moving to the University of Canberra Hospital, as are all rehabilitation services. Arthritis ACT will continue to have the same level of access at UCH as they currently have, but whether or not there is an opportunity for the government to further support access to a hydrotherapy pool at other locations, including potentially the pool at Canberra Hospital, is something we will explore with Arthritis ACT in particular.

MS LE COUTEUR: That was the obvious suggestion. Sure, most is going to be happening on the north side—and that is fine; that is needed—but the pool is already here at the Canberra Hospital.

Ms Fitzharris: The pool is very old

MS LE COUTEUR: Basically the suggestion has been: why can't you still have that pool open so that south-siders can make some use of it?

Ms Fitzharris: People right across Canberra will be able to access the University of Canberra Hospital pool. It has many features which, as I understand, are superior to the current pool. I certainly understand access. The government supports Arthritis ACT to provide access to other hydrotherapy pools.

As I say, in terms of how we explore other options for the hydrotherapy pool at the Canberra Hospital, one thing to note is that the Stromlo pool that the government is building will have a hydrotherapy pool in it. Between now and then, which I understand is late next year—Mr Steel might be able to guide me on when that pool will be completed.

MR STEEL: Early 2020.

Ms Fitzharris: Perhaps we can look at a transitional arrangement between now and then, when there will be another new hydrotherapy pool available on the south side. There already are a number.

MS LE COUTEUR: Given that there will be people travelling to the pool at Stromlo, as you are saying, Mount Stromlo is not on a rapid bus route and the new hospital is not on a rapid bus route.

Ms Fitzharris: Yes, it is.

MS LE COUTEUR: For the people who are likely to be using this long term, this is a substantive issue: that it is not that easy to get to.

Ms Fitzharris: In terms of the feedback that I have had, that has not been the majority of the feedback. The majority of the feedback that I have had to date has been about people who all tell me they drive to the Canberra Hospital currently, and drive to the other hydrotherapy pools that they currently access, some of which are located on the south side. Perhaps we need to understand that, in relation to both the hydrotherapy service provided by ACT Health and access to a hydrotherapy pool, there is an intersection between those two but they are not always exactly the same thing.

MRS DUNNE: Minister, are Arthritis ACT being offered the same service that they currently provide, night and morning, six days a week?

Ms Fitzharris: Yes, but I will ask Linda Kohlhagen to talk about the difference between the current pool and the pool at UCH.

Ms Kohlhagen: I would just like to add that UCH is on the black rapid bus route.

Ms Fitzharris: Yes, it is on the route.

Ms Kohlhagen: I believe that bus runs every 15 minutes between Gungahlin and Belconnen. We have offered the Arthritis Foundation sessions during the middle of the day as well.

MRS DUNNE: As well as their existing sessions?

Ms Kohlhagen: In the morning?

MRS DUNNE: Yes.

Ms Kohlhagen: Yes. We have had that discussion with the CEO of the foundation. One of the other things to note is that, in thinking about the design of the hydro pool, there is external access, so people will be able to have easy access and not have to wander through the main part of the hospital. That has been a deliberate discussion and obviously a design feature, knowing that there are community agencies that use the pool and also that there are a range of people in the community who will go to the ACT Health hydrotherapy service and might not receive a service from any other part of UCH. So it will, hopefully, be easier for people to come in and out. In relation to parking, we have plenty of parking at UCH, so access to the facility is very good.

But the important thing is some of the design features. It has very flat access. You could use a wheelchair and enter the pool through a ramp. We have a hoist where you could sit on the side and be transferred. And we have deliberately put in an overhead hoist that goes from the change rooms. If someone is quite dependent and needs to go from the change rooms straight through to the pool, the overhead hoist can take someone up to 250 kilos. Obviously it is going to cost less to maintain, because it is relatively new. And the whole aesthetics of the facility are much improved from what they are at this point in time, right through from the change rooms to the toilets et cetera.

MRS DUNNE: I have seen commentary that there was not enough demand for two

hydrotherapy pools, but we do have quite a number of hydrotherapy pools as opposed to warm pools. But it has been pointed out to me that there are groups in the rheumatology area that do not have access to regular sessions, and also people with haemophilia who would benefit from hydrotherapy who do not have access at the moment and are looking for access. Are they being accommodated? Minister, I welcome the fact that you are in discussion with Arthritis ACT, because their needs are substantial, but my understanding is that there are other groups out there who would benefit from access to hydrotherapy as well.

Ms Kohlhagen: I think a wide range of people would benefit from hydro. As you have mentioned, there are a number of pools, both on the south side and the north side, that are heated to maybe 31 or 32 degrees.

MRS DUNNE: That is not enough.

Ms Kohlhagen: No; the feedback I get is that they like it 33 to 35, so slightly warmer.

MRS DUNNE: Yes.

Ms Kohlhagen: The hydrotherapy service that we would provide, from an ACT Health perspective, is a time-limited program as well. Depending on the assessment of each individual, it may go six, eight or 10 weeks. Then, hopefully, people would transition to community programs. As part of the commissioning of UCH, we do not manage the pool at this point in time, but I have not had any feedback from other community groups directly to suggest that they have people with other needs who would benefit from using the pool. We are certainly open and happy to talk to people.

MRS DUNNE: It is my understanding that the haemophilia group wants access to a hydrotherapy pool and they cannot get it now.

Ms Kohlhagen: I am not aware of that, but I am happy to chat to them further if they approach us.

MRS DUNNE: Perhaps you might approach them.

Ms Fitzharris: Some of the correspondence with Arthritis ACT has indicated that they have had some of those conversations on behalf of other community organisations. That is why I think we can have a discussion about access to a hydrotherapy pool. Where that is located is another question. In terms of the life expectancy left, and maintenance costs and safety costs for people using a pool, they are the sorts of things that we need to work through.

MS LEE: I am going to "Upgrade and maintain ACT Health assets budget". I understand that in answer to a question on notice by Mrs Dunne, QON 1,267, talking about the budget—

Ms Fitzharris: That is always a hard one to respond to, as I have no idea, from memory, what exactly that is.

MS LEE: I will try to give you a bit of info. It was about the budget for the replacement of the electrical main switchboard in buildings 2 and 12. It stated that the budget was $9.8 million, coming out of the broader overall UMAHA budget of $95.3 million, but that the scope of the work for the replacement of the electrical works had been expanded and it was going to come out of the existing budget. You failed to provide an answer about what those additional costs are. I am just wondering what—

Ms Fitzharris: I will ask Colm Mooney to talk to that.

Mr Mooney: Your question relates to a question on notice that was taken, and a response provided. The original UMAHA budget was $95.6 million, through the papers in 2016-17. That was the reference in the question on notice.

MS LEE: Yes.

Mr Mooney: We have a contract in place with a company called Shaw Building Group to a value of around $9 million. The information that was provided in relation to the response to the question was about the extra items that were required. In terms of the specific point about the actual budget impact, we made reference to a commercial-in-confidence aspect, which is still present because we are going through—

MS LEE: Why? Why is this?

Mr Mooney: Why? Because we are going through, with the contractor, the actual review of the specific variations. Obviously, from the perspective of those negotiations with the contractor, we want to keep that information basically in the context of the overall budget rather than being specific about the electrical main switchboard.

The actual UMAHA program was a body of work that consisted of about 140-odd items. The electrical main switchboard was one of those items. I do acknowledge that it is probably the most significant part of the UMAHA program.

MS LEE: It was over 10 per cent.

Mr Mooney: That is why, with responses to one of the other questions as to when UMAHA would finish, we refer in that QON to the actual completion times.

Given the nature of the project and the extent of the work that is being done, particularly in a live 24/7 operating hospital, the program is taking a bit longer than was originally expected. Our advice was that, at that time, the building 2 electrical main switchboard would be finished in June next year and building 12 in November next year. That is just in recognition of the work that has to be physically done. There is an enormous amount of work being done on the electrical main switchboard.

Just to put it in context, when you consider that it is a live hospital, in some cases we will be running new cables, almost 70 kilometres of cables, in the hospital to facilitate the new installation of the electrical main switchboard. It is not an insignificant task

and we have to do a huge amount of planning, in conjunction with all of the clinical areas, to make sure that when we make interruptions they are planned interruptions and we make sure that the work happens safely and operations continue.

MS LEE: You said it was commercial-in-confidence because of those negotiations.

Mr Mooney: Right.

MS LEE: And you are saying that in June and November next year they are due to be completed?

Mr Mooney: No. The program that we are working to basically has completion of the all the works by June, for building 2 electrical main switchboards. There are two switchboards per se in the actual project. It is building 2 by June of next year and building 12 by November of next year. We are going through negotiations with the contractor at the moment.

MS LEE: Will you be able to release that information—the additional cost—prior to that?

Mr Mooney: Yes. When we have finalised those negotiations, matters like that will be ultimately updated on our contracts register as the contract is updated.

MS LEE: As of today you cannot give us that information?

Mr Mooney: No, I cannot.

MS LEE: As you alluded to, and it was also in the response to the QON, there are going to be additional costs coming out of the existing UMAHA budget.

Mr Mooney: Yes.

MS LEE: What are some of the items or works that are going to be delayed or not undertaken as a result of that? Where is the money coming from?

Mr Mooney: It is coming from within the overall budget. We have had—

MRS DUNNE: So what has to give?

MS LEE: Yes; that is the question.

Mr Mooney: Within that program, we had contingency; we are tapping into contingency, primarily. As I said, with the actual program of works, we have contingency and we sort of re-prioritise program items.

MS LEE: Which are?

Mr Mooney: For example, we have elements of electrical residual circuit devices. We cannot do that work until the electrical main switchboard is done. It is that type of re-prioritisation of the projects.

MRS DUNNE: How much is the contingency in the UMAHA budget? How much of the UMAHA budget is contingency? Is it in the 90?

Mr Mooney: Everything is in; everything is rolled over.

MRS DUNNE: Everything is in there. In the $95 million, how much is contingency? Ten per cent? Twenty per cent?

Mr Mooney: Our normal process would be around 25 per cent contingency for cost plans.

MRS DUNNE: In this project, the original scope was pretty much under spec, because you have said that you originally proposed to roll out 5½ kilometres of new cabling and remove four kilometres of new cabling. The actual result now seems to be that you are going to roll out 73 kilometres—nearly 20 times what you originally proposed—and do away with 31 kilometres of existing cabling. What sort of pressure does that put on to the electrical system in buildings 2 and 12?

Mr Mooney: To answer the second part of your question, we have comprehensive building and continuity systems in place now for the electrical main switchboard—and indeed for all of our critical systems.

One of the things, following the start of the project, which would have been in terms of work on the ground in late April or May of 2017, is that we have introduced business continuity switchboards. These are completely separate systems that allow us to bypass all of the systems, including the electrical main switchboard, in the event of any issues. We have all of that in place at the moment. That is a significant level of assurance that we have, compared to not putting that facility in place.

Going back to your earlier question, the reason why we have had to increase the amount of cabling that we have had to replace essentially goes back to the need to maintain service all the time. With consultants, and also with Access Canberra, we have worked out that we will need to replace all of the cables, essentially, between the electrical main switchboard and distribution boards on all levels of floors on any buildings. It is that point. The scope has now gone from just replacing the electrical main switchboard and connecting in the cables to basically putting in new cables from the boards to all the distribution boards. That is something that we had to do in recognition of the compliance of the completed system when the finished project is signed off by the regulator.

MRS DUNNE: What about at the other end of the system, from the distribution point to the power points? Are you going to have to rewire them?

Mr Mooney: Once we have the electrical main switchboard in place, the new system, we will be in a much better position to address localised maintenance without having to shut down everything. Earlier, I touched on some re-prioritised projects using residual circuit devices that have to be done. One of the things that we have found challenging is that, with devices in local switchboards, in order to change them we would have to shut down everything. What we are doing with the new electrical main

switchboard is not only modernising the whole system, providing a much better level of redundancy and putting a backup in place but also providing a much better level of maintenance functionality so that we can physically do work on these systems and locally shut things down rather than having to shut down, essentially, the whole system.

MRS DUNNE: Do you have regular problems with circuit-breakers tripping out?

Mr Mooney: We have—

MRS DUNNE: That is a yes?

Mr Mooney: To explain that, earlier I touched on the business continuity plans we have in place. Just taking electrical as an example, we have a 24/7 arrangement both with our own staff and with a local contractor who trains all staff three times a year in the latest information on the evolving programs so that, in the event of an issue arising, nobody comes into the site in a cold state; they are fully aware of what the condition is. We have documented boards and such like. When we do have those instances, and we have had one or two of them, we have been able to identify where the problem is and fix it with no break in service.

I could not sit here and say a circuit-breaker is not going to trip. It trips in my house at home. It will trip in a hospital, particularly with that size of facility. But we have put in place risk mitigation to address that so that ultimately nobody experiences any downtime, because we have people onto it.

MRS DUNNE: While we are on UMAHA, has there been any subsequent work since the AECOM report to review other infrastructure in the hospital?

Mr Mooney: One of the elements of the original UMAHA program was a strategic asset management plan for all ACT Health assets. That body of work commenced with a set-in framework. From that, detailed strategic asset management plans have been developed. They were essentially endorsed in February of this year, after quite an extensive process of pulling together the most up-to-date snapshot of all of our buildings.

What we have done with that strategic asset management plan is categorise buildings, going from critical to surplus. And we have linked our strategic asset management plan to our risk registers so that we have a much more refined level of granularity in terms of priority of what our risks are. That is by consequence, likelihood, and then what is our asset priority index.

Obviously that allows us to take a more strategic view in terms of the deployment of our resources, both financial and human. But, as was touched on earlier on, with the speciality services plans and the territory-wide services framework, it gives some further context to what our health service will look like in the future, because the infrastructure bit can be considered with some up-to-date knowledge—and knowledge that is continuously being updated.

After the strategic asset management plan which we have for the Canberra Hospital

and all of the community health buildings, we also have what are known as asset management plans for individual buildings. We have started them on our priority ones—being, as you would expect, building 1 and building 12, which is the tower block, the emergency department and the operating theatres. That is a living document that constantly evolves as things happen in facilities.

MRS DUNNE: Is there sufficient money in the UMAHA budget to address the needs that arise out of the strategic asset management plan or is there a need to go back to cabinet for more money, and have you gone back to cabinet for more money?

Ms Fitzharris: As Mr Mooney said, every directorate has a strategic asset management plan. It is a live document that governments will continue to implement. There is not a single point in time by which everything must be funded that is in the plan over the longer term. There are risk prioritisation and recommendations made to government as further money in this year's budget, and I expect that we will continue to upgrade and maintain Health assets and build new ones. Every directorate will have strategic asset management plans.

MRS DUNNE: I am actually interested in the Health Directorate at the moment.

Ms Fitzharris: Yes, but all organisations will have strategic asset management plans that they need to be alive to each year. In terms of the recommendations made to government each year about providing funding, we have—

MRS DUNNE: Since the AECOM report, the one that is now available, has there been any other external assessment of risks that fed into the strategic asset management plan?

Mr Mooney: Yes, there has been.

MRS DUNNE: When was that done?

Mr Mooney: It is an ongoing process. We have contractors or consultants who have come on board to assist us in certain specialist fields. We have overhauled our planned preventive maintenance program. We are looking at things weekly and monthly. That all feeds into the strategic asset management plan.

MRS DUNNE: How much money is there in this budget and in the outyears for the strategic asset management plan?

Ms Fitzharris: Perhaps we will take that on notice because we may not have—

MRS DUNNE: Because there is UMAHA money; there is more money. I would like to see how much money is being spent on asset management in the hospital.

Ms Fitzharris: Okay. That will be UMAHA; that will be the building infrastructure fund, which was previously known as the capital upgrades fund program, and which is a proportion each year, and ongoing funding as well.

Ms Doran: I think that is right. We are in a process of transition and planning in this

space. There is regular money for the maintenance of assets in the budget. As we are building new infrastructure, we are ensuring that we put in that allowance, going forward, for regular maintenance.

There is the building infrastructure fund, as the minister mentioned, which is a regular allocation in the budget as well. UMAHA has come as a piece—you might almost say exceptional, on top of that—responding to some particular risks that have been identified in the suite of assets.

What our planning now allows us to do is to move over the next four or five years to what I would see as a steady state where we have a planned maintenance program that not so much responds to risks but keeps our risks under control and has a sustainable and understood level of funding to support the ongoing maintenance of our buildings.

Ms Fitzharris: There is also money that the government invested in Calvary: the upgrades and maintenance.

MRS DUNNE: Through the development of the strategic asset management plan, have you identified anything else that was missed in the AECOM report?

Mr Mooney: It has provided more detail. There are still the same types of generic headings—electrical, heating, ventilation, air conditioning and hydraulic. It is what you would expect in a large portfolio of properties. Within the strategic asset management plan, excluding UCH, which did not fall into that category at the time that the plan was being done, we looked at 67 buildings within our portfolio, about 267,000 square metres of space.

Within that space you have the usual suspects—as I said, HVAC, or heating, ventilation and air conditioning, hydraulic, electrical, ICT and network infrastructure. It is not so much the ICT software but it is the backbone where buildings have grown over years, the services have developed and things have been shoe-horned into place. It would not necessarily have been done in the best way, and that is what we have to unpick.

Ms Doran: What the asset management plan has added, particularly to the AECOM report, is a classification of the buildings and the services they provide, and the criticality of those buildings within the whole infrastructure program. It gives us the two dimensions to the analysis going forward; one being the risks but then weighing those risks against the building and its criticality in the service provision. It allows us to manage the program in a much more targeted way.

THE CHAIR: On the electrical upgrades, what is the process when an RCD trips? What is the policy that needs to be followed by patients or staff on a ward?

Mr Mooney: If something trips at a socket then our facilities management people will be called. They will do an investigation and confirm with the area. If there was an electric shock instance or something like that, it would be put on RiskMan and normal protocols would be followed, to the point even of notifying WorkSafe ACT. That would be the case for an electrical fault issue, over and above just a simple trip of a switch.

THE CHAIR: If there is a simple trip of a switch, building maintenance are still called?

Mr Mooney: Yes.

THE CHAIR: Do you keep a log or a register of how many instances that—

Mr Mooney: There would be a work order done.

THE CHAIR: I imagine this will be taken on notice. Could we have, for the current financial year, the number of instances where that has occurred?

Mr Mooney: Yes; we can get it.

THE CHAIR: How many instances have there been of an electrical shock or a mild electrocution?

Mr Mooney: I will take that on notice, but we can provide it.

Ms Fitzharris: At which location?

Mr Mooney: At the Canberra Hospital?

THE CHAIR: TCH.

Ms Fitzharris: Not the 67 buildings?

Mr Mooney: Just the TCH?

THE CHAIR: The TCH is obviously the—

Mr Mooney: Yes, TCH would have a number of buildings within that.

THE CHAIR: prime area of focus for the electrical issues that are existing now—unless, minister, there are electrical issues at other sites that we need to know about.

Ms Fitzharris: No. I think you just get a sense of the range of buildings. I just wanted to clarify that, because I am conscious that there is a lot of work involved for officials.

THE CHAIR: As an additional point, could we have the number of electrocutions or electrical shocks that have occurred at sites other than TCH.

Ms Fitzharris: I should not have asked!

THE CHAIR: And the location of where that occurred—the building or the facility, please.

Mr De'Ath: Mr Wall, noting the time, there were some questions taken on notice. We are able to provide some responses to the committee, should they wish, or we can, in

the usual course of business—

THE CHAIR: We might get through those now and then we will suspend for lunch.

Ms Doran: If you are happy to go back to the mental health session, there was a question seeking the split of the expenses under output 1.2 across the mental health judicial and drug and alcohol components. Of the $195 million there, $145 million in round numbers is for mental health. In the justice space it is $13 million, and drug and alcohol is $37 million. I can clarify that the AMC does come under that output class, so those initiatives are included there.

THE CHAIR: The funding that is going towards Winnunga is inclusive of the $13 million in round terms?

Ms Doran: Winnunga in the justice space? I will take that on notice.

THE CHAIR: Is the budget line item for the Winnunga model of care at the AMC funded out of that $13 million in justice?

Ms Doran: That would be right, yes. If I can go on to a couple on Calvary, in terms of the performance agreement, there was a question about the performance indicators there. Those indicators at the moment are defined around separations, NWOW and elective surgery numbers, and those numbers are then split by specialty and birth numbers.

On the last question, which was on the re-profiling or the rolling over of some funding for Calvary for imaging equipment, I can clarify that that equipment was in respect of some mobile imaging equipment and CT scanners. The reason for the rollover is that the procurements are actually in place. There has been a delay, though, in delivery time due to the need to put lead wall linings into the construction space. That is the reason for needing to roll over into a new financial year.

THE CHAIR: Thank you for those answers. The committee will suspend for lunch.

Hearing suspended from 12.32 to 2.01 pm.

THE CHAIR: Welcome back, everyone. We will be continuing with output class 1, health and community care, and the sub-output classes that belong within that. We will go to Ms Orr.

MS ORR: Minister, there has been considerable demand for the emergency department services recently. What specific budget initiatives has the government put in place to respond to this demand?

Ms Fitzharris: I will ask Chris Bone to talk in more detail. There have been significant investments at Canberra Hospital, as well as at Calvary. I will ask Chris Bone to go through those.

Mr Bone: The funding allocated in this budget is to help us deal with the systemic issues related to attendances in the ED, and the moving of patients both through the

ED to discharge back into the community and the admission of patients through into the hospital as part of the ongoing care.

Primarily, we targeted medical workforce in the emergency department. There was a submission made that, with the number of patients presenting, particularly in the latter part of the day, the afternoon and overnight, we need to deal with that surge that occurs in the late afternoon. Those patients carry through to overnight. It puts us in a better position if we have patients managed and discharged from the ED, if they do not need admission to the hospital, first thing in the morning. That sets us up for the start of a good day.

There is medical workforce in there. There is some nursing. There is also allied health. For those people who do not need to be seen by a specialist, allied health—advanced practice physios, for instance—can manage and treat people and get them back into the community and hooked into primary health care or other health providers in the community for their ongoing rehabilitation. I will ask Mark to speak a little more about some of the other initiatives.

Ms Fitzharris: Could I say, before Mark jumps in, that the investments in this year's budget are best described as whole-of-hospital investment, even though they are broken up into specific projects. It is to make sure that, in terms of what we might see as pressures on the emergency department, they are actually around how the hospital as a whole is able to operate, and making sure that we sustainably fund the operations of the hospital as a whole.

Mr Dykgraaf: The minister and Mr Bone have covered off on the key issues that we face in regard to the emergency department. The budget initiatives are aimed across the facility. At the front door of the emergency department, we note the ongoing rise in the presentation rate at Canberra Hospital. In the 2016-17 year it was at 9.9 per cent. This year we are running at a four to 4½ per cent increase in the presentation rate. We note the continued challenge of the sheer gravitational pull of Canberra Hospital—people from the north side coming past Calvary to come to Canberra. Some of that is driven by clinical need. Some of that is driven by the fact that the specialist doctors might be at Canberra Hospital. Some of it, of course, to expand on the clinical need comment, is driven by issues of trauma.

We note also that emergency surgery has received funding in this budget. We note that emergency surgery is rising, at over six per cent per year. Elective surgery is rising at around two to 2½ per cent per year. The budget initiatives this year are focused on the emergency department and then on a wider bed strategy in the hospital, noting the winter strategy that we have in planning at the moment and which will be implemented in July, and also the surgery initiatives, both emergency and elective surgery.

MS ORR: What were the surgery initiatives?

Mr Dykgraaf: We note that there is funding applied. We note that government has announced that we will be increasing elective surgery to around 14,000 elective surgeries in the coming financial year, and 14,000 for the three years post that. It is very important in terms of meeting demand overall, and there are also additional

funds to deal with the emergency surgery demand.

MS ORR: Last year it was reported that there was a lot of pressure put on the ED due to the flu season, noting that it was a particularly bad one Australia-wide, but, even apart from that, what have you done this year to mitigate any impact that the flu season might have?

Mr Dykgraaf: Indeed. I can speak to that.

Ms Fitzharris: We can have probably two people speak to that.

MS ORR: As many as you like.

Mr Dykgraaf: I will speak about the hospital and health services. We have in place at Canberra Hospital a winter plan. As part of that winter plan, we will be operationalising 72 additional beds. We have a flu vaccination program for staff. We have a communications strategy external to the hospital that is being run by our media and communications team. So there is significant planning both at Canberra Hospital and at the wider health services. On that note, I might pass over to Dr Kelly.

Dr Kelly: Thank you for your question. Last year we had an extraordinarily bad flu season—somewhere between two and three times the average over the previous five years. That was reflected not only throughout the community but also—and particularly at the Canberra Hospital and at Calvary, to a certain extent—in terms of admissions to the general wards and to intensive care.

Every year we have extensive planning for the flu season. On the back of last year the minister asked what else could be done to prepare for this flu season. There are a range of matters that we have introduced over and above our usual winter planning. Mr Dykgraaf has already mentioned that in terms of Canberra Hospital. It is a comprehensive plan which includes Canberra Hospital, Calvary, general practice through the Capital Health Network, pharmacies and others, to prevent issues where we can and to be prepared to scale up when the flu season comes, to respond.

One of the major elements of that was the introduction of the flu vaccine to children aged six months to five years. That was an ACT government-funded program, mirroring those that have happened in states up and down the eastern seaboard. That has been extraordinarily successful. As of yesterday—I am just trying to remember the figure; I looked at it earlier—looking at the proportion of children that have been vaccinated, it is more than six times what we had last year, and last year was already twice as many as the year before, so it has been en masse. It is about 12 times two years ago, so that has really been taken up by the community, within our own community health centres and in general practice.

Vaccination is one of the issues. The other thing we have done is to work very closely with aged-care facilities. That has been building on a number of years of work that we have done in that area. Again, there has been very high coverage of flu vaccine for elderly residents of Canberra broadly, and particularly in the aged-care facilities. Over 85 per cent of Canberrans over the age of 65 have received the stronger flu vaccine that was introduced into Australia earlier this year.

They are two of the issues that we have worked on closely. The other one that Mr Dykgraaf also mentioned was looking at what we could do to increase our uptake of flu vaccine by our own staff. That has been slightly stymied by recent developments, a shortage of vaccine across Australia, but we have had a very good uptake of vaccine amongst the staff of Canberra Hospital and Health Services.

MS ORR: Going back to the expansion of the surgery procedures, what is actually driving the demand for and the pressure on surgeries?

Ms Fitzharris: On both elective and emergency?

MS ORR: Yes, both.

Mr Dykgraaf: In relation to elective surgery, there are a number of drivers. In the broad you would say that it relates to an ageing population and increasing population size. If you look at the increase in elective surgery, at two to 2½ per cent it is not that far away from population growth.

If you look at the issues around emergency surgery, what drives that primarily is the fact that Canberra Hospital and Health Services is the trauma centre for Canberra and region. That trauma can be from something quite minor—a fractured finger that requires pinning—right through to something for which we might bring you back on the helicopter.

That again relates to population growth, particularly in the South Coast corridor, and it relates to the age of the population that we see in the region—significant numbers of retirees et cetera to the South Coast. Of course, at this time of year you will see it from the ski fields. It is a function of population growth, and it is a function of Canberra Hospital and Health Services being a trauma centre.

MS ORR: You mentioned that there is a bed strategy being put in place. Am I right in understanding that there has been a winter bed strategy?

Mr Dykgraaf: Both.

MS ORR: I appreciate that the wider bed strategy is coming, but would you be able to comment on the winter bed strategy and what you are finding from that process?

Mr Dykgraaf: Certainly. In the 2017 winter, we instituted a process for winter planning that involved 34 additional beds. There are a range of operational processes that we institute as part of the winter season. We manage closely what is occurring each day coming through the hospital.

As part of the 2018 winter season, we have expanded that program because of demand, and we have 72 beds coming online. We already have some of those operationalised, particularly in the surgical area—around 20 of those. We use those somewhat flexibly. We do open and close them. Most of those beds will come online from 9 July. We are moving one unit from near the ED into the tower block. That will create 16 additional beds for the ED.

We are opening an additional 16-bed medical ward, which is particularly important at this time of the year, with respiratory illness. We note, of course, that at this time of the year, with minor respiratory illnesses that might not affect somebody who is younger, for somebody who is older and has chronic disease, that is a significant impact, and that is where we see a lot of our presentations. They are some examples—surgical beds, medical beds, emergency department beds, beds in oncology and paediatrics.

MS ORR: How do you manage the staffing across that?

Mr Dykgraaf: We have recruited, quite deliberately, additional medical officers inside the ED. We have engaged additional medical officers for the wider hospital. Those recruitments are functionally complete. In relation to the nursing recruitment, that continues, but we staff up our nursing pool and, because of the simple churn of staff turnover each year, we would expect around 10 per cent staff turnover. We can bring on many of those new nurses on permanent contract, to deal with the winter, noting that our routine turnover will mean that we will not be overshooting on our staffing. It needs to be carefully managed but it is quite a routine business process.

MRS DUNNE: I refer you to the operating statement for the ACT hospitals network and the notes on page 48, which is the last page in statements C. Could somebody run me through some of these dot points, please. It says, for instance, that there was a decrease in the estimated outcome of cross-border revenue but an increase in commonwealth revenue. Can someone talk me through that, please?

Ms Doran: I will start, and I will ask our chief financial officer to come up. The changes in commonwealth revenue, I believe, reflect some reconciliation payments that were received in 2017-18 which increased the revenue from the commonwealth above what we were expecting, based on just the 2017-18 year expected revenue. The way in which the LHN accounts work is that they balance out to the same quantum, so if the commonwealth revenue goes up, other elements of controlled recurrent payments necessarily go down. So that $43 million largely comprised $40 million—

MRS DUNNE: That is the $40 million in the third dot point?

Ms Doran: That is right.

MRS DUNNE: There is $40 million in the third dot point on page 48.

Ms Doran: That is right. It is from the revenue, and the other component of it would have been from cross-border revenue.

MRS DUNNE: So you are saying that we got $40 million in extra payments, essentially back-payments from the commonwealth, so they have to be balanced out. What actually happens to that $40 million? Does that go into the health budget or does it go into consolidated revenue?

Ms Doran: It effectively goes into consolidated revenue, the whole-of-territory budget. The health budget is predefined to an extent, so if the commonwealth revenue

changes in the course of a year it does not directly impact the health budget. The health budget automatically balances out to the predefined quantum and any additional amount goes into the whole-of-territory budget.

MRS DUNNE: My understanding from this third dot point is that in 2017-18 the ACT received $40 million in essentially back-adjustments that covered the period 2015-16 and 2016-17.

Ms Doran: 2016-17, that is right.

MRS DUNNE: That is commonwealth money which is earmarked for health, but it did not go into the health budget?

Ms Fitzharris: No. I think it is fair to say that it has already been spent in health.

Ms Doran: Yes; that is right.

Ms Fitzharris: You might have seen national debate around this, about the commonwealth having to pay when, in terms of timings of payments, it has already been effectively invested and health services have already been delivered.

MRS DUNNE: But you did not know you were going to get it?

Ms Fitzharris: Yes.

MRS DUNNE: You did know? When did you know that you were going to get $40 million in back-adjustment for 2015-16 and 2016-17?

Ms Doran: It is a continual process, with the commonwealth updating our data, so we work on estimates in the budget which are refined over time. There were some more significant elements of reconciliation back through 2015-16 and 2016-17 that related to some particular issues that were being negotiated between jurisdictions and the commonwealth in terms of types of activity that were covered or the extent to which they were covered.

The way in which the health budget is struck within the territory means that those sorts of things are taken into account in the aggregate. I think the reason that is done is to avoid these sorts of volatilities which can happen with commonwealth funding because of time lags or adjustments. That volatility is taken to the whole-of-territory budget as opposed to it directly hitting the health budget, but it does not mean that we miss out on revenue; it just means that we have certainty.

MRS DUNNE: I am more concerned that you have had a windfall and whether that windfall goes to ACT Health

Ms Fitzharris: No.

MRS DUNNE: Or into consolidated revenue?

Ms Fitzharris: No. Technically, in terms of the money flows, it goes into

consolidated revenue, but in its practical spend, it has already been spent within ACT Health. In broad terms, the commonwealth pay us for activity. As this national health reform has rolled out, that process has been refined over time. As Karen Doran said, we estimate activity. If there has been more activity than we estimated, the commonwealth will pay us for that; if there has been less, there will be a reconciliation.

MRS DUNNE: There is a reckoning at the end of every year?

Ms Fitzharris: There will be a reconciliation, but also there is discussion about the refinement of each activity over time. There has been a lot of discussion about this amongst health ministers, and I think Queensland are still arguing with the commonwealth about whether or not they should be paid for this level of activity at this price. There has been some disagreement, or refinement, of what is categorised as a particular activity and to what extent the commonwealth or the national bodies have been able to properly categorise how much that activity costs. That is part of the reconciliation of our activity that was delivered close to two years ago.

There is no windfall gain here. It is not a windfall gain. It is paying the ACT government for health services already delivered. We have already invested in the delivery of those health services; this is just the commonwealth reconciliation process working its way back.

THE CHAIR: Surely those figures were budgeted for in the 2015-16 and 2016-17 financial years? Otherwise you would have been operating at a deficit.

Ms Fitzharris: That is right, and that is what Karen—

Ms Doran: That is what I am saying.

THE CHAIR: So you did operate at a deficit to that extent?

Ms Fitzharris: No.

Ms Doran: No. If I may—

THE CHAIR: I understand it is a bit of money-go-round and, I guess, following the paper trail.

Ms Doran: It is to an extent. The commonwealth revenue is a component of revenue that comes towards the health budget. In setting the health budget, as part of the ACT government processes, we look at all activity, all expected costs. We strike a budget that covers all items that we expect.

THE CHAIR: Yes.

Ms Doran: That is where the minister is saying that it has already been budgeted for, we have had the money, and the money has been expended during those previous periods. The process with the commonwealth happens somewhat in parallel to that and somewhat discretely from that, in that it is a more lagged process and there has

been greater negotiation about which components of the activity that we fully budgeted in our ACT budget the commonwealth will pay for. When that revenue flows from the commonwealth, it goes effectively into consolidated revenue, because it has already been accounted for in our budget.

THE CHAIR: Essentially Health has taken a loan from treasury to cover those expenses until reimbursement comes from the commonwealth, and then the money goes back.

Ms Doran: I think it is fairer to—

THE CHAIR: I am just trying to simplify it. I understand that—

Ms Doran: I think it is fairer to say that the territory budget takes the risk of volatility and timing differences that might happen on those revenue flows.

MRS DUNNE: Can I get an assurance that all commonwealth money that is tied to health goes to the health budget?

Ms Fitzharris: Yes. In fact, yes, you can, but I would also mention that we spend above and beyond what the commonwealth pay us.

MRS DUNNE: I understand that. Is that acquitted? If so, how is it acquitted to the commonwealth?

Ms Doran: It is acquitted through the processes of submitting both activity data and expense data through to the national bodies that are independent bodies set up to monitor this process.

Ms Fitzharris: You can be assured that this is a very robust process nationally between the Independent Hospital Pricing Authority, IHPA, and the National Health Funding Body, established broadly under agreements between the commonwealth and the states and territories to give some assurance that there is a national approach to the payment of commonwealth funds to states and territories for a said amount of activity at a certain price.

The budget papers have for a number of years included in budget paper 3 a sentence which says:

> A Health Funding Envelope is used to provide funding certainty for the Health Directorate and the Local Hospital Network regardless of changes in the Commonwealth funding contributions and other sources of income.

That is the simplest explanation for what we have been talking about.

It certainly is the case that most states and territories would argue that the commonwealth do not quite pay their fair share, but we have agreed to a national system and we will continue to talk to the commonwealth about providing even further support to the states and territories. You can be assured that health funding from the commonwealth is absolutely invested in ACT Health to provide health

services to Canberrans.

THE CHAIR: Whilst we are looking at the numbers and Mr Vivian is up here, we will delve into a couple of other areas. What was the capital expenditure budget for the 2017-18 financial year?

Mr Vivian: I will take the question on notice, but I will just draw your attention to the fact that there is actually a capital appropriation, which is the—

THE CHAIR: That is for 2018-19 and beyond.

Mr Vivian: Yes. If you go to statements C, page 21, that shows you the actual capital appropriation. Then, if you keep going a bit further, it talks about the 2018-19 Health Directorate infrastructure program, which is all the capital expenditure through there in the statements. I think that gives you the information that you are looking for.

THE CHAIR: That does for going forward. The question was specifically about what the overall budget was for 2017-18. I was curious. The following question would be: how much of that budgeted amount has been spent this financial year?

Mr Vivian: I will take that question on notice, but if you go back to the previous year, you will see that budget that you are talking about and where we have commenced. I will put that in a response to a question on notice.

THE CHAIR: Have all the initiatives in last year's budget been delivered on?

Mr Vivian: We are talking directly about 2017-18? We have not delivered the capital program to the full extent. We have done—I think the figure is—a $94 million rollover. You will see that in the figures. We will address that in the question on notice.

THE CHAIR: For the $94 million rollover, what projects have not been delivered? That is looking at the list on page 21, is it? Is that correct?

Mr Vivian: You will not see that listing. We will address that in the question on notice.

THE CHAIR: Okay.

Ms Fitzharris: The detail can come, but some of that is just the timing of payments over financial years. It does not necessarily mean in any case that there is a project that has not been delivered; it might just mean that there is a difference in shift of payments over financial years as opposed to delivery of the project itself.

Mr Vivian: Just to add weight to what the minister is saying, if, for example, we needed to access some of that $94 million because we could deliver more of the project than was expected, that would unfreeze the appropriation to allow us to have access to those funds. This was a cross-directorate initiative that we were profiling of capital; it was not just health.

MRS DUNNE: Could I just follow up on some of the infrastructure things? On page 23, the better infrastructure fund, there are two items: "Improving health facilities—Departmental" and "Improving health facilities—Territorial". Can someone explain to me what the source of that funding is? If it is departmental, is it self-funding?

Mr Vivian: No. Departmental will come from the capital appropriation, and territorial will relate to the Calvary expenditure when we provide it.

MRS DUNNE: Sorry, I did not hear the end of that. The territorial is what?

Mr Vivian: The territorial will relate to the Calvary capital expenditure—expenses on behalf of the territory, what they call an administered item, which means we do not control it. When the capital gets provided, it sits on their balance sheet.

MRS DUNNE: Okay, sorry. Let me go to "More mobile dental clinics". I do not have a problem with more mobile dental clinics; I think it is a good idea. I am just a little concerned as to how that is a capital investment. You are essentially buying vehicles which are not an asset; they just depreciate as you buy them. Why is that considered capital rather than expense?

Mr Vivian: Sorry?

MRS DUNNE: Why is expenditure on the mobile dental clinics considered a capital investment rather than an expense? You are essentially buying motor vehicles, which are not an asset.

Mr Vivian: If you are purchasing a motor vehicle, in fact it would be a purchase of an asset. If it was a financing lease, that would also be capital. I would have to go and look at the specifics for that.

MRS DUNNE: So even if you are leasing them it is capital?

Mr Vivian: If it was a financing lease. If it was an operating lease, it would be. I would have to go and look at the specifics of those leases.

MRS DUNNE: Everyone knows that a vehicle is not an asset; it just keeps declining in value. I am just wondering about the financial treatment of motor vehicles.

Mr Vivian: We will get the exact detail, but if you go and purchase a car and you own the car—I would have to look at the specifics with these dental vans—it would be an asset. I agree it is a bit of a black hole, like a boat, but ultimately it would be an asset on your balance sheet.

If we have entered into financing leases, then they are assets. If you have entered into operating leases, then they peak at P&L. I might add that there is going to be a change in the accounting standards that is going to shift all operating leases to financing leases in the future. I think that is effective from January 2019. So what you will find right across Australia is that when we have multiple operating leases they will end up being capitalised as well. That is where it is going in the future.

THE CHAIR: My attention was drawn to page 21. There is the replacement of polyethylene aluminium composite panels for the Centenary hospital there.

MRS DUNNE: I was going to let that one pass.

THE CHAIR: I am not as generous. What aspect of the panel replacement does that $1.6 million cover? The entire project?

Ms Fitzharris: It is the full extent of the project. Yes, it is the project.

Ms Doran: Yes, the full extent of the project.

THE CHAIR: If the panels are not up to standard and the building is accepted, given that it is a relatively new build, how is it that non-compliant materials were used on its initial construction?

Ms Fitzharris: They were not.

THE CHAIR: Why do we need to replace the panels?

Ms Fitzharris: Because further information has come to light. We have been through this.

THE CHAIR: I know, but has there been a change in the Australian standard at any point in the last couple of years that would warrant it?

Ms Fitzharris: Well—

THE CHAIR: As someone that comes from the industry, I am still grappling with this. If the material was not fit for purpose when it was put on the building—

Ms Fitzharris: It was.

THE CHAIR: What has changed to deem it not fit for purpose? Is it something that government is doing above and beyond what the Australian standards require?

Ms Fitzharris: I am somewhat surprised at this line of questioning, given that there has been the opposite line of—

THE CHAIR: There is an appropriation of $1.6 million for this.

Ms Fitzharris: Mr Wall, have you missed the debate in the Assembly in the past year, particularly from your colleagues, about what—

THE CHAIR: No, I have not, but I am still trying to understand it.

Ms Fitzharris: I recall your colleagues making incredibly alarming and outrageous claims about us keeping those panels. I am just curious.

MS CHEYNE: We are in an alternative reality.

THE CHAIR: I still do not think that it is completely clear why—

MS CHEYNE: He is not reading off the script; that is the problem.

THE CHAIR: I do not think that we require a script, Ms Cheyne.

Ms Fitzharris: I am very happy to go through this again, after hours of debate. I am really happy to do that and to give you the explanation of why we are changing the panels. I will ask Mr Mooney to talk to that, noting my surprise at the line of questioning.

THE CHAIR: The purpose of this, I thought, was to scrutinise the budget. There is an appropriation line item for this exercise.

Ms Fitzharris: I appreciate that.

THE CHAIR: I am, as a member of the community and a member of the Assembly, still not a hundred per cent clear as to why it is the taxpayer footing the bill and what changed in the intervening period between when it was built, certified and a certificate of occupancy issued and the point of the decision being taken that the panels were not fit for purpose. What was the underlying change that determined that?

Ms Fitzharris: I fully appreciate your absolute right to scrutinise this project, but I would note that it has been extensively scrutinised already in the Assembly in a number of different ways, with the very opposite line of inquiry. Having said that, I will be very happy to—

THE CHAIR: Obviously, if the decision has been taken that the panels are not suitable and they need to be replaced, that is fine and, in the interests of public safety, that is the appropriate course of action. Don't get me wrong on that point. Where I am curious and keen to still understand, and it is in the detail, is what changed if the building was certified, accepted, handed over at the completion of construction and deemed to have been compliant, and it now is not?

Mr Mooney: Just to clarify, the building is still compliant. However, from the time it was built, as the minister said, last year we had the issue with the Grenfell fire. That sparked a lot of interest and investigation. We followed up, as part of that process, by checking our buildings. We identified the Centenary Hospital for Women and Children building as having these materials. Because of the nature of the building, a multistorey building, and the type of patient in the building, it represents a credible risk. On the basis of that new information, a decision was taken.

THE CHAIR: My understanding of the use of the composite panels is that the national construction code and the Australian standard had not allowed for the use of those materials on multistorey buildings for quite some time.

Mr Mooney: I cannot go into all of those details; that is a question you should best ask the building regulator and my colleagues from EPSDD. However, in conjunction with the immediate follow-up of the Grenfell fire, there was a whole-of-government

review group set up. We are part of that group. As I have said, following investigation of that particular building, having identified that particular type of polyethylene aluminium composite panel material in place, a decision was taken, because it represented a credible risk, to remove it or plan for the removal. That planning has started and is being implemented as we speak.

THE CHAIR: It is still no clearer, but I will move on.

MS CHEYNE: Is the replacement on time?

Mr Mooney: We will finish the work next month; hence the reason that, from a technicality point of view, in the budget papers the money is being expended in this coming financial year.

MS CHEYNE: Because it is being completed then?

Mr Mooney: Correct. Essentially, we appointed a contractor in late December and started the work on the ground in February-March.

MRS DUNNE: Could I go back, while we are on the money side, to the increased capacity, improving health facilities, territorial, and the way it relates to more surgery? How much of the more surgery will be conducted at Calvary? What proportion will be at Calvary and what proportion at TCH? Is there a plan to take any elective surgery out to the market in the private sector? How does that happen?

Mr Bone: Of the 14,000 elective surgeries projected for next year, a proportion will be allocated to TCH and there is an increased proportion to Calvary. There is a proposal that a number yet to be determined will go into the private sector, through the private panel that we went out to tender for 12 months ago.

MRS DUNNE: Who is on the private panel?

Mr Bone: I would have to take that on notice.

Ms Fitzharris: I recall in the inquiry we had around the supplementary—

MRS DUNNE: Supplementary appropriation.

Ms Fitzharris: we provided that response to a question on notice.

MRS DUNNE: I think you are right. Does that mean there is a competitive tender for anything that goes out to the private sector?

Mr Bone: There would be a competitive tender.

MRS DUNNE: Is it possible that, with the proportion of surgery that goes to Calvary, some of that can be sublet off to Calvary private?

Mr Bone: That is possible.

MRS DUNNE: If Calvary gets—pick a number—30 per cent of the 14,000, can it sublet some of that 30 per cent of the 14,000 to Calvary private or can it only go to Calvary private through the panel?

Ms Fitzharris: Would we purchase that direct from the two separately or would we do it—

Ms Doran: That is something that would be managed in the negotiations with Calvary under their performance agreement. At the moment it is a matter that we are discussing with them about the subcontracting arrangements.

MRS DUNNE: It is an open question as to whether or not Calvary private will have to compete on the panel?

Ms Doran: Calvary private are on the panel and can compete on the panel. There is also—

MRS DUNNE: Yes, but if they can have an arrangement with Calvary public, they may—

Ms Doran: That is right.

MRS DUNNE: not need to, and is that truly competitive?

Ms Doran: That is a discussion we are having with Calvary at the moment.

MRS DUNNE: I would hope so.

Ms Doran: If we were to allow them to subcontract directly, it would be in a transparent process that ensures the competitive tensions are maintained and that it would be effectively the same as working through the panel on a competitive process.

MRS DUNNE: How would you do that?

Ms Doran: That is what we are discussing with them at the moment. There are also potentially some benefits, some efficiencies, to come from them being able to subcontract directly in terms of managing the provision of different types of specialty services that meet the resources that they have available. But any process that is agreed to will be a fully transparent one and, as I said, one that preserves those competitive tensions through the mechanism.

MRS DUNNE: How will we know? How will these Assembly members know that that has been done competitively? What will we see that will guarantee to us that it has been done competitively?

Ms Doran: That is something I can take on notice. But to the extent that we are transparent, we have transparent information from Calvary, that would be information that could be made available to the Assembly.

MR COE: I have a question on finances, too. With regard to the arrangement that the

directorate has with Shared Services, I understand that bill is in the vicinity of $50 million; is that right?

Mr Vivian: Yes, that is correct—a bit over $48 million.

MR COE: Where is the line between what IT is delivered by Shared Services and what IT is done in house by the directorate?

Mr O'Halloran: The answer is that the line moves and it does depend on what the issue being examined is. In broad terms, with technology matters that are purely related to the operations of ACT Health or where clinical involvement is required, generally ACT Health takes the lead. Where it is traditional, pure IT such as desktop computers, networks, storage, firewalls and those types of things, Shared Services will take the lead.

ACT Health and Shared Services liaise on that very closely. We have, generally, multiple contacts a day about those types of matters. ACT Health is very heavily involved in those clinical applications. We have 254 ICT applications, which we maintain the majority of.

MR COE: What is different in the shared services provided to Health as compared to the other agencies? If you are in effect doing a lot of the clinical side of things in house, what makes the shared services package for Health different from that of Education, CMTEDD and everything else?

Mr O'Halloran: Part of the difference is potentially some of the hardware that Shared Services provide to us. At the moment we have, for example, what we call COWs, or computers on wheels, which are designed for use in a clinical environment. It is an all-in-one computer on a special trolley that can go through infection control and so forth. That is used at the bedside by our staff when treating patients. For example, that is one element where Shared Services provide quite a different set of hardware to us that no other directorate uses.

They provide an enhanced level of service to us in terms of hours of operation and support. ACT Health funds Shared Services an additional amount of money to ensure that we have 24/7 support at any time for any ACT Health staff member. We also have a number of Shared Services staff members embedded within ACT Health facilities.

MR COE: What about with regard to things like data storage? Obviously, Shared Services offer that as a product to other agencies.

Mr O'Halloran: Yes, they do.

MR COE: What does Health do?

Mr O'Halloran: The majority of our data is currently stored by Shared Services.

MR COE: What data is not stored by Shared Services?

Mr O'Halloran: There are a small number of systems where data is maintained on third-party managed equipment that is based in our data centre at Canberra Hospital. That is systems such as nurse call, duress, security CCTV footage and so forth. There are a small number of cloud-based applications where it is maintained in the cloud by a third-party vendor.

MR COE: Is Health proposing to shift more data from Shared Services into Health-managed facilities?

Mr O'Halloran: As part of the overall approach to the use of cloud computing by the government, ACT Health, when evaluating all new technologies, looks to a cloud-first policy. That may mean at times that that data may be hosted by a third party. It also means at other times that that data is in fact hosted by Shared Services.

ACT Health was one of the lead directorates in terms of moving towards the Shared Services Microsoft Azure tenancies, and starting to move our data into those tenancies. We have been very active in moving to the cloud, where we can, with Shared Services. Over time there will be other aspects where we may move to the cloud with a third-party vendor that is not Shared Services.

MR COE: Is the Shared Services model working well for Health?

Mr O'Halloran: Which part of the Shared Services model?

MR COE: The whole package. It is a $50 million deal, of course. Do you think that Health is getting—

Ms Fitzharris: It is not a deal.

MR COE: It is a deal, isn't it? You come to an arrangement, don't you?

Ms Fitzharris: Yes.

MR COE: It sounds like a deal. Do you think that the directorate gets good value for money for that?

Mr O'Halloran: The directorate operates 24/7 from 40 to 50 sites across Canberra, with a large volume of ICT demand. We have a large number of Shared Services staff dedicated to us; that does come at a cost.

MR COE: I understand that, but is the directorate getting value for money for that $50 million?

Mr O'Halloran: I would suggest that we are receiving considerable value from the expenditure of that $50 million—or $48 million or so.

MR COE: Is Health proposing to shift any services that are currently being conducted by Shared Services in house so that that bill could be reduced?

Mr O'Halloran: Health and Shared Services regularly assess which is the best party

to undertake services. As part of that, at times we have shifted services or service provision from Health to Shared Services. At times we have shifted that service provision from Shared Services to Health.

MR COE: In terms of the ongoing digital strategy, does that digital strategy include Shared Services doing more work, a broader scope or a narrower scope than what they are currently doing?

Mr O'Halloran: I think that, over time, the answer is that as we move to the cloud there will be a decrease in the volume of traditional maintaining of ICT systems and infrastructure. Shared Services are already seeing that change now, as they are moving some of our existing workload to the cloud, where they are no longer providing staff to maintain the networks and the systems.

We would see, as we continue down the cloud path, whether it is with Shared Services or someone else, that work will continue to change. What we are trying to do, however, is also engage with Shared Services to receive further enhanced services, to have their staff come on site more and work with our staff in wards and community health centres to provide extra services. I think you will see that the services that Shared Services provide to us will change and will vary, and not necessarily increase or decrease.

MR COE: Does the agency have any concerns about the level of privacy or controls that Shared Services offer, as opposed to what you can do in house?

Mr O'Halloran: Shared Services currently implement the *Australian Government Information Security Manual*, which is adopted by all directorates under the protective security policy framework. ACT Health has at times asked Shared Services to impose additional controls for us. Every time we have asked, those have been implemented. We will continue to review those, I would expect, over time, as the cybersecurity position of the ACT government changes, those controls will continue to be tightened, to protect our information.

MR COE: So there are no concerns with data that is currently being held at Shared Services?

Mr O'Halloran: Every time I have asked Shared Services to review something or amend it, they have made those changes.

MS CHEYNE: I want to go to a different line of questioning. I am aware that the federal government, in last year's budget, announced that there would be a my health record for every Australian. I also understand that there will now be an opt-out period that is coming up.

Ms Fitzharris: Yes, my health record has been around for some time. Health ministers agreed last year or the year before that, rather than being an opt-in model, we would move to an opt-out model in the current calendar year. It is something that I often ask at events that I go to: who knows about my health record, and who has a my health record?

Every Australian will have one created for them in the current calendar year, unless they choose to opt out, so there is quite an implication of that for consumers. I think that ultimately it is a very good program for us to have, for patients to be able to have a my health record. Obviously, quite a considerable amount of work needs to be done on the supply side, and that does impact on ACT Health as well as on all other health providers.

Recently, the CEO of the Digital Health Agency wrote to me, acknowledging how significant this change would be, as these records start to be created for people. I believe that in the second half of the year members of the Assembly may want to understand that further, so I have taken up the Digital Health Agency's offer to brief all members of the Assembly, if you would like to have that, on what this might mean for yourselves and for constituents. I expect that that will take place in coming weeks; they will be able to provide briefings.

MS CHEYNE: That will happen to coincide with this opt-out period that is coming?

Ms Fitzharris: As I understand it—Peter might be able to provide more detailed information—every adult with a Medicare number, or every person—

Mr O'Halloran: Every person, and it includes detainees in corrective facilities as well, unless they opt out.

Ms Fitzharris: Yes; they will have a my health record created for them; therefore your treating practitioners can upload information to that. There will be levels of controls and so on. They have made the offer, I think, in recognition that members of parliament are able to talk to constituents about something. From my point of view it is one of those huge, nationally significant commonwealth decisions that has the greatest impact at the state and territory level. Obviously, there is quite a lot of impact on ACT Health as an organisation as well.

MS CHEYNE: What is the impact on the workload for ACT Health over the coming period in preparing for this? Maybe we have not budgeted for it; do we have the capacity to deal with it or are other things going to suffer while we are having to get this up and running?

Mr O'Halloran: The short answer is no, absolutely; things will not suffer. We have managed to negotiate funding agreements from the Australian Digital Health Agency which have funded the cost of us providing additional materials to be uploaded to the my health record.

For example, at the moment all pathology records for inpatients from the Canberra Hospital are uploaded to the my health record if the patient has consented. That will continue across to the University of Canberra Hospital when it opens, and at Calvary it will occur by the end of the year.

Diagnostic imaging results will be uploaded from the next couple of days onwards for all TCH patients and then UCH, and Calvary by the end of the year as well. For all of the technical work to do that, additional staff have been engaged to do that technical work and those system changes, with full cost recovered from the Australian Digital

Health Agency.

We also have in place a fairly comprehensive communication engagement strategy across all of our clinical staff, Canberra Hospital and Health Services, and at Calvary, to educate them on my health record, what it means for them and how they can access it and use it. Once again those costs are being met by the Digital Health Agency.

MS CHEYNE: What training are we going to be providing to health professionals in ACT Health about accessing this data? Will they be able to look up anybody's records?

Mr O'Halloran: The training is already in place; in fact it has already been very well used. There are e-learning courses that are available for all staff on this, and a lot of staff are doing those across Calvary and CHHS. We have also had a series of all-staff forums. In the past two months we have had over 500 or 600 staff attend those, and we are providing face-to-face training and support for any other staff members who wish to have it.

There are very strict privacy controls and constraints against misuse of the system. In fact it is an offence under commonwealth legislation to have unauthorised access to the system. The Digital Health Agency put in place a range of controls. Patients can choose, for example, if they wish to be notified by text message every time someone accesses their record. Every time any ACT Health staff or Calvary Public Hospital Bruce staff access a my health record, we log the details of that staff member's access. The patient can view that at any time through the my health record system. If they have turned on those notifications, they can receive that as well. The existing processes and policies we have in place in relation to being part of a treating team or having a need to have access to the patient's record that we have maintained for all of our other records still apply.

MS CHEYNE: With that training you just talked about, you said there had been quite a big uptake of it. Is it compulsory to go?

Mr O'Halloran: The training is not compulsory at this stage, but we are incorporating it in future compulsory training sessions. For example, as new nursing staff, junior medical officers and the like are coming in, we are incorporating that as part of the training for it.

Ms Fitzharris: From my anecdotal experience as a member of the Assembly, it is one thing that certainly will become better known over the course of this year to the community. There are enormous benefits to come from this, but I think a level of understanding still needs to be built, and I think it is important that we have that engagement with the community at a very different level to the commonwealth Digital Health Agency. They are looking to provide as much information as possible to people, so they have made that offer through me to the Assembly. Hopefully, you will see more information about that in coming weeks.

MS CHEYNE: Finally, is it our responsibility or their responsibility to communicate that this is coming, or both? I think there is very low awareness.

Ms Fitzharris: Yes, I agree. It is their responsibility, but I think we have a stake in that, and that is why I have taken up the offer from the Digital Health Agency to provide that information to Assembly members, and that will be open to everyone.

MS CHEYNE: Will ACT Health be doing any broader advertising? Are there little posters that will go up in waiting rooms?

Mr O'Halloran: Absolutely; that is the short answer. We have already started that with the recent University of Canberra Hospital open day. We had a stand there. We had over 500 members of the public stop and talk to the staff about my health record and how it is being used.

Ms Fitzharris: It was the closest one to the cafe, so maybe—

MS CHEYNE: Strategically placed; well done!

Mr O'Halloran: I don't know what you are suggesting, minister! Yes, there was a very high level of interest. As part of the engagement plan, there will be a lot of additional materials being promoted by ACT Health. Also, we are actively engaged with Capital Health Network, who are promoting it through pharmacies and general practice surgeries.

MS LE COUTEUR: This is possibly relevant to a previous question. I was going to ask you about the $500,000 funding going to the Health Care Consumers Association to help with navigation of the health system. Possibly, from what you are saying, it should be helping with the new my health records, but that was not part of my original question.

Ms Fitzharris: I think that would be very complementary to broader work that has been going for a long time with the Health Care Consumers Association. This was a Labor commitment from 2016 to improve patient understanding of navigation through the health system and what particular things we might be able to do to make that easier, associated with building health literacy and new ways to help consumers navigate the health system. Others might want to talk about this, but at the moment we need to do further work with HCCA to determine exactly what that service agreement would look like. That is noting that we have a longstanding, important relationship with Health Care Consumers anyway, and they are very deeply engaged in the work of ACT Health.

MS LE COUTEUR: I was going to ask how many positions are going to be funded and what supports will be provided, but it sounds as though I may be asking that too soon.

Ms Fitzharris: A bit too soon, yes; we still need to strike that agreement with Health Care Consumers. It would be fair to say it is building on work that is already well underway, and I think we have a pretty good shared understanding of the outcomes we want to achieve from the work.

MS ORR: Minister, you have mentioned a few times that there is a system-wide approach to health. The thing that we have not spoken about as much as I would like

to is what we are doing outside the hospitals for health care. There is hospital in the home and some other responses within community services. Can you run me through what you are looking at as part of that wider project?

Ms Fitzharris: In terms of the territory-wide health services framework, it does relate to all aspects of care. As Jodie Chamberlain mentioned earlier, it is about acute care, community-based care and preventive care. It is implicit within that that it is not just a hospital-based approach.

We could talk more about hospital in the home, what that means and how it is delivered, both in people's homes and also in community health centres. We can talk about the nurse walk-in centres. We can also talk about a range of other broader prevention programs that we have under way.

From a broader point of view, it is important to acknowledge that in this portfolio everyone's commitment is to keeping people healthy and well. That broader approach to our health system is one important way that we help people stay healthy and well. For example, many people will be familiar with the towards zero growth policy framework, which was developed a number of years ago but was nation leading in terms of preventive health. It was very clear in that framework that was developed, and the subsequent initiatives that rolled out underneath that, that keeping our community healthy and well had aspects that were in every portfolio, expanded into the community sector and into the private sector. We have partnerships with the private sector and the community sector as well as work underway through that across all government directorates. For example, I know that in the planning space the active living principles have gone into the territory plan. In terms of the transport agenda, there are clear programs that relate to preventive health and people's health and wellbeing.

There is a heap of stuff in there, but maybe Chris could talk more about hospital in the home and what that expansion, also funded in this year's budget, looks like.

Mr Bone: Dr Kelly and Mr Dykgraaf mentioned the funding for how we manage our resources across the 12-month period and the peak that comes with winter. Part of that is about how we safely keep people out of hospital: hospital avoidance measures, if you like. That is heavily reliant on primary health care through GPs and the walk-in centres, with people being able to access those sorts of health care without coming to the ED.

The other component, which is where there is more focus, is on the hospital in the home situation, is about how we safely discharge patients and provide them with ongoing care in the community. It is much broader than hospital in the home, but hospital in the home is just one example of that. Right now there is funding for how we go about providing hospital in the home across the territory.

We currently have a working project group headed up by Sue Andrews from the Health Care Consumers Association; a member from Calvary, who is the senior sponsor; and a clinical lead from TCH. It is really representative of across the territory and how we go about doing that. The primary focus of that group is to see how we can better develop our hospital avoidance strategies. That is about how we keep people

safe and well in aged care facilities, in their own home or through the walk-in centres; it has also been about how we safely look after them and minimise their stay in hospital. While the stay in hospital is really critical, it is also not the best place to stay and complete your recovery. How do we support people doing that, whether it is rehabilitation; whether it is acute care in the home; or even, in a more advanced state, whether we provide chemotherapy in the person's home. That is a part of that strategic planning group that is being headed up by Sue Andrews.

It is not just about the hospital; it is actually about the system that supports people's wellness and periods of illness through the continuum.

MS ORR: The minister mentioned the nurse-led walk-in centres. Where do they fit in that, and when will the Gungahlin one be ready?

Mr Bone: I can talk about where they fit; someone else might have to answer the second part. They fit in hospital avoidance. It is intended that members of the community can go to the walk-in centres and see appropriately qualified, credentialed healthcare professionals. They do not need to book; they do not have to plan. They can be seen reasonably quickly and have their ailment addressed.

Clearly, there is a demarcation in terms of the seriousness of the presenting person's health issue. From there, we have some of them escalated to GPs, and some of them escalate through to the ED. But the majority of them are treated in the walk-in centre. In that broader strategy, it is a hospital avoidance strategy, and it works very well. We are looking to see how that develops over the next few years in terms of different options for the delivery of health care in those walk-in centres.

Ms Fitzharris: I think it is September—someone can correct me if I am wrong—for Gungahlin.

Ms Le Couteur, could I just note your earlier point about the involvement of Health Care Consumers. As Chris mentioned, the fact that a Health Care Consumers representative is chairing this work on hospital in the home is a really good example of how deeply they are involved in advocating for consumers but also understanding and being part of the design and delivery of services.

Mr Mooney: In relation to the construction of the Gungahlin walk-in centre, going to that question, we are due to finish construction at the end of August. The current planned date for opening is the first week of September.

MS ORR: There are plans for two other centres, I believe, in the future?

Ms Fitzharris: There are two in addition to Belconnen and Tuggeranong. There is one that is further funded in this year's budget for the Weston Creek region and also further planning in terms of the city or the inner north, and that is combined with longer term planning about the city health centre. With those two services, one is currently operating in the city and another is to be added, a walk-in centre. There is further work under way on determining the service needs and the location of those centres in the longer term.

MS ORR: Great. While we are talking broadly about the community health, our Indigenous population community has an ongoing need for healthcare services that are suitable for their cultural needs. Can you just run me through what the ACT government is doing to improve health care for that particular group of our community?

Ms Fitzharris: The flagship initiative from our point of view and in our discussions with Winnunga Nimmityjah is the significant expansion of their current facility in Narrabundah. That was funded in last year's budget. That is a part of broader discussions with Winnunga about their service capacity.

Over the past year we have taken a broader approach, with Winnunga and demonstrated through other partnerships. For example—I think it was discussed earlier today—we have talked about their role at the AMC. In those discussions with Winnunga, their desire for the new and expanded facility in Narrabundah was one that they wanted further ownership of.

That centre is effectively on the budget and on the books. It has shifted a column. What it means for Winnunga is very significant in terms of having an Aboriginal-owned facility that we will be able to support them to build over the next year to 18 months. That was quite a significant milestone in working with Winnunga on supporting them to expand.

There are a range of other programs and funding agreements.

Mr Bone: ACT Health, through the specialisations, particularly cardiology and general medicine, provide specialist resources to work with Winnunga. Winnunga do not have to come to us; we take the specialists to Winnunga so that people can have cardiology referrals, infectious disease referrals and general medical referrals by these specialists. There are a number of people throughout TCH who work with Winnunga in their space to ensure that they get not just the right medical care but culturally appropriate care.

MS LE COUTEUR: I have a supp on Winnunga and then I will go back to hospital in the home. It is great that Winnunga is going to own it in the long run. In the short run what level of ownership are they having in terms of the building design?

Ms Fitzharris: A significant amount. An integral part of the arrangement with Winnunga is that they have already put forward a couple of proposals, so they have already advanced that work and are very proud of the work that they have done to date. We will continue, and we are happy, to work with them on that.

MS LE COUTEUR: Most of the funds are in 2021. When are we expecting the centre to be completed and operational?

Ms Fitzharris: That is still to be fully determined, in terms of the actual build, but we will have much greater clarity on that later this calendar year. At the moment that is how the grant is phased. The grant will be subject to various milestones being met and, if those move forward, which I hope that they might, they will be paid after the completion. We certainly know that their current facility is not fit for purpose and

there is pressure on it. We will continue to work closely with them to make sure that we can progress this as quickly as possible.

MS LE COUTEUR: Getting back to hospital in the home, there will be 3,000 patients, I understand, this year.

Ms Fitzharris: Extra.

MS LE COUTEUR: Last year how many were there?

Ms Fitzharris: This year it was 3,000 additional.

Mr Bone: We will look that up.

MS LE COUTEUR: If it is going to take a while, I could ask another question. It is about the eligibility criteria for accessing it. Are they going to be changed with the expansion or is it just that previously you had a lot of people who would have liked to go home and could not?

Mr Bone: Part of the terms of reference for the group looking at hospital in the home and the broader range of services is to look at the eligibility criteria. Are they suitable for our current delivery of services in the community? I am expecting that the eligibility criteria will expand, but that group will come back and make a recommendation to me.

MS LE COUTEUR: I assume that you have some data about the patient outcomes from hospital in the home, and that is why you are expanding it. Assuming I am correct, can you share some of that? Presumably, things are going better for the patients: fewer infections, possibly, and quicker time to recover?

MRS DUNNE: Better food.

Mr Bone: Better accommodation.

MS LE COUTEUR: Could you provide some detail on notice?

Mr Bone: I am happy to provide that on notice. I can provide you with some performance markers.

MS LE COUTEUR: I am assuming that you will give us some very positive answers.

Mr Bone: The best one is that the patient satisfaction is incredibly high.

Ms Doran: I can now provide the numbers. In 2016-17 we had 1,314 come through the hospital in the home on a territory-wide basis. In 2017-18 we are expecting 1,500, and that has been a growth of around 14 per cent over that period. As we have discussed, the budget initiative is providing funding to ramp that up by an extra 3,000 a year, but that will be an interim year, this year, as we ramp that up.

MRS DUNNE: Are those figures for participants or patient days, or something else?

Ms Doran: This is separations from the hospital in the home—

MS LE COUTEUR: So that is participants? I would assume that it was participants. This could probably be part of the answer to the question on notice that you are giving me about satisfaction. I assume it is vastly more cost effective for ACT Health to look after people in their own homes? I assume that you probably have some figures around that.

Mr Bone: We will take that on notice.

Ms Doran: We will take the figures on notice. Yes, it is more efficient, to the extent that using hospital beds for more serious, more acute needs patients is much more efficient than having them used for patients who can be looked after in other environments.

MS CHEYNE: One of the previous answers was about the walk-in clinic at Weston Creek, and that there is a $2 million provision in the budget for that. Is the $2 million just for the design or is it for the design and construction?

Ms Fitzharris: It is both. There may be additional construction funding that we will provide at a later date, but we expect it to be open next year. At that point we would need to provide funding for the service; for the nurses and staff who are going to work there.

MS CHEYNE: That is why it is currently listed as capital provision?

Ms Fitzharris: Yes. There is a bit more work to do to nail down exactly the full cost, depending on the final location.

MRS DUNNE: It would be remiss of me to not talk about staff culture. You would be aware, minister, of at least two letters from various parts of the hospital complaining about a variety of things, but principally about the culture in the women's and children's hospital, and from other areas in the hospital as well more recently. You often say that there are respectful pathways for dealing with a culture of bullying. Could you outline what they are?

Ms Fitzharris: Certainly, and I will ask the director-general to comment more broadly in terms of work that is currently underway. I certainly note your claims about the overall organisational culture. I would strongly refute your characterisation of the culture. It has certainly been part of my clear direction to the director-general and to ACT Health that having a healthy culture is important. Having the right processes in place is important. Also, there should be a demonstration from the highest levels of the organisation of what a positive culture looks like. I will ask the director-general to talk you through the range of different measures that are in place, and the work that he has been leading, particularly more recently.

Mr De'Ath: Thank you, Mrs Dunne, for the question. The organisation has four signature values of care, excellence, collaboration and integrity. There is a very structured piece of work that I am currently leading in relation to taking us back to

these core values, and they involve a number of critical actions.

One is the development of a comprehensive and practical consultation framework to ensure staff voices can be heard. Identifying and highlighting the really great work that takes place across the organisation and making that quite public within the organisation is already well underway. There is building a cohesive and values based executive team, with an absolute emphasis on executive values based behaviour. There is collaborative leadership events: bringing leaders from across the organisation together and rebuilding that into our culture, to talk about leadership and what that means. There is developing the capabilities within our organisation to lead change and support staff through the organisational reform agenda. We have a considerable volume of work to get through there. I want to ensure that all of our people who are involved in that know how to manage themselves through change, and those who need to lead change know how to lead through change.

We will be elevating those values, and are already elevating those values, and the profile of those within the organisation. There have been a number of staff forums held with our staff so far, four, in fact. The first two were led by me and the minister; the second two were led by me. We are absolutely introducing the emphasis that we believe needs to take place in the organisation.

I can assure the committee that this is being led firmly from the front and that I have certainly received very clear direction from the minister on what should be taking place in our organisation.

MRS DUNNE: There has been discussion about an inquiry into bullying practices at Calvary. Have there been any inquiries into bullying practices at the Canberra Hospital?

Ms Fitzharris: Would you mind clarifying what you mean by inquiry?

MRS DUNNE: Investigation about accusations of bullying. Do you conduct them? How often do you conduct them?

Mr De'Ath: When matters are raised, they are thoroughly looked into. When necessary, people who are either party to raising the concerns or who feel they are in receipt of such behaviours are also engaged with. Can I say, Mrs Dunne, that we take these matters extremely seriously, whether they are brought to our attention anonymously or not. We want to really encourage a culture where people can feel comfortable to legitimately raise their concerns without fear or threat. That is a very strong message that I have given to the executive team in our organisation.

MRS DUNNE: I welcome the statement, Mr De'Ath, that you encourage people to make comment without fear or threat. But the clear message I get from people who speak to me is that they say, "For goodness' sake, please protect my identity, because my job would not be worthwhile if people thought that I was telling you about the culture of the place." I think that you have a long way to go to improve the culture.

I have a few specific questions about the culture. There were issues raised about Calvary hospital and that there was an agreement that there should be an investigation

into that behaviour. What has happened since then?

Ms Fitzharris: I think it related to those media reports. I subsequently wrote to the CEO, Martin Bowles—

MRS DUNNE: He is LCM, not Calvary.

Ms Fitzharris: Yes, but he is in charge of the whole operation. I wrote in terms of those claims that have been raised about Calvary Public Hospital in Bruce, asking for those claims to be thoroughly investigated. He wrote back to me assuring me that they were.

MRS DUNNE: They would be?

Ms Fitzharris: They were being, yes.

MRS DUNNE: I am aware of a number of public interest disclosures that relate to a range of things, including bullying. How many public interest disclosures does ACT Health have on its books at the moment?

Ms Fitzharris: I am not sure. I am not aware of any, but we might take that question on notice in terms of how those are raised in a variety of different ways.

MRS DUNNE: When you are taking it on notice, can you also tell me, in addition to how many are currently on foot, how many have been dealt with according to the relevant legislation, and if not, why not. And can you tell me what areas these cover and what recommendations of completed PIDs have been implemented.

Mr De'Ath: I have asked Ms Hammat to come to the table. The public interest disclosure work is obviously shrouded under some pretty strict rules in relation to what we can and cannot say.

MRS DUNNE: Yes, I understand that.

Mr De'Ath: I will see if Janine wants to comment other than to say that any of those matters we will take on notice.

Ms Hammat: I will just reinforce that we will take that on notice, but as Mr De'Ath said, there are strict rules around public interest disclosures. Part of those strict rules is that there is some absolute confidentiality around those processes, focused on the legislation. We can probably come back with numbers, but without details.

MRS DUNNE: I am aware of some, and I am aware because I have been told that statutory time frames have not been complied with and people are considering whether or not to make a public interest disclosure to me as a member of parliament. That raises the question: if there are some beyond their time frame, how many are there and what is being done in ACT Health to address public interest disclosure?

Ms Hammat: Any that I am aware of at the moment are the subject of preliminary assessments. I am unaware of any that might be outside the time frame, but I will look

into it.

MRS DUNNE: Thanks.

Ms Fitzharris: I would note that those are often managed outside of ACT Health. We will clarify.

MRS DUNNE: I have reservations about the way public interest disclosure is managed. There are many entry points, but they always end up back with the agency.

Mr De'Ath: While I note you are questioning the importance of it, and I think the intent of it, I just reiterate my earlier position that the culture that we are striving for is one where these things are not necessary.

MRS DUNNE: I would agree that that is where you need to be.

Mr De'Ath: They are important and critical.

MRS DUNNE: But you are not there now.

Mr De'Ath: But I absolutely want to ensure that people can talk and be open in terms of their views in the appropriate places, and receive an appropriate response.

MRS DUNNE: Mr De'Ath, you said in relation to complaints, whether they are anonymous or not, that you take them seriously and you act on them. I am in receipt of two, and I presume that you are in receipt of two as well, one from the women's and children's hospital and one from another area in the health department that has not seen the public light of day, which makes serious complaints about a bullying culture, down to depriving people of their morning tea facilities, but also makes other allegations of impropriety. What action have you taken this month in relation to that report?

Mr De'Ath: In relation to the first letter I think you refer to, there have been a number of actions taken. I might ask Ms Chatham to speak to those. In relation to the second, if we are talking about the same thing, I am currently looking into those matters as well. I want to reiterate the position that it is disappointing when you are dealing with anonymous material. It is difficult to deal with.

MRS DUNNE: It is.

Mr De'Ath: I would always encourage people to come forward, as I said, without fear of threat or reprisal. I absolutely am open to these, knowing about things that people are concerned about, and ensuring that they are dealt with in an appropriate, professional manner.

Ms Chatham: I really welcome an opportunity to discuss this letter. It has been a very difficult time for the service in managing this very public letter. I would like to first say that the people who wrote the letter did so with the best intentions. Their intentions, I think, were—

MRS DUNNE: I think we agree about that.

Ms Chatham: Yes. There were many claims in the letter that were not accurate. To that end, we have written to staff a letter, which I think you are in receipt of, and also we have written to the public to address that there are a whole range of concerns in the letter that were not accurate.

What is accurate is that the staff have been under relentless pressure due to demand. When you have relentless demand pressure, that is impacted through low resilience of staff, sometimes sick leave, and just a sense of being overwhelmed at some times. In response to the demand, we have put in multiple strategies to deal with the demand. In many ways, the excellence of care that we deliver there, despite the demand, demonstrates that many of those strategies we have put in have worked really well. That some staff have felt overwhelmed and tired—I think that would be the way to describe them—is very concerning, and we are doing lots and lots of thing to support staff.

MRS DUNNE: Can you enumerate some of the things you are doing to support staff?

Ms Chatham: I meet with staff regularly. I try to communicate what is going on with managing the demand. Also I am trying to listen to them, to work out what concerns they have had. I very regularly walk around the departments, so we have informal meetings.

I think staff do come forward within the women's and children's department. In a recent consultation period, we had 123 staff return comments during the consultation process. We have reiterated, over and over again, that it is okay to come forward, and it is important to come forward, and share their concerns, whether they are clinical concerns or bullying concerns, because unless we know about them, we cannot do anything with them.

I, too, have heard that staff are sometimes afraid to come forward, as you have. But we are repeatedly telling staff that it is okay to come forward. We investigate any issue that is raised, whether it is a clinical issue, a safety concern or a bullying complaint. Every issue is investigated. And they are not only investigated: we theme them; we look at clusters of things that may occur; we provide staff with access to counselling services through EAP. In December, we had a week of three psychologists there to support staff. We brought them into the department to support staff to manage the stress of demand on the service, not just in maternity but also in NICU and the special care nursery.

Mr De'Ath: Thank you, Ms Chatham, for that detailed explanation in that specific area. I think it would be fair to say that in my experience over many years of leading organisations, one of the best ways to manage these types of issues is to set a very clear tone from the top, to set very clear expectations throughout the executive ranks for expected behaviour, and to make very clear to staff the opportunities and avenues to raise any of their concerns. That action has been taken.

MRS DUNNE: But it does not seem to be filtering down to the coalface.

Mr De'Ath: I would not agree with that. We are receiving very positive feedback at the moment from staff about some of these changes and some of these messages that have been delivered. I am very pleased to receive that. I, along with anyone else in the organisation, need the barometer checks on how we are going with making the necessary changes. The feedback that I am receiving is that those messages are resonating with people.

MRS DUNNE: Thank you.

Ms Chatham: I also note that in the actual area where the concern was raised, the staff recently nominated their manager for an award. They received the excellence award for excellent management in that area. That was staff nominated. So I think that there are all sorts of other indicators that demonstrate that the culture is—I am not saying it is great, but I am saying that it is being worked on and improved all the time. I am very proud of the service that we deliver, and I am very sure that we are heading in the right direction. I am particularly proud of the quality of care that we deliver.

Ms Fitzharris: Referring to the nursing and midwifery awards four or five weeks ago, a number of the awards did go to maternity nurses, both at Canberra and at Calvary hospital. The midwife of the year is a Calvary midwife.

In terms of the government's investment in managing better and providing more resources to maternity, that is happening both at Centenary hospital and at Calvary hospital, and relates to the matters we spoke about earlier: increasing the number of postnatal beds, investing in the upgrade of Calvary, and broader work underway to continue to support Centenary hospital, in particular, in terms of their expansion.

Mr De'Ath: In a very short space of time, can I say how extremely proud I am of the work that our people do within the system. Our latest figures, for January to March, on survey responses, were from 671 surveys issued, with a return of 173 responses. That is a good outcome; that is a good measure. In response to a question on people who would say they would have recommended our hospital to family and friends, 89.6 per cent say yes. For those who would rate the quality of care as good and very good, the figure is 87.9 per cent. These are phenomenal outcomes, and that is a direct result of the tremendous work that our staff do in the system. I just want to acknowledge that. At a time where some things are questioned, at the end of the day the work that people deliver is outstanding.

Ms Chatham: Can I just add that maternity services' latest feedback from the inpatient survey is that 93 per cent of patients report a positive or above experience with the service. You cannot do that when you have a really bad culture. We have areas of concern, but they are being worked on.

THE CHAIR: We might adjourn there for an afternoon tea break.

Hearing suspended from 3.33 to 3.52 pm.

THE CHAIR: We are back for the afternoon session, continuing with output class 1, health and community care. Minister, I have a few questions regarding the announced restructure of health. Budget statement C states that "these budget

statements do not anticipate the planned restructure". When will detail of the restructure be presented to the Assembly and the community?

Ms Fitzharris: This is a very important piece of work that is underway within ACT Health. It is certainly the intention for ACT Health to be separated into two organisations on 1 October. As a result the budget papers currently do not make any assumptions about exactly how that will work in regard to the budget. There will be further work undertaken in the lead-up to 1 October. Certainly, that will involve considerable consultation with staff and stakeholders, which is building on the range of things that Mr De'Ath spoke to recently about discussions within the directorate about the future of the directorate. It will also obviously involve a level of technical work around budgeting and a range of other management-related activities that will be undertaken. A transition team has been appointed. In terms of the specifics of that, I will ask Mr De'Ath to comment on those.

Mr De'Ath: We are undertaking a very significant body of work at the moment in preparation for separation on 1 October. We are just concluding, through the Head of Service, a piece of work that more clearly defines the roles and accountabilities of the two organisations. That provides a very good signpost for us at the moment on how to comprehensively plan now for the requirements of each of those two organisations.

The next step in the transition planning, while there are parallel things happening, is for some consultation with various stakeholders, internal and external, about the higher level roles and accountabilities work. We will work through, very comprehensively now, the various components and elements of work that are required to head to 1 October.

That will engage quite a number of people. I have appointed a director to the transition office, who reports directly to me. At this point in time, while we have some staff appointed to support that work, we are setting up some more structured mechanisms to engage throughout the organisation in the planning process.

THE CHAIR: Is it anticipated that a further appropriation will be required once the structure is determined?

Mr De'Ath: No.

Ms Fitzharris: No.

THE CHAIR: Why wasn't the restructure taken to cabinet prior to the announcement?

Ms Fitzharris: My understanding is that certainly these decisions are decisions ultimately with the Chief Minister. That was a decision, on my recommendation, that the Chief Minister made. I have spoken with my cabinet colleagues about it, most notably with Minister Rattenbury, and that is normal business for government.

THE CHAIR: When did the discussions with Mr Rattenbury occur?

Ms Fitzharris: Minister Rattenbury and I work very closely together and have since

we were both appointed to our respective roles in the health portfolio. We have many meetings to discuss areas of intersection between our various portfolios, but most often that work intersects in the health portfolio. We have very regular formal meetings about that. We are obviously cabinet colleagues and discuss a range of different health matters in the cabinet context as well. We have had discussions since we were both appointed to these roles in late 2016 about the overall direction of the organisation and the government's priorities for health care, whether that is health care that I am responsible for or mental health care that Minister Rattenbury is responsible for.

We had discussions about a range of different issues, including whether or not the current structure was the right one for the government to be able to deliver on its priorities, and whether it was a contemporary one, if you look across the country in terms of how other jurisdictions operate.

THE CHAIR: You have stated again here today, as you have previously, that you and Minister Rattenbury speak regularly about health matters.

Ms Fitzharris: Yes.

THE CHAIR: The information published under the Freedom of Information Act online shows only two diary meetings in Minister Rattenbury's diary with you as the minister for health, one on 31 January and one on 28 February. So the trend is that it is on the last day of the month. At which of those meetings was the restructure of Health discussed with Minister Rattenbury?

Ms Fitzharris: Minister Rattenbury and I have regular meetings. They are more regular than that. I will also look at my diary; that is also published. We also have informal conversations. We have conversations in the cabinet room. We have regular conversations about health, and there are also conversations with the director-general that span across our health responsibilities.

THE CHAIR: What notes or minutes are taken during those meetings and conversations?

Ms Fitzharris: There are no formal minutes taken out of meetings between ministers. We follow up on the range of issues that we chat about.

THE CHAIR: Okay.

MRS DUNNE: I want to refer to the contract 1806DGO, which is between CMTEDD and the Nous Group, to provide advice on the governance model for ACT Health. It was supposed to have commenced on 18 May and was due for completion on 15 May. Has that project been completed?

Ms Fitzharris: I do not think so. You said 18 May and 15 May.

MRS DUNNE: Sorry, 18 May and concluded on 15 June.

Ms Fitzharris: Yes.

MRS DUNNE: Has that project been completed?

Ms Fitzharris: That is the work that Mr De'Ath referred to—I do not have the specific number of the contract but I am assuming it is the work that Mr De'Ath mentioned in his answer around the work that the Head of Service is doing around the governance between the two organisations. Yes, my understanding is that that is the case, but that is a question for Chief Minister's, who, I believe, are appearing tomorrow.

MRS DUNNE: Okay; I will save that one until tomorrow. I was wondering whether I should come back tomorrow. The answer is yes. In relation to the restructure, you met, according to the FOI diary listing, on 16 March with the former Director-General of Health. Did you discuss with her then the decision taken the previous day to restructure the health portfolio?

Ms Fitzharris: Yes.

MRS DUNNE: Was she advised that she would not be reappointed as director-general under the new structure?

Ms Fitzharris: It was during that meeting that we discussed the future organisation, and she subsequently left the organisation.

MRS DUNNE: In the accreditation report that came out the following week, the accreditation talked, amongst other things, about a high churn rate of senior executives. Did you contribute to that—

Ms Fitzharris: No.

MRS DUNNE: by making this decision and losing your director-general?

Ms Fitzharris: No.

MRS DUNNE: You are perfectly comfortable with the churn rate of staff at the Canberra Hospital?

Ms Fitzharris: I think the accreditation report was completed before there was a public announcement about the former director-general's departure.

MRS DUNNE: So—

Ms Fitzharris: That is not my understanding of what that particular comment in the accreditation report relates to.

MRS DUNNE: It is a broader comment, but in the same time frame you are contributing to that by losing a director-general.

Ms Fitzharris: Yes, a director-general did depart, but I do not agree with your question about whether that was part of that comment in the accreditation report.

MRS DUNNE: No, I did not say it was.

Ms Fitzharris: Okay.

MRS DUNNE: I said you have contributed to it. You have contributed to the churn?

Ms Fitzharris: I think one employee leaving is not necessarily contributing to the churn that is referred to, in that much of that did occur some time prior to the former director-general's departure.

MRS DUNNE: Is the restructure on track to be fully implemented on 1 October?

Ms Fitzharris: Yes, it is.

MS CHEYNE: Abortion access: I know this is of some interest to members around me. I know that there have been some live bills, but I am interested more broadly in whether there is some work underway more generally about how we can improve access for women while, importantly, still making sure things are safe.

Ms Fitzharris: Yes, there has been for quite some time, and since then also we have Ms Le Couteur's bill, which is before the Assembly at the moment. In effect, we are bringing the work that was already underway into discussions around Ms Le Couteur's draft bill. I am looking forward to having a debate about that in the Assembly later this year.

In terms of the intent of the work that is underway, and what I understand to be the intent of Ms Le Couteur's bill, it is to improve access and to make sure that that access is safe access to abortion services in the ACT. We can talk about a bit more of the detail, while noting that some of it will be subject to specific discussions in the context of the bill that is coming up for debate.

MS CHEYNE: I am interested in whether any of the things that we are looking at to improve access have a cost associated with them.

Ms Fitzharris: Potentially, yes. That is part of the work that we are currently doing as well.

MS CHEYNE: All right.

Ms Fitzharris: But not just about cost either.

MS CHEYNE: No, just in the context of estimates, but I will not pre-empt the debate.

MS LE COUTEUR: I want to go to pill testing. Do you want to talk about where we are up to with that, given what seemed to me quite favourable reports on our first foray into this?

Ms Fitzharris: I would ask Dr Kelly to join us. Yesterday we received a report from the STA-SAFE consortium that conducted the pill testing trial at the Groovin the Moo

festival recently. It had findings which had previously been part of the public discussion about this, most notably after the festival itself. The recommendations from the report noted its success and encouraged the government—and me as minister—to consider how we might talk about this in a national sense and with a more national approach. There were some findings in there that were of real interest, and this provided the detail about the conduct of the trial itself, which I can ask Dr Kelly to speak to in more detail.

I just would note that this is the first trial to be undertaken in Australia. It was hugely significant. It went through a very thoughtful and considered process over more than a year, after a lot of broad public advocacy and then quite detailed work by the consortium. At every point we had further questions of them about how the trial would take place. They answered those fully. The ACT government working group, led by ACT Health, included colleagues from across all relevant directorates. Very notably, it included ACT Policing.

That is an important part of understanding the extent to which the ACT government seriously considered this proposal and allowed it to take place. As a result, we have had a report which points to its success, and I think gives everybody an opportunity now to progress drug policy with this harm minimisation approach.

We will look forward to continuing the work, but I might ask Dr Kelly to talk about some of the detail of the findings and anything else he would like to mention about pill testing.

Dr Kelly: Thank you, minister, and thanks for the question. It was a big weekend. I think the minister has already mentioned this. This was an Australian first. It is interesting to see how other jurisdictions have taken that in Australia. I would echo the minister's comments about the chief of police. She, in particular, has been a really strong advocate for this harm minimisation approach rather than some of the more, should we say, draconian measures that are used in similar circumstances in jurisdictions not too far away from this one. That is, to me, a very innovative approach but also a brave one from police and other parts of ACT government.

From the health perspective, this fits very clearly and carefully within the harm minimisation framework of the national alcohol and drug strategy. There are three arms to that framework: it is about decreasing supply; it is about decreasing demand; and it is about risk reduction. This is part of that process.

We are very happy with the results. This was a report prepared by STA-SAFE. They have a number of recommendations. STA-SAFE is the consortium of a number of organisations that were brought together for this particular pill testing trial. The minister is already on record as saying that she is happy to receive that and to consider those matters carefully, including further opportunities to trial this again. We will await the external group coming to us with a proposal.

MS LE COUTEUR: Minister, will you be advocating for it further? There was nearly a trial last year, which we are told was aborted because of federal government issues. I do not know why; I have no actual knowledge as to exactly what happened. But will you be advocating in that context—the festival, presumably, will come up

again—or conversely, in the national context, through COAG, for instance?

Ms Fitzharris: I would also mention that there was an extensive amount of very good work done within ACT government. There was the work done by the STA-SAFE consortium, and there was important work done with the music festival organisers. They should also be thanked and congratulated on, in effect, the big step that they also took. It is really important to consider their operations, which are national in the case of Groovin the Moo and other festivals, so that both governments and proponents of pill testing understand their needs. They let us know what they required. I think that particularly the consortium went above and beyond, as they did with the government, to respond to those issues.

We never quite got to the bottom of what happened with Spilt Milk, but I think your assumption is probably correct. We would be very open to and welcome a proposal from the same consortium to conduct pill testing at Spilt Milk. With effectively one already having been conducted with a report that is open and available for everybody to read, there is more evidence now available than there was previously. Some of the comments from people nationally said there is no evidence to support why we should do pill testing, and I think we are starting to build that evidence.

What is clear to me is that there is a lot of evidence about the dangers of drug use. Everybody knows that. We have to try to start some new things without all of the groups taking a leap of faith in each other to make sure that we could start this. We could not start to build that evidence base. Government will consider it. We will continue to look at that.

Dr Kelly: This is not a panacea; we all recognise that. My view of the pill testing is that it is a way of getting this very difficult to reach group of young risk takers literally into a tent in this case to talk to them about health matters. That is what this was about. The pill testing was really just a way of getting them into the tent and giving them the information which we know now from the report—and that mirrors what has been shown with international evidence—so that people take that information and make choices about that, which includes taking less drug or not taking the drugs at all.

To me, there were two potentially very toxic drugs. All drugs are bad, but these two that we particularly found were ones that have been associated with overdose and even death. And that influenced the taking of those. That is enough for me. That is two people who were definitely helped. The information we gathered through that exercise has been very helpful both to health authorities and to the police in relation to drugs more broadly. For those two reasons, a surveillance reason and a very proximal harm reduction for two young people on that day, I think it is an extraordinary thing. I am very supportive of it and very grateful to the minister for her leadership in relation to this, and to the others involved across government.

MS ORR: I had questions on pill testing but they have been very comprehensively answered.

MRS DUNNE: I want to touch on the surgical procedure interventional radiation and emergency building. The election commitment was for $500 million and to be

completed in 2022. It has now blown out to 2023-24. Is that correct?

Ms Fitzharris: Yes. It is the 2022-23 financial year. And now, based on further work that has been done, that is likely to be in the following financial year, yes.

MRS DUNNE: So 2023-24 or 2024-25?

Ms Fitzharris: 2023-24.

MRS DUNNE: The budget papers only cover this budget and the outyears, and there is a period beyond that. I would like to get some idea of what the spend is likely to be on the entire construction. There is only roughly $400 million in the budget, but it was promised $500 million. I am presuming there is money in the years beyond the outyears.

Ms Fitzharris: Certainly we can talk in more detail about that. It has certainly been the case, and the Treasurer would not want his minister seeking to have things beyond the outyears in the budget. We had this discussion last year about more money to be invested to bring this project fully to life. You can expect to see that continue over subsequent budgets. That is completely normal in terms of budgeting over a four-year cycle.

As the work continues to develop, bearing in mind the conversation we had earlier around this being part of comprehensive territory-wide health services planning that will inform the infrastructure planning, that work will continue to evolve. That is the envelope that we have set for it. That was based on the types of expansions we wanted to see in terms of health service capacity in the territory. We will continue to work on achieving that. We cannot provide specific detail on every element of that project yet, but that is what the funding in last year's budget and this year's budget continues to do.

MRS DUNNE: How much has been spent so far? You are still in the planning phase?

Ms Fitzharris: Yes.

MRS DUNNE: Is that design or also planning for—

Ms Doran: In last year's budget there was $3 million allocated towards the early planning design work. In this year's budget that has been supplemented to continue that design work and early planning work.

Just in terms of budget processes around large capital projects, this is the structure that we see where, while a broad envelope of money has been identified for the project, that is held provisionally in the budget until such time as the planning and the business cases are developed to a point at which time the budget committee releases the money more formally as capital injections. At the moment, we are still holding the bulk of that money provisionally, and the profiling and—

MRS DUNNE: Where do we see that in the budget?

Ms Doran: It is the $400 million that you see held.

MRS DUNNE: It is $400 million, but it was originally a $500 million project. Has it been scaled back?

Ms Doran: No. We make some assumptions about the profiling of the spend over the outyears of the budget in order to hold the moneys in a way broadly representative of the project for longer term budget planning. As the detailed works occur, the designs develop and the business cases develop, that capital quantum and profiling over time will be refined. That will come through each subsequent budget process, including beyond the outyears of the current budget, to pick up the full cost of the project.

MRS DUNNE: Do you envisage that, essentially, and to use the unfortunate term, it will be shovel ready in the outyears and most of the work will be done in the outyears? Because 80 per cent of the money is in the current budget cycle.

Ms Fitzharris: That is right. Currently the budget cycle goes out to 2021-22 but, as you note, in terms of—

MRS DUNNE: You have also said, minister, that it is not going be finished till 2024-25.

Ms Fitzharris: No, 2023-24.

MRS DUNNE: 2023-24, sorry. That is two years beyond that. Are you only going to be spending $100 million in those last two years?

Ms Doran: As I said, that is indicative profiling at the moment, which will be refined as we develop the project in more detail.

MRS DUNNE: So you have no idea at this stage what it will actually cost?

Ms Fitzharris: In terms of the original commitment about the types of capacity that we want to add to the ACT hospital system, there was obviously preliminary work, as there are with these things before they go through detailed business case processes. Certainly in terms of the time from being shovel ready to building a major new part of the hospital like this, it is a very significant project so we will take the time in the planning and design phase, and then also in the construction phase.

Ms Doran: The profiling is based on some understanding of projects of a similar scale and time frame.

MRS DUNNE: Has this been back to cabinet? The timing has changed from the election commitment, so did that go back to cabinet?

Ms Fitzharris: Yes.

MRS DUNNE: And the money has gone back to cabinet?

Ms Fitzharris: What do you mean, sorry?

MRS DUNNE: Has the funding envelope, for want of a better word, changed on this?

Ms Fitzharris: No. Every budget initiative goes through multiple budget cabinet meetings.

MRS DUNNE: I understand that, but in 2016 it was $506 million.

Ms Fitzharris: Yes.

MRS DUNNE: Is it still $506 million? Is it some other figure simply because it has blown out by two financial years?

Ms Fitzharris: One financial year.

MRS DUNNE: Is that going to increase—

Ms Fitzharris: One financial year.

MRS DUNNE: It was 2021-22 and now it is 2023-24.

Ms Fitzharris: It was 2022-23.

MRS DUNNE: It is going to be 2022-23?

Ms Brady: If I may?

Ms Fitzharris: Yes.

Ms Brady: To confirm, the completion time frame we are working to is financial year 2023-24.

MRS DUNNE: But it was originally supposed to be completed in—

Ms Fitzharris: 2022.

MRS DUNNE: 2022.

Ms Fitzharris: Yes, correct.

MRS DUNNE: Completed in 2022.

Ms Fitzharris: Within the 2022-23 financial year.

MRS DUNNE: That is not what it said in the budget commitment.

Ms Fitzharris: I thought it said 2022.

MRS DUNNE: It said 2022 simpliciter.

Ms Fitzharris: It is also important in terms of budgeting and in terms of provisions. We are asked as ministers to anticipate the impact on the budget. Because we know we are going to spend a significant amount of money on new hospital infrastructure, it is important that is in the budget as early as possible, so that the government can be transparent about what it knows it will spend in the future, even if that detail has not yet been fully committed, because of the very considerable planning work that we need to do.

MRS DUNNE: There is $400 million—80 per cent of the original commitment in this period. But there are still two financial years after that. I am just trying to work out what is going to be in the final two financial years: just $100 million, or do you envisage that it will be more than that?

Ms Fitzharris: At this stage I could not say. We would not anticipate that at the moment, but we need to go through this work. In next year's budget we will have more to say about that. Noting questions about rollovers between years, it may be that some of this money is subsequently rolled forward in order to meet the final end date. It will be difficult, with a project of this scale and size, to determine that now for financial years that are three or four years in the future. You could expect to see further investment in this in next year's budget, to account for the 2022-23 financial year.

MRS DUNNE: Could I change tack but keep the theme going, which was an election commitment? I want to get an update about meningococcal vaccine, because that was an election commitment. I thought of asking it this morning, but the time passed; we were talking about other vaccination. There was an election commitment for—

Ms Fitzharris: Meningococcal B, yes.

MRS DUNNE: B, for babies. Has that been fulfilled?

Ms Fitzharris: The funding to further investigate that is in this year's budget, as part of the meningococcal initiative. In terms of the advice we have received, which Dr Kelly can talk more to, we need to do some further work around the meningococcal B commitment. That is why it is funded in this year's budget, alongside meningococcal W, which is continuing.

MRS DUNNE: Which is for adolescents?

Ms Fitzharris: Adolescents, yes.

MRS DUNNE: I would like to get my head around why we are having to do more work on meningococcal B. I thought early immunisation was pretty much uncontested as a public health measure these days.

Ms Fitzharris: As I understand it, nowhere in Australia publicly funds that, and they are also separate—

MRS DUNNE: The outgoing South Australian government committed to it in the last election. I know that there is pressure on the incoming South Australian government

to do that. I thought there was work being done in WA as well.

Dr Kelly: Thanks for the question. To answer your first premise, Mrs Dunne, immunisation is absolutely a public health thing which is uncontested, so I will have that on record; that is great.

There was an election commitment, as you mentioned. Just to clarify the South Australian situation, the outgoing government did commit. They went out, and the current government is indeed considering that, as we understand. We are in close contact with them as to what they may or may not announce soon.

The minister is quite correct to say that there is currently no publicly funded meningococcal B vaccination in Australia. There has been in other countries intermittently, and there are issues which we need to address. That is part of what the minister has said we will be doing this year, in terms of B.

MRS DUNNE: What are the issues?

Dr Kelly: Cost and effectiveness would be clear components. I will talk about the meningococcal ACWY vaccine, which was committed to and has rolled out for adolescents. The main driver for that is that that is where the epidemiology is showing the meningococcal issue is at the moment. In the past, between 2014 and 2017 there was an increase of more than 50 per cent in meningococcal cases across Australia, while having a very rapidly decreasing number of meningococcal cases prior to that time. The driver for that increase was meningococcal W and Y, two slightly different causes of meningococcal disease. It did not involve B, so B has continued to decrease in its numbers. It is an extremely rare disease, anyway, and it is very rare here in the ACT. We only have a couple of cases a year, if that. Most of those in recent times have also been W or Y.

There are two peaks of meningococcal disease, one in young babies and the other in adolescents. It is the adolescents that are actually the ones who spread more than the young babies. From a population health point of view and from an individual protection point of view, it makes sense for this particular type of meningococcal disease program to target 15-year-olds, and 16 to 19 is the catch-up program. That has been mirrored in other parts of Australia.

That program commenced in the first term of the school year. It is a school-based program. I want to acknowledge, very strongly, Liz Chatham's group that go out to schools as part of the maternal and child health team. Together with them, we have rolled that program out to all high schools in the ACT, all 45 schools. There have been 3,958 vaccinations delivered, which is approaching 80 per cent coverage, which is higher than we thought we would get to. Now we are concentrating on our catch-up program.

That is something that has been very rapidly introduced, and it will continue. It is funded in the coming budget, alongside the work on what should happen with meningococcal B.

MRS DUNNE: The other part of the election commitment was free whooping cough

vaccine to pregnant mothers in the last trimester. What has happened with that?

Dr Kelly: That was a program that has been running for some time and was recommitted to in the budget last year. Since then the commonwealth government have announced that they will include that program in the national immunisation program. Essentially, what we have got now will be funded under those national agreements.

MRS DUNNE: Is that a free immunisation? Is it like a flu injection or is it like the immunisation program for babies? You turn up at maternal health and—

Dr Kelly: Yes. The vaccine, the actual needle bit, is free. If that is done through one of the ACT government-funded facilities, that would be free.

MRS DUNNE: But if you went to your GP, you would pay for the visit?

Dr Kelly: Yes—the same sort of thing as with the childhood vaccinations.

MRS DUNNE: What is the time frame on working out your thinking on meningococcal B for babies?

Ms Fitzharris: Over the next 12 months.

MRS DUNNE: Is it likely that you will deliver on the election commitment from 2016?

Ms Fitzharris: That is why we need that advice now. Yes, it is our intention, but we need the advice and the work done. That is funded in this year's budget.

MRS DUNNE: What does the vaccine cost?

Dr Kelly: I would have to take that on notice. I do know it, but I just do not have it with me. It is quite expensive. In recent times things have improved. Previously, there was a worldwide shortage of meningococcal B. That was one of the other issues in the past couple of years that we have been grappling with. The meningococcal B vaccine currently requires four doses in young kids, so it is quite a substantial change to the vaccination program. These are the sorts of issues that we need to further look at and see what we can do to fulfil that commitment.

THE CHAIR: Dr Kelly, what is the interval of the four immunisations that are applied?

Dr Kelly: It is through the first year. It coincides with other times when children are getting their vaccine in the first year of life.

THE CHAIR: The system-wide data review: I want to ask a few questions around that. The budget states that the system-wide review of data reporting was completed in the 2017-18 year, and the process is now moving into the implementation phase. The budget statement reads:

> The work undertaken by ACT Health on the System Wide Data Review will contribute to an improved capacity within ACT Health to access and analyse detailed and robust data on activity, performance and financial outcomes.

When will the system-wide data review finally be completed and either made public or presented to the Assembly?

Ms Fitzharris: It has been completed, and I gave a statement on that in the May sittings.

THE CHAIR: May sittings? There we go.

Ms Fitzharris: What is currently underway is a range of consultation with a wider range of staff in ACT Health, and on the implementation plan. I would hope to present that to the Assembly in the next couple of sittings.

THE CHAIR: One of the three weeks in August.

Ms Fitzharris: I might have to take that one on notice, Mr Wall, and get back to you in August.

Mr De'Ath: Did you want to comment further, Karen?

Ms Doran: The minister has covered it fairly comprehensively. The report was given to the minister early in April, and, as she said, a statement was made in May. While a range of stakeholders were involved in the consultation processes in developing the report, that was largely around identifying governance issues and data management issues. It was decided that, on the back of the completed report, it would be useful to undertake further consultations around the recommendations and the road map in that report, and to use those processes to inform the development of the implementation plan to supplement the report and the advice to the minister.

At this stage we are aiming to have the report, the implementation plan, and the government's response for the August sittings of the Assembly.

THE CHAIR: Once the implementation plan is finalised and ready for release come August, as you are suggesting, it is then full swing into the implementation?

Ms Doran: Yes. We are already moving on elements of implementation, but the implementation plan will give a much more detailed definition of the activities to be undertaken. It will probably be a rolling implementation plan, but we will look to detail the first at least six months of activities, and then build on that going forward. This will be a long exercise, but we need to prioritise—

THE CHAIR: When can we expect the first quarterly performance report?

Ms Fitzharris: After the first quarter of this financial year, so July-September—

MRS DUNNE: In a sense it will be actually up and running come 1 July?

Ms Fitzharris: Yes.

MRS DUNNE: I am unclear; is it the case that you have a copy of the report from the task force?

Ms Fitzharris: I have received the review, and the review is subject to further broader consultation. In terms of the data-wide review completing, the review work has been completed, as Karen Doran said. There now needs to be further consultation and work on the implementation, and the government's response. I would like to present that as a package in August.

It is also of note, which was discussed at public accounts earlier in the year, with the supplementary appropriation, that the government made an early investment in the data warehouse as a result of some initial findings out of the data review. Certainly, in terms of your questions about the quarterly performance report, it is really important that we start to get that out again. That has also been a priority, to make sure that not only that report is completed but that ACT Health was able to provide all the right input into its various national reporting requirements over the course of the year while the data review was underway. It was a huge effort, not only on the review itself but on making sure that ACT Health was able to meet its obligations to various national reporting bodies over that period.

Mr De'Ath: There is an important body of work to be undertaken now, further to this, in relation to the separation on 1 October. It is very important that, for our operational space, we are very clear about the data and information that they either generate or hold, and an oversight agency, and what is required in there to monitor on an ongoing basis. It is an ongoing evolution as the system evolves.

MRS DUNNE: You received a report in March, minister.

Ms Fitzharris: The review was completed on 31 March; I received it some time after that, in April.

MRS DUNNE: Who are you consulting with in the consultation process?

Mr De'Ath: It is particularly internal, actually. We wanted to get a comprehensive view, particularly from our clinical side of the business, in terms of how the various pieces of information in there related to, or were useful to or otherwise, the core business of the organisation.

MRS DUNNE: Is it likely that any of the recommendations will change as a result of the consultation?

Mr De'Ath: It is entirely possible.

Ms Doran: Yes. In the broadest sense, the recommendations will not change. They may be refined, but I think the consultation will add to the detail of the implementation plan and the prioritisation within that plan in order to reflect, as Mr De'Ath said, the needs of the clinicians.

MRS DUNNE: So the report that was finalised on 31 March is not necessarily the final report? It may change?

Ms Fitzharris: It may.

Mr De'Ath: It may. That is the point of the consultation. You do not completely lock something in until you have completed a process around it. The minister wanted to ensure that that was an extremely robust process with the right input. So there may be further refinements to the report.

MRS DUNNE: Can you give us a guarantee that the recommendations will not be watered down?

Ms Fitzharris: Yes.

MRS DUNNE: How will we know?

Ms Fitzharris: I will take that one on notice. Since the announcement around the future structure and governance of ACT Health, I have asked for an extra effort to consult with ACT Health staff. Upon completion of the review, I wanted to make sure absolutely that that consultation with staff was as intensive as it could possibly be. The review has been completed and there is some further work. I will present a full package to the Assembly in the next sittings.

MRS DUNNE: Would that full package include the original report if you changed the report?

Ms Fitzharris: I will take that on notice and bear that in mind when I see the work that the consultation has provided back on the original review, yes.

MRS DUNNE: Can you assure me, minister, that the 200-odd copies of the report that were received by ACT Health will not be pulped?

Ms Fitzharris: I do not believe they have, and yes.

Ms Doran: No. A large number have been used in the consultation process.

MRS DUNNE: All right, but they will not be pulped?

Ms Doran: They will not be pulped.

MRS DUNNE: What did it cost? I think I know the answer to this question; it is probably a known unknown. What did the data review cost?

Ms Fitzharris: We will take that on notice.

MRS DUNNE: Thank you.

MS CHEYNE: Is there someone who can speak about sexual health?

Ms Fitzharris: Yes.

MS CHEYNE: Don't all jump at once.

Ms Fitzharris: What was your question?

MS CHEYNE: Where do I begin? This is very serious. Among all the different health issues, sexual health is obviously pretty important. We want to have a healthy ACT in all facets of people's lives. I have now searched all the budget papers, I think, and I cannot find any reference to sexual health. I know we have an amazing sexual health centre, which seems to be well used, but I was wondering if we have any accountability indicators or strategic objectives in terms of presentations and the triaging that happens in that centre?

Dr Talaulikar: The sexual health centre, as you pointed out, does provide a very good quality service. It has a walk-in system; it does not have a defined referral accepting patronage. That is deliberately designed because of the sensitive nature of the condition and the population which is seeking assistance. In terms of a future strategy that is being looked at as part of the specialty service planning, we look at the growth, we look at the pattern of reference, and we look at the pattern of issues which are coming up and then decide on the workforce requirements. There is also the infrastructure capability and the infrastructure design.

MS CHEYNE: Just referencing that, is that because we might not at the moment have necessarily the workforce required to meet the demand for that free service?

Dr Talaulikar: The demand keeps increasing on a year-to-year basis. At this point in time, we are able to cope with the demand, but it is quite likely that going forward we might need to redefine that.

MS CHEYNE: What is the demand reflective of? Do you know? Is it reflective of people perhaps taking their sexual health more seriously or becoming more aware of the service, or do we just have a lot of STIs?

Dr Talaulikar: For the major population which seeks assistance from the sexual health centre, there are two subgroups. One is adolescents; the second is men having sex with men. The ACT is quite a magnet for the LGBTI community, and that community does seek higher service support from the sexual health centre. That does tend to be a demand area.

MS CHEYNE: So that is where the demand is growing?

Dr Talaulikar: Yes.

MS CHEYNE: Do we keep any data about how healthy we are as a sexually active population? This is going to go down in the history books with me asking these sorts of questions. I am trying to think of ways to say things sensibly. Do we have data in terms of whether chlamydia is rampant, whether gonorrhoea is going down, whether chlamydia is under control? I am just trying to get a sense of whether we have any data on that in the ACT?

Dr Talaulikar: We do to some degree, but I will have to take that on notice. I can provide you with it.

Ms Fitzharris: I think that is why we invited Dr Kelly up.

MS CHEYNE: I cannot wait to see the extract of that in *Hansard*.

Ms Fitzharris: Dr Kelly might be able to speak to that; he has a Chief Health Officer's report due out shortly. I think there is probably some concern that we might have about some aspects of it.

Dr Kelly: Mr Chairman, I could answer the question on notice I took earlier around the cost of meningococcal vaccine while I am here.

THE CHAIR: Yes, please.

Dr Kelly: Meningococcal B vaccine, Mrs Dunne, costs $120 a dose times four, so it is almost $500 per child.

MRS DUNNE: Almost $500.

Dr Kelly: Just by comparison, the meningococcal ACWY is $29, and it is only one. So that is one of the other issues we had.

MRS DUNNE: It is a big number, is not it?

Dr Kelly: Yes, it is a big number, and you times that by 5,500 children every year. So that is that issue; I will put that to the side.

Going to sexual health, yes, we do have numbers. Not all sexually transmitted infections, but most, are what is called notifiable diseases, so there is an obligation of health practitioners, and particularly laboratories, that make that diagnosis to notify me as the Chief Health Officer; for me to keep a list of those and a number; to investigate where that is necessary; and to provide—

MS CHEYNE: What does that mean in terms of investigating?

Dr Kelly: With chlamydia, for example, we have over 1,000 of those per year. We do not do much investigation around chlamydia ourselves. In terms of sexually transmitted infections, the really important part is contact tracing, so working through and with clinical colleagues in the sexual health clinic but also more broadly than that in general practice and with other providers to get that message out as much as we can to others who may potentially have that sexually transmitted infection but do not know it.

With the person who comes—this is particularly, in the case of chlamydia, an issue for women—it is often asymptomatic. For men it is quite obvious and painful, but not necessarily early on for women, who can be incubating that infection or having longer term effects of it without knowing. Getting treatment early is obviously an important

thing. With chlamydia, I would not call it rampant, but there is a lot of it, and there is no sign that that is going down. HIV has increased over the past few years—very small numbers.

MS CHEYNE: Really

Dr Kelly: Yes. Very small numbers, but it is worrying. The ACT was part of a New South Wales based trial of pre-exposure prophylaxis using the treatment for HIV but before exposure to HIV as an approach to help to decrease that. Gonorrhoea is increasing, and, worryingly—not so much here but in other parts of Australia, but inevitably here—it is increasingly becoming drug resistant. That is a concern. I am pre-empting the CHO report, minister. Those things are a worry.

MS CHEYNE: This is a serious question, but I know it is going to sound stupid. Should we be advising Canberrans that if there is someone from interstate coming to visit that they want to engage with, perhaps everyone should be tested? No: it is a serious question.

Ms Fitzharris: Maybe everyone should just practise good sexual health.

Dr Kelly: I think safe sex is a very important message regardless of where people are coming from. I do not want to be like Mr Putin, who put out a particular message in relation to the World Cup, apparently, exactly similar to that: "Watch out for those people coming from outside. They are far worse than us," or words to that effect. Those things are concerning.

The other element which is related is bloodborne viruses, hepatitis C and hepatitis B. Going back to your point about what we do in terms of investigation, with any new HIV case, obviously there is a lot of investigation around that, and less so with gonorrhoea and chlamydia, because they are much more common. Contact tracing is an important component clinically.

The last one I would mention would be syphilis, which is another sexually transmitted infection which had almost disappeared but has come back again, particularly in men who have sex with men, but not exclusively so. These are all issues that are not going away.

MS CHEYNE: Did it disappear from the ACT or nationally?

Dr Kelly: We are similar to the national trends.

MS CHEYNE: Finally on this—I know it has been the highlight of everyone's day—

Dr Kelly: We need to talk about it; that is the thing, so thanks for bringing it up.

MS CHEYNE: We do, and I am not sure it has ever been reported, so I am going to ask about it every time.

MRS DUNNE: You won't be invited back again!

Ms Fitzharris: I hope it is not a recommendation to manage maternity demands!

THE CHAIR: There is a public servant out there thinking, "Now I know what work I need to write next week"!

MS CHEYNE: Because these are notifiable diseases—if that is the right word—to you, do you get de-identified data? Are there some people who contract chlamydia, get treated for it; six months later they contract it again, get treated for it; then they contract it again? It is de-identified, but do you get to see whether there are trends in terms of people who are still practising unsafe sex but are not learning from the issue? To me, that is a cost. If there is not an education element then there is an increase in cost, surely, to the sexual health services.

Dr Kelly: We get identified data. That is part of the notifiable diseases under the Public Health Act. We do not transmit that data anywhere else, at least in an identified way. But we do transmit the information to the national authority. It is combined at the national level. One of your earlier questions was about where you could find this data. The federal government has a website on which you can see, by state, different types of disease by month, by year—however you want to look at that. We consolidate our data for the Chief Health Officer's report every two years, but actually quarterly in our population health bulletin. That is also available.

MS CHEYNE: You can see if there are some people who are—

Dr Kelly: Yes, we can. We do not target those—

MS CHEYNE: I can't find a description.

Dr Kelly: I know what you mean. Certainly, this is an issue on which we work very closely with clinicians, as well as with non-government organisations. We have contracts with peak bodies in relation to these matters. I am particularly thinking of the AIDS Action Council. They do a lot of peer support and work with peers, mainly men who have sex with men again, but not necessarily only that group. We work with Winnunga and other organisations in the community and by putting information out to general practice through the Capital Health Network. This is an area where public health and clinical medicine work very closely together.

MS CHEYNE: Given that chlamydia and gonorrhoea are increasing and syphilis is making a comeback, is there any money set aside in terms of doing some awareness campaigns—"Just when you thought it was safe, it's not safe," or something. I am clearly not a marketing manager for sexual health—but trying to raise people's awareness, I suppose.

Dr Kelly: You mentioned also looking through the budget papers and not seeing anything specific. It is certainly there, in the budget; it is just not a new initiative. I will certainly take on board that we need to look at that. It is very much part of the work that the non-government organisations particularly lead. All of the ones that we fund also have very strong social marketing campaigns and so forth.

I think that there are some general messages there which may be a bit old and are not

being noted as they were previously, around safe sex in particular. There are some quite specific ones that need to be targeted to higher risk groups around these matters.

MS CHEYNE: I know that the sexual health centre supplies free condoms, and I am sure other places do, but have we thought about expanding where those are supplied to?

Ms Fitzharris: No. Certainly, Sexual Health and Family Planning ACT do that. There is also a ministerial advisory council on sexual health, chaired by Richard Refshauge. They do good work. There is also a trial underway at the Tuggeranong walk-in centre around sexual health. So there have been some trials of expansion of services at the walk-in centres. There is an advanced physio trial at Belconnen walk-in centre and the sexual health one at Tuggeranong walk-in centre as well. That is another aspect of some of the work that we are already doing.

Understanding some of the issues that may be findings from the Chief Health Officer's report gives us further new information about how we might prioritise future investment. That is an important part of the Chief Health Officer's report, to provide that snapshot at a population level.

MS CHEYNE: In terms of being able to access safe sex, whether you are in a committed relationship or not, or married or whatever—I was thinking in terms of what we were talking about with abortion and access there.

Ms Fitzharris: We look forward to your recommendations.

MS CHEYNE: I will put it on the record: condoms can be expensive for some people, depending on their activity levels, I suppose. I do not think they are often on special, for example. I am being quite serious. In terms of making sure that we are doing what we can to support everybody, no matter their ability to access it, that would be something I would like to see more about.

Dr Kelly: I will take that on board. I think equity as a general principle is a really important thing.

Ms Fitzharris: We look forward to the recommendations from the estimates committee.

MS CHEYNE: It will be titled, "If it's not on, it's not on."

THE CHAIR: Dr Kelly, is there any data in the STI space on different parts of Canberra geographically having a higher level of infection or cross-infection than others?

Dr Kelly: In terms of sexually transmitted disease?

THE CHAIR: Yes; or is it consistent across the territory?

Dr Kelly: It is pretty consistent, I think. There are certain groups, as I mentioned, that are at higher risk. Dr Girish has already mentioned that men who have sex with men

are a particular area. Adolescents and young people are also at high risk, particularly of chlamydia.

In terms of blood-borne viruses, of course, those who inject drugs are of particular concern there, and that relates to our needle and syringe program—a similar reduction measure to free condoms. But no; it is widespread through the community. Chlamydia is our number one notifiable disease in the ACT, and it has been for some years. It has not really shown any sign of dropping.

THE CHAIR: You mentioned that HIV infection is on the increase. What sort of numbers are we looking at there?

Dr Kelly: It is still small numbers, fewer than 20 a year. But it did jump up from fewer than 10 to towards 20. And in the recent year—

THE CHAIR: Statistically, it is quite significant.

Dr Kelly: Yes, but the absolute number is small. It increased but it has stabilised in the past year. We hope it will remain like that and start to drop again.

THE CHAIR: If not go backwards.

Dr Kelly: Yes. I think the availability of PrEP on the PBS will be a major change there, with the recognition that it may be people's choice then to not use condoms as a safe sex measure. That is one of the tensions in this that we have to be very careful of. Whilst it would do a great thing to decrease HIV, and that is enormously beneficial in the long term, in the short term, it may well—and this is something we need to closely watch—increase things like chlamydia, gonorrhoea, syphilis and hepatitis A, in that same kind of watch.

MS LE COUTEUR: While we are on numbers, you said syphilis was increasing. What sorts of numbers are there for that? I was very concerned. I thought we had basically got rid of it.

Dr Kelly: Yes, we basically had. In the national sphere, for the first time in decades, we have had congenital syphilis in Australia, which is just extraordinary.

MS LE COUTEUR: We have?

Dr Kelly: Congenital syphilis, passing syphilis from mother to child.

MS LE COUTEUR: I know what you mean; I was just shocked.

Dr Kelly: Incredible, yes.

MS CHEYNE: I do not know what you mean. Can you say it again?

Dr Kelly: Syphilis is a sexually transmitted disease but, like HIV, it can also be spread by blood and can be transmitted from mother to child when in utero, pre-birth. That has not at the moment happened here in the ACT, but in other parts of Australia

it has happened on several occasions in the past couple of years. That talks a lot to people not understanding what the disease is, even. When I am saying people, I am talking about the people who have it, but also us.

THE CHAIR: The wider community, yes.

Dr Kelly: Or the doctors who are seeing patients and are not recognising these matters. Because it had almost disappeared, people have kind of forgotten. In terms of the numbers in the ACT, I will have to take that on notice.

MS LE COUTEUR: Okay.

Dr Kelly: There are some. It is, again, not enormous numbers, but it is increasing, and that is the concern.

MS CHEYNE: With that on notice, can we see just how things are trending generally?

Dr Kelly: Yes. I will provide the notifiable disease report to the committee.

MS CHEYNE: Great.

THE CHAIR: Thank you.

MS LE COUTEUR: That is shocking.

Dr Talaulikar: To end on a positive note, the new hepatitis C medications are likely to change the course of the disease substantially and possibly reduce numbers quite drastically. They can cure the disease with six months therapy.

Ms Fitzharris: Whereas previously?

Dr Talaulikar: Previously it was a chronic disease with massive costs, a chronic liver disease with hepatocellular carcinoma.

MS CHEYNE: This could cure it?

Dr Talaulikar: Yes. It can cure it with six months of therapy. So let us try to end it on a good note.

THE CHAIR: Yes.

MS CHEYNE: But is it expensive?

Dr Talaulikar: Yes, it is, but not compared to the total burden of the disease.

Ms Fitzharris: And funded under the PBS.

Dr Talaulikar: Yes; it is being funded under the PBS.

MS CHEYNE: That is what I love to hear.

MRS DUNNE: We are always in favour of cost-shifting to the commonwealth.

Ms Fitzharris: They are funded under the PBS—2016.

Dr Kelly: Yes.

Ms Fitzharris: 2016, unless they have changed it.

MS LE COUTEUR: I hope we have a media story on this, because what you have just talked about is really disturbing.

What I am going to talk about is, hopefully, not as disturbing; it is a media story, however. As part of the end of life committee, we have been talking about palliative care. The reason it is a media story is that the Health ED, Denise Lamb, was quoted in the media as basically saying that we are exploring what is going to happen for a palliative care ward, an end of life ward. I appreciate that this is early days, and it is not in the budget, but how are our explorations going?

Ms Fitzharris: Since we appeared before the committee a few weeks ago? They are continuing. I am not sure if we will have much more of an update than what we had last time. I believe that in terms of palliative care, the review of the model of care, the other committee—

MS LE COUTEUR: I thought that might be the answer, but in case there was.

Ms Fitzharris: I signed that off yesterday or the day before, to provide that report to the committee. It should be on its way to you.

MRS DUNNE: Over the past couple of years we have had a couple of instances of accreditation issues. Correct me if I am wrong, but I think gastroenterology lost its accreditation.

Ms Fitzharris: For training.

MRS DUNNE: Its training accreditation.

Ms Fitzharris: Urology.

MRS DUNNE: It is possible that that has had an effect on the numbers. We have a big waiting list in gastroenterology. I do not know if there is a causal relationship between those.

Ms Fitzharris: Bowel screening is probably one of your biggest.

MRS DUNNE: Bowel screening is a big thing. I just wanted to check. Are there any other areas? It has been put to me that rheumatology does not have very many trainees, and that is a problem for the quality of training. Are there any other areas under review at the moment, having their training accreditation looked at, or have there been

in the recent past?

Dr Talaulikar: I can confirm that gastroenterology has never lost accreditation.

Ms Fitzharris: It was urology.

Dr Talaulikar: It was urology, not gastroenterology.

MRS DUNNE: It was urology, sorry; that is why I said correct me if I am wrong. When did it lose its accreditation? I get the "ologies" mixed up.

Ms Fitzharris: It was 2015.

MRS DUNNE: Is rheumatology at risk because of the low number of trainees?

Ms Fitzharris: I will ask Jeff Fletcher, our Chief Medical Officer, to come to the table.

Dr Fletcher: I acknowledge the comment on the table.

Rheumatology comes under physician training. Rheumatology has one advanced trainee and has a junior doctor as well within that team. They are not at risk of losing their accreditation at the present stage that I am aware of.

We have just created a 0.5 position for a network director that did exist. We have looked at funding that completely out to 0.5. That was a recommendation by the college of physicians for our basic physician trainees who sit within their second to third and fourth years of training before they become advanced trainees.

MRS DUNNE: What does a network director do?

Dr Fletcher: As an organisation, as a tertiary level hospital for adult care, we network with rural hospitals. We network with Goulburn Base Hospital and send trainees to Goulburn Base Hospital. We also network with Bega base hospital and Moruya base hospital. We also have a network with Albury and Wodonga with paediatric training.

MRS DUNNE: Is there anywhere else in the hospital that has had or is having trainee accreditation reviews at the moment?

Dr Fletcher: Yes. We have a few training accreditations coming up. Medical imaging has had an accreditation just recently. We have ophthalmology having an accreditation next week. And also—

Ms Fitzharris: Radiology?

Dr Fletcher: Radiology is medical imaging. And also general surgery. The Royal Australasian College of Surgeons is having an accreditation on 5 July. They are the ones that are coming up at the present stage. Advanced training for paediatrics is another one coming up.

MRS DUNNE: How often do you have accreditation visits?

Dr Fletcher: It can depend on the college. They may be up to five years. If we get a really good accreditation result, it can be up to five years. Sometimes it may be one or two years, depending on the concerns raised by the college with respect to training positions and trainees. And it can go down. It can be unaccredited, like urology, and it can go down to six months in some specialities where there have been concerns raised about training previously.

MRS DUNNE: Are there issues about critical mass? If you have a small number of people in training, does that affect the quality of the training?

Dr Fletcher: No, not necessarily. Depending on where we are from a tertiary level perspective, there are certain parts of training or certain parts of Canberra Hospital that we do not supply training in. For paediatrics, we have advanced training, but we do not necessarily have advanced training in paediatrics for certain subspecialties because we are not a big enough hospital to provide that subspecialty. We also do not do renal transplantation. Some of the renal trainees need to go off to another organisation to complete some of their physician training, which can be a loss to us, because sometimes they do not come back.

Dr Talaulikar: We need to create a network with New South Wales so that we can have trainees rotating through. That is the case with rheumatology, and it is the case with pulmonology or respiratory medicine.

MRS DUNNE: What was the bit between rheumatology and respiratory medicine?

Dr Talaulikar: Pulmonology, which is another name for respiratory medicine.

MRS DUNNE: You said, Dr Fletcher, that there had recently been radiography?

Dr Fletcher: Radiology accreditation, yes. That happened at the same time, on 19 March.

MRS DUNNE: So it was at the same time as the general accreditation?

Dr Fletcher: The general hospital accreditation.

MRS DUNNE: How did that go?

Dr Fletcher: We are providing the radiology—we are looking at the factual accuracy of the report that they provided to us. There are some issues in radiology that we are needing to deal with, with respect to trainees and their training, which we are dealing with in a collaborative fashion with the medical imaging department and the radiologists.

MRS DUNNE: And the college?

Dr Fletcher: Yes, collaboratively with the college. I have taken on the role as the Chief Medical Officer to engage with the college and work with the college on how

we can improve the training resources for our medical imaging and radiology registrars.

MRS DUNNE: Was it a good report or a bad report?

Dr Fletcher: We started off at level A and the report at present has dropped us down in relation to how our training commitment to the radiology registrars is at present.

MRS DUNNE: Down to what?

Dr Fletcher: The training level is an A, and we have dropped from an A to a D. In the preliminary report we have to look for factual accuracy. As we respond to that, that will improve, hopefully, from my talking to the college, up to a B or a C. It will take 12 months to get back to an A.

THE CHAIR: What is the basis of going from an A to a D in the preliminary report? That is quite a stark—

Dr Fletcher: Some of it is around a network. In radiology we have had trouble creating a network with other facilities.

MRS DUNNE: This is the network that Dr Girish was talking about?

Dr Fletcher: Yes. For certain specialties we need to create certain networks. For radiology, we have a lot of private practice partnerships out in country settings. We are looking at creating a network position with Orange, which is still on the cards. Because we are a small tertiary-level hospital, creating a network with New South Wales, where there are lots of training positions, is very difficult. I have had a discussion with the college just this week. We are accredited in medical imaging for paediatric training. In New South Wales they are struggling to have paediatric imaging or radiology registrars complete their component of paediatric medical imaging. We are looking at, hopefully, networking with a New South Wales hospital to provide the paediatric component of their medical imaging training.

MRS DUNNE: What is the path from D back to A?

Dr Fletcher: One of the things is looking at creating a network. We have directors of training within medical imaging, and we are recruiting within the department two new directors of training. They will work with the medical imaging registrars. We have medical imaging registrars on the panel, to help us select the directors of training. So they are integral in how we select those doctors for training.

We will also be looking at the way we facilitate what we call certain components of imaging, such as breast screens, such as O&G, such as the paediatric rotation, and nuclear medicine. We have all those components of training with medical imaging. We just need to work out how we can improve that for the trainees. Once we do this, the hope from talking to the college at the end of last week will be that we should be able to move back up to a level A, where we have been for 25 years, within 12 months.

I am hoping that the preliminary factual accuracy of the report that is due on 6 July

will be enough to get us back up to a B or a C, just on the initial discussions I have had with them.

THE CHAIR: Does the accreditation by colleges such as radiology have any oversight of decisions taken within the hospital to treat patients, or is it purely in a training capacity?

Dr Fletcher: It is training capacity. All of the colleges are training capacities. We have, up to SRMO 3 through to postgraduate fellows, or fellows, up to 323 trainees in that position.

MRS DUNNE: Are there any other reports that you have received, or are the rest in prospect?

Dr Fletcher: The rest are occurring. They are coming up in the next two months.

MRS DUNNE: While we are on the subject of accreditation, where are we with being ready for July?

Mr De'Ath: Thank you, Mrs Dunne, for your question. We are very ready. There has been an absolutely enormous amount of work undertaken in the organisation; a lot of liaison with the ACHS and the commission in terms of preparations. We have completed the upload to the ACHS which was required two weeks prior, the evidence upload. In fact at 5.30 tonight there is a conversation with the ACHS in relation to the plan for when they are meeting with us from 3 to 5 July. We have some insight into how those meetings will take place. We are confident we have covered all the bases and we are looking forward to the ACHS coming back and meeting with us and confirming a final decision with us on 5 July.

MRS DUNNE: We have addressed the issue of ligature points in the adult mental health unit?

Mr De'Ath: We absolutely have.

MRS DUNNE: When did Health become aware that there were issues with ligature points in the adult mental health unit?

Mr De'Ath: On that question, Mrs Dunne, I would be particularly cautious given the coronial inquiry that is underway that relates to that matter. I do not think it would be appropriate for me to make any further comment or speculation in that area at this time.

MRS DUNNE: Okay; I will put a pin in that for a later date.

Mr De'Ath: Thank you.

THE CHAIR: I am happy to give my substantive question to you, Mrs Dunne, if you have further questions.

MRS DUNNE: Yes.

Ms Fitzharris: Could I note the extensive work that has been done on accreditation? A lot of people in this room and many others have been working extremely hard on this. I want to say thank you for the incredible, considerable effort that has gone into this in the past few months.

Mr De'Ath: Mr Wall, we do have some points of clarification regarding questions on notice that we can outline before the close of proceedings, if you wish.

THE CHAIR: Okay. We will exhaust the question opportunities first.

MRS DUNNE: I have a couple of issues in relation to public health. One is a structural issue. In the new structure, where does public health belong?

Ms Fitzharris: In terms of?

MRS DUNNE: Where will it be?

Ms Fitzharris: Do you mean on 1 October?

MRS DUNNE: Yes. Under the new structure, where will public health be?

Ms Fitzharris: In terms of that work—

MRS DUNNE: Is it a policy area or what?

Ms Fitzharris: That work is still underway.

Mr De'Ath: Yes.

MRS DUNNE: In relation to the restructure, where will the clinical leadership team —the chief nurse, the chief medical officer and the chief allied health officer—be? Will they be in the hospital or in the policy area?

Mr De'Ath: They will be over on the policy side of the organisation.

MRS DUNNE: What is the thinking behind that?

Mr De'Ath: Quite clearly—and I might ask one of the chiefs or all of the chiefs to contribute to this point—we have had a situation where they have been significantly drawn into the operational space of the hospital. In my discussions with all three of the chiefs, they have made it very clear that they have a significant role to play in terms of oversight of the system. I will ask Dr Fletcher to comment.

Dr Fletcher: The role of the chief medical officer, the chief allied health officer and chief nursing and midwifery officer in ACT Health, in the past year or two, has taken two components. One is that we have a strategic role, and the strategic role is looking at how we deliver services along the territory-wide health services framework, how we deliver services across the territory, how we deliver education across the territory and how we deliver research across the territory.

I would see the role of the chiefs, as we call ourselves, as looking at the delivery of education, research, teaching and training across the whole of the territory, including components within Calvary, and linking with the universities, such as ANU, University of Canberra Hospital and ACU, and CIT, to ensure that we can provide a good teaching program.

We also have the training colleges, as we have spoken about before, and how we link them into the service. Mr De'Ath was also saying that we have been caught up, in some of that role, in what would be operational components of that role, which has meant that we have not been as strategic in developments as we could have been over the past two years.

Moving across to the administrative side after the restructure will allow us to work on the strategy, which will include workforce planning, and education and training. It is a very exciting time for the three of us to be in that space.

Mr De'Ath: We are looking forward to the chiefs playing a critical role in the system stewardship, inputting into the policy. Dr Fletcher mentioned the research component, development of the workforce and development of the profession; so that is terrific. We are a bit cautious about what we say about what sits where at the moment, as we work through that process, but this is one we are very clear on.

MRS DUNNE: Can I ask about PFAS at the former Charnwood fire station site? Can somebody answer that?

Dr Kelly: Thanks, Mrs Dunne. What is your specific question?

MRS DUNNE: Can you outline for the committee what PFAS is and what it does in health terms, for a start?

Dr Kelly: Some of my colleagues, including the chief medical officer for the commonwealth, call PFAS the gift that keeps on giving, insofar as it is an issue that the whole country is facing—in fact, the world is facing—in relation to these matters. PFAS is a compound that was invented in the 1970s or earlier than that. I think it was seen as a wonder compound for the 3M corporation in the US, insofar as it is water resistant, fat resistant and a very stable compound. Its use has been extensive. If anyone has a Teflon-coated pot in their kitchen, that has PFAS in it. If anyone has a Gore-Tex jacket, that has PFAS. It has a wide range of uses.

The issue you have raised here, though, and the one that has mostly been worrying national authorities on the environmental side, environmental health and health authorities, is in relation to its use in firefighting foam. Again, because of its properties, it was an excellent retardant of fire and saved many lives because of that. It was extensively used in training, particularly in the defence department. It has been mostly a commonwealth issue until recently, in relation to defence facilities around Australia, most notably in and around Williamtown, north of Newcastle, and in a couple of other places related to defence facilities.

I have been involved with the issue at Jervis Bay. HMAS *Creswell* in Jervis Bay was

using these firefighting foams. While providing public health advice and services in Jervis Bay, I have been involved with community consultation and so forth in that place.

What you are referring to specifically is the ACT situation. Last year we looked at and tested our waterways and our drinking water, in consultation with Icon Water. They tested the dams, and it is fine. There is no PFAS in any of our drinking water and it is below any dangerous level within our lakes. Of course, we will find PFAS anywhere that this firefighting foam has been used. The firefighting foam has been used in training facilities by our Fire & Rescue services, and presumably in relation to the fire stations.

The particular facility you are talking about has been sold off and has been used for other purposes. The health protection service under me did give some advice on the development application for changing the use of that site in the past year. Particularly, some quite stringent measures were put around the use of that site.

In recent days there has been some media in relation to this issue. I participated in a cross-government teleconference about this yesterday. The work is being led by the EPA; that is, Access Canberra, under Chief Minister's. They are appearing tomorrow, I think.

Ms Fitzharris: Yes.

Dr Kelly: That is something that, in terms of the actual site, the development application and the issues around that station—

MRS DUNNE: What are the health implications for PFAS in the environment?

Dr Kelly: Just to finish that sentence, those specific things should be asked of the other groups, but we are working together as one government.

There are no definite health implications of PFAS. That is the bottom line, and why it is difficult to work with this. As a precautionary measure, these are very stable compounds that can stay in the environment for many decades. They tend to bioaccumulate in fish, for example, or other animals. If it is in the water supply, it can come into the body through water as well.

Whilst there are no definite proven health effects of PFAS, the concern and the precautionary measure is that we do not know what is going to happen in 10, 20 or 30 years time. They are very stable compounds and there are other ones that are known to be more dangerous. This is not Mr Fluffy; this is not asbestos. There is no clear "this leads to that", but there are some animal studies suggestive of some things; so we are certainly continuing to look at that very closely.

Associate Professor Martyn Kirk, at the National Centre for Epidemiology and Population Health at the ANU, was the one that led the asbestos study, you might recall, around the Mr Fluffy houses. He is also now running a national study looking at this matter, particularly at Williamtown and so forth; the ones that are very much affected.

In terms of the local situation here in the ACT, it is not in our water. We do not have much in the way of food supply that we produce ourselves, but it is unlikely to be in that either. That is a summary; but it is an emerging issue.

MRS DUNNE: If it is anywhere, it is isolated to places where the foam would have been used?

Dr Kelly: Yes.

MRS DUNNE: Fire stations or fire training areas, and that is probably about it?

Dr Kelly: Yes, and the airport, which is commonwealth land, but that is one place. The commonwealth started looking at the defence facilities, where they were using it for training, and the next places have been at airports where training has happened. If you recall, at the airport, when you have taken off to the north, the training facilities are at the north part of the Fairbairn end, well away from the Molonglo Reach drainage area, which is at the other end of the airport; so it has not got into Lake Burley Griffin.

THE CHAIR: Mr De'Ath, you have some answers to questions taken on notice so far today?

Mr De'Ath: Some points, yes. I will hand over to Ms Doran.

Ms Doran: Going back to the questions around electricity incidents at Canberra Hospital, in terms of electric shocks, there have been six incidents in the past financial year; five of those were notifiable incidents. The one that was not was related to a defibrillator; it was not related to building infrastructure.

MRS DUNNE: They are supposed to give you an electric shock!

Ms Doran: That is right, yes; it was sort of intended! In terms of breaks in electricity supply, there were 21 cases at the Canberra Hospital and six that were not at the Canberra Hospital—in other sites—again in the 2017-18 year.

Ms Fitzharris: Mrs Dunne, you were asking earlier about Katy Gallagher. I know you did not raise it directly here but you have subsequently, in a media release, raised her employment. That is part of Calvary national's employment; it is not part of the ACT government's contract with Calvary.

MRS DUNNE: Thank you.

Mr Bone: There was a question on notice about who was on the private panel provider for the surgical work. I can confirm that Calvary John James Hospital, Barton Private Hospital, Calvary Private Hospital, Capital Coast Surgery, and Canberra Microsurgery are the providers on the panel. It is our intention to go back to the market to refresh. There were others who did not respond in the last round. Given that we have 14,000 procedures to deal with, we will go back and refresh that panel. They are the ones currently.

THE CHAIR: Members of the existing panel will be retendering or they will maintain their panel's—

Mr Bone: I would assume that they would maintain their status.

MRS DUNNE: What price are we setting for surgery? Are you using the national efficient price or something greater than that?

Mr Bone: There is no price point. This was just to have a panel of providers who may be interested in tendering for it.

MRS DUNNE: When you tender, are you—

Mr Bone: We would look at the specialty and the volume of work, and that will be part of the tendering process. There is no price point set.

MRS DUNNE: There is no price point set, so you will not necessarily tender out at the national efficient price?

Mr Bone: We may not. We have a price set for ACT Health for elective surgery, which is $5,444 per weighted activity unit. Depending on the activity and the volume of activity, we would negotiate a price at the time of contract.

MRS DUNNE: What was that number?

Mr Bone: The national weighted activity unit? It is $5,444.

MRS DUNNE: So that is $432 above the national efficient price?

Ms Doran: As it was announced for 2018-19, yes.

Mr Bone: I have a correction to make on behalf of Ms Chatham. When she was talking about a woman who could not access the community midwifery program, she indicated there were four a month. She has come back and indicated that a total of nine women since February this year have been unable to access the program.

THE CHAIR: I will close today's hearing. Thank you very much, minister, and all the officials who have been here today. For any outstanding questions that have been taken on notice, could answers please be returned to the committee secretary within five days. Day one, for the purposes of accounting, is from tomorrow. The committee will now adjourn until 10 o'clock tomorrow morning.

The committee adjourned at 5.28 pm.