LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2019-2020

(Reference: Appropriation Bill 2019-2020 and Appropriation (Office of the Legislative Assembly) Bill 2019-2020)

Members:

MISS C BURCH (Chair)
MS B CODY (Deputy Chair)
MRS G JONES
MS C LE COUTEUR
MR M PETTERSSON

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 20 JUNE 2019

Secretary to the committee:
Ms Annemieke Jongsma (Ph 620 51253)

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 Corrections and Justice Health, Minister for Justice, Consumer Affairs and Road Safety and Minister for Mental Health

ACT Health Directorate
De'Ath, Mr Michael, Director-General
Riordan, Dr Denise, Chief Psychiatrist
Fletcher, Mr John, Executive Group Manager, Corporate and Governance
Shuhyta, Ms Amber, Executive Branch Manager, Mental Health Policy Unit

Canberra Health Services
McDonald, Ms Bernadette, Chief Executive Officer
Grace, Ms Karen, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
Mooney, Mr Colm, Executive Director, Infrastructure and Health Support Services
Hammat, Ms Janine, Executive Group Manager, People and Culture

THE CHAIR: Welcome. The proceedings today will examine the expenditure proposals and revenue estimates for the Health Directorate in relation to budget statements C. When taking a question on notice, it would be useful if witnesses could use the words, "I will take that as a question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript. I ask witnesses to familiarise yourselves with the privilege statement and to confirm that you understand the implications of the privilege statement.

Minister, the partnership between Winnunga Nimmityjah, ACT Corrective Services, and Canberra Health Services was first announced in December 2017. When did the health service actually commence operations in the AMC?

Mr Rattenbury: It was 7 January 2019.

THE CHAIR: What contributed to the delay in starting?

Mr Rattenbury: There are a range of factors in doing something brand-new like this. There was quite a discussion about how the model of care would work. There was quite an extended period of negotiation. While I would not seek to speak for Ms Tongs, the head of Winnunga, she and I had a couple of discussions about the fact that we needed to get it right, not get it done quickly. We probably all would have liked to see it happen a bit more quickly, but there was some back and forth.

We also needed to prepare a suitable space for Winnunga. As you may know, our health centre at the AMC is under considerable pressure—we have just commissioned a contract for an expansion of space—so we had to turn one of the previous health wards into a suitable space for Winnunga, at least for the short term, until we have the expansion of the health centre, so there was some physical work to be done as well.

MRS JONES: I believe they have actually been put in David Eastman's old cell. That is not part of the health ward, is it?

Mr Rattenbury: Yes, it is.

MRS JONES: He was living in a health ward?

Mr Rattenbury: Yes.

THE CHAIR: What facilities are currently being provided to Winnunga?

Mr Rattenbury: Do you mean in terms of the physical space?

THE CHAIR: Yes.

Mr Rattenbury: They are operating out of what was formerly one of the health wards. It has been converted, so my understanding is that they have all the equipment they need. I think they could do with more and better space, but that will come when we make the expansion of the health centre. As I said, that contract has now been let.

MS CODY: Minister, I want to talk to you about eating disorders. I note there was some significant work done. There was a petition in the Assembly, and there seems to be some more work done in this budget. Can you expand on that?

Mr Rattenbury: Sure. You recall, of course, that we appeared before the health and community services committee and had a good discussion about this.

MS CODY: Yes.

Mr Rattenbury: That petition did trigger ACT Health to do some further work, which we undertook with both the young petitioner who started it and a range of community organisations. That led to us releasing our eating disorder strategy in 2018, which we have also presented to the health committee. This year the budget brings forward resources to start the implementation of that. It particularly focuses on establishing an eating disorder specialist clinical hub.

One of the things that really came through in the eating disorder strategy was the need to build expertise in our medical community in the ACT, to try to identify those clinicians who have an interest and perhaps create a group of people that someone with an eating disorder can go to. You may recall the terrible story of a former ACT Health staffer who had sought medical help and had been told, "Just go and have a steak and a beer and you'll be right, love." So, clearly, we have got some work to do to educate our own medical community about how to deal with it better.

That is the broad direction of the strategy, and the budget this year starts to make that investment. As you might have seen, the commonwealth government has also, through the election campaign, committed additional funds to supporting eating disorders in the ACT. We have now commenced those conversations with the commonwealth. I am pleased that they have recognised the strategy we have put in

place. We will now seek to align those resources to the strategy we are rolling out.

MS CODY: What sorts of things will the strategy deliver on initially? What are some of the starting points?

Mr Rattenbury: It will initially establish an eating disorder specialist clinical hub and a partnership with non-government organisations. We have been very fortunate that groups, particularly the Butterfly Foundation, have been good partners for us in this discussion. They have engaged with the ACT government, shared a lot of their expertise and really sought to support the work we are doing. We want to continue that partnership and use their expertise—and I mean that in the kindest sense of the word—to make sure we do the work as well as we can.

MS CODY: Has there been a decision made about where the hub will be located? It is more of a—

Mr Rattenbury: It is not intended to be a physical hub in that sense; it is really more of an expertise hub. So you will not see in the budget a whole lot of capital to create that. The commonwealth money has flagged capital investment, and that is the discussion we now need to work through with the commonwealth.

MRS DUNNE: Where are you up to with your discussions with the commonwealth? They have committed to an actual centre, so where are you up to with that? Are you saying that the centre that you have in mind is a virtual centre rather than a physical centre? If there is going to be capital money, why wouldn't you actually have a physical centre?

Mr Rattenbury: That is the work we need to do on what is the best model of care, essentially, Mrs Dunne. I am grateful and pleased that the commonwealth is flagging flexibility in the best approach. They want to have that discussion with us.

Our initial thinking is that, with the gap in ACT services, the best place to use the capital infrastructure would be in what might be broadly called a step-up, step-down facility. I do not want to define it too clearly at this point. In thinking about the continuum of need for people with an eating disorder, some will need to go to hospital, but ideally that will be a very small group who are very unwell and need serious medical intervention.

We think the bigger gap is a step back from that point, and that an inpatient facility that is probably more in the step-up, step-down mode will be right. Whether that is where we would then base a whole lot of clinicians or whether it would be more residential in nature is the detailed work that needs to be done. It is not that we need physical space for expertise at this stage. That is my thinking at the moment, but we remain open on that.

MRS DUNNE: What is the time line on the discussions? When do you think that you and the commonwealth might come to an arrangement?

Mr De'Ath: I acknowledge the privilege statement. The commonwealth are in discussion with us around a range of commitments that have been made. The eating

disorders one is in the range of $13½ million. There is no definite time line at this stage on that. As the minister has outlined, there is a significant body of work to do now. We would probably look forward to reporting in future hearings on that activity.

MRS DUNNE: Maybe in the annual reports.

Mr Rattenbury: I would certainly hope that by the end of the year we would have a much clearer picture, yes.

MR PETTERSSON: In regard to the data and modelling that you use for inpatient treatment projections, I am reading your position statement on eating disorders and it talks about at any one time expecting between two and four admissions. It also goes on to talk about data not being captured for people seeking treatment interstate. What are you doing to better capture the actual numbers?

Ms Shuhyta: I have read and understood the privilege statement. Originally, our data projections and data modelling were using the national mental health service planning framework, which was an established tool that all jurisdictions in Australia have contributed to. It looks at the ACT demand based on a national model. That takes into account the interrelationships between jurisdictions as well, in terms of Canberran demand.

We have been speaking with the InsideOut institute in New South Wales about New South Wales admissions, and our counterparts in New South Wales Health about admissions of Canberrans. We are seeing anecdotally that a lot of those admissions are to the private hospital system in New South Wales, rather than public mental health patients needing admission in New South Wales.

Part of the budget commitment in terms of building and establishing the eating disorders clinical hub is about developing those future models of care, getting better data projections and answering some of those questions that we have not been able to really pinpoint. Expanding our capacity to be a clinical leader in the area should expand our capacity for future projections and demand.

MR PETTERSSON: Do you have any idea how many people are seeking private care outside the ACT?

Ms Shuhyta: Because people who may be seeking private care are entering into private hospitals, that data is not available to us. On the national mental health expert reference panel there is a representative of the Private Hospitals Association who we have those conversations with, but it is even hard for that body, as a peak body, to pinpoint the admissions to psychiatric facilities because it is dealing with so many private entities.

MR PETTERSSON: I can understand that you cannot get that information, but it is almost a chicken and egg situation. Clearly, these people are going interstate and seeking private health care because public health care is not available here. Because we only have a small number of people accessing public health care here, we can only justify a small number of services.

Mr Rattenbury: That is part of what we are trying to do. In putting together our eating disorder strategy and boosting our capacity, we should start to engage more people in the ACT. You are right in the sense that it is a bit chicken and egg. Our job is to improve our service and to start to improve our capability. That will start to draw some people back into the ACT system. We will start to get a better understanding and, through a process of continuous improvement, and without sounding too cliched about it—

MRS JONES: Build it and they will come, as you say.

Mr Rattenbury: Yes, we will get there, I think, over time. For me, this is the beginning of it. The commonwealth injection of funding will help that as well. Because it will provide inpatient beds, that will give us a real boost in momentum.

MS LE COUTEUR: This is an overall question about the ACT Health sector, but you are the first up and it is also relevant to your other portfolio. I understand that Canberra's hospitals have the honour of being one of the biggest emitters of greenhouse gases across the ACT government's operations. Given that the government has the carbon neutral government target, what is Health doing on that issue?

Mr Rattenbury: I cannot think of the figures off the top of my head, Ms Le Couteur, but Health would be—certainly, from an energy consumption point of view—electricity and gas. Obviously, as we move to 100 per cent renewable electricity, that will drop for Health. They still have gas. Certainly, with my climate change hat on, as part of the current development of the climate change strategy through to 2025, we have been engaging with ACT Health, and there will be some health-related initiatives in that strategy when it comes out.

Obviously, with Health making a significant infrastructure investment as well, we need to make sure that those buildings are climate wise. For me, that means two things. One is making sure that they are producing as few emissions as possible; also, they should be thermally well designed so that they are prepared for Canberra's hotter future.

MS LE COUTEUR: Traditionally, the Canberra health precinct has a lot of gas in it. I can remember lots of discussions about co-generation and things. Will the new SPIRE building also be based on gas, or have we moved—

Mr Rattenbury: That has not been finalised yet. That is under active discussion at this time with the Health team. We have to be very cognisant, of course, of the critical 24/7 requirement for uninterrupted power supply and all of those things—the obvious things. That is one of those questions we are trying to look at, at the moment—what the available technologies are.

Having gone through this with a few other ACT government buildings in recent times, we are right at that threshold point where the technology is starting to come through, which means you can do all electric, but it is not quite available, or necessarily economic, for all situations just yet. We are right on that tipping point on a few things. For example, Dame Pattie Menzies House, which will be the new headquarters for

EPSDD when that is rebuilt, will be all electric. We have just had the first all-electric school. So we are getting there, but it is still a bit horses for courses.

Mr De'Ath: It is fair to say, in relation to SPIRE, that it is under very active consideration.

MS LE COUTEUR: Good. Are there any other issues that Health is working on, apart from the power issues? With Health's environmental impact, clearly power is part of it; what about plastic waste? I noticed in the government's discussion about single-use plastics that Health was explicitly not part of that. Is Health itself doing work on this?

Mr Mooney: Within my group we look after the domestic and environmental services group—the cleaning contract, recycling and things like that. For example, we recently, just last month, won an innovation excellence award with Actsmart for our activity in that space, in terms of recycling. That is on the ground in terms of recycling.

In other environmental initiatives, if I look at the other aspect of my portfolio, which is around infrastructure, a lot of the stuff that we are doing in the infrastructure space in upgrading of building services is introducing new, more energy efficient plant and equipment—new boilers and new chillers. These are all going to be coming online. Boilers that are much more energy efficient are online already. Chillers will be coming online a bit later this year.

We have an active program and consideration when it comes to any new builds. We look at the most energy efficient arrangements that we can put in place in order to meet environmental standards. As the minister said earlier, it is always on a case-by-case basis. With the 24/7 nature of our buildings, the technology available at the moment does not always lend itself to introduction right now.

MS LE COUTEUR: Has the ACT considered joining the Global Green and Healthy Hospitals alliance, which I understand is designed to assist health facilities to become more sustainable, as its name suggests?

Mr Mooney: It is not on the radar at the moment, but we will certainly take it under consideration to look at it.

MRS JONES: Going to the health services at the prison again, it has been brought to my attention that there are some 90 inmates who identify as Aboriginal and would like to be transferred to Winnunga Nimmityjah for their health services, and that over the seven or eight months—I think you were saying it was January this year—that it has been in operation only 16 or 17 people have been transferred to that service. Why is the transfer rate so slow?

Mr Rattenbury: I have received that information as well. As you can imagine, that was of concern to me. I have looked into that and I am happy to give you some new numbers. From the period of January this year to 18 June, just last week, there have been 43 formal requests for transfer of care to Winnunga from justice health services. Of those 43, 20 have been transferred and three more transfers will be occurring this week. That is 23 out of 43 formal requests by the end of the week. Twelve of the

43 were released prior to transfer. Two of those 12 referrals were not accepted by Winnunga and are currently on hold. Eight out of 43 were not transferred. Six currently are with Winnunga for consideration of accepting the transfer. Two are pending justice health services review for suitability of transfer.

MRS JONES: Thank you.

Mr Rattenbury: I am not sure where the 90 figure comes from. They are the numbers that ACT Health has.

MRS JONES: That is what I have been told by Winnunga themselves. If that is a misunderstanding, that is fine. You say that there are 43 who have had a formal request, but what defines a formal request as opposed to what they see as a request? That is something else to go into the detail of.

Mr Rattenbury: Yes. We do have regular meetings with Winnunga at a number of levels, including the CEO of Canberra Health Services and senior officials at the GM level from JACS. Is it a quarterly meeting?

Ms McDonald: Yes, a quarterly meeting.

MRS JONES: I guess you could understand the frustration that is being felt there. The other thing that was raised with me is the time of day when that service is available. If someone is being medicated to a system with sleep and the service concludes at 5 o'clock or 6 o'clock for Winnunga, and I think the last time they can see people is around 4 or 4.30 or something like that, that makes it quite difficult. That has been raised with me.

On the health front in the prison as well, but not just for the Aboriginal people, there are the blister packs of medication. The other side of the equation is that people are being given blister packs of their medications in the cells, which means they are tradeable. I know it is a very complex matter. I am wondering if you have given any thought to the timing of medications when people do go across to Winnunga as well as when they do not, essentially.

Mr Rattenbury: An operational question like when people receive their medications is one that, to be honest, I would not expect to have to intervene on. We have structures in place for—

MRS JONES: Well, I think—

Mr Rattenbury: No, I will finish. We have structures in place where that should be able to be resolved, frankly, on the floor of the jail. If it cannot, it should be escalated to managers. Ultimately I will intervene if that cannot be resolved, but I like to think we are building a relationship where matters like that—

MRS JONES: So you are upset because they have come to me instead of you? Is that what you are saying?

Mr Rattenbury: No, not at all. You are projecting there, I think.

MRS JONES: No, I am misunderstanding.

Mr Rattenbury: I was simply saying we have systems in place where ultimately I will intervene if I have to, but I really think we should have a strong enough governance structure—

MRS JONES: That is an interesting theoretical position, but these people are obviously frustrated if they have spoken to me about the time frames in which the Winnunga service can operate in the prison.

Mr Rattenbury: Sure, and I am happy to take that on board.

MRS JONES: You mentioned earlier that there will be a rebuild of the health centre or some adjustments to the health centre. But at the moment the spot they are operating out of has a box toilet in the corner. There are concerns about whether that really is an appropriate space for them to be working out of. Is your view that that is appropriate, or is it just that that is the best we can do for now?

Mr Rattenbury: That is the best space we have available at the moment. To be fair, our health staff are probably working under less than optimal conditions there, in the sense that it is more crowded than we would like it to be.

MRS JONES: Yes; this is an ongoing issue.

Mr Rattenbury: That is why we have committed funds to expand the health centre at the AMC.

MRS JONES: Will Winnunga be operating inside the external walls to the facility that you are building?

Mr Rattenbury: That is a discussion we will need to have with them as we develop the operating procedures around that facility.

MRS JONES: Can you advise what the internal process is or who the internal person is that should be approached if they want to operate for longer hours?

Ms McDonald: I acknowledge and accept the privilege statement. In the operation of Winnunga health service within the justice health system, we are working in partnership. We have an operational committee that meets on a regular basis every week to try to address issues of the creation of the service and the transfer of patients across. I myself have attended a meeting with the Winnunga team, with the CEO and our senior staff, to discuss issues as they arise.

As you understand, this is an evolving service. It is a brand-new service. We are really happy to have Winnunga providing that health service within the AMC and to work in partnership with them. As issues arise in terms of access to Winnunga services, we are happy to work with Winnunga on increasing the hours of service. But, as you would understand, Winnunga have to provide the medical staff and the nursing staff to actually provide that service.

MRS JONES: I do not think they are concerned about being able to do that.

Ms McDonald: Some of the conversations we have had are about the availability of staff. We are happy to take that point and that advice and have discussions with Winnunga. As you would understand, Winnunga would like to get as many patients as possible across, and we are trying to facilitate that as quickly as possible and in the safest way possible as well.

MRS JONES: Of course. Speaking about safety, my understanding is that the medical records in the prison are paper based and that as a patient is being allocated to Winnunga their paper files come with them. But it is my understanding that some of the paper files associated with their drug needs or use or taking are not being provided with them, which means it is being left, to an extent, up to the conversations that the health staff are having with the inmates themselves. Are you able to also take on notice what can be done to address the fact that there is not the complete and full medical picture coming across with each of those individual people?

Ms McDonald: I will take on notice that particular point. But, just to clarify, in terms of any patient that is transferred from our justice health team across to the Winnunga team there is a full handover. There is a full transfer of as much medical information as possible.

MRS JONES: Apparently "as much medical information as possible" is not the complete picture at the moment. That is what they have said to me in a direct meeting. I would not have come up with this. I do not know enough about how it operates.

Ms McDonald: We will absolutely follow up on that. But we have had discussions with Winnunga about that complete handover.

MRS JONES: I am sure there are discussions going on. I am just letting you know of something that may have fallen through the cracks.

MR PETTERSSON: I was wondering if you could tell me what work is being done to divert people with mental illness away from the justice system.

MRS JONES: Where to begin?

Mr Rattenbury: Yes, thank you, Mrs Jones. That explains the blank; it suddenly went out of my head. You will see in this budget that there is additional funding for this. We particularly are trying to line up the work that we are doing in the justice and corrections space with our mental health space. We are really cognisant that there is a large crossover of people who are in the corrections system who also have mental health issues.

The particular emphasis in this budget is to increase our capability in the forensic mental health services team in the community sector. They are the ones who interact with the courts and can help people in situations of maintaining bail conditions, for example, and the like. It is really with that strong emphasis of keeping people out of custody where it is safe and practical to do so.

MR PETTERSSON: Did you say the forensic mental health team?

Mr Rattenbury: Yes.

MR PETTERSSON: Can you expand on their role?

Ms McDonald: I might invite Karen Grace to the table to expand on the new services and the expansions at this point in time.

Ms Grace: I acknowledge the privilege statement and understand the statement. In this budget we have funding to increase our resources in this space. Primarily there are two aspects to this initiative. One is to improve our court liaison services for mental health. That is specifically aimed at better transition of service to people who are on bail and helping to support people on bail to access appropriate mental health care. We also have funding to increase our clinical capacity in that area so that we can provide ongoing assessment and support for people that are on bail. We also have additional funding within the prison to provide additional health supports within the prison.

MRS JONES: What will they be?

Ms Grace: That is a range of primary health care and mental health supports as we expand the service in the prison.

MRS JONES: Yes, I understand that. I was hoping for some specifics.

Ms Grace: The main area is in the bail area. It is around diversion; it is around supporting in the community. Last year we received money to expand AMC, and that includes ongoing growth this year for—

MRS JONES: Just the continual growth of the service that we have for more people?

Ms Grace: Yes.

MR PETTERSSON: Just to clarify, there are two types of staff that are being recruited here. There are staff that connect people to services, and you said there is also—

Ms Grace: There is a court liaison position. That is to identify and support transfer and consultation with our services. The additional funding is to increase our existing capacity within our community mental health services to be able to support people in the community that are on bail.

MRS DUNNE: Minister, the information that the opposition has received through questions on notice indicates that there were 129 assaults on mental health staff between January 2017 and June 2018. We have had this discussion before, but can we talk about what programs are in place to enhance nurse safety in mental health wards in particular.

Ms McDonald: Mrs Dunne, I might take that question, if you are comfortable with that. Across the whole organisation we have taken an extremely intense focus on occupational violence, in particular in our mental health facilities. Each one of our mental health facilities has particular strategies, given the types of patients that they are caring for at any particular moment in time. Each of them has increased their risk assessments of patients, their debriefings after an incident has occurred, and support for our staff and our patients after an incident has occurred. But it is also looking at other strategies. Do we have enough staff? Do we need the presence of security in our facilities in different ways? What are the sorts of strategies that we can put in place?

We have had a consultancy that is close to completing their work to look at what is best practice both nationally and internationally in the management of occupational violence in health services. They are close to completing a strategy for us which will be rolled out over the next three years across our organisation.

The different things that are looked at in that strategy include the environment. Do we have the right environments for our patients and the staff that increase the safety and security of everybody and reduce occupational violence? Do we have the right training across all our services, and what can we do to improve those? Do we have the right information on and expectations of our consumers, our patients and anyone who visits the health service in terms of what they will do? And do we have the right risk assessments, both for individual patients but also about risk in different environments across our organisation?

This has given us a really solid foundation in terms of areas where we can improve. It has also highlighted areas such as Dhulwa, where we do this extremely well. And we are actively working to ask our staff, and encourage our staff, to report any occupational violence incidents so that we can respond appropriately by providing support. We are also doing the assessment and debriefing with our staff to find out how we can prevent incidents in the future.

There are a number of strategies going on across all our services, including our mental health services. I think the committee will understand that, with the complex and high acuity types of patients we have in some of our services, a violent outburst can be unpredictable. To reduce it to zero is almost impossible, but trying to prevent it and reduce the harm from any sort of outburst or occupational violence incident is what we are trying to work on in particular.

MRS DUNNE: I notice from the risk register that there are a whole lot of actions in this space. Some are supposed to have been completed, but according to the risk register, which I think was given to the *Canberra Times* on the 13th of this month, they are not recorded as being completed. They are things like developing a communication plan by 31 May and reviewing the local risk assessment and occupational violence and risk assessment tool by the beginning of May. Have those things been done but not entered in the risk register? And are the other elements in the risk profile on track?

Ms McDonald: Some of those things have been delayed slightly because we have been undertaking the work with the consultants to develop the strategy. They will be completed as soon as possible. We wanted to get the work from the strategy included.

That risk will be updated in terms of putting the strategy into place, and those actions and the implementation plan will be put in along with that risk. That risk will be re-evaluated, and a new action plan developed.

MRS DUNNE: Have you actually engaged consultants?

Ms McDonald: Yes.

MRS DUNNE: It is unclear from the risk register whether or not you have engaged consultants.

Ms McDonald: Yes, we have engaged consultants, and the consultants are close to completing their work. They have been with us for the last six weeks, undertaking the best practice literature review, developing the strategy and developing the implementation plan. There is a very detailed implementation plan that is still in draft form. It is yet to be endorsed by our occupational violence working group and our executive, but that is very close to being complete. I had a look at it yesterday with the consultants and our advisory group, and we have a very detailed occupational violence implementation plan and strategy for the next three years.

MRS DUNNE: Could I just go back a little. You said—I do not want to verbal you; I just want to make sure that I heard it correctly—that Dhulwa does this quite well.

Ms McDonald: Yes.

MRS DUNNE: But a year ago we were seeing a lot of problems in Dhulwa.

Ms McDonald: Yes, we were.

MRS DUNNE: What has changed that this is less of an issue in Dhulwa than it was a year ago?

Ms McDonald: My statement is on the advice of the consultants who have reviewed our high-risk areas as part of the work that they have been doing with us. Their comment was that Dhulwa has very good systems and processes in place. There has been an increased focus at Dhulwa in particular to talk with our staff. We have been working closely with the ANMF as well in terms of really talking with our staff, debriefing any incident that happens, learning from that and changing our process systems and processes in response to that.

MRS DUNNE: The figures that I have go to June 2018. Could those figures on occupational violence be updated from June 2018, on notice?

Ms McDonald: Sure. I will take that question on notice.

THE CHAIR: Turning to opioid and drug programs, there is $1,075,000 being budgeted to expand opioid replacement treatment services to provide a range of additional drug and alcohol services at the AMC. What exactly is this funding providing and what are these additional services?

Ms Grace: Out at AMC we currently have an alcohol and drug service that is fairly limited. At present, all it allows us really to do is to provide support for the opioid replacement treatment program out at AMC. What we are planning on doing with the new money that we get through this initiative is to employ two additional alcohol and drug nurses out at the prison. That will enable us to provide a more comprehensive alcohol and drug service for the prison; it will allow us to be much more proactive and take a more harm minimisation, as well as early intervention, approach to the management of alcohol and drug issues out at the prison.

It will also allow us to provide an extended hours service. At the moment we only have one nurse, so that is only Monday to Friday. The addition of two more nurses out there will allow us to provide a seven day a week service out at the prison to support the detainees.

THE CHAIR: Is more money being spent on the methadone idose system?

Ms Grace: Not at this point.

THE CHAIR: How many inmates are currently on the methadone program?

Ms Grace: It is 104.

THE CHAIR: Do you have that breakdown by gender?

Ms Grace: No. Not at my fingertips, no.

Mr Rattenbury: We will take that on notice and provide it.

THE CHAIR: Thank you. How many doctors inside the AMC can prescribe methadone to a detainee, and what is the process for prescribing increases or decreases in doses?

Ms Grace: We have addiction specialist support within the prison that manages the methadone program. They will undertake the reviews and the adjustments of the doses. That service, as I said, is fairly limited at the moment, but we do have the capacity to manage the adjustment of doses for all the detainees accessing the program.

MRS JONES: I think the question was: how many doctors are involved in that process?

Ms Grace: I will have to take that on notice.

MRS JONES: Thank you.

Dr Riordan: I acknowledge and agree with the privilege statement. I also cannot give you an exact figure, but I can explain that there will be a combination of the doctors who work in primary care and some of the staff who work specifically within mental health who will be able to take responsibility for prescribing. Obviously the practitioners in primary care are our GP staff. Most of the GPs there will have undertaken courses. There are courses that people can undertake to be approved to

prescribe opiate substitutes. My understanding from informal conversations is that most of the doctors there actually are authorised to do that. At the moment, I think we employ one full-time doctor within justice health and then we have a series of very longstanding VMOs, visiting medical officers, who provide a long-term, ongoing commitment to the centre.

MRS JONES: Would it be fair to say that the majority of this particular matter, the prescription and adjustment of the prescription of methadone, is dealt with by that one main person predominantly?

Dr Riordan: I think it would be dealt with by that whole team in terms of monitoring and reviewing. Given that approximately 20 per cent of the detainees would be involved in the program, they are going to be reviewed on a regular basis by that team of GPs.

MRS JONES: Perhaps you could take on notice exactly how that unit functions, the team that is specifically drug focused that you were talking about earlier. And could you also take on notice how many people are in it and describe how patients who want to discuss particularly their methadone taking are dealt with.

Dr Riordan: I am happy to take that on notice.

MS CODY: There is an initiative in this year's budget to move away from insecure work across the ACT public service. I understand there is a whole-of-government response to that, which is great, but I am also interested in seeing how each individual directorate is managing insecure work. Do you use labour hire? How many contractors versus permanent staff do you have? What are your strategies to help move away from labour hire and contract staff?

Mr Rattenbury: It is an interesting question because we do face workforce challenges in the mental health space which have been well documented in this and other committees. We do have a degree of what would be broadly called labour hire; others might comment on the specifics.

For us, the challenge is that I would take more permanent staff as soon as we could identify them. That is probably our bigger challenge in this space—finding suitably qualified and interested permanent staff. We have the positions available. At this year's COAG health ministers meeting in November, I have asked for there to be a specific meeting focused on mental health, and one of the specific areas we are looking at in that is workforce issues. There are some bigger long-term issues there about training enough people to bring through the system and the like. To me, that will go to some of those questions around creating a stable, permanent workforce, which I think is the most desirable outcome.

MS CODY: Absolutely.

Mr De'Ath: We are happy to respond in terms of the ACT Health Directorate.

MS CODY: Are you going to respond across the whole directorate or—

Mr De'Ath: We are happy to make a comment in relation to the directorate, should you wish.

MS CODY: Yes. I would have asked you about it in the next section.

Mr De'Ath: That is what I thought was coming.

Mr Fletcher: I acknowledge the privilege statement. The Health Directorate's HR team is involved in an overview of our staffing profile, including our contracted workforce. We review job descriptions, job tasks and engagement activities on a one-by-one basis.

The majority of our contracted workforce exists within the digital services space, so we are trying to find a balance between permanent employment of staff and a range of staff that are involved in a number of short-term projects in either the infrastructure side of the organisation, in relation to capital works type projects, or in the digital services space. It is certainly something that is front of mind.

We have a new workforce that has a different profile from the former Health Directorate, although we do have people involved in the clinical side of things, in our health protection services side of things. The majority of our staff are, of course, administrative. That is a body of work that is underway at the moment, given that we are a relatively new organisation. We are reviewing that profile with a view to finding that right balance.

Mr De'Ath: I think it is incumbent upon directors-general to have, as I have, an expectation of executives in all cases to look at where secure employment can be offered, as opposed to any other arrangement. It is fair to say that there is a far greater discipline over this now, going right through to whether we would look at, say, purchasing a consultancy or whether we would move that in house and use existing staff. It is much more disciplined at this stage, and evolving.

Ms McDonald: Janine Hammat, my executive director of people and culture, can address that for Canberra Health Services, if you would like.

MS CODY: Sure.

Mr Rattenbury: Obviously, my earlier comments were very much mental health focused, specifically.

MS CODY: Yes, I understand that; thank you. They are absolutely relevant, and I take those on board. Everyone seems to be able to answer it across the board; we might as well knock it off.

Mr Rattenbury: I thought it would be handy just to clarify my comments.

Ms McDonald: I might reiterate Mr De'Ath's comments that we are absolutely looking at opportunities. I also support the minister's comments that, in trying to attract the workforce and offer permanent employment, there are certain parts of our workforce that would prefer locum appointments and those sorts of things. We are

trying to find that balance. We are certainly in conversations with all of our unions and associations that represent our workforce in terms of trying to work with them to find the areas of most concern where we can offer that job security and permanency, where possible. Janine can talk to those.

Ms Hammat: I have read and understand the privilege statement. What I would add to what has been said so far is that we are definitely members of the insecure work task force for the ACTPS, and actively involved in that.

In terms of the temporary nature of some of our employment, a lot of graduate positions tend to be temporary, before they have completed certain competencies and training requirements. Having said that, we are committed to looking at what we do with those graduate positions going forward.

We have recently instituted in Canberra Health Services a workforce planning function. We will be doing a lot of work in this space to ensure that we are attracting and retaining all of the right staff that we need for the skilled work that we do. We will be focusing on some high priority areas in the first instance, while having generalised approaches across the organisation as well, especially in relation to insecure work.

MS LE COUTEUR: Budget statements C, at page 35, refers to reducing the use of seclusion in mental health episodes. I note that our estimated outcome, at 16 per cent, is three times the target. Is there any reason for this?

Ms McDonald: There absolutely is and we can explain that. I invite Dr Riordan to answer that question for you.

Dr Riordan: Obviously the whole issue around providing the most intensive support for people who are extremely agitated, and certainly doing that in a way that is safe for them, safe for the staff and maintains that respect and dignity for all parties involved, is an integral part of what we do within the health services. I think there has been an increase seen in the numbers of seclusion and restraint. I think there are several factors that contribute to that.

One would be the high level of acuity of some people presenting particularly to the emergency department area and needing that acute de-escalation. That is often associated with people who may be coming in and are acutely intoxicated, on substances such as ice and methamphetamine. Those people can present in a way that really is quite agitated, to the point of then presenting significant risks to themselves and to others. And there is a real challenge in those situations about the extent to which medication as an intervention to try and control some of that agitation and help alleviate some of that distress can be used.

It is complicated because often we do not know exactly what people may have taken. Therefore, any medication that we give will have the potential to interact and that becomes something that means that we have to, I suppose, follow the mantra that we tend to use, which is go low, go slow and try to make sure that what we are giving people is going to help in meeting their acute medical needs but not actually compromising them further.

In terms of people who are admitted to the inpatient facilities, I think again we have to recognise that there are a range of people with a range of different needs. Obviously, what I do not ever want to do is describe things in a way that might lead to individuals being identified.

The general principles that apply, that we need to consider in these situations, are to recognise that some people have highly complex needs. I guess I am thinking particularly of something like an ongoing, chronic, enduring mental illness such as schizophrenia, combined potentially with intellectual disability, combined again with behaviour that is difficult and that challenges the system. I think that those sorts of presentations become really quite complex to manage.

I think that what we are also finding is that, when people who have been living in the community and who maybe have that combination of difficulties are moved into an acute hospital setting, which may actually not be the appropriate environment for them, those systems are then challenged by those behaviours and we have to work fairly intensively to try and get the combination of both, I suppose, that bio-psychosocial intervention and what might be the combination of psychological supports, of environmental changes that might be necessary and also what might be the appropriate medication—recognising as well that in those situations people who have that highly complex level of presentation often also act or react somewhat idiosyncratically to medication. There is all of that going on.

Obviously, what we do recognise within the health services is that any episode of seclusion or restraint is going to be extremely distressing for the individual, for their families and for all parties. We work very hard to try and absolutely reduce the number of occasions where that might happen.

What we also have become more skilled at doing is treating people admitted to an acute inpatient unit—and I think this would be something that would be common across Australia. I think that acute adult mental health wards have also at points in time been the places where people who have needs that might otherwise have been met and responded to in community settings, where those community providers are not able to meet their needs, come to hospital. Often there is a significant delay in finding the right, appropriate accommodation for people to go to. I think that what we have to—

MRS JONES: Do you mean after their stay?

Dr Riordan: After their stay, yes, and that their stay in an environment which we would recognise is not ideal for them is protracted because of there not being necessarily—

MRS JONES: Somewhere to go?

Dr Riordan: That is right. In those situations I think that what the staff, our service, would become more skilled and sophisticated at is recognising that maybe particular individuals need to be cared for by a smaller team of nursing and care staff so that, rather than having the more regular changes of nursing staff over shift periods we

would try and limit it so that their care is provided by a smaller group. We try to make sure that there are appropriate behavioural support programs and also try to make sure that there are appropriate debriefings for individuals, families and carers. I recognise that it is a very challenging and distressing area.

MS LE COUTEUR: The message that I get from what you said is that it seems highly unlikely that this is going to change any time soon. However, your target is, as I understand it, to get down to the national rate, which is seven per cent for next year; so you are halving?

Dr Riordan: Yes.

MS LE COUTEUR: From what you have said, that sounds entirely unlikely.

Dr Riordan: I think it is reasonable to say that in small jurisdictions such as the ACT, similar to other jurisdictions such as Tasmania and the Northern Territory, we are more likely to see some of those swing variables in figures because a smaller number of people having particularly difficult experiences can skew that. I would be confident that we would be able to work quite proactively to reduce those rates, yes.

MR PETTERSSON: I note in the budget the creation of electroconvulsive therapy services at Canberra Hospital. Is there much demand for these services in the ACT?

Dr Riordan: I am happy to take that question. I think the short answer is yes.

MRS JONES: It is a last resort.

Dr Riordan: I will to try to explain that to you. Electroconvulsive therapy is a well evidenced-based, effective treatment for severe mental illness. It also has a particular role to play in certain conditions, such as major depression, where there is catatonia. That can often lead to people not eating and drinking. Therefore, they have a significant health risk. That is a presentation that we are particularly more likely to see in our older population.

It can also be very effective in treating severe depression, mania, hypomania and some forms of psychosis. Historically, I think probably since about 2011-12, there has been no regular dedicated service for ECT delivered out of the Canberra Hospital. That has meant that the only public service delivering ECT has been at the Calvary hospital. What that has meant is that people sometimes have had to wait longer for their service and that some people just do not get access to that service. They may then be treated in other ways, which may eventually lead to a resolution of their symptoms, but it is often a much more protracted recovery process.

I think it also means that people who we know do respond to that treatment do not start that treatment as quickly as they might like. For example, if we know that somebody has responded well to ECT and they present as unwell, they might have to wait two or three weeks, maybe even longer at times, to be able to start that treatment.

The other thing that has happened is that for those people who are acutely unwell who get admitted at the Canberra Hospital, which is obviously our largest main unit,

perhaps ECT has not been considered as promptly as one might like because of the pragmatic difficulties of being able to provide that treatment. Alternatively, if they have been able to get that treatment, they have either had to wait for a bed to become available and for them to become well enough to be transferred to 2N at Calvary, or to have treatment which potentially involves being in a fasting state, needing to go somewhere by 7.30 or 8 o'clock in the morning. They would have to be transferred from the Canberra Hospital to Calvary hospital to have their treatment.

MRS JONES: Because ECT is done under general anaesthetic; is that correct?

Dr Riordan: ECT is always delivered entirely under general anaesthetic. It is delivered at the Calvary hospital in a designated treatment suite. It is delivered by a psychiatrist with an anaesthetist present and under constant monitoring.

MRS DUNNE: I want to follow up on that, Dr Riordan. It seems to me that ECT has a bit of a bad rap because of its treatment in popular media. For instance, when the minister made this pre-budget announcement, one of the media outlets here used a very unfortunate graphic to go with it. Do you get resistance from patients and patients' families about the treatment? If so, how do we get around that?

Dr Riordan: Most of the ECT that is given in the ACT—again, consistent with the rest of Australia—is given on a voluntary basis, in that the people themselves and their families are very much in agreement with the treatment. I think it would be fair to say that for people being prescribed ECT in the first instance, that can sometimes be quite a daunting sort of prospect for them and their families. There is usually quite a significant demand for psycho-education that goes into that. I think that when people have had a previous course of ECT and then maybe become unwell again in the future, often what we have are people themselves and certainly their families and carers advocating for ECT.

We also have some people who, as part of advanced care agreements, have said that if they themselves do not have capacity to consent to ECT, they give an advance care agreement to say they would like ECT. If people lack capacity then they cannot consent to ECT because they cannot consent to the procedure from some legal point of view.

MRS DUNNE: If there is an advance care directive in place, does it have to be specific for ECT, to specifically opt for ECT? Is it the case that a substitute carer cannot make that decision?

Dr Riordan: A substitute carer cannot make the decision, but there is provision under the Mental Health Act for people to apply to the tribunal and to be prescribed ECT in the case that they themselves cannot consent.

MRS DUNNE: Do you experience resistance when it is first suggested to patients because of how it is perceived publicly?

MRS JONES: Stereotyped.

Dr Riordan: Far less of that than one would expect, actually. I think that people are

given information and people's suffering is so great that they are often very relieved to know that there are other treatments that might be available.

THE CHAIR: Thank you. We are out of time, so we will suspend here and return at 10.45.

Hearing suspended from 10.32 to 10.50 am.

Appearances:

Fitzharris, Ms Meegan, Minister for Health and Wellbeing, Minister for Higher Education, Minister for Medical and Health Research, Minister for Transport and Minister for Vocational Education and Skills

Canberra Health Services
McDonald, Ms Bernadette, Chief Executive Officer
Mooney, Mr Colm, Executive Director, Infrastructure and Health Support Services
Hammat, Ms Janine, Executive Group Manager, People and Culture
Chatham, Ms Elizabeth, Acting Chief Operating Officer
O'Neill, Ms Cathie, Acting Executive Director, Cancer, Ambulatory and Community Health Support
Kaye, Mr Todd, Acting Executive Director, Rehabilitation, Aged and Community Services
Grace, Ms Karen, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
Bracher, Ms Katrina, Executive Director, Women, Youth and Children
Taylor, Ms Jacqui, Executive Director, Medicine
Wood, Mr Daniel, Executive Director, Surgery and Oral Health

ACT Health Directorate
De'Ath, Mr Michael, Director-General
Peffer, Mr Dave, Acting Deputy Director-General, Health Systems, Policy and Research
Coleman, Dr Kerryn, Acting Chief Health Officer
Arya, Dr Dinesh, Chief Medical Officer
O'Halloran, Mr Peter, Chief Information Officer
Chambers, Ms Kate, Chief Finance Officer
Fletcher, Mr John, Executive Group Manager, Corporate and Governance
Lopa, Ms Liz, Executive Group Manager, Strategic Infrastructure
Culhane, Mr Michael, Executive Group Manager, Policy, Partnerships and Programs
George, Ms Jacinta, Executive Group Manager, Health System Planning and Evaluation
Shadbolt, Associate Professor Bruce, Deputy Executive Director, Research, Centre for Health and Medical Research
Shuhtya, Ms Amber, Executive Branch Manager, Mental Health Policy Unit

THE CHAIR: Before you speak for the first time, can you please confirm that you have read the privilege statement and understand the implications of the privilege statement in front of you.

Minister, why did the government make an election announcement about SPIRE without having first done any feasibility planning or early design work on the project?

Ms Fitzharris: We made that commitment in 2016 with some early work, as you would, and said at the time that it would require further work. That is what we have been doing since that commitment was made.

THE CHAIR: What involvement did ACT Health have in developing the SPIRE proposal in preparation for the election announcement?

Ms Fitzharris: Quite a bit of involvement.

THE CHAIR: When did the government first ask ACT Health for advice on the SPIRE project?

Ms Fitzharris: I was not the health minister at the time, so I could not precisely answer that question.

MRS DUNNE: You can take it on notice?

Ms Fitzharris: Yes, in that it was an election commitment made and, as you know, various election commitments may have a level of detail in them. There will be varying levels of detail, and that was certainly the case with the scope of SPIRE at the time. We have since expanded that scope. It is by no means unusual that commitments are made to do further work. When you look at the commitments, like all election commitments, they were made clearly spelling out that there was more work to do.

THE CHAIR: Did the restructure of ACT Health in October 2018 cause any delays to the development of the project?

Ms Fitzharris: Prior to the actual separation of ACT Health into two organisations, I had asked for further work to be done in terms of territory-wide planning. Some of that work, which in my view it was essential to do, meant that there were a couple of months where that work took primacy over some of the specific design work for SPIRE. But it was very closely related to territory-wide health needs and territory-wide modelling.

THE CHAIR: What impact have the changes in the scope of SPIRE had on the ability to complete the project within estimated time frames?

Ms Fitzharris: No particular impact; it is still the same time frames. In fact, I hope that they support the government to deliver it in those time frames. The work that has been done, particularly since December last year, when the new location on the Canberra Hospital campus was identified for SPIRE, and with the subsequent clinical engagement since then, has set the project up extremely well. That clinical engagement will continue very strongly over the more detailed design phase of the project. This is a very significant project; it will require very detailed input from infrastructure specialists and clinical input into the design of the centre.

THE CHAIR: It was previously announced that the project would cost $500 million. Why don't the budget papers outline this budget framework and those figures?

Ms Fitzharris: The budget papers do outline why. The commitment was that it would be a $500 million project. In that time we have seen an expansion of the scope. You could expect that we will invest even more in SPIRE. We are also mindful of what is happening in the infrastructure market, both locally and, particularly, nationally. But

we think we have a pretty strong record, particularly with the delivery of light rail, on major infrastructure projects.

As is the case in our budget this year—and I note it was the case in the New South Wales budget delivered earlier this week—there are a number of not-for-publication figures in terms of commercial confidentiality. Once we get through that process and have identified a contractor for the SPIRE project, the number will be published. There is a provision there in the budget, so in terms of budgeting for the project, that is there, but we do not yet want to signal the full cost to the market so that we can get best value for money.

THE CHAIR: What is the target construction commencement date?

Ms Fitzharris: Preparation for the site will commence this year. An important part of the construction of SPIRE is making the space available. That will commence later this year with the demolition of some existing buildings on the Canberra Hospital site. Work to do the decanting for that is underway now.

MRS DUNNE: A comment was made at a public seminar recently that the delivery date of sometime in 2023 would appear to be ambitious, on the basis that you would be spending in the order of $14 million a month for the rest of the time between now and then on what is essentially a brownfields site. You said that you expect that the officials will deliver to the government's time line, but the time line has slipped from the election commitment. What commitments will you give that it will not slip again, despite the scepticism in the community that you can deliver in that time frame?

Ms Fitzharris: The one that I have given, and the priority that the government places on the project. I am not sure of the context of those comments at a seminar, but this is the highest priority infrastructure project for the government in this term. I am pleased with progress, and we look forward to approaching the market for the delivery of the whole project. We recognise that there is a very busy infrastructure market around the country. I think that the delivery mechanism and the collaborative work across Canberra Health Services and the new Major Projects Canberra unit will give real priority to this project.

MS CODY: I was out at street stalls over the weekend and I had a few people come up to me who were unclear as to exactly what SPIRE is going to give them at the hospital. It included a couple of nurses, which was interesting. I was just wondering if you could outline very quickly, on the record, how SPIRE will benefit the hospital.

Ms Fitzharris: It is very exciting; there is a lot in SPIRE and I know there has been a lot of engagement on what it will deliver in terms of clinical services. I might ask Bernadette McDonald to talk through that.

Ms McDonald: SPIRE will basically give us a brand-new emergency department. I will keep it really general.

MS CODY: Very high level, yes.

Ms McDonald: Yes, high level. It will give us a brand-new emergency department.

Alongside that emergency department, we will have medical imaging, which will have an MRI in it and, I think, three CT machines to service the emergency department and also the patients within the SPIRE building themselves. We will have new theatres, an increased number of operating theatres that will be in line with current guidelines and guidelines at the time in terms of space and size, and interventional procedures, and what we call a hybrid theatre. I will not go into all the detail about what that is, but it has specialised equipment within a certain number of our theatres that allows the most advanced of procedures.

We will also have a new intensive care unit and an increase in our intensive care numbers. We will have paediatric intensive care beds in there as well. We will have some day case beds and spaces for day procedures, and also some overnight surgical beds to service SPIRE, 64 of those. There will be a coronary care unit—our coronary care unit will be new—along with some cardiology rooms for our interventional cardiologist.

It is taking the most complex of services that already exist, giving them a brand-new environment, and increasing the scope of the services that we have. So our capacity will go up. It is also a really great opportunity for us to look at new technologies; models of care; how we deliver the services; how patients, visitors, staff and everyone move through the organisation; the best ways that we can create storage and clinical education spaces for our more complex patients; and the most high-tech services that we have in the organisation.

In terms of communication with staff, we have had a lot of staff engagement in looking at the scope and looking at what we need. That will continue in the design phase and the model of care which we are working on at the moment. Then there is the detailed design so that we get the flow right and we get it to work well for both patients and staff.

We have sent out notification to staff to say, "Here is what is involved." We will have a regular newsletter, probably every month. It will be an all-staff email saying, "Here's what is happening," so that people can be up to date with what is actually happening. As you can understand, not everybody reads the emails that come out with all the details and those sorts of things, all the media and press releases. We are trying hard to make sure, not only through email but through our senior managers, that our staff cascade the information about SPIRE down.

A lot more staff will be involved in focus groups, as well as our consumers and carers. They will have a lot of input into our governance structure over the build. It is very exciting, I have to say.

MRS DUNNE: Ms McDonald, you said there will be a new emergency department, a new ICU and new coronary care. What happens to the existing facilities? We also have new theatres but it is net new theatres. Are we going to have two banks of theatres, one in SPIRE and one in the current building, building 12? What is going to happen?

Ms McDonald: That is the first question that I asked. When I was told about SPIRE, I asked, "What are we doing with all of the other space?" We will go through a master

planning process, which is also getting underway, to look at the whole site and at what are the best uses of the spaces that will be vacated, following SPIRE.

MRS DUNNE: That is my question: we are building theatres and we are building emergency beds; will the current emergency department become—

Ms McDonald: It will move.

MRS DUNNE: It will close?

Ms McDonald: It will close, yes.

MRS DUNNE: In its current position, and move.

Ms McDonald: Yes.

MRS DUNNE: What about the theatres, because we are building—

Ms McDonald: At this stage the plan is for the theatres to close and move across. All of those services will move into new facilities.

MRS DUNNE: With all of the theatres, we have a net gain. I am sorry; I cannot remember the number.

MRS JONES: Nine.

MRS DUNNE: Nine. All of the theatres will be new?

Ms McDonald: Yes, all of the theatres in SPIRE—

MRS DUNNE: Essentially, all of building 12 will be decanted to SPIRE.

Ms McDonald: Yes.

MRS DUNNE: Everything?

Ms McDonald: Yes, except for medical imaging, which is in that space next to the ED. Our big medical imaging department will stay there and we will have another medical imaging department, not as big, to service SPIRE. Moving patients across, obviously, is not a good way to do it.

MRS DUNNE: You need medical imaging that is close to theatres.

Ms McDonald: Those complex services that we have in that building, yes.

MRS DUNNE: Can I congratulate you; you anticipated what I would ask when you said there would be a master plan for the whole site.

Ms McDonald: Absolutely, yes.

MRS DUNNE: That is part of this process?

Ms McDonald: We are working with the Health Directorate now to undertake a master planning process for the whole site.

MRS DUNNE: Who is doing that?

Ms McDonald: The Health Directorate is working with us, but we do not actually have consultants on board or anything like that.

MRS DUNNE: When we say the whole site, do we mean all the way along Hospital Road, up into Gaunt Place—

Ms McDonald: The whole site, yes.

MRS DUNNE: And across the road into the car park?

Ms McDonald: Yes.

MRS DUNNE: What will be the bounds of the master plan?

Ms McDonald: That is to be determined, but I would like it to be for the whole site. That is my intention.

Ms Fitzharris: The site and the car parks on Yamba Drive—across from that, yes. That is an important process because we know there are a range of opportunities on the site that will come from SPIRE being built. The helipad will be located on the top of SPIRE, so the existing helipad area of the hospital will not be used. Also, we are taking this opportunity to green the site up a little bit.

MS CODY: "Green" as in—

Ms Fitzharris: As in look at the site as a whole and make it a site that is attractive, that is pleasant to be in. It is a big and busy site. There are a lot of opportunities that come from this, and it has been important. Another key issue that consistently comes up, of course, is parking; so we have taken a very close look at that.

MRS JONES: That will then stage the process, ultimately, of replacing the other parts of the hospital that require replacing?

Ms Fitzharris: There is very much an ongoing process to make sure that the campus as a whole is modern and fit for purpose; that it is an acute hospital campus not only for the city but for the entire region; and that the services available there are appropriate services.

We had this discussion in the context of the location of the hydrotherapy pool and the movement out of that site for subacute and rehabilitation services. What happens on the Canberra Hospital campus is very important. What is happening around the rest of the city and where services are located is also important.

MS LE COUTEUR: I want to talk about the boundaries of your planning, particularly traffic issues. Garran primary is there, and that—

MRS JONES: Has its issues.

MS LE COUTEUR: That has its issues, and the fact that the hospital is further away from the Woden bus interchange than is conveniently walkable for most people. How are you going to deal with the bigger issues? I suppose I will make my obligatory plug for the old CIT site as being the obvious expansion place. How are you going to look just a little bit further out than that site?

Ms Fitzharris: There have already been discussions with Garran primary. There are a range of ongoing issues. I know that my transport portfolio and school crossing supervisors are working with Garran primary on that. There has been discussion specifically about making sure that we communicate very clearly with them around the construction of SPIRE. Those conversations have already begun.

As you know as well, with the old CIT Woden site and an expansion of the hospital per se for acute services, it is actually quite some way from the main hospital location. The parking there is very highly utilised by both ACT Health and CHS staff. That question is one that I know we have spoken about. The Minister for Urban Renewal will have a conversation with the community about the best use of that site. Its proximity to the hospital would lend itself to becoming part of that conversation, but as to whether it is about an expansion of the hospital itself, I think we are looking at the current footprint of the hospital, on the other side of Yamba Drive.

MS LE COUTEUR: What about transport issues and getting to the hospital? As I alluded to, it is a distance from the bus interchange and it would be a distance from the light rail—presumably, about the same distance, in fact. Are you looking at that?

Ms Fitzharris: That is partly a transport question. That has come up for me in the transport portfolio. There are playing fields, a cemetery and housing in between the hospital and—

MS LE COUTEUR: Yes, I am well aware of that.

Ms Fitzharris: As we recently discussed, that is also part of our thinking about the redevelopment of the Woden town centre and accessibility between Woden town centre and the hospital. EPSDD are very engaged in the SPIRE project, and Transport Canberra is also engaged in terms of transport to and from the campus.

MS CODY: I was very interested to read this morning's announcement on the new children's plan. What does this mean?

Ms Fitzharris: I think there are others that can join from a clinical point, and paediatric services, as well as more community-based services. The genesis of this, for me, was a lot of feedback from staff and the community around what more can we do and how can we continue to grow and expand our services.

It has been a comprehensive children's health plan. From my point of view, there are

two particular projects. One is around new parents. We have strong maternity services and a new maternity model that will be implemented later this year. We have some great follow-up services with our midwives and a range of services for women and their babies not long after they have gone home. We have parent groups, support clinics in the community and breastfeeding support, but we can do more. I am really keen to learn from the community and assess what more we can do.

There are also some new initiatives that have come from a lot of work on the importance of the first thousand days of a child's life and supporting parents through that journey of having a new baby and considering their mental health.

The other component is looking at how we might grow paediatric services. We know there will likely always be services that people will need to access interstate, but we think there is room to grow some specialisation in the ACT. We will look clinically at that.

A number of families have had experiences they really want to share with us, and I think we can learn a lot from them. That is another important piece of this work and I am particularly excited about that because they are many of the stories that I hear in my role as an MLA that a number of families have shared with me. We have asked the Health Care Consumers Association to work with those families.

Finally, we need to find the best way to hear from children directly about their experience of services. It is a really great piece of work. We have put a 12-month time frame on that and there will be updates over the course of that 12 months.

Mr De'Ath: I think this might assist the committee in understanding the roles and the separation of the entities now. This is a really significant policy direction; it is about looking at our service planning and service mix opportunities and working across the system to develop and provide advice.

This is a very exciting initiative, at the minister's direction, to be working through the issues around this, looking at comprehensive engagement, as the minister has outlined, and digging into and examining the experiences of people and what the service system needs to look like. We are really looking forward to delivering that over the next 12 months.

MS LE COUTEUR: Last week my husband was, unfortunately, admitted to the emergency department. There was virtually no waiting, and full marks to the ED. However, my question relates to what happened after that. He has private insurance and he was very strongly advised that he should move to the national capital hospital if he wanted to get the surgery he needed quickly. With hindsight I should have asked more questions about the time lines, but I was there as a freaked-out wife rather than as an estimates committee member.

We were okay; we had private insurance and moved on, but I am concerned that our public health system is not able to offer non-elective surgery in what seems to be the appropriate time line. That was the clear message. We may have misinterpreted, but the message we were getting was that if we could move we should. So we did move.

Ms McDonald: Let me start by saying I am very sorry he had that experience and has been unwell, and I hope he is recovering well. I do not know the particular circumstances of your husband and nor would I discuss those publicly anyway for confidentiality reasons. But patients are asked, "Do you have private health insurance," and an opportunity is given to patients to move into other services if they wish to.

There is certainly no pressure from clinicians, and I apologise for that if there was. That may have been a misunderstanding, but an offer is made to patients to move if they would like to, and quite a few patients are happy to do that. But that is not made based on time lines and nor should it be communicated that it is just based on time lines and that you will be treated more quickly, although that may be the case, given that we have a huge demand for emergency surgery and emergency procedures.

Sometimes a procedure will be done quicker if a patient is in a private hospital, just based on demand and clinical urgency. We have to make judgements on the clinical urgency of our patients and treat them in the time frames required, which means some patients wait longer, unfortunately.

We work very hard to try and meet the demands of our services and our patients as quickly as we can and in a timely way, based on clinical urgency. But there is an opportunity for people to use their private health insurance if they choose to. It is certainly not something we would put pressure on about. I would certainly not want my staff to put pressure on anybody to have to use it. It is a question worth asking because sometimes if we do not ask that question and make that offer, somebody says, "Why didn't you ask me and tell me I had an opportunity to move to a private hospital?" Finding the balance is what we need to do.

MRS JONES: What is the status of the north side hospital project scoping study, and when will it be completed?

Ms Fitzharris: This is a project working with Calvary and looking at how we continue to invest in Calvary, in recognition of the work we have been doing on an ongoing basis and also the growing needs on the north side. You will have seen new theatres opened or upgraded at Calvary the year before last; an upgrade of the maternity unit last year; an upgrade and expansion of the ED, which is underway at the moment; the opening of two new theatres; and investment in neurology in Calvary.

You would be familiar with the building health services program, which is part of the work I referred to earlier about having a territory-wide approach to how we invest public money in public health services. That, by definition, must include Calvary, and so that work has been underway very collaboratively with Calvary.

MRS JONES: How has it been managed up till now, the territory-wide concept or the precinct-wide concept? It sounds like there is a big body of work to do, which is fantastic, but have we not done that before?

Ms Fitzharris: I cannot really comment on what has happened previously. This has a long history; some people in this room have a much longer history with it than me. Some of the figures we see on occupancy at Canberra and Calvary hospitals suggest

that we have capacity in our public health system. That is not always like for like, so it is not quite as simple as that. There are obviously historic issues around ownership of Calvary.

Planning is now underway, and the building health services program, which Michael and Liz can speak to, is a role for the Health Directorate, as the steward of the whole system, as distinct from the role of Canberra Health Services in delivering public health services through Canberra Hospital and the other locations.

Ms De'Ath: It really is important to note that, particularly in the context of the territory as a rapidly growing jurisdiction, these things are evolving and changing in line with that. Probably some 12 months ago now I led a fairly intensive series of 10 meetings to re-examine some of our assumptions, our data, the demographic and so on and where we were heading with this. That was the building health services steering committee.

We had a number of important players at the table—Calvary, what became CHS and so on. Out of that there evolved directions which influenced SPIRE and our thinking about the north side scoping study and so on. I will ask Liz Lopa to talk about that a little bit more, but I wanted to set that context that we are constantly examining these things and looking for the right service mixes.

Ms Lopa: I have read and acknowledge the statement. We are working with Calvary very closely on what the expansion of Calvary and the north side hospital will look like, not just from an infrastructure point of view, as in what it will actually look like, but what services need to be looked at for Calvary from a territory-wide approach. I am working very closely with my colleagues in the Health Directorate around service planning and what services need to go in, and the infrastructure naturally follows that, rather than leading the charge with constructing a building and then working out what we are going to put into it.

We have bedded down the scope of SPIRE and we know it is going to be at the Canberra Hospital. That naturally leads to a conversation with Calvary around what it will look like going forward, what services it will offer on its campus and what infrastructure will need to follow. I met with Mr Dykgraaf this week to have some conversations about that exact topic, and I am off to have a bit of a walk around the Calvary site with him in the next couple of weeks.

MRS JONES: Is that the start of the scoping study?

Ms Lopa: The scoping study started with the work and the committee that was chaired by Michael last year. That was before my time at the Health Directorate. That scoped out what services should be offered across the territory. Now that we have done all the scoping work that needs to happen with SPIRE, I think we need to really concentrate on and ramp up that work with Calvary and have those detailed conversations with them, following that work.

MRS JONES: Am I understanding correctly that this idea of the north side hospital is about what is available on the north side or is it about changing the old Calvary public into something bigger, or am I missing something here?

MRS DUNNE: Just to augment Mrs Jones's question, at one stage there was to be a north side scoping study, which actively left open the question whether Calvary would be the public hospital. Have we actually decided that Calvary will be the site of the expanded north side hospital services?

Ms Fitzharris: Certainly it is the case, in my view, that Calvary is well located. It is a public hospital. In looking at the role of Canberra Hospital, the role of University of Canberra Hospital, the role of Calvary, we should invest in the expansion of Calvary. But the process needs to take place to provide—

MRS DUNNE: The expansion will happen on the Calvary campus, not somewhere else?

Ms Fitzharris: Yes, that is my expectation.

MRS JONES: That will be referred to, perhaps, as the north side hospital?

Ms Fitzharris: I think north side scoping was part of broader work around, as Michael said, what services we need across the territory, where they are best located, the right role delineation between Canberra Hospital and Calvary hospital. Part of that was also in anticipation of UC Hospital opening, because that adds another level of—

MRS JONES: A lower acuity?

Ms Fitzharris: Yes, a lower acuity, and also what we are doing in our community health centres and what might be a very specialised centre; for example, QEII and Clare Holland House. This idea of territory-wide planning has to be driven by the Health Directorate to understand what is available. In addition, in the process of all of this happening as well, we knew that Calvary were building their own private hospital.

MRS JONES: There is space in the building as well that they have vacated that could be possibly better used?

MRS DUNNE: In their own building?

Ms Fitzharris: In the existing building, yes.

MRS JONES: Is there a cost that has been put on this project, for the scoping study?

Ms Fitzharris: There is an allocation for the scoping study, yes.

MRS JONES: And how much?

Ms Lopa: I believe it is $2.5 million.

MRS JONES: Do you want to confirm that on notice?

Ms Lopa: We can.

MRS JONES: Will larger projects in Canberra—or we do not know yet—be involved in the delivery of whatever is decided to be done? Is that the idea? You are not sure?

Ms Fitzharris: In theory, yes.

MRS JONES: Are we expecting there to be additional beds at Calvary public on the north side to accommodate extra patients once the additional theatres go into service?

Ms Fitzharris: Yes, I believe so. We will take that on notice and give you the specific numbers.

MRS JONES: What work is the ACT government doing with the Little Company of Mary to upgrade or replace the 61 per cent of infrastructure at Calvary public that is nearing the end of its life or needing rejuvenation?

Ms Fitzharris: The document you are referring to was a document, as I understand, for that building health services committee to inform exactly that discussion. It demonstrates the level of planning and strategic thinking that is going on.

MRS JONES: What is the recruitment retention strategy for specialists? Secondly, have urology services at Calvary hospital been included, in an attempt to make sure that we maintain our specialists?

Ms Fitzharris: Sorry, is that a broader question around—

MRS JONES: No.

MRS DUNNE: You are expanding urology at Calvary. Do you have the staff to expand the services at Calvary?

Ms Fitzharris: Yes, and Calvary are working on that. We have been in discussion with them for some time about that.

MRS JONES: Is there any particular work going on to maintain other specialist services and expand our specialist offering at the Calvary campus?

Ms Fitzharris: I might ask our Chief Medical Officer to more broadly talk about the medical workforce across the territory.

Dr Arya: I acknowledge the privilege statement. I think medical and specialist workforce planning has to occur at the same time as the infrastructure and facility planning work. I think your point about recruitment and retention is quite valid. As we progress the service development work we will also progress the workforce planning work.

Mr De'Ath: I might add, if I can, that, again, an important part of the role of the ACT Health Directorate and the office for professional education and leadership, which Dr Arya is the Chief Medical Officer of, is about doing exactly that thinking around workforce and making sure we have a clear direction ahead of time, getting ahead of the game. These are very, very dedicated functions of the system, as opposed

to getting embedded into the operational space, for which Ms McDonald has her own staff working in that context, as does Mark Dykgraaf. It is very important, I think, to understand that this is an important part of these roles.

MR PETTERSSON: With the announcement of Canberra's fifth walk-in centre at Dickson, I was hoping you could tell me a little more about how walk-in centres are performing and how they work in the wider public health services.

Ms McDonald: While Cathie joins us, I might make some introductory comments about that. Walk-in centres are performing extremely well. The numbers continue to grow. Cathie can talk to the types of services that we are providing and what people are seeking when they are coming to our walk-in centres. We certainly have had increases in numbers. I might let Cathie O'Neill answer that question.

Ms O'Neill: I have read and acknowledge the privilege statement. Could you repeat the question?

MR PETTERSSON: How are walk-in centres performing and how do they work in the wider community?

Ms O'Neill: The walk-in centres are performing extremely well. We have just had our two busiest weeks on record. Across the three sites we have seen over 1,400 patients each week over the last two weeks. They are proving to be extremely popular with consumers.

Even though we have significantly increased throughput, we are managing to maintain relatively good average wait times of less than 30 minutes and we are managing to treat almost all the patients that present to the walk-in centres entirely at the walk-in centres, with fairly low and consistent need to redirect. They redirect only a few patients to emergency departments. We are constantly reviewing the scope and the number of protocols that can be implemented through the walk-in centres so that we can continue to try to take some pressure off emergency department and outpatient presentations.

MR PETTERSSON: At what time are the majority of patients presenting at walk-in centres?

Ms O'Neill: It is relatively evenly spread across all days and all hours. We are starting to see some trends at the individual centres. For example, Tuggeranong seems to be busier than the other two centres at certain times of the week. Gungahlin is seeing more young people than the other two centres. But the numbers are not significant enough in those trends for us to start looking at altering our staffing, for example.

MR PETTERSSON: What services will be offered at the new inner north walk-in centre?

Ms O'Neill: It will be the same as the services offered at the other, by then, four walk-in centres. It will be for the one-off treatment of minor injuries and illnesses. It is interesting that we use the term "minor". That is from our perspective. We need to

do some further work with the communities because "minor" is pretty subjective. What they can treat in the walk-in centres is actually quite comprehensive. They can deal with cuts, fractures, suturing and complex dressings. There is quite an extensive range of protocols.

MR PETTERSSON: You mentioned that walk-in centres are increasingly popular. Is there any work being undertaken to plan for the future expansion of walk-in centres?

Ms O'Neill: Not beyond the five at this point in time. We are fairly busy just getting those five up and running. Obviously, we are keeping a pretty close watch on the trends for those centres. We will continue to see what we need into the future, beyond the fifth one opening.

MR PETTERSSON: I am not talking about the new walk-in centres. Of the existing centres, is there any talk of needing to expand existing services?

Ms O'Neill: We have been piloting some additional programs in the walk-in centres. For example, at Belconnen, we have been running an advanced practice physio. That has been running for six months and it has proven to be very effective in providing some supplementary specialised treatment for musculoskeletal injuries. The flow-on effect of that has been the ability to upskill the nursing staff working in those centres to be able to also treat those.

We have done a trial with sexual health, running some after-hours drop-in services. They were quite successful. We are in the planning stages of how we can start to expand the scope of the walk-in centres. We have deliberately made the decision for Weston Creek, for example, to integrate the walk-in centre with the broader community health centre there, to give us more flexibility to expand if we need to so that we can access additional rooms after hours, for example.

MR PETTERSSON: Excellent.

MS CODY: How is the Weston Creek walk-in centre coming along?

Ms O'Neill: It is coming along very well. We have endorsed the preliminary sketch plans, so we have the broad outline of what will go in there and how that is all going to work. Demolition has started on the site, ready for refurbishment. It is on track for the walk-in centre to be completed by November, ready for operations in December.

MRS JONES: Where exactly is that site?

Ms O'Neill: It is adjacent to Cooleman Court. There was an existing health facility there, so we are undergoing a refurbishment of that site.

MRS JONES: Is it the brown building next to the community centre?

Ms O'Neill: Yes.

MRS JONES: There is work going on to repurpose the inside, but there will not be building works outside?

Ms O'Neill: Correct; other than some parking modifications to make it a bit easier.

MRS DUNNE: Staying with the infrastructure issues, could I go to the Centenary hospital upgrade, please? Could somebody run me through the figures? Two years ago, in the 2017-18 budget, there was $68 million over three years for that project. This year it is $40.55 million over two years, with completion in 2020-21. Firstly, with the completion date, from my recollection—and I am open to correction—we were told last year that it would be completed in 2019-20, but it is now 2020-21. Is that correct?

Ms Fitzharris: It has been 2020-21 for some time, but a very small element has already been delivered. It will be delivered progressively over that time for final completion.

MRS DUNNE: Could somebody talk me through the apparent diminution of funding?

Ms Fitzharris: Yes, certainly. There are a couple of elements related to that. One is the location of the paediatric intensive care unit, which, after work with the clinical staff, will move from the Centenary hospital into the SPIRE build. Another element was in terms of where and how the various elements of the project could be delivered on the campus. I think it is important to note that the scope of the work has not changed; what has changed is where it might be delivered and under which project.

MRS DUNNE: In fact, the paediatric intensive care—

Ms Fitzharris: Is now included in SPIRE.

MRS DUNNE: beds will not be delivered until 2023-24?

Ms Fitzharris: That is right, yes.

MRS DUNNE: So the initial project, in that sense, has blown out.

Ms Fitzharris: I would not say that. In terms of the model of care—

MRS DUNNE: The timing has blown out.

Ms Fitzharris: there was a lot of work.

MRS DUNNE: The timing has—

Ms Fitzharris: The timing now will be different, but there will be increases in neonatology, which will be in the time frames of the Centenary hospital as well.

MRS DUNNE: With the adolescent mental health beds unit, which was promised in the budget before last, when will that be delivered?

Ms Fitzharris: That is within the scope of the Centenary hospital. That is part of the—

MRS DUNNE: You said, minister, that some of those things have been delivered. What has been delivered?

Ms Fitzharris: The custodial birthing suite is the one that has been delivered.

MRS DUNNE: Is that the only element of the project that has been delivered?

Ms Fitzharris: Yes. Is your question specifically when will the adolescent mental health unit open?

MRS DUNNE: Yes.

Ms Fitzharris: In terms of the detailed project plan for that, we might take that on notice.

MRS DUNNE: I am happy for you to take that on notice. We have had some problems in the past with building quality in the Centenary hospital. What quality control measures will be in place for this project?

Ms Lopa: At the moment we have been through the proof-of-concept design for the elements of the Centenary hospital. We are moving into preliminary sketch planning. We are making sure that we get our design right; then we will go out to a building contractor. As with any project, we are mindful of the quality of the works that get done. We will be making sure that they go through the proper certifying process et cetera. I know Mr Mooney and his infrastructure team at Canberra Hospital will be making sure that the works are fit for purpose. We will go through a very rigorous process in the commissioning phase to make sure that all of the works are of a high quality and fit for purpose for the services that will be delivered in them.

MRS DUNNE: What procedures will be in place to ensure that the things are fit for purpose? Mr Mooney may want to come to the table so that he is not up and down all the time.

Mr Mooney: Good morning again. I acknowledge the witness statement. I did not do that earlier on. I omitted it last time. In answer to your question as to what steps are being taken to address or mitigate quality issues in both the women's and children's build, but indeed any build, it is not just one step. It is a number of steps. As Liz Lopa alluded to earlier on, the engagement of facilities management is a key element of this from the outset of the job.

How we facilitate that is through a number of specifications. We have generated, as part of the infrastructure and health support services group, facility management specifications for all aspects of building services at the Canberra Hospital and, indeed, across our portfolio. We also have mandated, in conjunction with infrastructure, finance and capital works, the role of an independent commissioning agent, which essentially works to assist the project manager.

MRS DUNNE: A sort of building inspector?

Mr Mooney: Not necessarily. The independent commissioning agent is a role that we

started on UCH. UCH is a good model from the point of view of the build in terms of design, construct and maintain. We got maintenance involved very early in the design. That is what we have replicated with our FM specifications.

MRS DUNNE: FM?

Mr Mooney: FM—facility management specifications. It is the role of the independent commissioning agent. We also have what we have titled an FM engagement document, which is a document that is written into our contracts. That is an obligation on the part of the successful contractor to engage with the facility management people through critical milestones of the project: approving the sketch plan, final sketch plan and documentation readiness. At all these points, we make sure that the contractor has fulfilled their obligations. Then we, as the facility managers once the building is handed over, are in the best position to actually maintain the building. They are the steps that we are taking.

MRS DUNNE: While you are here, Mr Mooney, and while we are talking about the Centenary hospital, I ask about the $2.5 million-ish refurb of the birthing suites after the water leaks. Is that now complete?

Mr Mooney: There are a couple of elements to that. The original issue with the birthing suites—

MRS JONES: The drainage.

Mr Mooney: The drainage, the spindle—I will not go into the spindle again.

MRS DUNNE: No.

Ms Fitzharris: You have photos?

Mr Mooney: I will not go into the spindle again.

MRS DUNNE: I can visualise it.

Mr Mooney: You can visualise it now. That work will be completed by November of this year. It takes time to do it. It is an ongoing process. But by November of this year all of the original birthing suites will be remediated.

MRS JONES: They are s sort of temporarily offline.

Mr Mooney: In conjunction with clinical services, we take them out. We do the work and then do the certification of the work after the construction is completed, and then hand them back over. But this is all done in conjunction with the clinical services area. We have some additional funding basically to do a full check on all of the bathrooms in women's and children's. That is also a body of work that is about to commence to essentially inform what the next steps will be if we do need to remediate them. It is a two-step process. We do not know how big or how small the issue is, but obviously our experience from the birthing suites was that it was—

MRS DUNNE: It was that it was big. It was big there.

Mr Mooney: It had to be rectified, for sure.

MRS DUNNE: Yes. Have we resolved the issue about whether it is a building warranty issue or is the territory copping that?

Mr Mooney: In terms of the birthing suites, we are dealing through GSO with—

MRS DUNNE: Still?

Mr Mooney: Still, but we are progressing on that front okay. But it is a process that we are going through.

MRS DUNNE: It has been a process we have been going through for a year.

Mr Mooney: It takes time, unfortunately. There has been a lot of research done and practical documentation to inform the territory's position so that we are in the best place to prosecute our case.

THE CHAIR: I turn to Clare Holland House. What progress is the government making on implementing the recommendations of the end of life committee relating to palliative care?

Ms Fitzharris: In terms of the recommendations from the committee, that government response is due very soon. That has not yet gone through the formal processes. I do not want to pre-empt the government's response to the committee's report per se because there is quite a lot in there. But we can certainly talk about a range of issues around palliative care and Clare Holland House. Do you have a specific question about Clare Holland House?

THE CHAIR: What progress are you making to improve services there?

Ms Fitzharris: We have funding which is combined funding from the commonwealth government and the Snow Foundation for a fairly significant expansion and upgrade of Clare Holland House. That work is underway. It is reflected in the budget papers this year. There is a lot of work in terms of territory-wide service planning about palliative care needs. That includes, obviously, funding the staff who will work in the expanded Clare Holland House in the future. But there has been extensive work done on the palliative care plan. Cathie might be able to speak with you about that.

MRS DUNNE: I have a technical question. The commonwealth government-Snow Foundation money appears in the budget as a capital initiative. I know that you have to put it through the books, but why was it listed as a capital initiative when there is no ACT capital associated with it?

Ms Fitzharris: We own the building. That is probably a technical question. We will take it on notice and get treasury to assist us with that answer, based on their advice.

MRS DUNNE: That would be useful. Everyone knows that it is not our capital

money, but it comes in as a capital initiative, so an explanation would be useful.

Ms O'Neill: I can talk about services. Are there specific questions you have?

MRS JONES: Are there some changes that are underway at present?

Ms O'Neill: There are. We have been working on a territory-wide palliative care project now for 12 months. We are aiming to bring together all of the palliative care providers across the ACT to provide a much more seamless service to patients at their end of life. I am pleased to announce that we have made some significant progress on that in the last couple of months.

We have now implemented a governance structure that brings together Clare Holland House, Calvary, ACT Palliative Care, Capital Health Network and us at Canberra Health Services. We have a tiered structure that is looking at the broader governance issues, but also weekly huddles have commenced now between Clare Holland House and Canberra Health Services specialist palliative care to make sure that we are actually—

MRS JONES: They are the ones who visit people in their homes?

Ms O'Neill: Clare Holland provides both inpatient and also home-based palliative care. At Canberra Hospital we provide an acute palliative care service.

MRS JONES: On the hospital campus?

Ms O'Neill: In the hospital.

MRS JONES: Are the people who visit at home associated with Clare Holland House?

Ms O'Neill: Correct, yes. But in respect of the medical staff, there is quite a lot of integration, and the same with the nursing staff. We are really trying to take that to that next level now, where patients have a seamless service so that it does not matter where they present in the system; we can make sure they are getting the best services.

MRS JONES: That is a good idea. It is incredible, actually. Clare Holland House would have to be the part of the health system that is uniformly praised.

Ms O'Neill: Yes.

MRS DUNNE: I want to move to the nurses who go into the aged-care facilities. Are they called the GRACE nurses?

Ms Fitzharris: Residential aged care, yes.

MRS DUNNE: Has that been expanded? It was a trial, a pilot; then there was some expansion. Could you talk us through that?

Ms O'Neill: I can talk a bit about the Inspired program, which is the inreach program

specifically for palliative care.

MRS DUNNE: So the GRACE nurses are slightly different?

Ms Fitzharris: Slightly separate. Inspired is palliative care, which has been expanded in this budget, whereas GRACE was expanded in the last budget.

Ms O'Neill: You may have seen some of the media where we got national acclaim for the Inspired program, with Nikki Johnston being awarded an OAM. We are very excited about being able to roll out that program right across residential aged-care facilities in the ACT. It has made a significant impact through being able to keep those people in their own home, the residential facility, and reduce the need for them to access acute hospital services.

MS CODY: This is only directed at residential aged care?

Ms O'Neill: The Inspired program is, yes.

Ms Fitzharris: There is another significant research component to palliative care. For example, the annual CHARM research symposium this year is focused on end of life care. The research component to this is important to a lot of the staff working in this area. There has been a lot of work done, and the CHARM symposium later this year will add to that.

MRS DUNNE: What is CHARM?

Ms O'Neill: The Canberra Health Annual Research Meeting. We have been able to attract some national speakers to that conference on the back of the significant research that is occurring here in the ACT.

MRS JONES: An area there is a great deal of interest in is how we can not only have conversations about other end of life matters but also improve our palliative care as we go ahead.

Mr De'Ath: Associate Professor Shadbolt can talk on CHARM in detail.

MRS JONES: Please tell us about CHARM.

Prof Shadbolt: I have read the witness statement, and I acknowledge it and accept it. CHARM has been going for 25 years in the ACT. It is our showcasing of the research that is going on across the ACT and surrounding region. This particular year we are looking at a theme around end of life. Last year we looked at cardiovascular health. This year we are looking at end of life care because it is such an important area.

We have talked to our academic partners; we have talked to our health services; we have looked across our primary healthcare partners et cetera. We see that end of life care is really important and is something that the ACT can do some really great research into and also bring that translation into improving the experience of people who are at the end of their life or in palliative care. CHARM brings those together and lets people showcase research that has been going on in the ACT. In this case we are

focusing on end of life care.

MRS JONES: Is there a process for referring to what is presented and then using that in planning for our system here?

Prof Shadbolt: Exactly, yes.

MRS JONES: There are processes for that to occur?

Prof Shadbolt: Yes. We have an end of life care research plan that we have developed with our academic partners and with health care and consumers. We are looking at co-design types of models. You might have seen in the newspapers recently that we had a nurse who won an international award for looking at how we can bring the patient's voice into that research model so that people can die better with dignity and so forth. It is really exciting work.

MRS DUNNE: What is the timetable? When is CHARM?

Prof Shadbolt: The workshops are on 30 July. The first day is 31 July; that is the end of life care day. On 1 August we showcase the individual posters and abstract submissions that have been put in for the ACT. We are actually having a drive-by with the ABC; there will be a panel discussion on end of life care.

MRS JONES: Can you tell us what you mean by drive-by?

Ms Fitzharris: It is with Genevieve Jacobs.

MRS JONES: Is that conference a closed one?

Prof Shadbolt: No, it is very much open. We encourage everybody. It is going to be on stream, so you can pick it up.

MRS JONES: Would you like to provide the committee with the details of that so that we can include it in the report?

Prof Shadbolt: Very much, yes.

MRS JONES: Thank you.

MS CODY: You said last year's CHARM was cardiovascular?

Prof Shadbolt: Yes; that is correct.

MS CODY: What were some of the outcomes from that—just so that we can look at what might come out of this next CHARM?

Prof Shadbolt: We have opened an electrophysiology care program here, an intervention program. That was part of that. One of the main presenters, Professor Pathak, who came across from South Australia, did his major work over in the US in terms of his PhD work. He is now able to demonstrate that you can actually reverse

things such as AF if you look at lifestyle issues, if you look at being able to have some ablation work done. It is pretty exciting.

MS CODY: I know all about that stuff; that is why I was asking you about it.

Prof Shadbolt: It changes people's lives dramatically.

MS CODY: It does. My father is walking around today due to all of the good care that was given to him through those services. With the announcement of new elective surgery beds at Calvary hospital, how does that interact with elective surgery beds at Canberra Hospital and wait times? Is this the right area to ask that in?

Ms Fitzharris: I think we have gone across all areas.

MRS JONES: It is pretty broad ranging.

MS CODY: Yes.

Ms Fitzharris: The point I would like to make in terms of surgery that is happening across the public health system is that elective surgery is a significant activity. However, almost as significant is the number of emergency surgeries, and if you look at—

MS CODY: Yes. I was going to ask about that as well.

Ms Fitzharris: Again the territory-wide work looked at where the best mix of surgery is delivered. There will need to be a mix at both hospitals. Certainly, we see significantly less volume of emergency surgery at Calvary, so they are then better placed to deliver more elective surgery. That is some of the broader territory-wide work we are doing. Some of that is reflected in the opening of theatres at Calvary. Bernadette can speak more about that.

Ms McDonald: Canberra Health Services has territory-wide surgical services which work across the system, with Calvary, with CHS and with private providers, to delivery our elective surgery targets—our elective surgery numbers that we sign up to each year. We work very collaboratively with Calvary in terms of what capacity they have, what capacity we have and what are some of the elective surgeries that could be delivered at Calvary in a more timely way, given that our numbers of emergency surgery patients keep increasing, and have done year on year in the past couple of years. A lot of our surgery at the Canberra Hospital site is emergency surgery, as well as elective. The balance has shifted more to emergency.

It is vitally important that we do work collaboratively and that our territory-wide surgical services do plan, to maximise the use of our capacity for elective surgery across both Calvary and Canberra Health Services, as well as with private providers. Some of that involves us looking at where surgeons work, who is employed where, and how we can actually do that across both sites. I might let Daniel Wood, who is our executive director for surgery, add some more detail.

Mr Wood: I acknowledge the privilege statement. My area of responsibility is

delivering elective surgery and emergency surgery to Canberra Hospital. I also sit on the territory-wide services management committee, which has representation from the Health Directorate and Calvary Public Hospital Bruce.

Probably over the last 12 months we have been undertaking a transition of low-acuity surgery to Calvary Public Hospital Bruce. That is in addition to the private provider program which has been in existence for about the last four or five years. That primarily started with the elective joint replacement program at Calvary John James Hospital, but now it has expanded to include other service providers within the territory. We look at appropriate surgery that can be done in another environment—not only the physical surgery but the post-operative care and management of the patient so that the patient has the best experience.

We find that a lot of the more complex surgery remains at Canberra Hospital because of the services that are offered over the whole patient journey at Canberra Hospital. For elective and emergency surgery, without having the figures in my hand, anecdotally, there is about a 50-50 split regarding what we do with emergency and elective surgery activity every year.

MS CODY: At the Canberra Hospital?

Mr Wood: At Canberra Hospital. The emergency surgery demand is going up. When you look at cases, sometimes it is not reflective of actual activity. You could look at elective surgery cases, but the cases that we do at Canberra Hospital are more complex and a lot of them take a longer period of time to complete safely.

MS CODY: As you have just pointed out, it is about making sure that the balance is right so that you are delivering on all of them. What can be done to minimise the inconvenience when elective surgery is cancelled at short notice?

Mr Wood: Elective surgery at Canberra Hospital is planned. There is ongoing planning. We are always looking at things that can impact on our ability to deliver. It is my understanding that we have exceeded the target for elective surgery at Canberra Hospital this year. That does not take away from the fact that sometimes elective cases are postponed. They can be hospital-initiated postponements and they can be postponements that are initiated by the consumer.

Planning is done by a very dedicated group of staff. In the surgical bookings office we have four dedicated elective surgery liaison nurses that liaise with the patients, the clinicians and the anaesthetists. But when we postpone any surgery, we are looking at patient safety first and foremost, and at our ability not only to provide the surgery but also to provide a safe postoperative environment. Whilst it is regrettable that at times we do have to postpone some surgeries, it is always taken with a multidisciplinary approach, with patient safety foremost in our minds.

MS CODY: Are there opportunities to, where appropriate, maybe move people from Canberra Hospital? I do not mean when they are in the middle of surgery, but for some people that have elective surgery booked at Canberra Hospital, it might be more convenient to go to Calvary hospital. Do we look at those sorts of—

Mr Wood: That is the planning work that the territory-wide surgical services team do. They liaise with specific clinical groups, and with me, as the executive director of surgery, to identify appropriate groups to move to Calvary. We also look at specific patients. For example, if there was a patient that was predetermined to go to Calvary John James for the elective joint program but who clinically required the services that can only be provided at Canberra Hospital, that patient would then be transferred over to the elective surgery waitlist at Canberra Hospital, and the procedure would be done there.

MRS DUNNE: Could I follow up on elective surgery? Budget statements C talks about the targets for people waiting longer than clinically recommended. The target is 430 but the estimated outcome is 571. What strategies are in place this year to try to reach that target, and is that target satisfactory? Could I start with the last question first and perhaps direct that to the minister: is it satisfactory that we would have as our target close to 10 per cent of people on the waiting list waiting for longer?

Ms Fitzharris: Certainly, my preference would be that people are not waiting longer. I think we need to give priority to the most urgent patients, and that is what does occur. Investment in theatre capacity at Calvary will assist us with that. We have seen an increase in the overall numbers of elective surgery; another 250 will be delivered next financial year. We really are breaking records in terms of the numbers for elective surgery.

MRS DUNNE: But we are not making inroads into that target?

Ms Fitzharris: In terms of percentages, as the numbers requiring elected surgery go up, and that number is a raw number as opposed to a percentage. We have had discussions about the representation of that. One of the things that have surprised me is the number of emergency surgeries, with significantly more emergency surgery delivered at Canberra Hospital than at Calvary. Bernadette will look at what is happening—why we are seeing so much emergency surgery and those numbers going up. That is why we are investing in more theatres at Calvary and in the future at SPIRE as well.

We will do everything we can to bring that number down to the target. The question, in setting budget indicators, is: do you move your target or do you keep your target and do everything you can to achieve that? That is the approach we have taken this year.

MRS DUNNE: That target, in percentage terms, is about eight per cent of the waiting list.

Ms Fitzharris: In terms of the prioritisation of that, and in terms of the percentage of people that are over bounds on that as well, that is something we are doing more work on. I can ask the clinical staff to give you an indication of how the overall program is managed.

MRS DUNNE: I think we have got an idea about how the program is managed, and I take the point about addressing acuity, but how do you monitor people who are there for longer than clinically desirable, to see whether their acuity is changing, and how

do you address that?

Ms McDonald: To be really clear, the numbers of patients on our waitlists are also increasing for our more complex ones, the category 1s and category 2s. Automatically those surgeries are more complex and they take a longer time. So it is not just numbers; it is the time they take on a theatre list to get though. That then reduces your capacity even further, which means that it is harder to get through the higher volumes in a quicker time. It is important to us that we are in contact with anybody who is on our waiting list and that we monitor whether they are okay. We always ask patients if they have any change in symptoms to go back to their GP and to come back to us—to either present to the emergency department or see their GP and get another referral so that they will be reassessed in terms of urgency. We have liaison nurses that work closely with our patients on the waiting list. Daniel might want to elaborate a bit on that.

Mr Wood: The elective surgery liaison nurses manage and monitor not only the filling of the theatre list but also the management of the waiting list at Canberra Hospital. There is an elective surgery liaison nurse at Calvary public as well. We have a central area where the central waitlist is managed for both Canberra and Calvary hospital, territory wide. The elective surgery liaison nurses are quite intimately knowledgeable about who is on their waiting list and the number of over-boundary patients in every category that we have.

MRS DUNNE: What is that term, over-boundary?

Mr Wood: Previously you may have heard it referred to as long-waiting patients. They are patients that are sitting outside the clinically preferred time frame. They manage and monitor those patients. Part of the territory-wide surgical services plan is to move clinically appropriate long-waiting patients so that they can have their surgery in another appropriate environment. A lot of that work has started with the elected joint replacement program. They took the long-waiting joint replacement patients and completed them in Calvary John James. We are now expanding that for other service specialties so that we can address the long-waiting patients that way.

MRS DUNNE: Other service specialties—such as?

Mr Wood: Such as urology, ophthalmology, gynaecology, and vascular.

MRS DUNNE: And that is at Calvary?

Mr Wood: Yes.

MRS DUNNE: The private outsourcing for the joint replacement that goes to Calvary John James—how is the tender for that managed so that we are sure we are getting value for money for this? It is a single select tender really. So how do we monitor the appropriateness and the management of that to address whether we are getting value for money? Where else are we outsourcing privately, presumably to Nat Cap?

Mr Wood: This is not my area of expertise, tender management. It is managed through the territory-wide surgical services team that sits under the Health Directorate.

The management of the private provider program is managed by the Health Directorate through the territory-wide surgical services team.

MRS DUNNE: Is there someone who can answer that question?

Mr Fletcher: I know a bit about that contract. That contract is currently the subject of some action from within the directorate. The corporate and governance division that I run has a strategic procurement team, a very small one, that at the moment are assisting territory-wide surgical services with a tender that they are developing to go out more broadly for the contract that the gentleman is referring to. My memory is that it is an open tender process. They have made an assessment that there are a number of providers who can provide that service, so it would be open to the usual procurement act arrangements and guidelines. The process will run like any other tender. The relevant people will have an opportunity to review tender responses, and a panel will make a decision and a recommendation about how the contracts are let and the services are managed.

MRS DUNNE: Is that the orthopaedic, the joint replacement tender, or are there others?

Mr Fletcher: That is the joint replacement tender, but if there are others they will be managed in the same way.

MRS DUNNE: When Calvary John James acquired that contract, and that was a number of years ago—definitely before the last election—was that an open tender, or was it a single select tender?

Mr Fletcher: My memory of the history of that contract is that at the time it was let it was a single select. That contract has been rolled on, but the market has changed and so there is an opportunity to contract for a better volume of services and also to introduce some competition into the process. So you are quite correct that it was a single select process at the start, but the next iteration of that tender is intended to be an open tender process.

MRS DUNNE: And it would be a higher volume.

Mr Fletcher: I do not know that there would be any particular restrictions. I think the intention is to appoint, potentially, a number of providers, so it will be a matter for the territory-wide surgical services team to manage that volume of surgeries. Certainly there is an opportunity to make sure that there is a maximum level of flexibility and an opportunity to meet the program.

MRS DUNNE: This is probably something to take on notice. For the joint replacement tender, what is the average cost per weighted separation or whatever we call it these days?

Ms McDonald: NWAU.

MRS DUNNE: Thank you. I have been doing this too long. You keep changing the names of things and I cannot keep up. What is the average cost of that, and how does

it compare to the national efficient pricing?

Ms McDonald: We will take the question on notice.

MS LE COUTEUR: Are there any plans to establish a neuromuscular clinic in the ACT? We have had a number of constituent representations about this. I understand that Capital Region Muscular Dystrophy has been having some discussions on this issue with your office and the directorate.

Ms McDonald: I think we will have to take that on notice, to be honest—unless there is a particular—

Ms Fitzharris: There is a particular program that we have supported recently. Is there someone here who can speak about that?

Mr Kaye: I acknowledge the privilege statement. In short, we are meeting with representatives from the neuromuscular advocacy group to see how we can establish services for this particular patient group within the ACT.

MS LE COUTEUR: So no decisions have been made as yet?

Mr Kaye: No firm decisions; no, nothing definite just yet.

MS LE COUTEUR: Would it be possible that it would be part of the rehab hospital? Given that it is you who came to the table, it would indicate that.

Mr Kaye: Quite possible, yes. It would be a collaborative approach because the neurologists that would potentially be involved in the clinic would come from the division of medicine. Quite possibly, those clinics could be run out of the University of Canberra Hospital.

MS LE COUTEUR: Would diagnostic services be part of that? Where would they live?

Mr Kaye: Can you define what diagnostic services you might be talking about?

MS LE COUTEUR: I am sorry. I am asking this on behalf of the constituents who have asked me. It is beyond my knowledge.

Mr Kaye: That is all right. At the University of Canberra Hospital we have radiology and video fluoroscopy available there. Any other diagnostic services outside of that would need to be delivered elsewhere.

MRS JONES: I turn to Canberra Health Services culture. What impact has the high level of bullying had on Canberra Health Services staff? What programs have you put in place to improve the mental health of staff?

Ms McDonald: Thank you for the question. In terms of the impact, I think the independent culture review that was published earlier this year has tried to measure and tried to articulate the impact of bullying and harassment at Canberra Health

Services—not just at Canberra Health Services but across the ACT health system; at Calvary and the ACT Health Directorate as well.

Since I started on 1 October last year, I have had lots and lots of conversations with staff and have encouraged my executive to have those conversations as well, to really understand where the issues are and what we can do about that. We have started work in that space. There is also the broader health system work and the overseeing committee. We also have an implementation steering committee to design what our strategy is to respond. In respect of Canberra Health Services in particular, I will invite Janine Hammat, my exec director of people and culture, to the table, because she has a lot of detail.

MRS JONES: Has something new been done?

Ms McDonald: Absolutely, yes. We have started restorative processes across the organisation in areas where we have identified absolute clusters of behaviour issues. We are working closely with specific areas across the organisation in that space. We have also started work on our vision, our role and our behaviours to get clarity and to get engagement of staff across the organisation about who Canberra Health Services is, how we want to behave, what the values of our organisation are and what the vision of the organisation is. That in and of itself has actually had a really positive effect to start bringing people together, to start people working more as a team and to be respectful of each other and to understand how we should be behaving with each other.

We have also employed—she is about to start on 1 July—an employee advocate, to provide another person who is outside of our current people and culture team for staff to go to if they have any concerns.

MRS JONES: Will that be like a secure line or email for people to contact her?

Ms McDonald: Yes, absolutely. That role reports directly to me.

MRS JONES: Good.

Ms McDonald: That role will not be giving me any confidential information. That role will be telling me where we have got issues and any key themes that are emerging so that we can take action and actually change practice.

MRS JONES: Yes. I am sure that, actually, some people would want you to know more about the detail and the people involved.

Ms McDonald: And a lot of those people have already come to see me.

MRS JONES: Good.

Ms McDonald: I have had lots and lots of people email me, lots of people come and meet with me. I have made it a priority to meet and listen. I have a lot of tissues used in my office by staff members who have had really poor experiences. I acknowledge that and I do apologise for what has happened in the past. We are actively working

with a lot of individuals across the organisation who have had ongoing issues to solve their problems and work with them—build their confidence back up to keep them as—

MRS JONES: Get some trust going.

Ms Hammat: Yes, build the trust back up in the organisation.

Ms Fitzharris: Recently CHS launched their vision, which might be really helpful for the committee to understand.

MRS JONES: Did you want to table a copy of that on notice for the committee?

Ms Fitzharris: Yes.

Ms McDonald: We can table a copy of that. Our vision is to provide exceptional health care together and our role is to become a health service that is trusted by our community. That vision and that role work together. That word "trusted" absolutely came through from the organisation. We had more than 5,000 conversations with our staff of 7,000 to get their input into what they thought our role and our vision should be. We are also undertaking workshops now with our staff about our values and behaviours. We have had more than 2,500 staff participate in those workshops.

MRS JONES: It would be interesting to go back in a period of time and survey the difference.

Ms McDonald: We have a culture survey planned for later this year.

MRS JONES: Yes. And then you can benchmark against it.

Ms McDonald: Absolutely.

MRS JONES: The problems I have personally seen have a lot to do with trust of middle and senior management, which is probably about the stress they are under, but nonetheless.

Ms McDonald: Absolutely. At all levels in the organisation we need to build the capability, especially in our managers and our middle managers and supervisors, in how they deal with conflict, how they respond when somebody brings a problem to them and those sorts of things.

Ms Hammat: We have also recently implemented an HR business partnership model in the organisation, so we have reasonably senior HR managers working in partnership with our senior managers to provide that assistance.

MRS JONES: So you get the clinical and the HR knowledge together?

Ms Hammat: Yes, that is right. We have only just implemented that. There are a lot of other initiatives we are working on and have worked on, including being able to go into certain areas and do specific cultural diagnostics and working out what sorts of

interventions we might need for those areas. As Bernadette said, we have had some specific restorative processes in place. We have come up with a fairly detailed guideline for consultation for managers, so we consult appropriately with our unions and employees on any changes we are going to implement.

MRS JONES: Is that consultation process a document that can come on notice to the committee to have a look at?

Ms Hammat: Absolutely; not a problem. We are also planning a raft of other strategies. They will be aligned with the strategic planning process of the organisation. It comes very quickly after the finalisation of the vision, role and values. We have done the vision and role; we are now doing the values and behaviours and we will align our strategic priorities from a people and culture perspective to those things. We will also be ensuring that all of those strategies align with the recommendations of the independent review.

Ms Fitzharris: On your comment around providing the appropriate support and capability development particularly of clinical staff moving into management roles, that was broadly discussed at the summit we held last year with the universities, Canberra Health Services, Calvary and ACT Health. The work that came out of that recognised this as an issue where we have a very aligned interest with the University of Canberra, which trains nursing and allied health staff, and with the ANU, which trains the medical workforce. They have a strong interest in the leadership of the professions, and they are fundamental to our city in educating. Many of them have ongoing roles in the health service as well as in the university in training and educating and providing professional development to junior staff.

There is a very strong interest in that from the partnership board, which was established out of the summit, and there is collaboration with ANU and UC, which both have some really good ideas in terms of developing expertise in this area from an academic and research perspective and making sure there is very good collaboration between research and practice for the staff between UC and ANU in particular.

MRS JONES: It is obviously not necessarily where you want to end up with every case of bullying, but has disciplinary action been taken against any staff or have any staff had to be moved or terminated? Has there been demonstrable change already?

Ms Fitzharris: I think so. The figures have been provided on multiple occasions through various questions on notice. But it is not appropriate to discuss individual employees.

MRS JONES: No-one is asking for names.

Ms Hammat: Sanctions are applied after misconduct investigations take place and they range from things like counselling and warnings right through to termination. There are some cases that result in termination. Some result in the resignation of the employee before termination, but we collect information on that.

MRS JONES: Can you demonstrate with those figures anything that has shifted since the review started?

Ms Hammat: I am actually just doing a piece of work on analysing those figures because we have really only been collecting them since we commenced as Canberra Health Services. I think there has been a decrease overall in preliminary assessments, but I need to go through those.

MRS JONES: So maybe that is more in the space of us to being able to recommend something if the analysis is not clear. But maybe you could take on notice if there is anything you can add.

Ms Hammat: Absolutely.

Ms Fitzharris: The oversight group for the culture review has met twice. The first meeting was constituted by the people that were recommended by the independent review. I felt there were a couple of organisations missing from that recommendation, so for the first oversight group meeting one of its first orders of business was to agree to expand the membership of that group. The fully constituted group met for the first time earlier this month.

MRS JONES: Is the representation on that body public?

Ms Fitzharris: Yes, absolutely. It is me, Minister Rattenbury, Michael De'Ath, Bernadette, Barbara Reid from Calvary, representatives from healthcare consumers, the ANMF, the CPSU, the AMA, the ASMOF, the VMOA, and the two deans of the University of Canberra and the ANU.

At the first meeting, one of the key issues we discussed—a communique has gone out from both meetings—was how we measure success. At our next meeting we will have a more detailed discussion on not only implementing the recommendations of the review—many are quite specific and some have a longer time frame than others—but being clear about how we measure success in improving the culture of the public health system. That is a specific piece of work we are doing, and that goes to your question. There are elements of that, like staff surveys, but how we measure success is something being discussed and that we are doing work on. We can probably assure you that that is very much a part of the system-wide approach.

MRS JONES: The benefit of that sort of change would be that if you can demonstrate it and it is being felt on the ground then there is some hope of genuine shift into the future.

Ms Fitzharris: Yes, and the report itself said that there was cautious optimism that they had felt was reflected to them by the people they spoke to. Our conversation is about how we measure that success and show that the cautious optimism turns into real optimism and real enthusiasm.

MRS DUNNE: I have a couple of questions that go in different directions. The first relates to the expansion of the oversight group. Who has been included in the expanded oversight group?

Ms Fitzharris: The additional members were the VMO association, the Visiting

Medical Officers Association, and ASMOF, the Australian Salaried Medical Officers Federation, and the two deans. One of the other items that we need to discuss is broader engagement, particularly with colleges. There has been a question about that.

MRS DUNNE: You are anticipating where I am going with that.

Ms Fitzharris: Yes. I think there is some work being done on how we do that, and we discussed that at the last oversight group meeting. How do you include all the medical colleges, nursing colleges and a representative from allied health? To have an oversight group that would include all those members would take your oversight group probably up to about 50. I think that is the work we are specifically looking at.

MRS DUNNE: I made representations on behalf of the College of Surgeons because they said, "We have been doing this." By everyone's admission, the College of Surgeons have made great inroads. How do we have the health system learn from our experience, which is a few years older than—

Ms Fitzharris: Yes, and you will know that on the independent panel was the former president of the College of Surgeons, who probably led the college in the time that they went through that. Yes, I am very aware of that and very aware of making sure there is equal representation across all the colleges who want to—

MRS JONES: Or also that they may be able to attend one meeting or something and present?

Ms Fitzharris: Yes. I recognise the work that the surgeons have done and that they have been very active in this space. I respect that immensely. Some of the recommendations in the review reflect some of the things that the college have been through themselves.

MRS DUNNE: Could I go back to the question about how you measure success. Ms McDonald mentioned the staff satisfaction survey.

Ms Fitzharris: The culture survey.

MRS DUNNE: We never see the results of that.

MRS JONES: Can that go in annual reports?

MRS DUNNE: How do we address the issue that the public, the Assembly, never see the culture survey? People who have sat in this position for the 18 years that I have been here have asked for this and we never see it.

Ms Fitzharris: I think it should be shared.

Ms McDonald: Yes, we are happy to share it. I am happy to meet with you, Mrs Dunne, and talk you through it as well, when we get it.

Ms Fitzharris: My understanding previously was that you needed to let those participating know. I know, for example, that there are a range of other staff surveys

that are shared across government. Particularly given the work that has been done, we should be measuring this and it should be transparent. Staff should be able to see the outcomes and other interested parties should be able to see it.

MRS JONES: It will help to change things?

Ms McDonald: Yes.

MRS DUNNE: The thing is that that might be able to be shared in the future, but what about the back casting and the comparison? You cannot measure progress if you are—

Ms McDonald: The provider that we have decided to use for the future survey is the same provider as we have used before. There will be some data that we can go back and compare because the surveys are basically the same surveys. Where possible, we will go back and do comparisons. Given that we have changed and split from the Health Directorate, we need to acknowledge that there are some differences in our circumstances. But, where possible, we will go back. The point of using a consistent provider is that you use the same survey and you can, over years, measure your changes in that.

MRS DUNNE: Can I say that I would be cautiously optimistic if that were to come about and I would really welcome the opportunity for that to become a much more publicly scrutinised document.

Ms McDonald: I agree. We can work with you in the design of the report that comes out of it, given that staff put their trust in being honest. And that is what we want. We want our response rates to be as high as possible. I think it is important for us to let staff know what would become public in terms of the design of the report.

Ms Hammat: There would also need to be a little consideration of the intellectual property of the company that does the survey, which would be easy enough to do.

Ms Fitzharris: Yes. You will see there was a preliminary survey done through the culture review itself as well—a quite narrow one—and that was made public.

Ms McDonald: Just one other point, a point of clarification: Calvary are separate. They use a different provider and, in terms of their results, there would have to be discussions with Calvary about their ability to publish those.

MRS JONES: Something worth discussing at this committee level is to end up with a situation, even if it takes a little time, where there is comparable data across both campuses.

Ms McDonald: Sure.

MR PETTERSSON: I was wondering if you could tell me what clinical research is scheduled for cancer over the coming years.

Ms Fitzharris: This could be a really long answer.

MS CODY: Do you want to answer it after the break?

Ms Fitzharris: That might be a good idea.

THE CHAIR: In that case, we will suspend now and reconvene at 2 pm.

Hearing suspended from 12.30 to 2.00 pm.

THE CHAIR: Welcome back. We will start with Mr Pettersson's question from just before lunch.

MR PETTERSSON: My question is about cancer services. Could someone please give me some information about what clinical research is being undertaken in regard to cancer in the coming years?

Prof Shadbolt: I can. The Centre for Health Medical Research within the ACT Health Directorate has been involved in recent times in a number of cancer projects. We have been leading the way. We have had ministerial interest in a program called the MoST trial, which is a molecular screening trial run out of Garvan and also with the National Health and Medical Research Council's clinical control centre in Sydney.

This is an amazing trial that we were able to get involved with. It is about rare cancers. Rare cancers make up about 50 per cent of cancers in total as a basket of cancers. The MoST trial is a basket trial, which means that you are able to bring in a whole range of different cancers and test a drug against them. We are able to do the screening for patients here in Canberra and identify a particular drug that may be of advantage to this person in terms of maybe being able to extend their life or, especially, extend the quality of their life.

It involves our oncologists here in Canberra being involved with a national expert network, which is extremely valuable. They are able to discuss cases and identify patients who may have some advantage from the screening. Their samples are sent down to Sydney and they are screened there, but their treatment is done here. That is the big difference. Before, they would have to go to Sydney, Melbourne or somewhere else, but we are now able to develop and deliver cancer treatment for people who have failed mainstream lines of therapy. They are able to get access to this particular trial, which is quite advantageous.

Because we were able to get in on the ground level, this trial also led us to having a seat at the Australian cancer genomics program and centre, so we are now part of a national network which is leading the way in terms of precision medicine around cancer.

There is palliative care research being led by Professor Chapman within the oncology area. We have heard a bit about that this morning, but you have probably read about it in the newspapers over the past six months or so. That is pretty amazing work. We are looking at cutting-edge ways of being able to improve how people die with dignity, how to improve their experiences and how to listen to them in terms of that dying

process.

There is a raft of clinical trials that we are involved with here in the ACT. We have the clinical trials committee that we have set up, and we have a very rigorous way of being able to assess the strategic benefit, the feasibility and the affordability of these trials. The vast majority of those are cancer trials.

With the JCSMR at the ANU, we have a targeted drug discovery program that we are jointly funding to some degree. That is using a platform technology as opposed to the basket technology that I talked about previously with MoST. The platform technology allows you to look at a particular single sample from a person and see whether there is a raft of different drugs that may lead to a response. That is being developed here with the John Curtin school and with ACT Health, with our oncology department. That is pretty exciting.

We are currently negotiating with the US to get some of their libraries so we are state of the art in terms of the libraries that are needed to run robotic arms.

We have the MOU that we have just signed with the Peter MacCallum Cancer Centre in Melbourne, which allows us to share expertise and resources between the ACT and a leading cancer institute in the world, the Peter Mac. We are excited about that.

With UC, with Professor Sudha Rao, we have been doing work in breast cancer research. With Professor Geoff Farrell from gastroenterology, we have been looking at hepatitis C research, which is closely related to cancer; he has been championing work with GPs to be able to deliver the cure in terms of being able to rid people of hepatitis C. In brain cancer research, we have some of the world experts at the John Curtin school in terms of preclinical research. That is another area. We are with the Hannan department.

I can think of others but that might answer your question.

MR PETTERSSON: Well and truly. In regard to the funding, I see that there is a million dollars per year for the next three years, but in 2022-23 there is no money. Is there a particular reason that that year does not have any funding?

Prof Shadbolt: Is this for the MoST trials?

MR PETTERSSON: I am looking through the budget papers.

MRS JONES: Investing in medical health and research.

Ms Fitzharris: That specific one will partly fund the work on the brain cancer mission that we have been involved with, but that particular initiative was an election commitment for $3 million. At this point we have spread that over three years. As the office establishes itself as we make more progress with ANU and UC in terms of partnerships, we will be looking to what we do in future years. It is establishing a really good system-wide approach to research across the territory. This great research has been outlined, but it is having that more strategic approach that gives us the opportunity to have a more strategic look at all of these things over the next year or so.

MR PETTERSSON: On the infrastructure side, I see that there is $13 million for improved infrastructure for acute aged care and cancer inpatients. Can you expand on how you are going to improve infrastructure for cancer inpatients?

Ms Fitzharris: Acute aged care has been completed.

Ms McDonald: We might get Colm to walk through where we are up to with oncology.

Mr Mooney: Sorry; could you repeat the question, please.

MR PETTERSSON: There is $13 million for infrastructure to upgrade the acute aged care and cancer inpatient infrastructure. Can you expand on what the infrastructure upgrades for cancer inpatients are?

Mr Mooney: That is the current work that is underway in 14A and 14B, the new cancer wards that are adjacent to the cancer building at the Canberra Hospital. Those works are underway under a contract with a company called Shape; they are due for completion in June of next year.

MR PETTERSSON: A little while ago the government said that it was going to cover chemotherapy co-payments. I was wondering if you have had much feedback on how that is being received.

MRS DUNNE: And whether it is happening.

Ms Fitzharris: It is both happening and it has been very well received, in short, both those things. It has been very well received by the patients across Calvary and Canberra hospitals.

MRS JONES: And no-one is paying a co-payment?

Ms Fitzharris: No. For the first six weeks or so, a co-payment was sought. That was an administrative issue. That has been rectified, and any co-payments that were paid in that period have been paid back.

MS CODY: Professor Shadbolt, I missed part of what you were saying about some of the cancer research you are doing. Is melanoma research in there? Did I miss that or is it not part of what you were talking about?

Prof Shadbolt: I will have to take that on notice. I do not know of any research that the centre is directly involved with. I know that there is research at the ANU. I will have to look into that.

MS CODY: More broadly—this is a bit of a biased question—following a melanoma diagnosis, I had all my cancer treatment at the Canberra Hospital and they were absolutely fabulous. Do we look into melanoma? Do we do work around melanoma at the Canberra Hospital? Is it more about the fact that they were my treatment options because it was such a great facility?

Prof Shadbolt: If a clinical trial is identified, we would look into that. I am not sure that there are actually clinical trials open at the moment. There may be. We certainly have done clinical trials of melanoma in the past. I know at the ANU there is some interest in the area; I just cannot give you the exact details.

MS CODY: I missed part of the response you gave, so I just wanted to just throw that in.

MRS DUNNE: I will take us in a different direction. Can we talk about the system-wide data review? Where are we at with the implementation of the review and the development of the various initiatives under the scheme? Where are we in responding to the Auditor-General's recommendations?

Mr De'Ath: Thank you, Mrs Dunne, for your question. I will turn to Peter O'Halloran in a moment to respond to the majority of that. In relation to the Auditor-General's report and recommendations, can I just say that we were really delighted to have the Auditor-General come and carry out that mid-stream review for us? This is a large, complex piece of work and we were very keen to see how we were tracking with that. We did have some strong recognition of areas that were going extremely well and we had some recommendations on issues that we should have a look at. Unless I am otherwise corrected, we have attended to all of the matters that were raised. I will hand over to Mr O'Halloran to respond in more detail.

Mr O'Halloran: I acknowledge the privilege statement. Certainly, as Mr De'Ath has flagged, we are progressing through the Auditor-General report findings. Specifically, I would note that the report was at a certain point in time. When the fieldwork was conducted for that, other activities had already occurred, I suppose, between the fieldwork and the actual report being published.

For example, the second implementation plan was published in March just before the report came out, before the fieldwork had been finalised. In short, we are progressing through. ACT Health has now published and adopted the same project program portfolio delivery frameworks that we used for the data repository, which I note the Auditor-General was quite positive about. We have now published those on our website for full transparency. We are now applying the same rigour and those frameworks across the entire system-wide data review. In fact, I have a planning day tomorrow with some of my key staff working on this further.

We are now progressing through the governance arrangements, noting the changes and implementing the governance arrangements that were identified. We are currently developing appropriate monitoring and oversight arrangements that were flagged and we are progressing that through solidly. I would also note that at the same time we have produced the quarterly performance report using the data repository. I think that that probably gives you the strongest evidence of the success of where we are going with data in the—

MRS DUNNE: Sorry, could you clarify something? In relation to the data repository, you just completed what?

Mr O'Halloran: We have used the data repository in totality to produce the most recent quarterly performance report.

MRS DUNNE: Right.

Mr O'Halloran: I think that that really speaks to the heart of where we are going in that work in that all of the data we are producing has come from core systems, has gone through agreed business process transformation, and everything has been documented, assumptions have been tested and we are producing robust data.

There are certainly areas that we are still working on. I think that the Auditor-General's report is very helpful for us in flagging those areas where we need to address work now. But we are moving on that and moving forward fast. I would also suggest that the bulk of the work in the system-wide data review is in fact the data repository, which is now progressing quite satisfactorily.

MRS DUNNE: Is the data repository work complete or is it just to a stage where you can use the structures?

Mr O'Halloran: The data repository work is ongoing. The first phase we developed is very much building the technical infrastructure, which was completed some time ago. What we are now in the process of doing is populating the tool, or populating the repository data from key systems. That is complete in many respects.

We will continue to bring new systems on as they emerge, systems that we have not previously reported on, and will continue to develop reporting outputs from it. To be honest, I would suggest that it is a never-ending piece of work because business processes are always changing, expectations and requirements are always changing. So the work will never be complete. However, we would certainly look at within less than 12 months to have completed the bulk of the population and extraction work.

The repository is being used more and more every single day for reporting. I note that we have a number of further submissions being provided in the next two months for everything from annual reports to national submissions to the commonwealth which we are increasingly sourcing from the repository. Every single day we are using it more and more.

MRS DUNNE: I am not sure whether this question follows on from that or is a different line of questioning. If it is a different line of questioning, I am happy to leave it until later. How does the system-wide data review link in, or does it link in, with the digital health record proposal?

Mr O'Halloran: The system-wide data review provided a number of recommendations, as you may recall, Mrs Dunne. One of those recommendations did actually note the difficulty we have in terms of extracting data from over 250 clinical systems we have at the moment to actually provide a single accurate answer. One of the items flagged in the recommendations was that we should look at having fewer systems. In fact, the digital health record in part and digital health strategy in part were based on that recommendation.

MRS DUNNE: I will leave it there. I might come back and ask more questions later rather than monopolise things.

THE CHAIR: On the ACT digital health record, is it going to be compatible with the My Health record being developed by the commonwealth?

Mr O'Halloran: Canberra hospital was the first public hospital in Australia to upload to what was then the controlled electronic health record, now My Health record. So we have had a long history of being very heavily involved in My Health record. That will continue in the future with the digital health records. Key data uploaded from the digital health record to the My Health record would be similar data to what we are uploading now, which is discharge summaries, pathology results, diagnostic results and over time additional information on discharge medications and so forth in more refined sets.

THE CHAIR: From a patient perspective, will individuals have two health records or will they be—

Mr O'Halloran: The two records are quite fundamentally different in what they do. The digital health record, in essence, is the full comprehensive clinical record for the patient for all of their treatment. That is everything from observations, which might be done every four hours, every half hour or even more frequently, all medications, all correspondence and the like, and that is the digital health record. It is the equivalent of what can now be collected in all of those various systems, and the paper record that people are used to traditionally at the end of the bed. It is a very detailed set of papers.

With the digital health record, when you look at the My Health record and the commonwealth, that is very much a summary set of information. So from a complete inpatient admission, we might upload half a dozen pages to the My Health record, which might be some diagnostic imaging results, pathology results or just a discharge summary. Patients will have the full complete record on the digital health record. The summary will be uploaded to the My Health record if the patient has consented.

THE CHAIR: Will health professionals be inputting information into both systems? You said that only some of the information will be uploaded into the commonwealth record.

Mr O'Halloran: Health professionals do not currently in the ACT public health system input data directly into the My Health record. They input them into the various systems operated by ACT Health or Calvary and then that gets uploaded for them.

THE CHAIR: What cybersecurity measures are in place? What measures are in place to protect individual privacy?

Mr O'Halloran: For our current systems or for the proposed digital health record?

THE CHAIR: The digital health record.

Mr O'Halloran: At the moment with the digital health record, the money was announced in the budget a very short time ago. We are just in the procurement phase

at the moment. We are designing the various system requirements to provide those appropriate cybersecurity protections and we are working quite closely with Shared Services ICT security on how that can look and we are working with the Health Care Consumers' Association and others discussing things such as privacy. But to discuss the detailed requirements, it is probably a year or two too early.

MRS DUNNE: Can I clarify this? My Health record is a summary that is derived from people's attendance at a hospital or visiting a specialist or GP, whereas the digital health record is essentially the digitising of someone's hospital record, their big fat paper file.

Mr O'Halloran: That is correct.

MS LE COUTEUR: Will that include an advance care directive, if someone has one, so that it will actually be accessible?

Mr O'Halloran: Yes is the short answer. Advance care directives are currently captured in our existing systems.

MS LE COUTEUR: I did not hear the second half of your sentence. I heard yes, but—

Mr O'Halloran: Advance care directives are currently captured in our existing systems and would continue to be captured in the digital health record in the future. There is, further, a link to the data that is captured in the My Health record in relation to that as well.

MS CODY: I have another question for the professor. In our earlier session we talked about CHARM.

Prof Shadbolt: Yes.

MS CODY: I asked you some questions about the last CHARM. I also note an announcement that the government had brought online a cardiac ablation machine. How is that going, and what other new services have come online to support people?

Prof Shadbolt: In terms of the melanoma question, the new director of the John Curtin School of Medical Research is one of the leading melanoma researchers in the country, if not the world. He will be here in a few months, and I am sure he will bring his research with him. In terms of what new things are happening regarding services—

MS CODY: Around cardiac ablation and other new services, yes.

Prof Shadbolt: In terms of translation of research into practice, which is really what you are asking me about, we have a long history of that here in the ACT. I will give you one example. It is not necessarily about ablation or anything like that; it is about preterm babies and weaning them off CPAP. We ran a clinical trial with Westmead Hospital, Royal Brisbane Hospital and the Canberra Hospital. It was led by the Canberra Hospital. We were able to demonstrate a particular method which was not

considered to be even of use by a lot of the other neonatologists because of the way they had been trained in how to wean preterm babies off CPAP.

We were able to demonstrate why this one method, which has become an international method, called CICADA, was able to reduce chronic lung disease in these children from 22 per cent down to nine per cent, and with a reduction in time spent in hospital by up to an average of two weeks. This made the front cover of the *Archives of Disease in Childhood*, and it is now being used internationally as a method for weaning preterm babies off CPAP. That was run out of the Canberra Hospital.

MRS JONES: What is the method, in a nutshell?

Prof Shadbolt: Basically, it is ceasing the baby off CPAP as soon as they are stabilised, and seeing how they go with that. The other method that was more favoured was to gradually wean them off. It actually had the worst outcome. This evidence-informed approach, bringing research into practice, will change the way that this is done, as well as the efficiencies and benefits we get for our patients. That is just one example. We have a whole raft of things coming with end of life soon.

MRS JONES: Fantastic.

MS CODY: Can we talk about the ablation?

Ms Taylor: The ECR service is up and running now. We are taking our first patients through the service. It is going really well. We have had about five patients through so far. Patient satisfaction is good; outcomes are good. The clinical teams are really excited about the service.

MS CODY: Has this prevented people from having to go interstate for this procedure?

Ms Taylor: Yes. This procedure is delivered at Canberra Health Services now.

MS CODY: I am no health expert but I guess that would be more beneficial regarding outcomes for the patient as well.

Ms Taylor: Absolutely. It is more real-time service, so patients are not having to wait. There are no transfer delays; it is on the spot.

MS CODY: How many doctors or technicians do you have that are able to undertake this?

Ms Taylor: It has been three doctors who do the service, the cardiac team. A whole raft of the team help: about 12 people in total, from the patient's coming into ED to being taken through to the lab. It is a holistic approach—MDT, nursing, therapy support, admin support and anaesthetic support—to get the patient through. It is a cohesive team that run the service.

Ms McDonald: With the doctors who do it, one of them is a leading researcher

himself. We do have a fellow that has come to support the research; so the service continues to evolve and develop. We also contribute to the broader research knowledge in this space.

MS LE COUTEUR: I would like to ask a few questions about older Canberrans. In particular, I read a recent report about elderly Victorians who are being treated in ED for hypothermia. Is that an issue here, given that Canberra is colder than Melbourne?

Ms McDonald: We would have to take that question on notice, check with our emergency department and look at the patients who are coming in. It is not something that has been flagged with me as a major issue for Canberrans.

MS LE COUTEUR: I would be interested in that. Certainly, the report that I read—it was in the *Guardian*—was very disturbing.

Ms McDonald: We will take it on notice.

MS LE COUTEUR: It basically said people did not have the money to heat their places.

MRS JONES: We certainly hear about that.

MS LE COUTEUR: We certainly hear about it, but it had reached the level where people were being admitted—

MRS JONES: Actually turning up to hospital.

MS LE COUTEUR: Actually turning up at ED. It was particularly socially isolated older people, who were doing much worse than younger people who are outside. They were inside in their homes and freezing. I would be very glad if you could let us know and reassure us about that, on notice.

Ms McDonald: Yes, we will.

MS LE COUTEUR: Looking more broadly at seniors health, at 117 you have money for strengthening care for older Canberrans. Can you tell us more about what that will mean?

Mr Kaye: This particular funding is all targeted at increasing staffing within the acute geriatric units at the Canberra Hospital both for allied health and for nursing staff. The nursing component of this is around supporting our current nursing staff in education, training and development, in order to lift their skills in the treatment of patients within these acute geriatric units. There is also some managerial support to free up the time of our CNCs on those wards, to allow the CNCs to spend more time on the wards, with the staff and with the patients, so that they can direct care and provide better care in that respect.

MS LE COUTEUR: You said it would free up some staff time. Will that include one-on-one time with patients? One of the complaints I have heard a number of times

is that there are not enough staff to feed people. The food comes but they either cannot get the plastic bits off so they cannot get to it, or if they can get to it, their rate of feeding themselves is so much slower than the hospital is expecting that they do not get to keep hold of the food for long enough to eat it. For those sorts of issues, will there be staffing for that?

Mr Kaye: We are not staffing specifically for that issue. We do have some other strategies in place that help particularly with the feeding of older people. We have a system in place where the tray that the meal comes on is colour coded and, depending on the colour code, it will indicate whether the patient requires some assistance with opening the particular cartons that the meals come in or if they require some assistance with feeding. We use a system within the aged-care units to help people to access their meals and to feed in that respect.

In regard to one on one, the other part of this budget is around allied health staffing. We will absolutely be increasing the number of allied health staff that we have on these wards. We will be able to provide additional physiotherapy, occupational therapy and social work services on these wards.

Whilst I could not, hand on heart, say that we will be able to provide more one-on-one care, within allied health we provide a lot of group therapy. We will be able to provide, hopefully, more therapy to the patients on those wards.

MS LE COUTEUR: I guess what is on page 115, "Expanding palliative care for older Canberrans", is complementary to this. Is it only going to be for aged-care facilities? For people who are ageing at home, there will not be an increase—

Mr Kaye: This does not come under my jurisdiction.

MS LE COUTEUR: It is only a page away.

Mr Kaye: I would not want to give you the wrong information.

MS LE COUTEUR: I was seeing the commonalities. They are aged care facilities whether you are in hospital or in a nursing home. Would someone else know whether there will be any expansion of palliative care for aged people who are—

Ms O'Neill: The Inspired program that that money relates to is run from Calvary hospital through Clare Holland House. I can talk generally to the program that they run, but we do not directly manage that program. As I mentioned earlier this morning, it has been highly successful, and in fact the commonwealth is looking at modelling this program across Australia now. It provides an in-reach model. It is a nurse practitioner led model that is able to go in and assess the residents, provide education to the residential facility staff and prescribe where necessary so that these residents get the appropriate care and do not need to leave the residence to access acute service. So we have increased the rate of people dying at their place of choice.

MS LE COUTEUR: And presumably that has decreased the rate of ED admissions, because my limited experience with nursing homes suggests that putting people in ambulances was a quite common occurrence when it did not need to be. Is this going

to extend to people not in aged-care facilities? Will there be more support for people needing palliative care who are at home?

Ms O'Neill: Not directly through that money, no.

MS LE COUTEUR: Someone else's—

Ms O'Neill: The home-based palliative care program continues to provide in-home support, and there has been an extension of funding to the community options program, which also provides support for patients receiving palliative care.

MRS JONES: I want to go to the public hospitals pharmaceutical reform agreement. What factors led the government to decide not to sign up to the agreement?

Ms Fitzharris: It was before my time. I think there was basically a cost-benefit analysis that said it would cost us more than it would benefit us.

MRS DUNNE: I understand that the ACT and New South Wales are the only ones who have not joined. It has been put to me that there are significant benefits of joining. What does ACT Health see as the disbenefits? Was ACT Health given a rawer deal than anyone else, or what? Why do you see disbenefits?

Mr Culhane: I acknowledge the privilege statement. Again, it is before my time. Based on my understanding, there was an analysis done and a range of factors were taken into account in that analysis. In jurisdictions such as the ACT you have a relatively small population to spread the cost of implementation across. That is one of the factors. They have system change costs associated with moving to the PHPRA and a very small tax base, whereas in another state that is much larger you have a larger tax base and, if the system costs are relatively fixed, you can amortise it to a greater extent. I know that that was one of the factors. New South Wales clearly came to the same conclusion in that they have not signed up to the PHPRA either. It is my understanding that some other states are not entirely content with the arrangements that they did enter into. In all, I think the ACT came to a position that it was not the best choice at the time. We have had and we still have other arrangements in place which provide equivalent sorts of access for patients to PBS drugs.

Ms Fitzharris: It does not limit the availability of PBS drugs within a hospital, but what is apparent is that there is different access in different jurisdictions and that that agreement is in need of an update to better meet national requirements.

MRS JONES: Is there a conversation going on still or is it—

Ms Fitzharris: I hope so, at a national level—

MRS JONES: That is nationally but I mean for us.

Ms Fitzharris: I have said that we should have this discussion nationally amongst health ministers. The commonwealth have said that they were looking at a new version, and so we await with anticipation what that new version looks like from them.

Mr Culhane: The agreements that were on offer to the states were bilateral agreements. They were not uniform in their nature in terms of what each jurisdiction negotiated. We understand that the commonwealth is looking to reopen discussions around the PHPRA, perhaps with a multilateral agreement entered into, and we are going to be talking to the commonwealth about that agreement. The current agreements were offered under the national health reform agreement. They were related agreements, so we—

MRS DUNNE: Was this the Rudd national health reform agreement? Was it at the time when Prime Minister Rudd was introducing national health reform? Was it part of that?

Mr Culhane: I am not sure if they were that agreement or an addendum to that agreement. The Rudd national health reform agreement was subsequently extensively amended, so I am not sure at exactly which juncture this PHPRA was offered. But in any case we are going to be talking to the commonwealth very shortly about that. At the same time we are not sure of their thinking in terms of when they want to reopen those discussions but we have had signals.

MRS DUNNE: What I am getting out of this is that these were one-on-one agreements and so what might have been offered to the ACT could have been substantially different from what might have been offered to another state or territory. You may not know.

Mr Culhane: That is correct: we do not know. And what was offered to a particular jurisdiction and what was agreed to with a jurisdiction might be different things again.

MS CODY: Mr Culhane, can you outline for me what was and is involved in signing up to these agreements?

Mr Culhane: To a bilateral agreement between the commonwealth and the ACT?

MS CODY: Particularly the PHPRA.

Mr Culhane: I cannot tell you exactly what is involved in terms of the PHPRA but generally for agreement between the ACT and the commonwealth my understanding is that it would be considered by the cabinet and is a matter for ministerial signature by the ACT and subsequently by the commonwealth.

MRS DUNNE: And possibly a bit of horsetrading along the way.

Mr Culhane: Yes.

Ms Fitzharris: And advice from health and treasuries, and discussions—

Mr Culhane: That is right. After the of negotiation and policy consideration process, that is the formal end of the stick.

Ms Fitzharris: I do not believe that it is still on offer as such. It is not a standing offer.

MS CODY: But you would imagine there will be—

Ms Fitzharris: I would hope that there is some national work done in the space to get equitable and nationally consistent agreements between jurisdictions.

MS CODY: Okay, thank you.

MR PETTERSSON: The University of Canberra public hospital has been open for about a year now. Do you have any measure of its success or feedback at this point?

Ms McDonald: It has certainly been very busy. That is one indication. We have had a lot of patients through; our utilisation and occupancy are high. I might let Todd talk on any other measures of its success. We are about to celebrate our first birthday.

Mr Kaye: As Bernadette said, we are about to celebrate one year of UCH being open, which is a great anniversary to celebrate. For the staff, patients and carers who go there, the informal feedback that we get is all very positive in terms of how beautiful and wonderful the facility is, how nice it is to work there, and how nice it is to recover and have your rehabilitation undertaken there.

In terms of some measures, by and large we receive far more compliments around the services provided at UCH than we do complaints. I am sure we have exact figures for that that we can provide if you would like. With outcomes, there are great patient outcomes from their stays at the hospital. I think that by all measures, we could say that at the moment, after one year, UCH has been a great success.

MR PETTERSSON: Do you know what the utilisation rate is? It was mentioned before, but not with an actual number.

Mr Kaye: Of the hospital?

MRS DUNNE: The occupancy rate.

Mr Kaye: Yes. From some figures we received to the middle of May, there have been something like 25,500 patient bed days at the hospital. Currently we have—I might get this wrong; I am sorry—68 RAC beds open and 20 mental health rehab beds available. From the data and statistics we have, it has been something like a 90 or 95 per cent occupancy rate over the year of it being opened. I would have to go back and check that, but off the top of my head that sounds about right.

MR PETTERSSON: That is all right.

Ms McDonald: We are also looking at our bed numbers. We have not got all beds open at this time. We are looking at whether we need to open more beds, and which patients may still be in Canberra Hospital who would be suitable for bed utilisation and help the flow of more acute patients through the Canberra Hospital. We are looking at our bed numbers across the organisation at the moment as well.

MS CODY: Representations were made to me by some cleaners at the UCH. They were talking about the agreement. Do we know where we are up to with signing their

enterprise agreement?

Ms McDonald: There are still negotiations going on, but just to be really clear, they are not negotiations with us; they are negotiations between the two external parties, who are the contractors and the union, the people who provide the service and the unions. I know they are proceeding; I am pretty sure they are not concluded just yet.

Ms Fitzharris: Not yet.

Mr Mooney: In brief summary, yes, it is as Bernadette summarises. The discussions are ongoing. The agreement that you refer to is between Medirest, which is a subcontractor to Brookfield Global Integrated Solutions, and a number of unions, primarily United Voice, representing the cleaners, and the Health Services Union.

MS CODY: Do you have much involvement in those discussions or is it mainly between them and the union?

Mr Mooney: It is between them and the unions. We have a contractual relationship with Brookfield Global Integrated Solutions. We are aware that discussions are taking place, and we are aware that the gap is closing, let us say, but agreement is not there yet.

Ms McDonald: We provide lots of support and encouragement to reach a conclusion to the negotiations, but we do not interfere or sit around the table, from their perspective.

MS CODY: I know that there was a great outcome at the TCH with the cleaners and the contractor there. It was wonderful. The cleaners were really ecstatic with that. Fingers crossed we get to a similar result.

MRS DUNNE: I want to go to emergency preparedness. There was an article in the *Canberra Times* this week, but also I have received representation from groups in the hospital about emergency preparedness. The issue was put to me in the context of the Christchurch incident and how prepared we are at a major hospital for a mass injury scenario. I presume that Christchurch, after two earthquakes and a mass shooting, might have their systems down pat. It was put to me that it is a long time, if ever, since there has been a live exercise here, and groups of health professionals have said to me that they do not know what would be required of them or how it would be rolled out.

That comes in on the back of the reporting in relation to the risk register about things like staff not knowing how to put up hazmat tents and do hazmat cleaning and things like that. So I just ask a general question about how often we do emergency exercises of any sort, whether they are desk or live. There was a quote in the paper the other day that said that we are a big tertiary hospital and it would be entirely inappropriate to do a live exercise, or words to that effect, which I found a little shocking.

Ms McDonald: I might start by talking about Canberra Health Services in particular and then hand over to our colleague Kerryn to talk about the broader emergency management response.

Just to clarify, the quote in the *Canberra Times* was not that we do not want or find it impractical to do emergency training in situations.

MRS DUNNE: I do not think it said it was impractical.

Ms McDonald: I think your wording was about that, that we would not do that. What we have to do is consider, when we do those training exercises, that we are still delivering our clinical services 24 hours a day.

MRS DUNNE: Absolutely, yes.

Ms McDonald: That was what was responded to in the article in the *Canberra Times*. I just need to clarify to say that we have absolute confidence in our ability to respond. Since we have split into Canberra Health Services and the ACT Health Directorate, my emergency management team have been working diligently to update all of our processes, update training of key personnel across the organisation, and do desktop exercises. We are in the process of working with the Health Directorate and all our emergency management partners across ACT Health in order to undertake a major incident training exercise later this year. That is on our calendar of events in our emergency training. We are also updating training of key personnel.

Unfortunately, we did have an incident. We had a major water pipes leak some months ago, and we did enact and stand up our emergency coordination centre. Whilst it was not a training exercise—it was a real exercise—it was also a test of our ability to respond. The organisation and key personnel responded extremely well in that circumstance. We then do a debrief on how that went, what else we can learn from that, and what we need to update.

What was not mentioned in the *Canberra Times* article was all the work that has been done in the past nine months since we transitioned to Canberra Health Services to make sure that we have people well trained. There will always be individuals across the organisation who will say that they are not exactly sure what they need to do in a major incident, because most major incident responses are done by a key well-trained team of people, and people then receive instructions and directions in what they need to do. Not every single person in the organisation will be involved in every single training exercise that we do, but people across the organisation have a basic level of emergency management training that it is mandatory for them to do across our normal emergency responses in the organisation.

I might hand to Kerryn Coleman to talk about broader emergency management.

Dr Coleman: I acknowledge the privilege statement. As Bernadette says, each of the facilities within the ACT, including Canberra Health Services as well as Calvary public, have their own incident management teams as well as their own emergency management plans. However, we also have an ACT Health management plan, which provides us with a framework for providing a coordinated response to any emergency management situation. My position as the Chief Health Officer coordinates and manages that.

Part of that is that we have a committee called the health sector emergency management committee where membership across the board, across the sector, all come together. We review our plans and ensure they are up to date every year; we touch base and have all of those discussions at that table.

One of the important things that was mentioned is that a mass casualty incident exercise is planned for later this year. With a mass casualty incident, the key lead agency is the ambulance agency. They will be the ones that coordinate the entire response. They activate out from the activation centre; then I stand up a coordinated response, and each of the hospitals will have their own. Our job is to make sure that there is coordination across the board, moving people between hospitals as necessary or going outside our jurisdiction to see if we can get assistance if need be.

MRS JONES: The ambulance presumably leads because they are the first point of contact for people who call for help in the case of a mass emergency. Do they operate out of the ESA's major incident room?

Dr Coleman: Yes, that is correct. They are part of Emergency Services Australia, and there is an excellent facility at Fairbairn which is set up exactly for this. We have our own health emergency coordination centre which we are outfitting really nicely at the Holder facility. We would have liaison people from all of the healthcare facilities come and sit with us at Holder and we would provide a liaison person at the Fairbairn facility so there is excellent interaction.

MRS JONES: The Fairbairn facility has electronic connection and has the big screen for the main table. Would you be live connected if something like that was occurring?

Dr Coleman: We are live connected to all of the health-related data we would need. We have had a big fit-out done with some new screens and we can have access to emergency lists and all of those kinds of things.

MRS JONES: I mean for communication between Fairbairn and Holder. Would that be in one room or would that only be a piecemeal?

Dr Coleman: I think the Webex connection is active all the time. There are of course phones, mobiles and regular briefings which we would attend.

MRS JONES: Will that have a media operation unit as well?

Dr Coleman: There is a defined room at Fairbairn and there is the PIC which stands up there. We would have our own media liaison person sitting in there, and then it depends on who and what the messaging is.

MRS JONES: So it is more like secondary response from the decisions being made at Fairbairn. It comes out to Holder and then is enacted from there?

Dr Coleman: It depends on what the incident is and who is leading. If it were a lead response by health, which it would be if there were a public health emergency such as a pandemic, that would be led by the Chief Health Officer position. It depends on how much requirement we would need to liaise with other facilities. If we need a lot of

liaison we would likely stand up at Fairbairn. However, if it is mainly a health sector response we would coordinate that. And it may depend on the size of the response required, and we could step that up or down as need be.

MRS JONES: I hope that there is not a fire in the health emergency because Holder is rather close to the west.

Dr Coleman: Yes, it has been affected before and there are backup plans.

MRS DUNNE: The exercise towards the end of the year is a full exercise with people on the ground or is it a desk exercise?

Dr Coleman: We will have to get back to you on the details of that; it is currently being looked at.

Ms McDonald: It is being planned at the moment to see what we can do. We would like to make it as real as possible and as broad as possible, but that involves more than just Canberra Health Services obviously. That is in the planning at this stage.

MRS DUNNE: The *Canberra Times* said yesterday that the Canberra Hospital is a major tertiary campus and that due to this reason it would be inappropriate to run major incident response exercises regularly. Is that accurate?

Ms McDonald: It is reasonably accurate in terms of regularly. We would do it once depending on the size of the training exercise you want to do. If you want to do an extensive major one, you would probably do it only once a year max because of the involvement of the number of people and interactions.

MRS DUNNE: Once a year is regularly. When was the last time you did a major exercise at the hospital?

Ms McDonald: I do not have that in front of me. I assume it was before my time; we have not done one in the past nine months, which is why we are planning to do one later this year.

MRS JONES: Can you take on notice when in the past five years that has occurred.

Ms McDonald: Yes, sure.

MRS DUNNE: The clear feedback I have received is that there are key groups of doctors who say, "I do not know what would be required of us."

Ms McDonald: Hence why we want to do the training exercise and why we are lifting the training across the board with all our staff.

MRS DUNNE: But you also made the point that there are some people who do not need to know. There is a high level of uncertainty amongst medical professionals.

Ms McDonald: Let me clarify. Everyone in our organisation does a basic level of mandatory emergency management training. When we are talking about mass

casualty most of these comments came after what happened in New Zealand and the shooting and people were stimulated to think whether they knew what to do. In fact, it is a good thing they did think that and say, "I'm not sure in that event." But we have to be very clear that there are different levels of knowledge and response expectation for different people in the organisation. At the moment we are doing our training and targeting where we need to target.

I have heard those comments as well and I think it is good that we all sat up and asked whether we are prepared, and that is the work we are doing now to ensure that we are well prepared and everyone is trained at the level they need to be trained at to respond.

MRS JONES: Is it right to say that, to some extent, if people are required they will be asked?

Ms McDonald: They will be asked; they will be told. People are on rosters. We have a trauma service and we have very experienced staff. We will work closely with them.

MRS DUNNE: The risk register says that Canberra Health Services has a chemical, biological, radiology and nuclear tent—a CBRN tent—that is not maintained and that there are no personnel on site who have been trained to erect it. Is that the case?

Ms McDonald: That was at the time when the risk was assessed.

MRS DUNNE: That was on 30 June 2019.

Ms McDonald: Yes.

MRS DUNNE: So is that still the case?

Ms McDonald: That is being worked on. The point of putting all of this information into a risk register is so we take action on those things.

MRS DUNNE: But, where are we in the process of taking action on this? It also says the old personal protection equipment is out of date and that they have not received advice on what would be appropriate PPE from ESA.

Ms McDonald: Yes, so our emergency manager Donna is working actively on all of those things at the moment, which is why they are listed in the risk register to follow up. I can take that question on notice in terms of where we are up to to give you a progress report on responding to those actions that she has identified need to happen.

MRS DUNNE: Because the risk register has a whole lot of milestones of 30 December and 30 June. So on notice could get an update on what the milestones are and how we are meeting the milestones for risk 609.

Ms McDonald: Sure.

Ms Fitzharris: There was also an article in the *RiotACT* last week about this which gives some more information about the work.

THE CHAIR: Strategic objectives 4 and 5 in the wellbeing index are based on how individuals perceive their health rather than objective measures. Why is that?

Ms Fitzharris: Just as a general comment, this is the first year we have had strategic objectives and indicators looking across ACT Health, Canberra Health Services and the local hospital network as well. I think we need to have an appropriate mix of both subjective and objective factors as well and we also need to hear from people.

Some of the work that has been underway in the broader government work around wellbeing speaks a lot to this: people's own experience of their wellbeing is measured in a number of ways. Some of them are objective, and some of them are subjective. But it is also important to ask people their own experience and understanding of their own wellbeing.

There will be a combination. And this is the first year that we have added these, both in terms of physical health and wellbeing and mental health and wellbeing. I think that that is a very positive move forward. In addition, obviously there is a lot of information provided through a whole raft of other reports that we contribute to nationally as well as in our performance report.

THE CHAIR: Why are you no longer using strategic objectives 7, 8, 9, 10, 11 and 12, which were based on more objective indicators, reported on by the Australian Institute of Health and Wellbeing?

Ms Fitzharris: Because they are reported on by the Australian Institute of Health and Wellbeing. There has been quite a lot of work and movement in these, for the reasons that we are separating some things out. And there has been quite a bit of movement. What the footnotes will explain is: if they are not referenced in the budget papers—these are budget papers and they also inform our annual reports—they will be measured in other places and reported on publicly elsewhere.

THE CHAIR: You mentioned the whole-of-government approach to the wellbeing index. Is ACT Health developing a wellbeing index or will that continue to be a whole-of-government approach?

Ms Fitzharris: ACT Health and Canberra Health Services will have major input into that wellbeing work, yes.

THE CHAIR: But it will continue to be whole of government? You are not developing—

Ms Fitzharris: Yes. It is, by definition, a whole-of-government exercise and there are a number of workshops taking place early next month, of which Health will be a major part.

Mr Peffer: I can expand on that. We have quite an instrumental role as part of the project that was announced by the Chief Minister and that is being rolled out right across government. The policy council, which is the council of deputy directors-general across the public service, have established a working group, a subcommittee, that is helping to inform that work and bringing in, I guess, the intelligence that is

being gathered from the academic and community engagements that are occurring, and pairing that with some of the data that we have within the public service.

We collect a range of data sets that are going to be instrumental, I think, in helping to shape what those indicators look like and benchmark and measure progress. An example of that might be our general health survey or the upcoming year 7 health check where we will actually be asking people not just about observable conditions and their general health but how they feel about their health.

I think, as the minister has outlined, that people might be physically healthy but will have a view about their mental health that may be influenced by a range of things such as their level of social inclusion, whether they have people in the community that they feel they are connected to, family, friends, that sort of thing. You can have someone who is perfectly healthy but with limited connection and their reported level of mental health is not where you perhaps would like it to be. I guess we will be feeding in our data to help shape those indicators.

MS CODY: I want to talk about organ donation rates. What are the rates? We currently have an opt-in policy.

Ms Chatham: Nationally.

MS CODY: Does the ACT have any other ideas about increasing organ donation rates? I can repeat all those questions one at a time if that is helpful.

Ms Chatham: That is okay. I will have to take most of those questions on notice because I do not have the information at my fingertips. But it will be very easy to get to you. I know that we are very proud of our success in organ donation. We have, I think, been a leader across the jurisdictions in our efforts. As far as facts and figures are concerned, we can easily get them to you. But we will get them to you on notice.

MS CODY: I will clarify. What are our rates of organ donation? Have these numbers changed over the past five years?

Ms Chatham: Yes, they have but I have not got them.

MS CODY: What is the ACT government doing to increase awareness of organ donation and rates of donation?

Ms Chatham: We are doing something with all those things but I will get back to you.

Ms McDonald: We will try to get those before the end of the session today. We have a whole team watching.

MS CODY: I know. I have said a couple of things and all of a sudden I get an email in my office.

Ms McDonald: We will take that on notice.

MS LE COUTEUR: My question is different. How is the homebirth trial going?

I would like it not to be the word "trial" of course.

Ms Fitzharris: Of course. But you understand why? You understand that it has a time frame? Katrina will answer that.

Ms Bracher: I acknowledge the privilege statement. I did not quite hear your question.

MS LE COUTEUR: How is the homebirth trial going? How many babies have been born? What sort of evaluation have you done?

Ms Bracher: From our service perspective and from the midwives who are involved in the trial, we are very positive about the trial. How many babies have been born? Baby No 28 was born on Tuesday. We have done, as we committed, the mid-trial process review. It was a little delayed. We were waiting for a sufficient number of babies to be born in order to do that review. It is just a process review. It is not a full evaluation of the trial. It is really around the processes to make sure that our systems are strong and our governance is good for the trial. The insurer and the minister insisted that we do that. It is actually good practice to do a process review for such a new service.

That process review is going through our governance meetings inside the division. It is actually going to be tabled at our next executive meeting within the service for consideration. And then we are going to brief the minister.

MS LE COUTEUR: The evaluation has not happened?

Ms Bracher: On the formal evaluation, we will be going to tender in the next few months to have an external, independent evaluation of the outcomes of the service. We have done an internal process review. The external evaluation of outcomes for women and babies and their families will be done towards the end of the year or early next year when we have had sufficient babies born through the trial.

MS LE COUTEUR: Will you keep on with the homebirth trial while the evaluation is happening?

Ms Bracher: The short answer is that we need to check that with the insurer. The trial was committed to be about a three-year period. If there are women and families who have been accepted on to the trial, when we get to that evaluation point, we will not be removing anybody from the trial. We might just not take additional women at that point. If women, early in their pregnancy, have been given the support to have a homebirth and they are still well enough to do that at the point of birth, we will support them to do that.

MS LE COUTEUR: Are you looking at homebirth in other parts of Australia? I am aware that there is one in Northern Rivers, because my daughter was a participant. I assume there are others. Are you looking at that in terms of your evaluation?

Ms Bracher: Certainly, the benchmarking was done across jurisdictions to set up the parameters of the trial. I do not have that report in front of me, but it was certainly

done. The insurer and cabinet insisted that that be done to support the rigour around our trial. When we do the external evaluation, our service will be benchmarked against those inter-jurisdiction services.

MS LE COUTEUR: I assume from what you are saying that you are not considering at this stage expanding the availability of this. It looks like in the short run it is going to go downhill while you do your evaluation. Is that a correct interpretation?

Ms Bracher: The parameters of the trial have to stay the same otherwise the evaluation will be evaluating—

MRS JONES: A non-existent service.

Ms Fitzharris: It will be invalid.

Ms Bracher: Yes, it will be invalid. So the parameters will stay the same.

MS LE COUTEUR: When do you think it is likely that you will have the evaluation? When is it likely that you will effectively restart it even, let alone expand?

Ms Bracher: That will be a decision for the minister and government.

Ms Fitzharris: You could assume that—

MS LE COUTEUR: It sounds like there will be a reasonable period of time with no homebirths?

MRS JONES: You are not sure yet.

Ms Fitzharris: No, not sure yet. I think that you could reasonably assume that this was quite a significant new service option, that you could safety assume that given that the trial was established around some very strict parameters, the government's intention is to continue that and we want the trial to be a success. The question will come about—I know we have had representations on where people live and how close they might live. I think that is the one area that we will need to look at through the evaluation. We do not yet know.

So far it has gone really well. I believe that the feedback from the participants and the midwives is very strong. All of those things add to the government's strong interest in this. We need to do this work. As Katrina said, we cannot expand a trial at midpoint or at any time, otherwise we will compromise the potential future rollout of it.

MS LE COUTEUR: Will the new phone intake line support people who want a homebirth?

Ms Bracher: The short answer is yes. The intake line is intended to be a very-early-in-pregnancy service for women to discuss all of the options, including homebirth if that is what the woman wants.

MRS JONES: I turn to the QEII centre. Tresillian has been appointed as the new

operator. Are you able to explain why the Mothercraft Society is no longer able to deliver the services? Were the reasons related to funding?

Ms Fitzharris: No, the Canberra Mothercraft Society met with me late last year. They advised me that they had decided as a board not to continue providing services. That had come after significant discussion that they had had internally and, I think, also in recognition that they as a society had brought QEII a very long way. It was now functioning as a hospital and they are a relatively small community organisation. They had decided as a board to move out of service provision and to take up new challenges. They said that, as they did 30 years ago, they were really excited to see what the next need was that they could fill.

MRS JONES: In that same way, with the new arrangements, can you explain if there has been change to the service or increase in the service or if the funding is any different? Can you give us an update on the new service and how that is intended to operate?

Ms Fitzharris: We hope a pretty seamless transition will occur. We had been contemplating, and we have let the new provider know, that we would look to possible changes in the future, which is something that we would have done anyway.

MRS JONES: I understand that postnatal depression in hospital care is not available, as in not in a hospital but in a facility. There is no special residential care for postnatal depression in Canberra that I know of. I have had that raised with me a few times.

Ms Fitzharris: As opposed to QEII where you—

MRS JONES: QEII, which deals more with the feeding issues, sleeping and settling. Mind you, they can be highly related.

Ms Fitzharris: They certainly support that.

MRS JONES: They can be very highly related, absolutely.

Ms Fitzharris: Yes. In terms of intake to QEII, perhaps we could take that on notice. There is certainly not a dedicated facility only for postnatal depression. I do not know whether anyone can talk about it.

MRS JONES: Perhaps you can take that on notice whether Tresillian is going to be able potentially to fill that gap. In the meantime, do you understand that it is the same funding envelope? Are staff continuing as far as you know?

Ms George: I acknowledge the statement. In the first instance the services will continue as they have been. The Health Directorate is undertaking a review of the services provided by Tresillian. We anticipate having that review completed by the end of this year, 2019. That will inform ongoing discussions about the future services. We have entered into a contract for one year plus a one-year option with Tresillian.

MRS JONES: That is fairly short, really, to start with.

Ms George: That gives us time to look at what services are needed in the community and then have negotiations about the services provided following this current contract.

MRS JONES: They will take over the service as it is with staff. Is that what you understand, or are you not sure?

Ms George: No, I know the answer to that. They are commencing the services as they are at the moment. They are in transition at the moment. They will take over on 1 July. The staff who are at QEII have been offered redundancies by Canberra Mothercraft Society. Tresillian has been talking with staff since 30 May and have told them that they intend to offer the majority of staff positions on a one-year basis, plus a possibility of one-year extension contract under the CMS EBA terms, though. Those discussions with staff are happening between Tresillian and the staff, and they are ongoing.

MRS JONES: What is the start date for Tresillian?

Ms George: 1 July.

MRS JONES: I think there is a lot of gratitude out there for what the Mothercraft Society has done over many years in Canberra. I am sure that many people here have visited people in the service or been in the service themselves.

MS CODY: I was about to say that I would like to put on record my thanks and my gratitude. Twenty-one years ago I was at QEII. They were wonderful to me and my first baby.

MRS JONES: And I was there visiting a friend a month ago.

Mr De'Ath: On that note, we were very aware of that sentiment. This has been very carefully managed in terms of a transition. I have a great deal of respect for the current provider and the enormous amount of work they have done as a Canberra institution, really. We have been very pleased with Tresillian's recognition of that, its approach to staff, approach to the service, approach to clients. They are embracing this with the same spirit.

MRS JONES: I imagine that any kind of public acknowledgement of what happened would be welcomed by the community because I think you would really dig into a heck of a lot of families in Canberra who have been helped by them.

Ms Fitzharris: I note that the CEO received an award in the recent Queen's birthday honours in recognition of her personal contribution.

MR PETTERSSON: The 2019-20 budget includes $87,000 for a scoping study to consider the ACT government LGBTIQ strategy and its implications for health services in the territory. Can you elaborate on the key issues the scoping study will cover?

Mr Culhane: The scoping study is going to look at what actions ACT Heath will put in place under the LGBTIQ plan. In terms of what the scoping study will look at

exactly we are currently in the planning stage. We have already had some discussions with the ministerial advisory council in relation to the breadth of the scoping study and what should be included, but at the moment the terms of reference are not set and we are still in a consultative phase.

MR PETTERSSON: Has anything prompted this scoping study?

Mr Culhane: The LGBTIQ strategy prompted it. The government is coming forward with a strategy. The directorate will develop the action plan under it. We are aware that work has already been done in a range of places looking at what further can be done for the LGBTIQ population in Canberra in terms of health. We thought it would be prudent to do a scoping study to inform that action plan in a more comprehensive fashion. The scoping study will draw on the existing work being done as well as consult widely with a range of interested stake holders.

MRS DUNNE: The original budget commitment for the Winnunga health and community services building was for $12 million dollars and completion this calendar year. But BP3 says $10.135 million dollars over the budget cycle. What has happened to the remaining $1.8 million dollars, and what is the completion date for the new Winnunga building?

Ms Fitzharris: Someone can clarify that, but I think that the $1.8 million was previously on some of the design work, but we can be specific about that. I met with Winnunga very recently and they are very pleased with progress. Some level of design work had to go on about exactly where on the site it was best located. You all know the site, and there is a little bit of land around. It is about not only where it goes on the site but making sure that they have business as usual and minimal disruption while it is being built.

MRS DUNNE: No-one has been shouting from the rooftops that they were diddled of $1.8 million dollars, but I was interested.

Ms Chambers: I have read and acknowledge the privilege statement. On page 20 of budget paper C you will see that Winnunga is scheduled to be completed financially by June 2021. We have already sent out the door a payment to Winnunga on signing some milestone payments. We have expended $1.165 million already, and the rest of that money is provisioned.

MRS DUNNE: It is provisioned, but the completion date is 2021.

Ms Chambers: June 2021 we have said financially complete.

Ms Fitzharris: That is financially complete, so we might come back to you on the completion of the actual construction, the day it opens its doors.

Mr De'Ath: October 2020.

MRS DUNNE: There is money in the budget for co-design and planning of an Aboriginal and Torres Strait Islander drug and alcohol residential rehabilitation facility. We have been talking about this at estimates for 12 years. Where will this

facility be located and when will it be delivered?

Ms Fitzharris: We do not know that, and that is what this work is for. We know it will be within the urban environment; that is, it will not be at a bush location or a more remote location.

MRS DUNNE: When this facility is up and operational will it have Aboriginal and Torres Strait Islander leadership?

Ms Fitzharris: Yes.

MRS DUNNE: And will the Aboriginal and Torres Strait Islander community be fully involved in the design and planning of this facility?

Ms Fitzharris: Yes. This work will be led by Winnunga Nimmityjah.

MRS DUNNE: The elephant in the room is that we have been through this process. Winnunga and various other organisations were involved in the design of the bush healing farm, but now we are saying that that is inappropriate, and we should not have drug and alcohol rehabilitation facilities in the country; we need to have them in an urban environment. Is there a risk that the whole rationale will change again?

Ms Fitzharris: No. You have been involved in these conversations longer than I have, but in more recent times what we can say in relation to the Ngunnawal Bush Healing Farm is that it is open though it is not yet doing as much as we want it to and the Aboriginal community want it to. There was recently a workshop held with a wide range of stakeholders about a very shared understanding of the role of the bush healing farm in a continuum of services. In that continuum of services, the Ngunnawal Bush Healing Farm will meet certain goals and objectives for the Aboriginal and Torres Strait Islander community. A residential rehabilitation service that will have more clinical services available in a more urban environment is the work that is being funded in this year's budget.

MRS DUNNE: Will the Ngunnawal Bush Healing Farm out past Tidbinbilla ever be residential?

Ms Fitzharris: Yes, and I have said that on multiple occasions in the Assembly.

MRS DUNNE: What will it be residential for?

Ms Fitzharris: That is the work that is currently underway. One way of thinking about it is like step-down facilities with the Ngunnawal Bush Healing Farm as a form of step-down from residential rehabilitation. There is a healing framework that is being developed as well, and a lot of people, right across the Aboriginal and Torres Strait Islander community, are going to contribute to that work. That was a key outcome of the workshop we held in March of this year.

MRS DUNNE: Who manages the Ngunnawal Bush Healing Farm?

Ms Fitzharris: Currently ACT Health do.

MRS DUNNE: Is there any sort of co-management with Aboriginal and Torres Strait Islander people?

Ms Fitzharris: There was a governance and advisory committee, which had not met for some time, for a variety of reasons. One of the key outcomes from the governance workshop was to re-establish that group as a matter of priority.

MRS DUNNE: Has it been re-established?

Mr De'Ath: I will need to confirm that with someone. While we are confirming that, I want to recognise the fact that the review being led by Russell Taylor is a symbolic acknowledgement of the need for Aboriginal and Torres Strait Islander leadership of the Ngunnawal Bush Healing Farm. In the workshop that the minister referenced, ministers gave a commitment about moving to Aboriginal and Torres Strait Islander led. This is very significant. The workshop that Russell Taylor has been leading, as a well-recognised member of the Aboriginal community, has been working towards re-establishing the governance mechanisms. It is part of the review requirements, and very good progress is being made in bringing the community back together around this issue. The community fragmented over this issue over a period of time; we wanted to bring that back together under Aboriginal leadership and get some direction that was agreed across the Aboriginal and Torres Strait Islander community.

MRS DUNNE: When you say "symbolic", what do you mean by that?

Mr De'Ath: I mean that, as with a range of pieces of government work in the Aboriginal and Torres Strait Islander space, it is very important to get views, considerations, directions and leadership on a range of Aboriginal and Torres Strait Islander matters. The health space is no exception. This bush healing farm is so significant in terms of cultural healing that I do not think that someone like me, as director-general, could profess to be an expert on cultural healing, and nor could many of our staff. Aboriginal and Torres Strait Islander people can be expert at cultural healing, and that is where the leadership should come from for the future direction. The end of July, I understand, is the convening of the governance committee.

Ms Fitzharris: The advisory board.

MRS DUNNE: Who is on the advisory board? Is it representative or are they individuals? Are organisations represented or are they individual people in their own right?

Mr De'Ath: A combination. I would have to come back to you on notice.

MRS DUNNE: If you could take that on notice, that would be great, thank you.

Mr De'Ath: We will take that on notice.

THE CHAIR: We will suspend there for a short break.

Hearing suspended from 3.29 to 3.48 pm.

Ms Fitzharris: We can provide some follow-up information on organ donation, if you would like that now.

THE CHAIR: Excellent; thank you.

Ms McDonald: In 2018 the ACT recorded the highest national consent rate as well as donor per million population, at 32.4. The Australian average is 22.2. There were 21 donors in the ACT last year. The trend in growth, ACT and nationwide, for the past five years has been an increase in organ donation, and, as a result, transplantation.

In the 10 years since the national DonateLife program started, organ donation has more than doubled, to nearly twice the number of people through transplantation. Through community awareness and education, DonateLife ACT encourage individuals to speak with their family and friends about their donation wishes and to register their donation wishes on the Australian organ donor register.

The DonateLife walk is an annual event which attracts approximately 5,000 participants in Canberra. DonateLife week in 2019 is Sunday, 28 July to Sunday, 4 August, so it is coming up. This year we are encouraging more Australians to register to be an organ and tissue donor and have a conversation about it with their family and friends.

Donor numbers could be further improved by increasing registration. We know that nine out of 10 families honour the wishes of their loved ones, if they are registered and have made their wishes known. There is a national approach to increase registrations. Our DonateLife ACT team are part of that national approach. The South Australian model uses a drivers licence. This appears to be a very successful model and we are looking at that model as well.

THE CHAIR: I believe we have some further information on the bush healing farm.

Mr De'Ath: We do, chair. With the committee's indulgence, we have the membership lists, as well as some other information that I think would be helpful for the committee. I am happy to ask Amber Shuhyta to come to the table.

Ms Shuhyta: I have the update on the Ngunnawal Bush Healing Farm advisory board. The workshop at the Ngunnawal Bush Healing Farm around governance really established to go back to the original advisory board membership and to discuss any changes to the membership at that first revisit to the committee. A range of community stakeholders was suggested to be a part of that advisory committee, but we will discuss that when the governance committee meets again, and that is forecast for late July.

The existing membership comprises two members of UNEC as co-chairs, another Ngunnawal elder and the health representative of the Aboriginal and Torres Strait Islander Elected Body. We have CIT, Canberra Health Services and Winnunga Nimmityjah on the advisory board, as well as members of the Health Directorate.

There is a process underway in terms of establishing a healing framework, which the

minister alluded to before, which is going really productively with UNEC out at the farm. A number of knowledge circles have been conducted with the Healing Foundation to establish the healing framework. The healing framework is looking at cultural healing that is broader than what was originally looked at in terms of drug and alcohol residential rehab. It is looking at a broader scope for what can be offered at the farm in terms of cultural healing and what UNEC's role can be in terms of cultural leadership at the farm.

The healing framework work will involve elders broader than UNEC and Aboriginal and Torres Strait Islander community members of Canberra, to really inform what trauma informed cultural healing really means to the Canberra community and what programs and staff would be consistent with that model. We really wanted to make sure that the model that was rolled out in the future was community led and community driven in terms of what a healing framework would look like.

MRS DUNNE: What happened to the model of care that was developed by Winnunga for the bush healing farm at about the end of 2017? Has it gone anywhere or is that informing this model of care?

Ms Fitzharris: A number of statements have been made in the Assembly about this. That model of care was not appropriate for the facility's location, as I understand it, so it was not followed up. It has caused significant concern to Winnunga, for which I have apologised directly to them and in the Assembly, and I have spoken about this on a number of occasions.

MRS DUNNE: It is not even being used to inform any of these other bodies of work?

Ms Fitzharris: The work that was done will be. I know that Winnunga will work with other Aboriginal partners on the work being done around the residential rehabilitation service.

MRS DUNNE: You may have said this, Mr De'Ath; I might have tuned out. When is the review due—the governance review?

Mr De'Ath: I cannot recall the conclusion date.

MRS DUNNE: So you did not tell us before?

Mr De'Ath: No, I did not.

MRS DUNNE: Take it on notice. And will that become a public document?

Mr De'Ath: I would expect it would. Can I take that on notice?

MRS DUNNE: Yes, sure.

Mr De'Ath: There are some important stakeholders to consult on that.

MRS DUNNE: Okay.

THE CHAIR: How vulnerable are ACT residents to an outbreak of measles and what is the government doing to minimise the impact on ACT residents against the outbreak in both Australia and overseas?

Ms Fitzharris: Vaccinating.

Dr Coleman: I missed the first part of the question.

THE CHAIR: How vulnerable are ACT residents to an outbreak of measles?

Dr Coleman: Not very vulnerable, which is very good. We have very good immunisation rates, particularly for those people who have had the full childhood immunisation. We do have a sector of the community born between about 1960-something and below that where they did not necessarily get two doses as children. We do recommend that people check if they have had two MMRs and, if they have not, they can go and get those.

We are not really vulnerable, which is one of the reasons why we have not seen an outbreak. We will only see a case of measles when it is brought in by someone who has acquired it overseas. The public health action that we do, whenever we identify a case of measles, is very strong. We go out and isolate that person so that they cannot transmit anymore, we identify all of their close contacts and we make sure that they understand what the signs of measles are; if they come down with it, they let us know as soon as possible. We can also give them medication to reduce the risk of getting measles if they are susceptible.

THE CHAIR: Do you know what proportion of the ACT population has been vaccinated?

Dr Coleman: We have vaccination rates for children, and they are close to 95 per cent. In terms of adult vaccination coverage, we do not have that.

MS CODY: If you have had the full—

MRS DUNNE: MMR.

Dr Coleman: The measles containing vaccine, yes.

MS CODY: MMR as a child, do you need to get a booster as an adult? How often do you need boosters?

Dr Coleman: You need to have had two measles containing vaccines. If you have had two in the past then you are at least 97 or 98 per cent protected.

MS CODY: I have absolutely no idea.

Dr Coleman: If you do not know, and if it is not recorded, you are eligible for a second one. Just go and get it from your GP. Please, if you are going to travel overseas, absolutely do that because that is where our population brings it back from.

MS CODY: Interesting; thank you.

Ms Fitzharris: It is handy public health advice.

MRS DUNNE: While we are on the subject can I actually compliment staff. My husband was at emergency recently and there was somebody—

MRS JONES: A case.

MRS DUNNE: There was a case and everyone apparently was rung. My husband was there and he was rung. That was within a couple of days. It was a very quick response.

Dr Coleman: Thank you. We had over 400 contacts in that follow-up and we did not have a secondary case. It was, I think, over 20 people who needed some form of vaccine or some immunoglobulin. Thank you. I will pass that on to them.

MRS DUNNE: Thank you very much. It was very efficiently done.

MS CODY: I have a question about women's health. There is some money put aside in this year's budget. What are the key areas that are being prioritised for that funding over the next 12 months?

Ms Fitzharris: For the maternity access strategy or the—

MS CODY: I noticed that there was talk about breast screening and there was talk about maternity. I am asking about women's health in general and what things we are prioritising, what things we are funding. I know that there is $114,000 set aside in BP 3 at page 81. I have also, as I said, seen other initiatives like an increase in breast screening and those sorts of things. I just want a generalised account of what we are doing with women's health.

Dr Coleman: I ask Katrina to give an update on women's health in general. But as you would know, there are multiple people who—

MS CODY: I understand that, yes.

Dr Coleman: But maybe about maternity and then anything else in women's health and then, if we need to talk about breast screening, Cathie can answer about breast screening.

Ms Bracher: Contained within the 2019-20 budget is an appropriation for the maternity access strategy. That falls within the women's health domain. We spoke briefly about that before. I can speak in a little more detail around what that money will go towards.

There are four-point something FTEs in the appropriation, and they are made up of midwives and a couple of administrative staff. They will form part of our maternity access assessment and referral team, and that is the team that will be offering, through that single phone line, very early in pregnancy an assessment with a midwife and then, taking into account the woman's particular requests and the clinical assessment that is

done by the midwife, give them some options for where to go and then support them with the referral either to many of the trials that are on: to the homebirth trial, to Calvary hospital or to the Canberra Hospital services.

Ms Fitzharris: I think the other one that you were talking about is the work around the mesh to support women who may have had mesh inserted. I think that is the specific one you are talking about.

Ms Bracher: That is right.

Ms Fitzharris: Can you talk about that one?

Ms Bracher: That is the other initiative and—

MS CODY: The line item is at page 81. It refers to more specialised women's health care.

Ms Fitzharris: Yes, that is the mesh.

Ms Bracher: Sorry, I do not have the budget papers in front of me.

Ms Fitzharris: That is the one.

Dr Coleman: Katrina can talk to that one.

Ms Bracher: Over the past few years there has been a mesh steering committee that has met weekly co-chaired by the clinical director of obstetrics and gynaecology and the healthcare consumers. They have been very actively involved in that. I will not speak to the work that they have done over the past couple of years in audit and making contact with women in the ACT.

The appropriation will be to set up a multi-disciplinary clinic that will have gynaecologists, pain specialists, physiotherapists, nurses to provide a multi-disciplinary assessment and treatment service for women who have been affected by the mesh implants. We are meeting next week—our monthly meeting is next week—since the budget was handed down and the budget announcements were made. We will be starting our first conversation with the consumer groups and the steering committee around what that clinic will look like. The intention is for it to be co-designed with consumer groups. My understanding is that Dr Arya, who was here this morning and who is still here, is also involved from a territory-wide perspective in the governance of that response to the Senate inquiry.

MS CODY: I do not know if this is an acceptable question but do we know the approximate number of women affected by mesh in the ACT?

Ms Bracher: We do. I have them in front of me. There were 300 women, I believe, of that order, in the ACT. Maybe if you have another question while I look.

MRS DUNNE: Can I elaborate: is that women who are symptomatic as opposed to the number of women who have received mesh? I think it has not always become a

problem. Not every single implant becomes a problem.

Ms Bracher: It is all women. That number, when I can find the number in the 300-order mark, is for all women in the ACT who have. Some of them are symptomatic, and some of them are not.

MRS JONES: But the procedure is still being used or is not being used anymore?

Ms Bracher: In the ACT we have stopped doing that procedure with mesh. Women still have surgery and the gynaecologist makes a decision on a clinically appropriate non-mesh treatment.

MRS DUNNE: Do we know what proportion of that 300-odd are symptomatic?

Ms Bracher: We would but I do not have that in front of me.

MRS DUNNE: Take it on notice.

Ms Bracher: The data I have got here was interim data.

MRS JONES: Would you like to take it on notice?

Ms Bracher: Yes, absolutely. We can give you total numbers, we can give you the proportions, if we can work that out, that are symptomatic as well.

MRS DUNNE: Are those figures for women who received mesh in the public hospital system? Is the private hospital system able to provide that information?

Ms Bracher: I will clarify that in the data that we provide.

Ms Fitzharris: We have written to them about that. It has been easier for us in the public health system than in the private. But that work is being done.

Mr De'Ath: Just to clarify, that question on notice will be taken by ACT Health Directorate as we look across the system to respond.

MS CODY: That particular initiative I pointed to is specifically relating to the mesh and that is where that funding is aimed. What about other women's health initiatives in this budget?

Ms Fitzharris: There is the women's and children's hospital. The expansion of that is probably one of the most significant expansions of postnatal beds. There is also work in the maternity access strategy that has been mentioned. The gestational diabetes work is very important, particularly given that the number of women with gestational diabetes is sadly going up at very alarming rates. That is a really important initiative. There is also the ongoing work that we have to support the safer families program in training of front-line staff.

This is the

MS LE COUTEUR: How many bulk-billing GPS are there across Canberra, apart from not enough?

Ms Fitzharris: A rate is recorded by the commonwealth government because it is a choice that individual practices make. Some provide a different range of services. My understanding from representations made to me is that GPs across Canberra will bulk-bill at different rates for different groups of people within their own clinics. Some have a cooperative approach where you pay a membership fee but all patients are fully bulk-billed, so there is a real mix.

The grants we had last year to support the expansion of bulk-billing have been rolling out, and we have a similar program this year to assist in primary care and GP practices to provide expanded services to the community. Our rates have been consistently a bit lower than others and a range of things has been done over time. But ultimately it is a decision for each GP to make. A range of factors affects their ability to bulk bill including the fact that in the next ten days the freeze on their payments from the commonwealth will be lifted. That will give them some relief, but the GPs will argue that it has not kept up at all with the rate of doing business.

MS LE COUTEUR: Am I correct in understanding the last bulk-billing GP in Civic, the interchange practice, has closed and moved out to Tuggeranong?

Ms Fitzharris: Interchange General Practice is in the process of moving to Tuggeranong, yes, but we are doing quite a bit of work around that decision. A practice will still operate in Hobart Place, but it may not provide the same level of bulk-billing. That is a decision for them. I believe that other GPs in the city area may bulk-bill some of their clients.

MS LE COUTEUR: How do find a bulk-billing GP?

Ms Fitzharris: They are private practices funded through the commonwealth. There is a range of different ways you can find out. We have some information available online, but it is not something we are responsible for.

On your particular point about Interchange General Practice moving to Tuggeranong, we are doing a significant amount of work in recognition that a number of their clients have very specific health needs. They are a particular group of people who need intensive work. We are working with a number of stakeholders on supporting their access to primary care.

MRS JONES: Even in the process of change people could have some adverse outcomes.

Ms Fitzharris: Yes, we are working with a range of community organisations very closely on that and there have been a number of stakeholder meetings around that issue.

MS CODY: Did you say in response to Ms Le Couteur's question that there is an online presence of bulk-billing practices.

Ms Fitzharris: There is information online.

MS LE COUTEUR: And you also said that you are of the belief that the inner north has bulk-billing practitioners.

Ms Fitzharris: There might be some practitioners who might bulk bill some of their patients. They might bulk-bill children. The National Health Co-op now have quite a significant presence at the ANU and they bulk bill all their patients. They are very keen that it is not only for staff and students but that it is a GP practice for the inner north.

MS LE COUTEUR: I know it used to exist and then it stopped at the ANU, and I had not realised it had continued.

Ms Fitzharris: It has continued within the National Health Co-op. So a number of the GPs that were at the ANU have moved and joined the National Health Co-op.

MS LE COUTEUR: Do you know if there is anywhere in the inner south?

Ms Fitzharris: I am not aware, and I do not think officially we are aware either. There are nurse walk-in centres as we discussed, which are another option for primary health care, and some services are provided by community pharmacies also.

MS LE COUTEUR: There is not a nurse walk-in centre there in the inner south. I have had a number of correspondences from people in the inner south saying they feel particularly badly done by.

Ms Fitzharris: If you look at the regions the walk-in centres are servicing—Gungahlin region is serviced by Gungahlin, Belconnen is serviced by Belconnen and the location of the inner north walk-in centre is to service the region of the inner north, inner south and the city. Depending on where you are in the inner south Weston Creek will be closer.

MRS JONES: I believe there was a government commitment in the last election on meningococcal B vaccinations for babies. Would you update us on what has been achieved and whether the commitment has been fulfilled?

Ms Fitzharris: Not yet, and partly that was advice received around where we had the greatest need in the last budget, which was meningococcal W. We focused on that in terms of public health needs. We are continuing to do work on meningococcal B and there have been discussions at the national level about whether that vaccine will come on to the national immunisation program.

From memory, most jurisdictions started doing meningococcal W by themselves before the commonwealth went through their processes, so we are awaiting a similar approach on meningococcal B because that is not on the national immunisation program. We are continuing that work.

MRS DUNNE: So the W is ACWY?

Ms Fitzharris: Yes, that is the vaccination.

Dr Coleman: ACWY covers against all those four serotypes whereas the men B is solely for the B serotype.

MRS DUNNE: What is the target audience for ACWY?

Dr Coleman: It is two doses. You get one at 12 months and then at 15 to 19 years of age. The reason is that there are two peaks of illness, so that is when the greatest stage of illness is and also where the most likely risk of transmission is. So by reducing carriage and illness in those two population groups we can reduce the spread of the meningococcal bacteria.

MRS DUNNE: There was money set aside in the last election campaign, and it was funded and costed. I have not had a satisfactory answer.

MRS JONES: I thought the minister said that they have not fulfilled it because they chose to go for the other meningococcal vaccine.

MRS DUNNE: Yes, but why aren't we going for B?

Ms Fitzharris: We had a similar conversation last year, and it was the same. We are continuing to do more work and looking at what the commonwealth is doing around whether that program would go through the relevant committees, nationally, around its effectiveness. There have been some ups and downs in terms of the expectation at the commonwealth level about that, but that is something we keep a watching brief on, and we will in the next budget round as well.

MRS DUNNE: Have there been any cases of B since the 2016 election?

Dr Coleman: The most recent case of B was earlier this year in an adult, and the one prior to that was in 2016.

MRS DUNNE: So we are talking about one every two years?

Dr Coleman: One every two or three years, yes.

Ms Fitzharris: But not in a baby.

MRS DUNNE: Not in a child.

Dr Coleman: I would like to also add that whenever you add another immunisation to a childhood immunisation program, there are a number of things that we want to consider just to make sure that we do not overcrowd that program and run the risk of undermining the really good work that we have done at the moment. When a men B is added, it is added at the two and four month value points as well as one year of age. Kids already get two or three vaccinations at those points, so when we add that in, we will need to really consider how that will work. Plus the Bexsero has an increased risk of fever above the other vaccines.

MRS DUNNE: So you can create trouble.

Dr Coleman: Yes, and at the under 12 months age, they are particularly at risk of those elevated fevers and seizures and those kinds of things. One of the recommendations is to take paracetamol before you get vaccinated, which is something that we do not currently do, so that is a significant change in healthcare worker behaviour. There are a few complications or challenges.

MRS DUNNE: I know a lot of parents who do anyhow.

Dr Coleman: Absolutely, yes.

MRS JONES: I mentioned the flu season. I believe it has been a month early this year. Is that right? Have we got some metrics on that yet and have we got advice for people?

Dr Coleman: The flu season has started early, probably by about two months.

MRS JONES: Two months early?

Dr Coleman: Yes; it looks about two months early. We do not really know why. I am trying to find the most recent data.

Ms Fitzharris: There was some helpful advice provided through Canberra Health Services on the difference between flu and a cold, which has been commented on, quite oddly.

MRS DUNNE: Everyone thinks they have the flu.

MRS JONES: People do often interchange the words. It is part of our culture, I think, in Australia.

Dr Coleman: We have seen quite a steep rise, but if you look at the curves on the influenza summaries that we provide on the web, it is very much that the curve is happening at the same pace; it has just shifted to two months earlier.

MRS JONES: The question is whether it continues to rise or whether it starts to dip.

Dr Coleman: Yes. I could not tell you the levels at the moment, but we are at about 950 notifications and around 100 hospitalisations. That is the latest data that we have. But nationally we still do not think that it is going to be necessarily a more severe season in terms of our severity indicators. By that I mean deaths or hospitalisations.

MRS JONES: It may go longer but not be more severe.

Ms Fitzharris: Or it may go shorter.

MRS JONES: Yes.

MRS DUNNE: But it has also been a good opportunity to remind people to have their

immunisations.

MRS JONES: Yes, if you are not already sick.

Dr Coleman: And there has been an excellent demand for vaccines.

MRS JONES: There are plenty of vaccines this year, I take it?

Dr Coleman: Yes. There has not been a problem with the vaccines funded under the national immunisation program and ACT Health. There have been some ups and downs with the private supply. Part of that is just due to the massive numbers of people who have wanted to get vaccinated. But I understand that there has been another amount come in and then distributed to pharmacies.

MRS JONES: Last year there was a significant issue with them running out. This year it is a bit better or maybe it is just in the private market?

Dr Coleman: Part of the problem is that for the national supply and the ACT health supply, we have to put in our order about five months early, so we guess-estimate based on last year and what we think. We add a bit more, thinking there is going to be more demand both at a local and a national level. Last year there was a bit more demand than we anticipated; this year, I think we have got it about right, but time will tell.

MRS JONES: Demand is a good thing in a way as long as we can keep up.

Ms Fitzharris: And 2017 was so bad, I think a lot of people looked to getting vaccinated in the next year and that is why there was the demand. It went up, but it was not as bad as we saw then.

MRS DUNNE: Where is the vaccine made? Is it made by CSL?

Dr Coleman: It is made offsite.

MRS DUNNE: What does offsite mean?

Dr Coleman: An off Australia site somewhere.

MRS DUNNE: Overseas?

Dr Coleman: Yes. I could find out and let you know.

MRS DUNNE: So it is not made by CSL?

Dr Coleman: I am not exactly sure. CSL makes one brand, but I am not even sure whether they make it onshore. I would have to confirm that.

MRS JONES: We will put it on notice.

Ms Fitzharris: We will take that on notice.

MR PETTERSSON: Thank you. Could someone tell me more about the fancy ACT Health app?

Mr De'Ath: Mr O'Halloran will be very pleased to hear it called that. He talks about it endlessly.

Ms Fitzharris: Has everyone got it?

MS CODY: No.

MRS JONES: No.

MS LE COUTEUR: No. What is it called?

Ms Fitzharris: You do not read all my media releases?

MRS JONES: Do not be offended, Minister.

Mr O'Halloran: The app is simply called ACT Health—

MS LE COUTEUR: I go into the app store—

Mr O'Halloran: Google Play or the Apple App Store. As of this morning, about 5,100 individual people had downloaded the app. We are seeing that growing day by day. In short summary, it will provide information for both emergency departments and the walk-in centres on waiting times and numbers of patients waiting to commence treatment. It will also provide mapping directions. Sitting here, I can see the closest walk-in centre to go to, based on the combination of both the waiting time and the driving time to get there. At the moment, Gungahlin is the best walk-in centre to go to. It is 48 minutes in total to get there and also wait for treatment. It is very popular. We are also providing information for inpatients guides across the three major public hospitals across the territory. There will be a range of enhancements to the app coming out every month or two between now and the end of the year which will cover a range of other functions and other digital services that we are rolling out to consumers across the territory.

MRS DUNNE: Such as?

Mr O'Halloran: Some of those are tied into earlier announcements that have been made, such as the ability for outpatient appointment check-ins to be performed through the app. There is some technology rolling out over the next few months that I think was previewed with the launch of the new health strategy by the minister some weeks ago. There is also the ability to provide additional feedback and a range of other services we are working through at the moment. As part of the rollout of the app there are wayfinding kiosks being deployed across community health centres. University of Canberra Hospital already has them and they are going across Canberra Hospital in the coming weeks, which will provide electronic wayfinding directions around those campuses.

MRS DUNNE: Is that rather than the lines on the linoleum?

Ms Fitzharris: Yes.

Mr O'Halloran: The lines will remain. Some of us are quite fond of them. In some cases, in fact, the kiosk will tell you which colour line to follow at times, because it does still work. That is as well as the ability for outpatients to check in from those terminals. Very much what we are trying to do is move patients away from having to stand at central outpatients or at individual clinics to being able to check in on their phone or on the kiosks.

MR PETTERSSON: Why did this app need to be developed? What were you responding to?

Mr O'Halloran: It is all about providing digitally enabled services to the community we are serving. We are trying to make it easier. In the same way, some years ago free wi-fi services were provided initially across Canberra Hospital and then across other ACT health facilities at the time, and Calvary 12 or 18 months ago. This is just the next evolution of taking some of our services to a digital level to make it easier for patients and consumers to access the services that best suit them.

Ms Fitzharris: While Peter is here, this is an opportunity to talk about some of the other components of the digital strategy that clinicians will be using and the devices that they will be using to support it from the workforce point of view.

Mr O'Halloran: There are some key things being rolled out that were funded in last year's budget, very much around communication first of all. We are putting in new back-end systems for things like telephone switchboards and pass messages from system A to system B. It sounds very unexciting. What that actually means in practice on the ground for clinicians is that we will be deploying across Canberra Health Services later this year and early into next year the equivalent of smartphone apps to replace our pagers and other messaging services.

The idea is that clinicians will be able to send the equivalent of a Facebook Messenger or a WhatsApp message in a secure way that is compliant with our legislation. It can be around individual patient matters, in which case we can capture full data about the patient. We can exchange photos securely, even down to the point of putting grids to do measurements for wound size and the like, all those types of things. That should relieve a lot of the requirement for clinicians to stand by phones when they are paging someone else to wait for support.

As part of that we are also rolling out what are called clinical work devices, which in essence are clinical grade smart phones. We have already got 2,000 of these devices currently in the process of being delivered. They will be rolled out to staff, particularly nurses and allied health professionals on the floor, to enable them to contact medical officers directly in real time to exchange those messages but also, over time, to start accessing our various clinical applications. We are trying to put the computing power in their hand at the bedside where they are providing care. That is quite a dramatic change.

The clinical work device—it sounds very boring when you say it like that—in essence is a clinical grade smartphone that passes infection control. We can disinfect it. We can put it under water and it will keep working. It is designed for shiftwork. Because we have in the public health system over 8,000 staff, we are obviously not proposing to buy a device for every person. So it is designed, for example, so they can tap on at the beginning of their shift using their ID card to log in to the device. Therefore it is also based on having a long battery life and you can do a hot swap with a battery with the device still powered up. It is very much designed around ensuring that all our clinical staff have the best tools to access information and communicate at the point of care at all times.

MRS JONES: Some of us would like a phone that worked under water.

Mr O'Halloran: During the procurement we actually tested it going into bedpans, which was a little too realistic. Thankfully it was probably water.

MRS JONES: I am sure it has happened.

MS LE COUTEUR: This app looks great fun but—

MRS JONES: I am not sure—service-y.

MS LE COUTEUR: Or fancy. I did actually know where the hospital was, so to that extent it is more like fun. And I am seriously hoping it is some sort of average in terms of the ED waiting time, because ED did much better for us last week than you are suggesting here, which is, I suppose, why I am saying it is fun. There are a lot of people, though, who do not have smart phones. They tend to be people who are more likely to be accessing hospital services, the old and the vulnerable. You will still keep all your existing communication methods, phones in particular, for those clientele? I would hate to see this overtake the traditional forms of communication.

Mr O'Halloran: The answer is yes. In fact the waiting times for emergency departments have been on the ACT Health website for some years. What we have done is to simply take that data and make it available through a smartphone app. The intention is that we supplement that method with other methods of sharing information. Certainly we are aware now of some staff that answer public enquiry lines that also have the app on their phones, and they are providing some of that data to callers who call up. It is very much trying to present the information through as many mediums as possible.

MRS DUNNE: Could I follow up on the technology. When is the Canberra Hospital going to get rid of its fax machines as a means of communications and making appointments?

Mr O'Halloran: In the past couple of years we have been slowly decreasing the number of fax machines. We are also doing some work to replace some of the phone lines that service the remaining fax machines to increase their reliability. There is a project currently underway using some software—the proof of concept will go live in the next few weeks—looking at enabling GPs to refer patients for certain services to Canberra Health Services directly from their practice management software.

In essence, the GP in their rooms will be able to say, "I need to refer this patient to Canberra Health Services," and pull through the form. That will pull down from an online cloud-based system. Most GPs already use some secure messaging anyway, so we are going with platforms they are already using. It will pre-populate that form directly from their practice management software. The GP can then go, "That information is irrelevant for this referral," and then pull it out and submit that to us electronically.

MS CODY: Did you say that is currently happening?

Mr O'Halloran: No. A trial of that will commence in the coming weeks, with the intention that it would roll out across all of those services progressively over the next year or so. That is a distinct change in where we are going.

Referrals coming in from specialists are more problematic because, traditionally, as you may be aware, Mrs Dunne, most specialists do not have practice management software, and in many cases do not even have computers in their rooms. Getting electronic referrals from them will be somewhat harder.

MRS DUNNE: You mean on their desks?

Mr O'Halloran: On their desks, but often you will even find that the record keeping of those specialists in their private rooms is some form of traditional manila folder. Progress is coming, in that we are starting to see more specialists with particular practice management software, but it is a slow, steady path.

The other part of the work we are doing is around moving away from so many outbound faxes. At the moment, we have a significant number of inbound faxes. We are moving to use the same technology to provide a lot of the data that is going out by faxes electronically over the next six months to most of the GPs.

Ms Fitzharris: I think the health system is singlehandedly keeping fax machines alive.

MRS DUNNE: This leads to a case study of mine. I have written to you, minister, about this case study. It is about a lady who lived on the south coast who was referred to an outpatient clinic. The GP faxed the request and was told, "Somebody should contact you in a number of weeks." She rang. "No, we never got the fax." The GP had to do the fax again. That took her from October last year to January this year. She was triaged as needing an appointment to see somebody within 30 days. Her last advice was that she might see someone in November, more than 12 months from when she was diagnosed.

So moving on from the fax problem, which I am glad to see, Mr O'Halloran, we are dealing with—

Ms Fitzharris: You never know where the problem was with the fax, though, in some cases.

MRS DUNNE: It is 1970s technology, which was pretty whiz-bang in 1970, but it is

not anymore. It is a real problem. Also, with some of these outpatient clinics, the wait times to get an appointment are horrendous. And it is not providing a service to people who need it. What are we doing about addressing the wait times?

Ms Fitzharris: In outpatients?

MRS DUNNE: In outpatients. It is horrendous. That is one case study, the most recent one I have come across.

Ms Fitzharris: So now we are moving from faxes to outpatients?

MRS DUNNE: Yes.

Ms McDonald: I might start. Cathie has far more detailed information about what we are doing, but we do have a timely care strategy and working group that we established a few months ago. One of the key points of our timely care strategy is that we have called it timely care, not just patient flow, because we actually want to promote timely care. We have included our outpatients department in our timely care strategy, and we are actively looking at ways to improve access to outpatients, in particular, for those specialist medical clinics and services that cannot be provided elsewhere. Cathie and I talk regularly about this and it is part of our timely care strategy. We might let Cathie talk to you about what we are actively working on at the moment.

Ms O'Neill: It is a challenge that is not unique to the ACT. I think every jurisdiction is struggling with access to specialist outpatients. We have had some good news stories in this space, but we have a long way to go to get it to where we would all like it to be.

It is really a combination of trying to manage demand and trying to increase capacity. There is a range of strategies underway on both sides of that equation.

Around managing demand, we are working with the services to identify the core service that that medical specialty is providing. We get a lot of referrals from GPs for conditions that probably do not really warrant tertiary specialist involvement. We are working closely with the Capital Health Network, particularly around the health pathways program, to ensure that GPs can better manage some of these patients in the primary healthcare centre before referral.

We are also working on a range of strategies around capacity. We have implemented a number of clinics where, for example, advanced practice nurses or extended scope physios are screening patients and often undertaking some of that early intervention to avoid needing to see a specialist.

We have also done quite a bit of work around follow-up appointments, particularly after surgery. Particularly with the advent of keyhole surgery, you do not need to come back to get your stitches out like you used to. We are working with the surgical teams to change their practices so that they only bring back patients for review if they really need to come back. We are also conducting a lot more phone clinics, just to check in on patients, again stop them physically having to come back.

One of the areas that we are now really starting to focus on is increasing the number of new patient referrals as a percentage of the total appointment load. At the moment, we are probably bringing back patients far too often. I liken it to the idea that we get these people on the bus but we keep them on the bus, yet we have all these people waiting at the bus stop. It is about how we get the interventions that these patients require and then hand them back into the primary care setting where they can be adequately looked after rather than using up appointments that we need to allocate to new patients.

MRS DUNNE: What is the timetable for this?

Ms O'Neill: It is a long piece of work. We are working on it quite hard, and we are seeing some improvements every month, but it is not going to be something that is going to be solved quickly.

Ms McDonald: It is really about working with each clinician in changing their practice.

MRS DUNNE: But it will be different depending on whether it is urology, neurology, respiratory or whatever.

Ms McDonald: Different requirements, yes. Exactly right. We think we have quite a bit of capacity if we can change the new to review appointment ratios. As Cathie says, people come and they may have a procedure or they may have an illness, and they keep getting review appointments and coming back for years on end when, actually, if the specialist referred them back to their GP and we provided support to the GP in how to manage people in the community in a primary care setting, that would free up a lot of capacity for us.

Working through with each unit and each clinician in changing their practice does take some time, but it is something that we are absolutely committed to. We are adding our new to review ratios for each of our clinics to our key performance indicators so that the executive is across this and looking at this. And I am holding my execs to account in terms of their interaction with their specialists in their units.

What often happens is that we all think outpatients is over here, that it is somebody else's responsibility, but it is actually all of us taking accountability for that. But it is clinical practice change with a lot of our clinicians who have a lot of long-term habits where we need to work with them to think whether they can do it differently. We are not taking away care; we are moving care to the appropriate position in our health system.

MRS DUNNE: That is a useful indicator, Ms McDonald. Is one of the other indicators the length of time it takes to get the first appointment?

Ms McDonald: Yes.

Ms O'Neill: And we monitor that.

Ms McDonald: We monitor that as well.

Ms O'Neill: We monitor that against each of the triage categories. Broadly speaking, most category 1 patients do get their appointments within that 30 days. There are a few specialities where we struggle because the demand is just so high, but we have done significant work.

Urology is a good example. We were really struggling to see category 1s in the time frames. Last time I looked at the data, there might have been 30 that were waiting just outside of that, and it was just outside the 30 days. So we have brought that down considerably. Gynaecology has been almost completely turned around, from having upwards of 400-long waits now down to all patients being seen within clinically recommended time frames. Neurosurgery has seen a significant reduction in long waits as well.

So we are making inroads, but for every inroad we make, there is a constant flow of referrals in.

Ms McDonald: In the 2019-20 budget, there has been some allocation for increases, I think in rheumatology and dermatology in particular, so that we can put on additional doctors and additional capacity for those clinics. We have the extensive long waits as well.

Ms Fitzharris: And urology through Calvary.

MRS DUNNE: Could the committee see some of those indicators and perhaps changes in the indicators over a period, and we can perhaps revisit it in annual report hearings.

Ms McDonald: Yes.

MS CODY: When will the government commence access to medical abortions as passed by the Assembly last year?

Ms Fitzharris: It commences on 1 July, so not very far away at all.

MS LE COUTEUR: Are all the preparations ready?

Ms Fitzharris: Yes.

MS CODY: What engagement has been undertaken by government with the community ahead of the commencement?

Mr Culhane: We have been working for some time with a range of stakeholders. Marie Stopes are running their education program for GPs on 25 June, if I recall correctly. We have been working with, as I recall, Capital Health Network, and a range of other parties around Canberra. If you want a list of the specific stakeholders I would need to take that on notice.

MS CODY: Do we know the numbers of doctors looking to prescribe?

Mr Culhane: I am not aware of the number of doctors. I think we would need to wait until the 25th. You have to go through the training in order to prescribe, so I think we need to get to that point. We could talk to Marie Stopes now and see how many doctors have signed up for the training, but we are still a week off.

MS CODY: Maybe we can follow that up in annual report hearings when you will have more idea of some data?

Mr Culhane: I think we would have a clear idea how many have been trained by that stage, yes. How many are prescribing is a question I do not think we could ever answer.

THE CHAIR: Has the Health Care Consumers Association delivered its feasibility study into the patient navigation service yet?

Ms Fitzharris: Yes.

THE CHAIR: And what was the government's response?

Ms Fitzharris: We are still working with them.

Mr Culhane: We have a high level report from the Health Care Consumers Association on the patient navigator. We are still looking at that. We have not put formal advice to the minister yet on that.

MRS DUNNE: That report was finished when?

Ms Fitzharris: Last year, from memory.

Mr Culhane: Yes, I think it was a while ago. That is right.

MRS DUNNE: There was an election commitment for 12 nurse navigators. They have not been funded?

Ms Fitzharris: Yes, they have. They were funded in the 2017-18 budget, from memory, but I will take that on notice.

MRS DUNNE: If we have not agreed on what the patient navigation service should look like, what are the 12 nurse navigators doing at the moment?

Ms Fitzharris: They are slightly different concepts in some ways.

MRS JONES: To quote another politician, please explain.

Ms Fitzharris: They are deployed across a number of different areas in the hospital whereas the patient navigation work takes a slightly different approach.

MRS DUNNE: What do the nurse navigators do and how does it fit with the patient navigation system?

Ms Fitzharris: We might take that on notice.

Ms McDonald: Just so we can give you the differences in terms of their roles.

MRS DUNNE: And also, where are the nurse navigators located?

Ms McDonald: We will take that on notice and give you all the details.

MS LE COUTEUR: You are probably aware of the submissions on the cannabis bill which said that a lot of people are having difficulties accessing medical cannabis. I understand that you answered a QoN on this recently where you said there were seven prescribers approved in the ACT with a total of 28 patients. Is there any way for patients who are seeking access to medical cannabis to be advised who those prescribers are? A number of patients say they cannot find a prescriber and have to go interstate.

Dr Coleman: I acknowledge the problem and I have heard the discussions around this. I will have to take that on notice and discuss that with our chief pharmacist as well as the GP representation to see whether this is something they would be willing to have available.

MS LE COUTEUR: Does the government provide any training for GPs or other interested health professionals so they are able to prescribe?

Dr Coleman: We hosted Professor David Caldicott last year in one training session. We are currently trying to organise another date to run another session this year.

MS LE COUTEUR: And is attending just that one session all that a GP is required to do?

Dr Coleman: With any new area in medicine it takes a little while for any healthcare professional to become comfortable with that area. Some of the professionals in the area are more than happy to provide some sort of mentoring or act in an advisory capacity if necessary. I know David is always happy to answer questions or things like that.

We provide a formal environment for a session, and then there are other informal supports. This is one of those really new areas where the evidence is not as clear as we would like. So it is going to take a little while to get that confidence in the healthcare workforce as well as our population.

MS LE COUTEUR: The other problem that patients have is that, even if they get a prescription, the medicines are very expensive as they are not on the PBS. Is there any way for the patients to access these drugs which they may be taking for a long period at a more affordable rate? Has the ACT government advocated to the federal minister to put them on the PBS?

Ms Fitzharris: Not directly, no.

Dr Coleman: One of the problems with these medications is they have not gone through the registration process with the TGA, which is why the extra formal process is required with the commonwealth. There is no medicine or cannabis product which has been assessed through the Therapeutic Goods Administration process, therefore, there is no mechanism to go through to the PBS.

TGA has put in place an alternative option, which they do sometimes when they recognise that there is a supply issue that has not gone through or perhaps another country has done that or there is some other way of recognising that there is a quality product they are willing to make available.

Mr De'Ath: Chair, if I may, on the former topic of abortion, for the record, 30 GPs have so far signed up for the training.

THE CHAIR: Thank you.

Dr Coleman: And I have an answer to the vaccine question. Five vaccines are currently available on the NIP. Two of those are made in the US, one in Europe and two in Australia.

Mr De'Ath: There was also a question earlier on presentations to the ED for hypothermia.

Mr O'Halloran: Across the two emergency departments in the ACT presentations over the past six financial years across all age groups have been fairly steady. From 2013-14 onwards, the figures are 23; for 2014-15, 22 presentations; 2015-16, 14; 2016-17, 21; 2017-18, 21; and for the current financial year up until 17 June, 22 presentations. That is across all age groups. The gender split is reasonably the same and identical so far for 2018-19—11 female, 11 male.

In terms of the age breakdown, because the total number of patients presenting is quite low they have been grouped into three age groups. For 2018-19, zero to 29, three patients; 30 to 59, 11; and 60-plus, eight. If we look at the trend across the past six years for the 60-plus age group the figures are six, seven, three, six, four and eight. Those numbers are statistically small so that is within the normal error we would expect.

MRS DUNNE: I have some questions about UMAHA. There have been some answers to questions on notice about UMAHA but I just want to clarify: there was an initial budget of $95 million plus change and there were some things taken off UMAHA and the maternity bathroom was put on. That is my recollection of the answer to the question on notice. What is the current budget for UMAHA and what are the time frames for—and some of this might need to be taken on notice—each of the projects?

Ms Fitzharris: Do you mean the current budget for this financial year or the whole—

MRS DUNNE: No, the whole project budget for UMAHA.

Mr Mooney: The current budget as it stands for the total program is just under

$91 million.

MRS DUNNE: It is down from the $95 million?

Mr Mooney: Yes.

MRS DUNNE: Where have the savings been?

Mr Mooney: Not so much savings. In the early years the project, from memory, had a budget, as you said, of about $94 million. We had some money that was repurposed for other projects, primarily a contribution to wards 14A and 14B and also some contribution in the early stages of SPIRE planning. There was approximately $10 million taken out and the money has been moved back in through other mechanisms.

MRS DUNNE: On notice, could you provide us with a flow chart or something about where the money has come in and out and where it has gone to?

Mr Mooney: Yes.

MRS DUNNE: Wards 14 A and B are the cancer wards that Mr Pettersson was talking about before?

Mr Mooney: Correct, yes.

MRS DUNNE: And the time frames?

Mr Mooney: In terms of the major packages, obviously the biggest one is the main electrical switchboard.

MRS DUNNE: That is 42 mil.

Mr Mooney: The main electrical switchboard. In terms of the actual work on the ground and new boards coming in, they will all be completed by the end of this year. The building 2 electrical main switchboard will be fully energised in July or August this year and then building 12 will be fully energised in December. I will caveat all that: subject to clinical operation constraints. There will be ancillary work after that but the actual boards will be functional and we will be able to gain the benefit after those dates.

MRS DUNNE: There was a big bank of, I think, three or so shipping container-sized generators on Hospital Road for a couple of weeks. What were they there for?

Mr Mooney: They were part of the shutdown. We have had a number of shutdowns, planned shutdowns, and the most recent one finished earlier this week. That involved work with Evoenergy where they were changing over essential plant in the substation adjacent to building 2 where the Woolies barbecue normally takes place. Directly behind there is the substation area. Evoenergy had work to be done in there.

In order for that work to progress, what we had to do was move off our main supply

into the campus that would normally be fed through building 2 and divert that to generator power. Those three generators were located on Hospital Road for a period of about 10 days. They, at a point in time when Evo were doing their work, were basically supplying power into the hospital's main switchboard network.

MRS DUNNE: Was that part of the switchboard upgrade?

Mr Mooney: Yes. But we needed to do that in order to allow the work by Evo to be done. The generator, yes, it is necessary support work that is required.

MRS DUNNE: Is that part of the $42 million, up from $13 million?

Mr Mooney: Yes.

MRS DUNNE: If UMAHA is $91 million, down from $94 million, and $42 million is for the switchboard, which is up by $28 million, what has not been done? There is $28 million that was not budgeted at the outset?

Ms Fitzharris: We are preparing this. We had this discussion in the Assembly. We are preparing this response to you as well.

Mr Mooney: To take a step back, the program for UMAHA was developed. The original figure, approximately $94 million, was made up of a number of individual line items. From memory, 149 items were provided before in terms of breakdown of extreme risk and suchlike. Each of those line items was just a single line on what was originally called the AECOM condition audit report, which had about 583 items, which was then diluted to 149.

Each one had a cost against it and within that cost we had added a percentage for preliminaries, essentially for design, and contingency. We also had within the overall program what was known as a delivery model option or delivery model contingency. There was contingency, a lot of contingency.

MRS DUNNE: On top of the original?

Mr Mooney: But there was contingency within the program because of the unknowns within the actual project. We were dealing essentially with pretty much undocumented building services. Whatever documents we had, dating back to the early 1970s, were not updated whenever any work was done—not in a consistent way. That was the reality that we were dealing with. As a result, we had contingency to deal with those unknowns. Many of those unknowns have eventuated. But we are still working within the program.

MRS DUNNE: On notice, can you provide to the committee a cost breakdown of what the original contingency was et cetera? What you are saying is that nothing was given?

Mr Mooney: We have reprioritised items. We have had savings in other elements within the actual program where we did not need all the contingency in some packages and we have reprioritised them within the actual program. I would say that

in terms of the electrical main switchboard, which is the biggest project—

MRS DUNNE: Yes, without a doubt.

Mr Mooney: We are at a point in time now where we are almost complete in terms of final negotiations with the contractor. I would not be providing exact detail on the electrical main switchboard until such time as all that is done and then that will come out through the ACT contract register.

MRS DUNNE: It may be something other than $42 million?

Mr Mooney: It is in the process of being finalised but within where we know the UMAHA program budget is at we have sufficient funding in place.

MRS DUNNE: There were projects like hydraulics and there was another project which has slipped my mind. Is the hydraulics program on time?

Mr Mooney: It is.

MRS DUNNE: And completed?

Mr Mooney: Yes. We will be finished the hydraulics program on, I think it is, 3 July. We are just aligning it with the winter beds strategy for their coming on stream on 11 July. This is level 7 in building 1 tower block where we are doing the final re-piping of the water system. I think we provided earlier advice that that was not going to be finished until July next year.

MRS DUNNE: That is why I am surprised.

Mr Mooney: The reason why that has changed is that, in consultation with the clinical areas, we were able to maximise the construction window in that space and we have been able to complete the work.

MRS DUNNE: That is commendable because it seemed to be lagging at one stage.

MR PETTERSSON: I know we touched on methadone this morning but I do not think we touched on this part of it. In the budget there is provision for a new opioid treatment service in Canberra's north side. If you could expand on what that will do?

Ms Grace: What we know, in terms of the opioid maintenance treatment program, is that, looking at the data of the people participating in the program, 50 per cent reside in Canberra's north. At the moment a significant proportion of those people will travel to the Canberra Hospital every day for dosing. This initiative will enable us to provide tier 1 opioid replacement treatment service on the north side of Canberra and be able to service that part of the population closer to home.

MR PETTERSSON: What are the separate tiers? Tier 1 is the—

Ms Grace: Tier 1 is our highest level. And that program is managed through the addiction specialists within the alcohol and drug service. They manage, monitor and

prescribe the treatment and the dosing happens at building 7 of the Canberra Hospital at the moment. I want to make sure that I get this correct. In regard to tier 2, again the specialists at the alcohol and drug service will prescribe the treatment but it will be dosed at a community pharmacy. For tier 3, the prescription is through a general practitioner and dosed within the community pharmacies as well.

MR PETTERSSON: Have you identified a site on the north side that you would like this dosing clinic to be located at?

Ms Grace: We are looking at potential within the Belconnen Community Health Centre but that is still being scoped at the moment.

MR PETTERSSON: Potentially, when could we expect this to be completed and the dosing clinic available on the north side?

Ms Grace: I might have to refer that to comm learning.

Ms Fitzharris: I think we will take it on notice in that it is such a recent announcement. And there is some work to be done.

MRS DUNNE: Could I ask a question about output classes and performance measures. In the yellow book there are performance measures, for instance, for reducing the waiting list for elective surgery, which appears both in the directorate and in CHS. In one place they are discontinued and in the other place they are picked up. I was surprised to see some of these performance measures in the directorate rather than in Canberra Hospital and Health Services. Can someone talk me through how we worked out which strategic objective went where?

Ms McDonald: We can talk about that but, just to start, whilst some of these indicators might not sit specifically under Canberra Health Services, it is because it is a measure of the system performance. We are certainly, absolutely, measured within that, and we measure it internally ourselves as well.

MRS DUNNE: Reducing the waiting list for elective surgery has been discontinued from Canberra Hospital and Canberra Health Services and put into the directorate. I would have thought that elective surgery waiting lists were pretty much—

Mr De'Ath: Mr Peffer can respond to that.

Ms McDonald: It is across the system. Elective surgery waiting lists include both Canberra Health Services and Calvary, in terms of performance. That is why it is a system measure and put under the directorate. If I am incorrect, correct me?

Mr Peffer: No.

Ms McDonald: But it is still absolutely monitored by Canberra Health Services, and we work towards that.

MRS DUNNE: I am not saying that it is not being monitored; I am just trying to get my head around the decision-making that puts some that appear to be hospital

oriented in the directorate rather than in the hospitals.

Mr Peffer: Just to expand on that, the simple response is that there are multiple hospitals in the city and responsibility for delivery does not lie with just a single entity, Canberra Health Services. Calvary is also a part of that mix. With the directorate having a system-wide stewardship role, responsibility for measuring and monitoring some of those outcomes is a system role, not a particular hospitals role.

MRS DUNNE: Minister, you are comfortable with where those performance measures are?

Ms Fitzharris: Yes. We have had quite a bit of a discussion about this given that this is the first time picking this apart. We will keep a close eye on that. But also, as I mentioned earlier, the data is reported on publicly and through the quarterly performance reports. These figures are also recorded. This is the first year we have done this; we will look to continue to refine that in terms of where the measures are and what the measures are in future years. It is a bit of a mapping exercise through these budget papers; there is not an easy way. Some people in the room have worked very hard to map these out and make sure that there are the right footnotes to reflect where it has been previously and where it is now.

MRS DUNNE: What you have done here is discontinue it in Canberra Health Services and move it over to the directorate, so you have to look in both places to see how you are going.

Ms Fitzharris: Yes.

MRS DUNNE: If in future you are going to reallocate them again, can you report on both of them. With what you have here, for instance—

Ms Fitzharris: You need to turn to page 38, yes.

MRS DUNNE: It is N/A because it is somewhere else in the report.

Ms Fitzharris: Somewhere else, yes.

MRS DUNNE: Can we keep the reporting in the same space?

Ms Fitzharris: We had this discussion, but we are happy to take suggestions from the committee.

MRS DUNNE: So that I do not have to go backwards and forwards and fill in the figures myself.

Ms Fitzharris: Okay. Removing the opportunity for error was an important part of it.

MRS DUNNE: As long as it is reported.

Ms Fitzharris: This will be the first time, and I think the only time, it will have this sort of mapping against the previous year.

MRS DUNNE: I want to go back to where we started, about SPIRE and ICU infrastructure in the interim. There has been a lot of reporting about ICU infrastructure. The FOI request that I received earlier in the year points to a paper that was prepared in April 2018 that said that there are 31 treatment spaces but ICU is currently funded for 22 ICU beds and that the ICU beds, the current spaces, do not meet Australian standards. There have been other issues reported about ICU beds. Minister, you have said that there is a strategy in place that will address these issues before they become critical. What are those strategies? It will be 2023 before SPIRE comes online. What are the strategies for meeting the ICU demand?

Ms Fitzharris: There is operational funding in this. As well, the commonwealth sought input from jurisdictions on the fund that they announced late last year. We put forward the ICU expansion in terms of capital as a priority under that. That has been funded and we are following up with the commonwealth on being able to deliver that program. Bernadette can talk you through the day-to-day matters and the operations.

MRS DUNNE: When you are doing that, Ms McDonald, can you talk about what you project the number of ICU beds to be, what the need is and where we will find them in the interim between now and 2023.

Ms McDonald: In terms of our immediate short term, in terms of day-to-day capacity in the intensive care unit, we are doing well. We have funded the beds that we have been running; we have been running a number of additional beds that traditionally are considered unfunded, because the demand has been there. We do have the physical capacity in ICU for 31 beds, so we can flex up and flex down as required in regard to demands.

If we are full and we are requiring other ICU beds, there are a number of things that we do. First, we look at whether we can move patients out into private ICU beds. We will transfer people out. We also look at our demand. If we have a high emergency demand and we have elective category 1s who are booked to go into ICU, we will see if we can delay for a day or two and move those surgeries around in order to manage it. This is the immediate day to day, if we become extremely full.

We monitor our ICU capacity on a daily basis. I have had, I think, one experience where we have had to move patients to National Capital. That was across the territory that we had real issues with ICU capacity, but that has been once in nine months that I have been here.

In the medium term, we were already planning. We had designers and architects in giving us some service options for what we could do if we needed to expand the ICU physical capacity. They came up with five different options, and we found two preferred options to give us seven to eight additional intensive care beds. That now will be funded by the commonwealth, from the commonwealth funding. That will be our medium term, which should come online within the next two years. That will give us another seven to eight intensive care beds, which we are forecasting will tide us over or give us enough capacity to get through to the SPIRE expansion.

MRS DUNNE: Are the 31 plus seven or eight across the public system or at TCH?

Ms McDonald: They will be at TCH.

MRS DUNNE: How many ICU beds are there at Calvary?

Ms McDonald: I do not know, to be honest. I do not manage Calvary, so—

Ms Lopa: I believe there are 10. I think the level is different.

MRS DUNNE: That was the number that I would guess.

Ms Fitzharris: We will take that on notice, and the level of those beds as well.

MRS DUNNE: As in how intensive those beds are?

Ms Fitzharris: Yes.

Ms McDonald: Yes. Certainly.

MRS DUNNE: And how many—this might be on notice—other intensive beds there are in the territory.

Ms Fitzharris: Yes, we will take that on notice.

Ms McDonald: Yes, we will take that on notice.

MRS DUNNE: Minister, at the beginning, you touched on the federal funding. When will that work begin?

Ms Fitzharris: When will the work begin or when will the funding come?

MRS DUNNE: I am more interested in when the work will begin, but presumably that is contingent upon the funding.

Ms McDonald: We have had some design options done and we are working through. Liz could probably talk in more detail about the progress of that project.

Ms Lopa: We had some high-level design options done, as Bernadette has just outlined. We went out for tender yesterday or the day before for a design consultant to come and do more detailed design on that work. So that tender is out in the marketplace now for a designer to work on those designs for the ICU expansion.

Ms Fitzharris: We learnt after the election that the funding under the commonwealth program was not a four-year funding program, but a six-year one. We are in active conversations with the commonwealth about bringing forward that funding as quickly as possible, but it has not been that long since the government was returned, so we need to continue that work. It is our very clear priority in that program.

MRS DUNNE: If you are going to up the capacity by six to eight beds, what are we doing about staffing?

Ms McDonald: We will start our recruitment strategies for intensive care nurses definitely way before we finish the build. We are always looking to recruit our intensive care nurses, and there are different ways we do that. We can go to national strategies to attract people, but there is also the pipeline of people coming through the postgraduate qualifications as well. We are looking at all our recruitment strategies.

They are very specialised nursing staff and medical staff, as you would understand. We have ongoing recruitment strategies in there. But, given our time lines, we will need to up those to make sure we have enough staff for both. It is not only for the expansion; it will be for SPIRE as well, going over the next four years.

MRS DUNNE: Just as a rule of thumb, for every ICU bed, how many staff do you need?

Ms McDonald: For nursing staff, it depends. The traditional ICU bed will be one nursing staff to one patient. But in terms of a 24-hour roster, in terms of the total numbers, I will take that on notice and give you the whole breakdown.

Mrs DUNNE: Yes; that is great. In relation to infrastructure and things that are coming online with SPIRE, that April 2018 document also recorded that the coronary care unit and the catheter suites do not meet current Australian standards. What is wrong with them that they do not meet current Australian standards?

Ms McDonald: I will ask Mr Mooney to talk to that specifically because it is not quite as simple as that.

MRS DUNNE: I am sure a line that says, "Does not meet current Australian standards," has a lot underpinning it.

Mr Mooney: That question referred to the coronary care unit and the cardiac cath labs. I can say that, like any construction project, at the time of their construction they were built in accordance with the building standards at the time.

MRS DUNNE: That was 1974.

Mr Mooney: I think it was. I will confirm that.

MRS DUNNE: Something like that.

Ms McDonald: Yes, the building was—

Mr Mooney: The cardiac cath labs were a little bit later. But at the time their certificate of occupancy was provided, they were built in accordance with the standards at the time. Thereafter, we check, from an Australian standards point of view, for things like body protection annual tests. There is no requirement to change the rooms, provided the normal standards are maintained, for which, as I said, body protection is an example. To say that they are not built to standard is a little bit of a stretch.

MRS DUNNE: No, they do not meet current standard, which is the—

Mr Mooney: Yes; correct. But the current standard at the time, they met.

MRS DUNNE: Yes. I understand that. That is not the current standard.

Mr Mooney: There are many buildings that would not be built at the standard right now, but if you look back at the time they were built, they were built in accordance with the standard.

MRS DUNNE: There are risks in not using the catheter lab and the coronary care unit, but are there risks associated with using them?

Mr Mooney: No.

Ms McDonald: No.

MRS DUNNE: Okay. Thank you.

MS LE COUTEUR: When will the new linear accelerator be operational?

Mr Mooney: If there are any other questions, Cathie can talk about the service; I can talk about the construction site.

Ms O'Neill: The new linear accelerator has been delivered. We have taken handover of that. The refurbishment of the bunker, as it is called—the room that it goes in—has also been completed. They are pretty significant pieces of machinery. Unfortunately, the commissioning time frame for them is quite lengthy. At the moment our medical physics team are in there, working to make sure that the machines are safe. We expect to treat our first patients on them by September.

MS LE COUTEUR: That is still a while off.

Ms O'Neill: It is still a while, but the team have been doing an amazing job down there. They have increased the number of patients treated on the remaining three machines so that we are still treating 100 patients a day.

MS LE COUTEUR: Do you expect, with the new machine, that the accountability indicators will be met for 2019-20?

Ms O'Neill: Not with this machine, because the moment this machine is commissioned we will decommission the other machine that is being replaced as well. It will end up being a year that we are without the four machines. In parallel, we have also had Icon come online with the—

MS LE COUTEUR: With what?

Ms O'Neill: Icon, the private provider that is on the grounds of the University of Canberra. They have the fifth licence in the ACT for linear accelerators. They have been treating patients since December last year.

MS LE COUTEUR: Will that be what you need to get the times right? Does it cost more for either the patient or ACT Health to have an outsourced provider?

Ms O'Neill: We are not outsourcing to Icon. It is a further option for patients to access private radiation therapy. It is a bulk-billed service with an out-of-pocket expense that is negotiated with each patient there. But what it has allowed us to do is to maintain our throughput. Whilst we are not meeting the target time lines, we are actually doing reasonably well in terms of getting patients treated in clinically appropriate time frames.

MS LE COUTEUR: Given what you have just said, are you looking at increasing the radiotherapy capacity inside ACT Health, as distinct from outside?

Ms O'Neill: At the moment we think that when we have got all five linear accelerators operating in the ACT it will be sufficient for the medium term, but we will certainly keep evaluating that.

MS LE COUTEUR: So you are expecting long term that the capacity will require the private sector to be in capacity as well?

Ms O'Neill: The licences for the linear accelerator are managed through the commonwealth. It is not something that the ACT has direct control over. We will need to keep monitoring the numbers and the demand and, if necessary, put a bid back to the commonwealth for an additional licence.

MS LE COUTEUR: Some of it now, obviously, is privately funded. There is an out-of-pocket expense, as you said. Is this impacting on people's ability to get treatment?

Ms O'Neill: No. If patients do not wish to access private treatment, they will be treated in the public service. We have actually had only positive feedback about the ability for patients now to choose.

MS LE COUTEUR: But, given that they are going to have to pay to go private, it would appear to be an availability issue. I assume that you provide excellent service.

Ms O'Neill: Some people make their decision about their care—about whether it is in the private or the public system—for a variety of reasons, yes.

MRS DUNNE: Sometimes because they can be more in control of their timetable and stuff like that.

Ms O'Neill: Yes.

MS LE COUTEUR: I want to ask about strategic indicator 7. It seems unbelievable that we are below the optimal level of hospital bed occupancy, but we keep on hearing stories about shortages of beds in hospitals. Have we got some bits that are under-utilised and other bits that are over-utilised?

Ms McDonald: I can start, if you like. I can talk for Canberra Health Services, rather than the system occupancy. In terms of occupancy, yes, we have capacity. At any given moment in time your occupancy might be 94 per cent, but in actual fact the flow of patients through the organisation is not just a smooth or easy. You use the capacity. What we are focusing on is the patient flow through the organisation so that when we get our peaks and troughs of activity we are actually maximising our capacity as well.

MS LE COUTEUR: You would expect the 86 estimated outcome to go up next year to your targeted 90 and people will flow more freely?

Ms McDonald: I think our occupancy at Canberra Health Services is higher than it is at Calvary, and that number is an actual system occupancy number. Our actual capacity occupancy is—

MS LE COUTEUR: It is at the bottom of page 37, which is what I am quoting from.

Ms McDonald: It is CHS, yes.

Ms Fitzharris: I think you will find that the Calvary occupancy sits quite a bit lower in general terms, but person-for-bed is not always a precise match. I think, as Bernadette said, you cannot have—

Ms McDonald: We try to maximise the use of our capacity and, to be honest, at peak times it depends on when you measure it. Sometimes we are at far greater than 94 per cent capacity and sometimes we will be a little lower.

MRS DUNNE: The accountability indicator is a target of 12 months for the mean waiting time for clients on the dental services waiting list. In 2018-19 the target was six months, and the estimated outcome was eight months. Why was the 2018-19 target not met? Now we are sort of blowing it out. What are the causes of doubling the mean waiting time?

Ms McDonald: Daniel can probably do this one, even though it is not in his remit anymore, as a last stand on dental.

Mr Wood: As the historical Executive Director for Dental Health for the last couple years, yes, I can probably answer that. In the dental health program that initial target was set when the national partnership agreement funding came through from the commonwealth. In every other jurisdiction the target has always been 12 months. It was an ACT Health-initiated indicator to have a six-month target time. That was before my time, but historically there was an agreement that, when that indicator was changed from what was accepted nationally, if the national partnership agreement funding decreased then we would revert to the nationally accepted target, which was 12 months.

For a long time we had a target of six months and we were meeting that target for a very long time. When the funding was decreased we petitioned the minister for the dental health program to review the target and bring it in line with every other jurisdiction in the country, which is 12 months.

MRS DUNNE: Is the availability of dentures part of that program?

Mr Wood: Yes, that is part of the program.

MRS DUNNE: Who is eligible for the denture program? Do you have to have a healthcare card or—

Mr Wood: From memory, you need a healthcare consumers card and you have to be over a certain age to access dentures. Dentures are made in house through the dental health program, but there is an external referral scheme as well. As we have talked about previously when we have come to estimates, the facilitation of dentures is not like my other area of surgery. It is not one-off; it is a course of care over a period. What we found in the dental health program was that, while we were meeting the time frame, denture times were being pushed out. One of the outcomes from this is that we have a renewed focus on the provision of dentures in the dental health program.

MRS DUNNE: And what is the wait time for dentures?

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

MRS DUNNE: I have got a case study. I think I have written to you about it or it may be in the pipeline, but it is not great.

THE CHAIR: In that case we will finish up.

Mr De'Ath: There was a question taken on notice on the abortion access site and stakeholders. I can confirm that, obviously, Marie Stopes is a stakeholder, as is the Pharmacy Guild, the Capital Health Network, the Australian Medical Association, Sexual Health and Family Planning ACT, the Women's Centre for Health Matters and the Royal Australian College of General Practitioners.

Ms McDonald: Can I submit the document on our vision and role that was requested by Mrs Jones earlier today?

THE CHAIR: You are tabling that?

Ms McDonald: Yes, we are tabling that.

THE CHAIR: On behalf of the committee, I thank the minister and officials who have appeared today. I particularly thank you all for your patience and flexibility, because I know we have jumped across a lot of topics. The secretary will provide you with a copy of the proof transcript of today's hearing when it is available. If witnesses have taken any questions on notice, could you please get those answers to the committee support office within five working days of receipt of the proof. If members wish to lodge questions on notice, please get those to the committee support office within five working days of the hearing, day one being tomorrow.

The committee adjourned at 5.29 pm.