LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING AND COMMUNITY SERVICES

(Reference: Annual and financial reports 2015-2016)

Members:

MR C STEEL (Chair)
MRS E KIKKERT (Deputy Chair)
MRS V DUNNE
MS C LE COUTEUR
MR M PETTERSSON

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 2 MARCH 2017

Secretary to the committee:
Ms K Harkins (Ph: 620 70524)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

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

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

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

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

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

Amended 20 May 2013

The committee met at 9.30 am.

Appearances:

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

Health Directorate
Feely, Ms Nicole, Director-General
Strachan, Mr Shaun, Deputy Director-General, Corporate
Seils, Ms Nicole, Deputy Director-General, Innovation
Kelly, Dr Paul, Chief Health Officer, and Deputy Director-General, Population Health
Mooney, Mr Colm, Executive Director, Health Infrastructure Services
Thompson, Mr Ian, Deputy Director-General, Canberra Hospital and Health Services
Bone, Mr Chris, Acting Executive Director, Canberra Hospital and Health Services
Lamb, Ms Denise, Executive Director, Cancer, Ambulatory and Community Health Support
Dykgraaf, Mr Mark, Executive Director, Critical Care
O'Donnell, Ms Rosemary, Executive Director, Division of Medicine
Kohlhagen, Ms Linda, Executive Director, Rehabilitation, Aged and Community Care
Reid, Ms Barbara, Executive Director, Division of Surgery and Oral Health
Chatham, Ms Elizabeth, Executive Director, Women, Youth and Children
Richter, Mr Matthew, Acting Executive Director, Policy and Stakeholder Relations
O'Farrell, Ms Patricia, Executive Director, People and Culture
Barr, Conrad, Executive Director, Health Protection Service
Kennedy, Ms Rosemary, Executive Director, Business Support
Buchanan-Grey, Ms Marina, Acting ACT Chief Nurse
Vivian, Mr Trevor, Chief Finance Officer

THE CHAIR: Welcome to the Standing Committee on Health, Ageing and Community Services inquiry into the 2015-16 annual reports. This is the second public hearing of the standing committee into the annual reports referred to it by the Legislative Assembly on 16 February. The committee is to inquire into the annual reports referred to it and report to the Assembly by the last sitting day in May 2017. Today the committee will hold hearings on the Health Directorate annual report and the ACT Local Hospital Network Directorate annual report.

I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the pink privilege statement that is before you on the table. Could you please confirm for the record that you have read and understand the privilege statement. I remind witnesses that proceedings are being recorded by Hansard for transcription purposes as well as being webstreamed and broadcast. As each witness appears for the first time, could you please acknowledge that you have read the privilege statement.

Before we proceed to questions from the committee, minister, would you like to make an opening statement?

Ms Fitzharris: I would. I acknowledge the privilege statement as well. Thank you very much for the opportunity this morning to make an opening statement to you and the other committee members. I would like to take the opportunity to make a brief statement about some of the achievements of ACT Health over the 2015-16 financial year and also outline some of the priorities I have as the new Minister for Health over this term of government.

The 2015-16 annual report highlights many achievements, particularly improvements made in areas such as clinical services policy and health infrastructure. In the clinical and service delivery space, I am pleased to say we have achieved record levels of elective surgery over the financial year, indeed 13,396 elective surgeries; improved performance in the emergency department; and reduced waiting lists for MRI scans, CT scans and ultrasounds. We also met our target of assessing 100 per cent of emergency dental clients within 24 hours.

Our public hospitals also continue to perform better than national and/or local targets for hand hygiene rates, hospital acquired infection rates, unplanned return to hospital within 28 days, and unplanned return to the operating theatre.

In the health policy area, and as the Assistant Minister for Health during some of the reporting period, I was proud to see the introduction of new legislation to protect the health of the Canberra community, including new regulations around e-cigarettes, ensuring play spaces become smoke free and seeing pharmacists being able to vaccinate adults for the flu without a prescription.

Across the health infrastructure space, we have seen the construction of a new paediatrics emergency department as part of the ED expansion project at Canberra Hospital; construction of building 15, a dedicated outpatient facility; construction commence of the University of Canberra public hospital; and the refurbishment of the central outpatients department. There have also been considerable reforms in clinical and infrastructure improvements in mental health. I am pleased to work with Minister Rattenbury as the Minister for Mental Health, and I know you will be speaking with him later today.

Importantly, Canberrans continue to be among the healthiest people in Australia, with outstanding life expectancy and a high quality of life. The Chief Health Officer's report last year shows many of these achievements, as well as where we have room to improve. We can talk in more detail about some of those aspects later, but if there is one simple message that the Chief Health Officer had that we can take out of the report, it is that we should all eat more vegetables.

These achievements are part of significant investments that the ACT government has made in our health system over the last 15 years. They demonstrate the importance we place on ensuring that the people of Canberra have access to high quality healthcare services when and where they need them.

As I hope you are all aware, the government has a 10-year health plan that will provide the foundation for us to continue to build an innovative and world-class health system for the ACT. This plan has five key components: preventive health,

empowering people to understand their own health and investing in prevention to reduce the burden of ill health and disease; access to the highest quality health services, and in particular the delivery of services where and when people need them; building essential health infrastructure to support health services across our community; investing in a highly skilled workforce; and harnessing our research capabilities to deliver health outcomes and support Canberra's higher education institutions.

This plan will also be supported by ongoing priorities in the Health portfolio, notably the clinical services framework, that will inform the strategic direction for health services delivery over this period.

As has been canvassed quite widely, ACT Health has continued to identify issues with its data and reporting. In the last sitting period I announced a comprehensive system-wide review that will take us back to the basics when it comes to the collection, analysis and reporting of our health data. This will focus on improved processes for data management and reporting and strengthening the ACT health data warehouse.

I want to make it clear today that ongoing work to improve ACT Health's data quality processes is a priority, and we will continue to be transparent with the community and our stakeholders about progress on this issue. This will include quarterly reporting to the Legislative Assembly, updating the Auditor-General on our progress, and just this morning I have sent a letter to all major health stakeholders, locally and nationally, about the review.

I would also like to take the opportunity to briefly update the committee on some of the progress that has been made to deliver already on our election commitments from 2016. Work to establish a medicinal cannabis scheme is well underway, with the appointment of two expert advisory committees. At the end of last year the government put out an expression of interest for the medicinal cannabis advisory panel, the medical advisory panel, and today I have announced that EOIs are open for the medicinal cannabis community advisory group.

Yesterday, while speaking at the annual Gift of Life walk, I was also pleased to announce funding of $150,000 over the next three years to Gift of Life to raise awareness of organ and tissue donation in the Canberra community. Last month we delivered $300,000 to fund spinal cord injuries under Australia's NeuroMoves program, right here in the ACT. This program will offer a full suite of innovative exercises to assist people with conditions such as spinal cord injury and acquired brain injury. It will be established at the John James healthcare campus and will start operating later this year when the facility is up and running.

I am also pleased to inform the committee that work to formulate a preventive health strategy has commenced. A forum will be held on 10 April with health stakeholders to discuss this important initiative. Today I would like to extend an invitation to this committee to join me at the forum. I will write with details shortly.

I would like to note that we do face challenges with certainty around national funding agreements. We have seen cuts from the federal government in public hospital

services and dental services. While we have certainty until 2020 for public hospital funding, I look forward to further work on ensuring certainty around that with the new federal health minister. We simply must get a better alignment of incentives between the states and territories and the commonwealth to provide not just acute care but also subacute, primary and preventive health care that will keep our community healthy. We have other stakeholders across the NGO sector and the professional sector that we will also work with, and I look forward to doing that.

In conclusion, the delivery of healthcare services to the community is one of the most important areas of service provision for any government, particularly for the ACT. All of the achievements I have outlined this morning are a testament to the incredible care given to the ACT community and our region by our hardworking and dedicated nurses, doctors and all staff across ACT Health. I would like to thank them all and all of the executive here today, and the director-general, for their leadership and support in focusing on improving healthcare access and services to our community.

I would also today like to especially thank Ian Thompson. Some of you have known Ian for a long time. He will be leaving ACT Health shortly to take up a position where I am sure he will continue to contribute to health policy reform in the ACT and across Canberra. Ian has been with Health since 2001, I believe. In my short time in the portfolio I have enormously valued his expertise, his calmness, his breadth of knowledge and insight into all things in the Health portfolio, and I thank him on behalf of the government for many years of highly valued service.

Thank you, Mr Chairman, and I look forward to taking questions from the committee.

THE CHAIR: Thank you, minister. We will begin by moving through acute services, and I will kick off. I want to ask about the Canberra Hospital's $23 million emergency department expansion. What benefits are flowing from that for patients and employees of the hospital?

Ms Fitzharris: I do not know whether the committee has had a chance to visit the hospital. You would certainly be very welcome; we can arrange that visit. I am sure you will find that the work they do there is extraordinary.

There are a number of components to the ED reforms, in both the system and processes, in expanding the footprint and the operation of the emergency department, as well as employing new staff, in doctors and nurses. The emergency department waiting room was recently upgraded and expanded. It is a much more pleasant environment for patients and their families to wait in.

Also, as I mentioned in my opening statement, having a paediatric area of the emergency department means that children will be taken straight through to the paediatric area. It is a much more amenable area for young children and their families to wait in. It is vibrant; it is new. It is separate from the main waiting area, and I think that is so important for families, who are often under considerable stress when waiting in the emergency department.

There are new wings to the emergency department. I will ask the directorate officials to take you through those. They have resulted in consistent improvements in our

emergency department waiting times at Canberra Hospital, and a much improved operating environment for the staff. The addition of the navigator role in the emergency department has also been very effective in seeing some of those emergency department waiting times decrease, as well as access to and the flow through imaging and diagnostic services.

I will ask the officials to take you through those matters. The head of ED, Mark Dykgraaf, will talk specifically about those matters.

Mr Dykgraaf: The question related to the ED expansion in the new space and how it has had an impact on patients and on families. The emergency department has now expanded by 21 treatment spaces. It works in a modular form. If you have not been in there, there is a very big corridor right down the middle, which we call the avenue. Off that hang the various different parts of the ED. We have expanded the ED by something like 1,000 square metres, in terms of space, and we now have three subwaiting areas.

We have the main waiting area, which is now no longer a main thoroughfare for people going in and out of the hospital. That has been very important. Previously, the waiting room had been a main thoroughfare into the hospital and it made it a fairly unpleasant environment, with doors opening on both sides. That has gone. We have a dedicated volunteer desk at the waiting room. We have an active volunteer program that was reinvigorated in November. That is about improving the patient journey through ED. At the moment we have volunteers who are with us five days a week through the day. We would like to make that seven days a week if we can, morning and evening.

The front entrance for patients and families is vastly improved. It is no longer a general thoroughfare. There is also a dedicated family room in the waiting area, where mothers can feed babies, change babies etcetera. Of course, there is a play area for the kids. We have a much better security desk at the front area, which is important for us after hours. We did have quite a lengthy debate around whether or not we would have glass screens in front of our staff at the desk, for triage and admin staff. The team in ED felt that it was better not to have that, as it was a more welcoming environment without it. Thus far it has proven to be successful. We do, of course, have desks that are difficult for people to get over the top of.

As you move into the ED, we have the fast-track area immediately behind the main waiting room. The fast-track area is made up now of 10 bed spaces and three assessment rooms, and it has its own subwait. The idea of that space is to decongest the space in the waiting room, and that has worked very well. It is a much more pleasant environment for families and patients as they come through, as you are not in the very congested front area.

As you move down the right-hand side of the emergency department, you will cross a corridor that takes you to medical imaging and then you are in the paediatric area. It was one of the areas that we opened earlier last year. Previously, our paediatric area was a six-bed space hanging off the acute area in ED. It was very congested and not a great space. Now it has six beds and two assessment rooms—like a general practice room—and it has a subwait waiting area for families and patients.

We have had quite a debate about the noise in there at times. We have done decibel readings in there when the place is full of kids and we know that it is under the safe hearing levels for our staff. It is very noisy on occasions, but it is a much better space. It is contained in its own area. It is also well decorated for kids. Of course, there are toys etcetera that we need to keep clean and those sorts of things. So if you are a family who needs to go in with your child, it is a much more welcoming space.

With respect to the benefit of the subwaiting area in that space, in EDs around Australia and around the world, there have been occasions when patients have got lost in all of that noise in waiting areas. We have deliberately said that, where we can, we want that waiting space to be next to the treatment space. It means our clinical staff are walking through; it means that they can see the patients. In terms of the patient experience, it is also a safer experience because we have our clinical staff moving through and around that waiting area.

If you move down the main corridor you will come to what we know as the de-escalation space. That is a shared space; it is a space that is operated by ED. There are two de-escalation rooms and two assessment rooms. As the name implies, the de-escalation rooms are lockable rooms with two doors into them. There are no hanging points in them. We use them for people who are drug affected and alcohol affected, and for some of our mental health patients.

We have gone through quite a comprehensive program with our colleagues in the mental health, drug and alcohol services and justice health division to improve our model of care inside ED for mental health patients. We think we have made significant progress in that regard.

The new space has enabled us to provide a much more positive experience for people with mental illness. We only use the de-escalation space to control people's behaviour. It is not a permanent space. Our operating procedure, in partnership with our colleagues from mental health, is that we keep patients in the de-escalation room only for as long as it takes to get the behaviours under control. We think that is a vastly improved experience for our mental health patients.

Behind that de-escalation space is the mental health short-stay unit. That is not part of the ED. It was part of the emergency department rebuild. It is a vastly improved space. I do not pretend to have detailed knowledge of that. That sits with our colleagues in mental health, but it is a much better space than what we once had.

Next to that, right at the back of the ED now, is the emergency medicine unit. It was previously a nine-bed unit in the old ED, which we fondly referred to as the clip-on, because we had clipped it onto the back of the ED. It was a good, reasonable space and it had nine beds, but this is a much improved space. It is much improved because it is bigger and because we have three additional beds. So we have gone from nine to 12 in that space. Between each bed is a three-quarter wall and with each bed is a television.

The emergency medicine unit is an up-to-24-hour unit for patients whom we do not admit to the main hospital. They are admitted patients in that area but they are not

admitted to the main hospital. We admit through that space anywhere between 25 and 35 to 38 patients per day. The average length of stay in that area would be in the order of six hours. It is a better space because people have a little bit more privacy. It is a better space because they have a television et cetera.

As you swing around and come back, you are now on the left-hand side of the ED, as you look down the ED. We have an area of nine beds which is part of the acute area of the ED. Those beds are not fully operational yet. They will be fully operational from 1 July. We have, however, used them as they have become open when we are under pressure. So we use them as overflow beds currently, but we have not yet opened that area. That is about issues of budget flow, and the budget becomes fully available for us from 1 July.

The main acute area of the ED sits in front of that. That is a 21-bed space. It is also vastly improved. It now has much more desk space. Within that space we have built two additional almost resuscitation beds, but not quite, that have direct observation. Our staff would sit as far away as we are from each other now and they can observe directly into those rooms. On the main flight deck you can see basically all of the beds—two-thirds of the beds in the acute area. So our line of sight with that area is much improved. We care for patients in that area who you would describe as category 2 or category 3 patients, and some category 4 patients, in terms of triage timeliness. That area is very busy. The whole of ED is very busy but it is a much better space in terms of how we use the area.

The flight deck is vastly decongested. So in terms of staff experience in the ED now, we do not have pretty much every member coming to that flight deck. We now have a series of staff stations that assist staff. It also makes the department less noisy. That being said, the department is always noisy.

THE CHAIR: What is the role of the newly created emergency department navigator?

Mr Dykgraaf: The navigator is a nursing position. We previously had two what we called clinical coordinators. We repurposed one of those into a navigator position and we have added some additional funding so that we could have the navigator overnight seven days a week. The navigator sits at the flight deck, so in the centre of the emergency department. Their role is to make sure that our patients are moving through in a timely fashion in discussion with senior doctors, in discussion with other nurses.

They, in a sense, are the air traffic controllers of the emergency department, if you wanted to put it that way. They observe everything that is going on. They might look at the times patients have been waiting and say, "Why has that patient of that category been waiting for that long?" and prompt one of our nursing pod leaders in one of the pods. The nurses are responsible for bringing the patients from the waiting areas into those spaces.

They also liaise with the hospital. They have at their desk the radio for ACT ambulance. They coordinate the arrival of patients on our helicopter. It is a very busy role, noting that they are working with a team in the order of 35 to 40 staff on

any shift inside ED. That is how many we have on the floor. It is a mix of doctors, nurses, allied health, wardsmen and so on. We found that with the establishment of that role and then the establishment of some wider disciplines our flow has significantly improved inside the emergency department.

MR PETTERSSON: I understand that you undertook a review in 2015 to improve several things. One of the outcomes was that there were lots of improvements in patient flow. You were just talking about this new navigator role. Has anything else been done to improve patient flow?

Mr Dykgraaf: Absolutely. We have also gone down a path of medical teaming. On any given shift we will have morning and evening three staff specialists—two to three staff specialists. We will have a number of registrars. We will have a number of junior doctors et cetera. We will have, depending on the roster, between 15 and 17 doctors on the floor, remembering that three or four of those are interns; they are very junior doctors.

We have divided the ED into teams led by a staff specialist or a registrar. All patients immediately at least get viewed by that senior staff specialist and then the work gets delegated to the other doctors inside that team. That has significantly improved initial assessment and timeliness of assessment.

Behind the navigator role what we have set up is a nursing pod leadership. I have described the department in some detail. We have nursing RN2s who are nursing pod leaders. That has been significant as well and we ask them to be very aware of timeliness of patients moving through their area.

MR PETTERSON: It may be that it is too soon to ask these sorts of questions. Anecdotally, it may be fine, but has it been working?

Mr Dykgraaf: Yes. One of the analogies that I use with our team is that we are now a 75-treatment space emergency department. We have 238 staff. We are the size of a small to medium facility. It is a big beast. We know that we are in the top 10 in size and activity of emergency departments in the country. It is a very big emergency department. Implementing change is a multi-headed beast and I have completely lost my train of thought in relation to—

MRS DUNNE: Does it work?

Mr Dykgraaf: Does it work? Yes, it does. It has improved significantly. The point I was about to make is that the change process has been a complex one. It has required tremendous focus from the ED leadership team and support from the service innovation group. But, yes, we have seen improvements in our overall meeting of performance. We have seen a significant improvement in relation to treatment times. We have seen a significant improvement in relation to waiting times. The one that I think is really telling is that we have seen significant improvement in relation to people who do not wait.

One of our key measures is the number of people that actually turn up and say "I want to see a doc, I want to see a nurse" and then walk off. Our did-not-wait rate has

improved significantly over the past 12 months.

Ms Fitzharris: I add that there are other changes. It is not just about the emergency department. It is also around the operation of the hospital as a whole, the imaging that I mentioned earlier as well. I will get the Director-General to talk more about that because there have been significant improvements, significant reforms, a lot of investment. We have seen that improvement flow through into a range of other areas as well. It is part of a broader health system but obviously a very significant operation within the hospital as a whole.

Ms Feely: I am going to do the handover to the Executive Director. We have done two things. In relation to the turnaround in performance in the ED, one of the keys was working out timings about how people travel through the ED and get appointments—whether it be for fixing up imaging, and we will talk about that in a minute, or back of house—how people are moved through the rest of the hospital, how beds become available and how we manage availability. I am going to throw to Ian, as this is his last annual report hearing, and he will give you an update on the fantastic turnaround we have had in relation to medical imaging in particular and also take you through the bed flow issues.

Mr Thompson: Yes, as the Director-General has just outlined, the changes in the rest of the hospital have a direct impact on the emergency department. Just to put that into context, approximately 35 per cent of patients who present to the emergency department are admitted to the hospital while the remaining 65 per cent return home. Obviously it is essential for the 35 per cent who are admitted, as well as the 65 per cent who go home, to access other services within the hospital, to be seen quickly and for their issues to be resolved and decisions to be made.

Medical imaging is a crucial part of it. A significant proportion of people who come to the emergency department will have an injury, abdominal pain, head injuries and so forth that require further assessment. Medical imaging is an essential aspect of that further assessment. We undertook a comprehensive review of medical imaging to look at the way that people access those services and the ability to improve efficiency.

For the emergency department in particular, one of the things that we focused on was having dedicated access to imaging services for the emergency department, with reserved spots early in the morning in particular, to enable patients to access the services and improve overnight cover. But we also looked at the overall flow through the medical imaging department. One of the consequences of that has been a 50 per cent reduction in the outpatient waiting times for people looking for an MRI scan. We have completely eliminated the waiting for people looking for a CT scan. That is one aspect of it.

The other aspect that the Director-General was talking about is the flow into other parts of the hospital. Obviously if you are going to be admitted to hospital you need to be admitted to a bed, to the operating theatre or to the intensive care unit. Ensuring that we have the space available in the rest of the hospital, as well as the processes to identify the right bed for people and how they can get there as quickly as possible, is an essential feature of the timeliness of people's experience in the emergency department and into the rest of the hospital.

We have always had a patient flow unit at Canberra Hospital but what we did was to review that as well. We reorganised it—changed the way that they manage and work with the divisions within the hospital. As a consequence, we have seen a substantial improvement in the ability of patients to get into the hospital, into inpatient areas, within four hours.

Ms Feely: In summary, in respect of our ability to actually run an efficient ED, there are matters that can be dealt with within the ED but it is a whole-of-system issue. Minister, I would like to take the opportunity to acknowledge the fantastic leadership of the ED team and also particularly medical imaging who have, again, within resources, within current allocations, been able to look at their models of care and work out how we can improve the patient journey through the Canberra health system. I think it is a real credit to them, and Mark has a number of things he can add.

Mr Dykgraaf: Yes, I will highlight some of the improvements this financial year. Our NEAT performance numbers now go to the end of February. For the period from 1 July to the end of February this financial year, for NEAT performance it is 71.3 per cent. For the same period last year, it was 55.6 per cent. That is a significant step up.

It is worth noting that the year-on-year growth in presentations at the Canberra Hospital sits just on 12 per cent growth rate. That is a significant change for us. In previous years, the growth rate sat between four to six per cent. From about 2008, every year we would go up by about four to six per cent. This past nine to 10 months our growth rate has sat at 12 per cent and it does not look like changing. It is consistent.

On a background of 12 per cent growth rate in presentations, we have improved our ED performance from 55.6 per cent to 71.3 per cent to this time in the financial year. In relation to our did not waits, I mentioned to you earlier that that is a key measure for us. For the same period in the previous year our did-not-wait percentage was 5.6 per cent, or 12 patients per day said, "We are not waiting anymore." To this period in this financial year, the did-not-wait rate is 2.6 per cent, or six patients are walking away, on a growth rate of 12 per cent. The performance of the ED has improved significantly.

I mention three other statistics for you. The average waiting time the previous financial year was 72 minutes on average per patient. To the end of February this financial year, it is 50 minutes. It is an improvement of 22 minutes year on year.

The previous financial year, our average treatment time was 174 minutes. To this financial year, our average treatment time is 136 minutes. That is significant. Our average treatment time is now just over two hours. That is really important when you relate it to what Ian was talking about in relation to flowing into the hospital. If we are to hit that four-hour target, we need to have treatment times in that sort of two-hour range.

The last metric I will give you, and clearly we study this pretty closely every day, is that in the previous financial year our average bed block—the time it took to get a patient from ED into a bed in the hospital—was 183 minutes. This financial year, it is

145. That metric speaks to the improvement inside the wider hospital—medical imaging, how we do our flow through our patient access unit and so on. The improvements over the past 12 months have been significant.

MRS KIKKERT: My question is: what proportion of the data in the annual reports for the Health Directorate and the local hospitals network is inaccurate and unreliable?

Ms Fitzharris: I think we canvassed this in the sitting period. Certainly, at this point I tabled the annual report in the December sittings. I have been advised by Health that at the time of the annual report tabling, and subsequent to that, there are no known inaccuracies in the annual report.

As I also indicated in a number of questions in the last sitting period, the initial focus of the work on data assurance was the previous quarterly reports, which are published each quarter for the 2015-16 period. The previous minister, Minister Corbell, in early 2016 had indicated that he had asked Health, after the Director-General had advised him of some inaccuracies in that report, for significant work to be underway.

I will say it again: to my knowledge and to the directorate's knowledge there is no inaccurate data in the annual report that we are discussing today. There was not at the time of tabling and there is not now. But as I also indicated, part of the review will be not only to assess the whole of the system that we have for data reporting but also to go back and verify the 2015-16 reporting that we have done to double-check if and when a mistake is identified.

MRS DUNNE: Could I follow up, please? There are a lot of issues around this. They have been canvassed in the Assembly, but you raised them in your introductory comments, and it is therefore appropriate that we delve into it a little bit.

Ms Fitzharris: Yes.

MRS DUNNE: For instance, you just said then that in June-July last year Mr Corbell became aware that there were problems in the quarterly reports. Mr Hanson raised those in the estimates process. You were there and Mr Corbell was there last year. Mr Hanson has had correspondence with the Auditor-General and I have had correspondence with the Auditor-General about some of these data issues. I would like to delve down a little bit and ask a few detailed questions. You engaged the services of PricewaterhouseCoopers last year in relation to the quarterly reports. When did you decide to do that, and what were their terms of reference?

Ms Fitzharris: I was not the responsible minister at the time, but I can hand over to the director-general to answer those questions.

Ms Feely: In current circumstances I will hand it to Ian and Shaun to answer these questions. But at the time of the estimates in June we had the third quarter report, from my memory. It was not the one that had been released at that time.

MRS DUNNE: I think it was the March quarter.

Ms Feely: Yes, that is it.

MRS DUNNE: Looking at the transcript, Mr Hanson was asking about the March quarter. It was not available, but the minister was able to make comment about how things had improved on more day-to-day data. He said he got a report every day. Do you still get a report every day?

Ms Fitzharris: Yes, I do.

MRS DUNNE: What do those reports—no, I will ask that question later. Sorry, I am distracting you.

Ms Feely: When Mr Hanson was asking those questions I had not actually received that quarterly report, so the minister was talking from memory. Sorry, I stand corrected, it was the December report that we had. The first time in my leadership of the Health Directorate department I became aware of issues was in the December report. Mr Hanson, from memory, was asking why the March report was late, and we had an exchange where I said to him I was waiting for it to hit my desk and then I would need to take some time to reassure myself that everything was right in that quarterly report given issues had reared their head in the December report.

MRS DUNNE: So what were the issues in the December report?

Ms Feely: There were, in effect, two issues: there was just an inaccuracy in the numbers, which were picked up on a review. The issue that was raised with me was a human error, that people had been feeling under pressure—please, these are my words, these are not verbatim—had deviated from the norm by rewriting their own script and, as a consequence of that process, a human error had entered into the calculation of the data and then for the subsequent reporting.

As a result of being advised of this, I queried it. We went through a process internally of asking why people under pressure would deviate from the norm and write their own script. I was assured at the time by the management that that was a one-off and would not occur again and that steps had been put in place to make sure it did not happen again. Minister Corbell, whilst very displeased that data issues had raised their head again, accepted that explanation on the basis of the advice that he was given.

Given we had an issue in the December report, I wanted to make sure that all the executives took time to very carefully look at the March report before any sign-off was given. As a consequence of issues that arose subsequently in this March report, we are where we are today in many respects about bringing PwC in and doing a review.

Shaun Strachan had responsibility in the early days for this. I asked him to go in after I started finding issues with the March data, and subsequently we brought in PwC, so I will have Shaun or Ian take you through the process.

Mr Strachan: In answer to your question, 2 August was the date that we formally approached PwC to come in and have a look at the issues around the review of data incorporated into a quarterly performance report for the first three quarters of

2015-16 and provide a level of review and assurance over the creation and the reporting of data. It was very much a governance review in terms of looking at systems, processes, the evidence-based approach, reconciliations and validation in relation to procedures that were formulative in the production of the quarterly reports.

Ms Feely: If I could add, in between the estimates hearings and August, I had asked that we take more time to actually delve into the governance and the processes in the department. As a consequence of, to my mind, issues not being satisfactorily explained, PwC were brought in.

MRS DUNNE: Could I delve into what are the governance issues? You are saying there is not a problem with the data set but the way that you manipulate the data set? I just would really like to—

Ms Feely: I am not at this stage saying there is not a problem with the data set.

MRS DUNNE: I do not want to put words in your mouth; I just really would like to get as good an understanding as possible.

Ms Feely: From a historical perspective, we have been putting these quarterly and annual reports out year on year for many years. With the December report—

MRS DUNNE: December 2015?

Ms Feely: Yes, the quarterly report. I think it was you, Shaun, who picked it up and brought it to me and Ian, and we were looking at it and thinking the numbers did not quite look right. From a governance perspective it is at that level. I had not even turned my mind to there being problems with the actual data set. I had not even gone that deep. It was really a matter of going, "How did this happen?" And the explanation I was given was it was a human intervention error. It was not about the data set at that stage and it was not about warehouse, and it was not anything deeper than that. So we corrected it and made public statements with Minister Corbell. We moved on in a few more months to the March quarterly report.

MRS KIKKERT: Where exactly did it go wrong?

Ms Fitzharris: Could I just make a broad comment. This is a much more open session than question time, so it is easier, in a sense, to have a conversation about it. It is a great opportunity, which I indicated in the sitting period, too. The hospital collects an enormous amount of data for its own operations but obviously also to do a number of different reports. If you look at the quarterly performance reports—they are all on the health website—they are a good snapshot, they are very succinct and quite different to the annual report. The AIHW has a number of different reporting requirements, and some of those obviously go into the Productivity Commission to do the report on government services.

At the time as I became aware of it as Assistant Minister for Health, the process was looking at the quarterly report. I talked in the Assembly about the focus having been on the various products we needed to provide data for. The directorate was able to have the time to go back and start to look at those more fundamental issues after the

quarterly reports were done and the annual report production was done, and those opportunities opened up to have a look more deeply into all of those issues. It really was not until early February, once some of the deadlines for some of the data sets had not been met for the ROGS reporting I think—

MRS DUNNE: But that was November.

Ms Fitzharris: With that in particular, some of the data sets were provided but not accepted and others were being negotiated for an extension to provide them. There was a sort of breakdown in communication; Health had not heard back from either AIHW or the Productivity Commission that the extension had been granted, so there was a small number of sets where there was uncertainty.

MRS DUNNE: The AIHW told me that they, in fact, had negotiated an extension but you did not meet that extension.

Ms Fitzharris: In some of those cases that is right, yes. So it was not until February when I came back from leave that the directorate was able to advise me that, having had the opportunity to look at the whole, they recommended we do a review. I said it would be a system-wide review that resolved this once and for all.

The question about what has happened, that is what the review will do. We are developing terms of reference for the review. We will not be able to give you all the answers today, which is why I committed to regular reporting to the Assembly. I also indicated from the outset that it is a long process, likely to be a 12-month process, to make sure that this issue is well and truly behind us. As minister I want to be able to report to the Chief Minister, to you, to the chamber, to the community and to all our stakeholders that we have undertaken a very robust process and that this issue is resolved once and for all.

MRS DUNNE: I think it was about 9 November that the department put out all of the quarterly reports for the previous year and you said, "We've done all these things in relation to the quarterly report and it's all tickety-boo." When did you discover that it was not tickety-boo? Is everything fine in relation to the quarterly reports? Or is it that the problems are so fundamental that we are now in a situation that we cannot, hand on heart, say that the stuff that came out in November is as tickety-boo as you thought then?

Ms Fitzharris: Yes. From what we know now we cannot identify any inaccuracies, but, clearly, there is a whole-of-system review underway. Part of that will consider whether, once we understand the picture, we go back and have a look at those and assess them. I cannot give you a categorical no answer now, but we cannot identify now any inaccuracies that we know of in the reporting.

MRS DUNNE: I have some questions for later on about things which I see as inaccuracies, but perhaps other members might like to ask some questions and I will come back to it.

Ms Fitzharris: I accept this is a significant issue the committee has an interest in, so I am in your hands, Chair.

MRS DUNNE: If I could provide to members copies of a table that is of my own confection; I thought I could not possibly talk you through this issue without a table. The ROGS report refers to, in relation to elective surgery waiting times, people who have not been seen within a clinically approved period of time—that is, the people who are on the list longer than they should be. The annual reports data refers to people who are seen in a clinically appropriate time. What I have done in this table is put the Health data in a maroon colour. It shows the people who were still on the waiting list. The ROGS data is the black data and it shows the people who are still on the waiting list. I converted the Health data, which is the people taken off, and if you have the people taken off, you are left with the percentage of people who are still on.

This is collected from three annual reports and the ROGS data as it was published in February. There are quite a number of discrepancies between what ROGS says and what the Health report says. I have asked health economists—I am married to one, so that was my first port of call, and I have asked other people—to see if they could explain to me the gap or the discrepancies in the data. I am now asking: is this one of the things you just do not know the answer to, or is there something obvious that I have overlooked.

Ms Fitzharris: I cannot comment on that. We can certainly take these back and have a look at them, but I would not want to be in a position right now, just having a look at that, with—

MRS DUNNE: Okay.

Ms Fitzharris: I could look up the ROGS report here, but I do not have that. Certainly we can take this away and have a look at that. We are very open to doing that. No-one more than I wants to get to the bottom of this.

MRS DUNNE: I am (a) not a health expert and (b) not a statistical nerd, but when you go through it forensically even I can see there are problems with that. When I go to people who know more about this than I do, they cannot explain it to me. If someone can explain it to me, or the answer is, "We really don't know, and this is the sort of thing that we are getting to," it would be useful. It may be that the AIHW and the Productivity Commission interrogate your data set in a different way, but I do not know.

Ms Fitzharris: I am not sure whether it is comparing apples with apples, or—

MRS DUNNE: I am pretty sure it is comparing apples with apples, but I am open to that criticism as well.

Ms Fitzharris: Certainly, if we could take that on notice we will be happy to get back to the committee on that. Could we have a copy of that emailed through as well?

MRS DUNNE: Yes, happy to.

Ms Fitzharris: Then we can have a look at that. I do not think to answer now would do justice to your questions, which I accept are very legitimate.

MRS DUNNE: I will put this on notice and add some extra questions to help you through that process.

Ms Fitzharris: That is welcome.

MRS DUNNE: I will ensure, through Kate, that you can get an electronic version of the table as well.

Ms Fitzharris: That would be great, thanks.

MRS KIKKERT: Minister, just following up, you mentioned that you receive daily reports. What are they?

Ms Fitzharris: They are daily reports that are received by a number of people around emergency department performance. I can let Mark Dykgraaf speak to those.

Mr Dykgraaf: They are daily operational reports. They look at a number of things, and they are provided to the ED leadership team, me, the minister and Nicole, the D-G. Those daily reports will tell us about the number of presentations that have come in the past 24 hours. There is a slight clarification in regard to the language we use: that report identifies the number of people we have actually discharged from the ED; we call them presentations, but they have actually discharged. The point I am making is that somebody might turn up at 11 o'clock at night; they will not appear in those numbers because they have not been discharged from the ED.

So we see those. Then we also see our four-hour timeliness broken down by our emergency medicine unit; our discharge stream, the people that go through fast track; and our admitted patients. Then we get the total figure at the bottom. And below that we have a table that identifies discharges from all clinical areas before 10, before 12, and before 4 o'clock. This goes to the whole issue of patient flow.

We know that the emergency department will start to ramp from around mid-morning. That is our usual pattern. Our discharges tend to be later in the day. What we are trying to do is to close that gap, get people discharging earlier. The bottom part of that table is about saying how the hospital has gone in relation to getting discharges out earlier in the day. Those reports go to all of our CNCs in all of our wards, they go to key medical staff, and so on.

MRS KIKKERT: Will you provide those daily reports to the committee? Is that possible?

Mr Dykgraaf: It is daily.

Ms Fitzharris: It is a daily operational report. If you hop onto the Health website you can see there a page called, "What is happening in your ED right now?" It has patients waiting to commence treatment, total number of patients receiving treatment, patients waiting for admission—

MRS KIKKERT: Do you receive more than what is written online?

Ms Fitzharris: I do, and I am minister responsible, so I expect to see that.

MRS KIKKERT: Can the committee receive those daily reports?

Ms Fitzharris: No. I do not think that is appropriate.

MRS KIKKERT: Appropriate?

MRS DUNNE: Would it be appropriate to see a copy of—

Ms Fitzharris: A copy of them? Yes.

MRS DUNNE: A one-day snapshot, just to have a feel for it.

Ms Fitzharris: I can—

MRS KIKKERT: As a committee, we just want to know what is going on; that is all.

Ms Fitzharris: Yes, and I accept that. Also, as the minister responsible, it is my role to make sure that the operations are being led by the director-general, and operational performance reporting like that. We can certainly show you the template and what that looks like, and a snapshot in time, but much of this information is already public.

One of the other things I said in my ministerial statement of priorities was: what does the community need to know about our operational health data so that they know how to access services and they know where they can access them? I would like that to remain a priority. We have technology now that can give us access to open data and useful, consumer-friendly devices that we can all have with us all the time. I had wanted to do that work in this year, but I would rather now focus on getting the data for those applications right. It is also, as I said, part of the review. A lot of this data is used for operational purposes within the hospital and for our stakeholders in understanding the national picture; there is real opportunity, using good technology, good applications, to provide consumer-friendly access to real-time data.

That is what I would like to achieve in this term: no matter where you are, no matter what kind of health service you want to access, you will be able to find that sort of information about ACT health service provision in your community. You will know where the walk-in centre is, where the Belconnen Community Health Centre is, what services you can access at those clinics and, in an ideal world, about other health services that are around you: access to GPs, access to other health service providers in your region, and perhaps even information about timeliness and performance reporting as well as the real-time information which is already available on the health website.

MRS KIKKERT: Thanks.

MRS DUNNE: With the committee's indulgence, could I go back to the announcement that you made about this root and branch review and compare it with the statements that were made by the department on 9 November. The departmental

press release said:

> ACT Health has worked closely with … PwC to ensure data assurance across our processes …

ACT Health had received the PwC report by that stage. What assurances did you have about the processes then? The press release seems to indicate that it is more than assurances about the quarterly report data.

Ms Fitzharris: The quarterly report and planning for the annual report as well. It was specifically for the quarterly reporting and subsequent to the annual report, and also around implementation of the Auditor-General's recommendations.

MRS DUNNE: The press release went on to say that there had been a number of improvements to ACT Health during the reporting process, and that this included undertaking a full data warehouse reconciliation and integrity validation check against source data. That sort of thing is almost repeated word for word in your statement.

Ms Fitzharris: Yes. PwC and that press release were about the quarterly reports. I guess, with the value of hindsight, the issues at that point in time were all about the quarterly performance reports leading into the annual report. The processes within the warehouse around those reporting products were what PwC were looking at.

MRS DUNNE: What other reporting products are we talking about?

Ms Fitzharris: I think the list of AIHW reports is this long.

MRS DUNNE: Okay.

Ms Fitzharris: And then obviously a significant national report each year, the ROGS report, the report on government services. We could provide a list to the committee?

MRS DUNNE: Yes.

Ms Fitzharris: We are happy to do that.

MRS DUNNE: Are you aware of Mr Bob Sendt's investigational review of the PwC report? Have you seen a copy of it?

Ms Fitzharris: Sorry?

MRS DUNNE: Mr Bob Sendt did some work on behalf of the Auditor-General on the PwC report.

Ms Fitzharris: No. I have not heard of that gentleman, and I am not aware of the work.

MRS DUNNE: Okay.

Ms Fitzharris: If you could give us more information—

MRS DUNNE: I have just been told by the Auditor-General that Mr Sendt, who is a retired auditor-general from Queensland, I think, did a review of the PwC. You are not aware of that?

Ms Fitzharris: No.

MRS DUNNE: I thought that you would be, Ms Feely, because you were copied into the same correspondence.

Ms Feely: I am aware of a review. The Auditor-General rang and told me that she was going to get Mr Sendt to look at the report, and had looked at the report, but I have not seen the report.

MRS DUNNE: You have not seen the report? Okay; thanks.

THE CHAIR: I am aware that Mr Pettersson and Ms Le Couteur have not asked questions.

MRS DUNNE: Yes, sorry.

THE CHAIR: There will be other opportunities. Mr Pettersson, do you have any questions for acute services?

MR PETTERSSON: I do. I see that a new executive position has been created, director of operations. Why was that needed?

Mr Bone: I can take that question.

Ms Feely: Mr Bone is the director of clinical operations, but I can answer that question.

Ms Fitzharris: Would you like to talk to him directly?

MRS KIKKERT: Please.

MRS DUNNE: Maybe he does not have the insights about why he has the job but somebody else does.

Ms Feely: We had the role of director of clinical operations put in there with specific responsibility to oversight the movement of flow operations and keep things moving to support the ED and the hospital. From past experience, it is a role that is in many other institutions, and I was quite surprised that there was not that sort of deputy support to the ED to keep things moving. It is about improving functionality and access for patients who come to our front door, making sure that we can have many people watching what is happening across the hospital, rather than maybe just the ED and the executive director. It is, in effect, a deputy role, but with specific responsibility to keep both strategic and operational issues moving through the health system. Mr Chris Bone, who is now here, was the successful applicant for the role.

When did you get the job?

Mr Bone: October.

Ms Feely: In October last year. Would you like to add anything? There is not much. It was my initiative to bring that in. We advertised it and went out to the market; Mr Bone was the successful applicant.

Mr Bone: I am currently acting as the executive director for Canberra Hospital Health Service; my substantive position is as the chief of clinical operations.

I agree to the statement.

My substantive role was brought in to ensure that there were direct links between the emergency department reform that was occurring and the rest of the hospital. As you have heard previously, 35 per cent of all patients are admitted to the hospital; of that 35 per cent, 65 per cent are admitted into the main hospital. Previously there had been issues in getting patients into beds in a timely manner. Part of this role was to undertake to pull those two parts of the organisation together, and that is what I have done.

Along with Mark and the emergency department, we designed a number of operational guidelines and policies that enabled us to move patients through the department in a timely manner, to get patients onto the ward where they get the best care and the most appropriate care with the teams that are responsible for them in an ongoing manner.

It meant that out of the ED—Mark previously mentioned the role of the navigator—they communicated with the access unit. Where they could not resolve issues, it got escalated to me. As a senior person in the organisation, I then delegated authority to intervene with the divisions. I usually went through the executive director for each of the divisions. Sometimes I went and spoke to individual doctors, teams or whatever to see what the blockages were. It was a position put in with the relevant authority to enable patients to move out of the emergency department within appropriate clinical time frames and get into the most appropriate clinical setting for their ongoing care.

MR PETTERSSON: You mentioned the interactions with the navigator and then escalating things to you. How often does that occur? How often is the navigator unable to fulfil?

Mr Bone: The first point is the navigator escalating to the access coordinator. If they could not resolve it, it got escalated to me. Earlier in the piece—I am going back to February, March, April—the escalations were probably once a day, of that order. There is less of that now. The processes have become more established and people understand what we are trying to achieve in terms of better patient care.

MR PETTERSSON: Thank you.

MS LE COUTEUR: Just on the topic of your dental health program on page 42, it is good to see that the waiting time is now down, it says, to less than six months. Do you

have any information about how many patients do not actually attend appointments?

Ms Fitzharris: I am not sure. We might have to take that one on notice. How many that have appointments do not arrive?

MS LE COUTERU: Yes. Anecdotally we are told that there may be some mythical number of people who do not. I guess, following on from that: what systems do you have to make sure that patients are aware and of actually turn up for their appointments?

Ms Fitzharris: We might have to take the specifics on notice, but do you have any information even anecdotally about why people might not come? Is it transport or is it other issues?

MS LE COUTEUR: I think it is largely time related. They say, "I want help." You say "Fine. It will be six months away." They do not get—

Ms Fitzharris: Barbara Reid would be available to talk about the dental program in more detail.

Ms Reid: Can I ask you to repeat the question?

MS LE COUTEUR: The question is: how many people do not actually present for appointments? It is great that you have got down to less than six months but how many do not come? Then a supplementary would be: are those emergency or urgent or the standard schedule? What proportion do you have of no-shows?

Ms Reid: I do not have an exact figure; so I would have to take the figure on notice for no-shows. But the processes that we actually have in place in making the appointments are: our administrative staff ring patients beforehand to confirm appointments, to make sure that they know an appointment is coming up. I believe we send out texts as well to make sure that they come. But I honestly do not have a number for you in that sense but I will get it for you.

MS LE COUTEUR: Thank you. Have we got time to move to other acute areas?

THE CHAIR: Yes. We were going to move to alcohol and drug services.

MS LE COUTEUR: I was going to ask about the hospital in the home program, another one.

THE CHAIR: I do not mind moving on because I think the alcohol and drug service is probably wrapped up within the next section if you want to move on to public health, which is a larger area.

MS LE COUTEUR: No. Hospital in the home is under acute services as far as the—

THE CHAIR: That is fine.

MS LE COUTEUR: I understand it has expanded. What expansions? Is it planned to

keep on expanding?

MRS DUNNE: Can I put on the record that I love hospital in the home?

Ms Fitzharris: We did make fairly significant election commitments about expansion which we will be talking about over the next couple of years as well but not only expanding the program in the home but also providing hospital in the home at community health centres as well. So there is certainly a lot of demand in the community to be able to get that access closer to home, closer to where you live. We have community health centres in all our regions now and we have further work to do in those community health centres to bring more services closer to where people live and provide more information about where they can access certain services.

Certainly the hospital campus itself provides a lot of services. It has a small part of hospital in the home there at Woden but where we can deliver some of those services out in the community, in people's homes and our health community health centres, we will be expanding them as well.

Ms O'Donnell: Essentially at the moment the expansion that you refer to is actually about the physical space at the Canberra Hospital at this point in time. And that is actually related to the fact that when people are in hospital in the home and are being treated at home by the nurses who go out and visit them, they come back to the hospital on a regular basis to be assessed. It was the expansion of that space; twice, three times a week they might come in to see some of their speciality clinicians who need to review them. That was the expansion of the physical space.

MS LE COUTEUR: Continuing on, what issues do you have with the home part of this? I particularly ask this because, speaking to some homelessness services, I have been told that at least one patient they are aware of who was suitable for hospital in the home was homeless.

Ms O'Donnell: Did not have a home, yes.

MS LE COUTEUR: But I imagine there are also issues more generally with a shortage of aged care beds. There must be people, apart from this person, who would have been suitable for out of hospital treatment but they did not have appropriate out of hospital accommodation.

Ms O'Donnell: I am not quite sure what the question is.

MS LE COUTEUR: In regard to hospital in the home, how many people cannot access this because of problems with the home part of it? I am aware particularly of one homeless person but there may be other people who have a home of some sort but—

MRS DUNNE: Who might need supervision.

MS LE COUTEUR: or it might be you cannot go home until your home has been modified; you need the walking rails if you are going to go home.

Ms O'Donnell: Specifically for hospital in the home, hospital in the home is hospital substitution. If they were not being seen at home under that service they would be in a hospital bed. Essentially the criterion is that they do have to have, as you have alluded to, carers or appropriate support at home to be able to manage during the times that there are not nurses visiting them at that point in time.

MS LE COUTEUR: I appreciate that. I was wondering how many people were in the situation that if they had a better functioning home they could be looked after at home. And you were saying yes we could discharge this person but they have not got a reasonably functioning home to discharge them to.

Ms Fitzharris: We can have a look.

Ms O'Donnell: We can certainly take that on notice.

MS LE COUTEUR: I was quite shocked when I found this happening, this homeless person.

Ms Fitzharris: It might be useful, if other committee members are not familiar with the program, for Rosemary to run you through it because it is a tremendous program and one that will be expanding. It provides a lot of opportunity for us to deliver healthcare services to people in different settings; there is also evidence that it can be better for a quicker recovery being in your own home.

Ms O'Donnell: And certainly there are few avenues by which people can access hospital in the home. Firstly it can be that they have already been admitted to hospital and need, say, ongoing antibiotic cover for a period of time when they really are not needing to be in a hospital bed but that can be delivered by hospital in the home. They can have at least up to two or three visits a day and they can be looked after by the nurses in that capacity.

The other thing is that they can actually be assessed in the emergency department and directly transferred to home and then be followed up for whatever care they need. Also we do have an expansion at the moment that we are considering around liaising with GPs where they can ring up and give an example, say, cellulitis, which is an inflammation that requires antibiotics. Essentially the GPs can ring up and say that this patient just needs a few days of IV antibiotics and then can go onto oral antibiotics. They can actually be admitted to hospital in the home directly. There are a few avenues.

We are also looking at, and we did it over a period of time in liaison with our geriatric medicine colleagues, actually providing hospital in the home in residential aged care facilities, which goes back to your point again about whether or not we have got the capacity, and being able to expand that and provide that service across the board is certainly an option.

MRS KIKKERT: How many patients do you have in hospital in the home?

Ms O'Donnell: At any one point in time what we have are, essentially, about 21 to 22 patients who are in their homes as we speak and who are managed by that program

and are having nursing visits. That varies over time because what you find is that sometimes people need two visits a day or three visits, some people need only one visit. They just vary what they need. Certainly, in times of high demand, we often actually put on extra resources, an extra car, get some extra nurses if we have got high demand, to manage those patients at home more appropriately.

MRS KIKKERT: You are expanding it to how many, or what is the program going to look like?

Ms O'Donnell: We still have to look at the feasibility of expanding it. The other thing is, as you will probably know or if you do not know, there is also a HITH program at the Calvary Hospital. There is a network of services and we want to expand and integrate that across the territory as well.

MS LE COUTEUR: This question goes here but is a more general question. Do you still have issues with people not being able to be discharged because they basically need a nursing home or an aged care bed and there is nowhere for them to go?

Ms O'Donnell: Yes.

Ms Fitzharris: Yes. Partly that is for a couple of reasons, as I understand it. Some people, because of their treatment, need to go into an aged care facility and may not want to or may not have one that particularly meets their exact needs at that time even if there might be a facility somewhere else in the city. As well, reductions in aged care funding from the commonwealth have meant that aged care is under considerable pressure. I think the ROGS reports show that. There have been significant cuts—$2 billion worth, from memory—by the commonwealth government over the past few years in aged care. That is a huge impact.

There is clearly demand in the ACT for that. We have the capacity to respond to that in part through our land release program but there are no funded aged care beds from the commonwealth. That provides a real barrier. But certainly I believe that at any given time 30 per cent of our patients in the hospital will be 65 and over. In terms of not being able to be discharged, I will let the officials speak to that.

MRS KIKKERT: Can I mention what you just spoke about, the need for extra beds at the hospital; is that correct? You just said that?

Ms Fitzharris: No, aged care beds in the community.

MRS KIKKERT: Aged care beds are not necessary, is that correct?

Ms Fitzharris: They are necessary but the commonwealth fund those and—

MRS KIKKERT: Would you have been able to fund that had light rail not gone ahead?

Ms Fitzharris: No. It is a fundamental—

MRS DUNNE: No, it is a different funding model.

Ms Fitzharris: It is a different funding model and an aged care bed in an aged care facility is very different from a bed in a hospital where you have a high clinical need and extremely skilled, well-trained professionals to care for someone. In a number of cases they just need to be in an aged care facility and be provided with aged care services. It is a commonwealth responsibility and really it is a fairly offensive question to ask, to be honest.

MRS KIKKERT: Sorry.

MRS DUNNE: It was about finding out—

Ms Fitzharris: It was about having a crack at light rail. Goodness me!

MRS KIKKERT: It was about funding and responsibility towards the people. That is what it was about. That is why I questioned it.

Ms Fitzharris: Yes, and implicit in your question was an accusation of us not caring for the aged people in our community because we fund light rail, when the commonwealth and the federal Liberal Party have taken $2 billion out of aged care.

MRS KIKKERT: And I feel that whatever the federal government is not providing, we as a government here can provide what is missing.

Ms Fitzharris: Wow! Let us have a conversation about that. I am very happy to have a conversation about what the federal Liberal government has cut not only from the ACT but from around the country and if every state government was required to fill in the black hole that the federal Liberal Party has put into state and territory budgets it would be a very dire situation. If you want to propose that we fill every gap that your party—

MRS KIKKERT: Not fill every gap, do our best.

Ms Fitzharris: That is a fundamental question about commonwealth-state relations and if we were to do that it would be a slippery slope and you would bankrupt every state and territory government in the country. Then the commonwealth would have a free run to not do anything and take no responsibility for the things that they are constitutionally responsible for. I am very happy to have an ongoing debate about wanting to do that because it is a very, very dangerous and slippery path.

MRS KIKKERT: I am looking forward to it.

MRS DUNNE: I do not know that they are constitutionally responsible for aged care but they take the responsibility. On the issue of what is called bed block—and it is a terrible term—anecdotally, and this is only anecdotally, I have been told that one of the problems is that for people who may be admitted to hospital for a short period of time from an aged care facility there are often problems in communication and logistics in returning them to the aged care facility in a timely way. Is that a real thing or is it just one or two individuals' experiences that have been reported to me?

Mr Thompson: It does happen from time to time but we have got discharge planners and liaison nurses who work very hard to maintain communication with the residential aged care facilities. The much more significant issues in terms of access to residential aged care are the longer term placement issues that the minister was talking about earlier.

MRS DUNNE: I realise that. A number of people have said that their elderly parent or aunt or whoever could not actually negotiate the return. They were distressed because they were paying fees at the aged-care facility—paying for their meals and things like that—and not utilising it. There seemed to be a breakdown in communication between the hospital and the aged-care facility and they did not necessarily have transport to facilitate that.

Mr Thompson: Those issues happen from time to time. Usually the delays are not long. Definitely, from the perspective of the hospital, we do everything we can to minimise the delays because, of course, that is about access to beds for other patients as well.

MRS DUNNE: Is patient transport part of that issue?

Mr Thompson: Patient transport can be from time to time. We use the ACT Ambulance Service and a dedicated patient transport vehicle as part of their fleet for transfers from hospital. Logistically, at times there are delays but, as I said, they are generally not very long delays.

MRS DUNNE: Mr Chairman, can I ask about the whole health system overhaul?

THE CHAIR: Yes, you can. I think we are moving back the other way.

MRS DUNNE: We are still on acute services and I do not really know where else to ask it.

Ms Fitzharris: In terms of that connection around aged-care beds, we have the residential aged-care liaison nurse position as well. Where there are different service provision responsibilities, as part of the work we are doing we are trying to understand where services can be provided and who might provide them. That connection between aged care and the hospital system is an important one. There is an aged-care liaison nurse position. We can talk in more detail, or provide more detail by taking it on notice, about how that position works and the other things that we are doing around that space. We can move on to another question, if you like.

Can I go back and provide an answer to the previous question about dental patients, Ms Le Couteur. The rate of patients that did not attend is 10 per cent. There are SMSs and calls to patients who do not have mobiles, so if they have a mobile they get an SMS. Generally, the people who do not attend are the emergency and priority appointments.

MRS KIKKERT: Do you do follow-ups with them?

Ms Fitzharris: I understand we do, yes. It may be that they have accessed treatment

elsewhere. Are there any other explanations? Sometimes the pain has subsided.

MS LE COUTEUR: It is a pretty high number.

MRS DUNNE: It is a big number.

MS LE COUTEUR: It is still a pretty high number. It must impact—

MRS DUNNE: I wonder how it compares to—

Ms Fitzharris: We can follow up on that.

MRS DUNNE: private dentistry: the number of people who do not show.

Ms Fitzharris: Apparently it is similar. For the emergency patients, 100 per cent of them are offered appointments within 24 hours. That is our target and we did meet that in this reporting period as well.

MRS DUNNE: I am open to guidance about where I can ask about the health overhaul.

Ms Fitzharris: What was the question again?

MRS DUNNE: There is one about the clinical services review and there is one about the review of community health services. I really want to ask about contracts.

Ms Fitzharris: The procurement?

MRS DUNNE: Yes.

Ms Fitzharris: This is for—

MRS DUNNE: Ernst & Young were contracted. It is variously reported as $560,000-something or $700,000. I have seen both figures for the clinical services review.

Ms Fitzharris: There are two things: the clinical services review, which was Ernst & Young, and the community review—Ernst & Young as well. And the contracts issue? What do you mean by that?

MRS DUNNE: We are spending in excess of $560,000 on the clinical services review. My understanding is that it was supposed to take 12 weeks. Is that correct: that the review was taking 12 weeks? I read that in a *Canberra Times* report. I want to clarify the length of time that it is taking and what the timetable is for the clinical services review. In addition, it was reported that the community health services provision review would be completed in October 2016. Is that correct? Has it been completed and, if not, what is the timetable for it?

Ms Fitzharris: Nicole Seils might be able to give you information about the clinical services review. It is a considerable piece of work to do some internal work which is,

I think, the work that you are talking about. There will be consultation on that, we expect, from late March around talking to all our stakeholders. This will underpin significant further transformation in the delivery of health services. From my point of view, it is putting people at the centre of the care that they provide, no matter where they receive it, throughout the ACT health system. It is really important that if you are unwell we do everything we can to stop the burden on you navigating your way through the system and we do everything we can to assist you in getting all the services that you need, clinical and non-clinical, to make you well. It is a really good and exciting piece of work. Nicole will be able to add to that.

MRS DUNNE: Can I just put it on the record that, when I read that it was going to take 12 weeks, I was surprised.

Ms Fitzharris: You thought that was real quick.

MRS DUNNE: Because of my understanding of what it was doing.

Ms Seils: I acknowledge the privilege statement for the committee. There is a 12-week planning piece of the puzzle, which might be where it has somehow been misinterpreted. That is to ensure, as the minister said, that we really address our consultation pathway and planning and alignment of all the moving parts. You have heard this morning that we have a lot of reform and change going on. So this is to ensure that we have properly thought through what it is we are going to do, how we will consult and the like.

Specifically on the clinical services framework, it is a product, a document, that is about the 10-year vision that will really lead the thinking and consultation as we go through the more detailed and clinically focused speciality service plans. It is another huge body of work. Quite often there is a nomenclature issue where people think a clinical services framework is a simple thing, but really it is a massive project and it has stages. One is the framework document. You have the speciality service planning and then models of care that fall out underneath that. That is more than a 12-month effort to do everything properly and ensure we do co-design and consultation and all the things you would expect so that people are not surprised by any change of direction and so on. I hope that clarifies it.

Ms Feely: In addition, as this work moves through, it will be focusing on quality, the workforce, the IT requirements and the infrastructure requirements. They will all fall out as we move through. It is a massive piece of work but a very exciting one because for the first time we are looking at territory-wide service provision and also at what we do in the southern New South Wales region. It is a big piece of work which is going to take time.

MRS DUNNE: And the $225,000 for the community health service provision review?

Ms Feely: I had my first briefing last Friday by Ernst & Young on the progress of the report. The community service part was with a particular reference to understanding what happens in the community areas elsewhere around the country and what were the services that were being delivered both by us and also externally to the community

in ACT Health. This is critical because the concept of the clinical services framework is from quaternary right out into the community. It is about breaking down the silos, putting the patient at the centre of the journey and making sure that we work as an integrated team in relation to how we deliver services. So understanding what is out in the community and what is being delivered in the community is an absolutely germane part of this. Going to Professor Kelly, the issue is about how we look at prevention and promotion. Those issues will eventually get looked at from a community perspective as well.

MRS DUNNE: Who has got that contract?

Ms Feely: Ernst & Young. Again, as they are looking at a holistic approach in terms of the clinical services framework I thought it was sensible that they also did that work for us, because they are interlinked and integrated.

THE CHAIR: Are there any further questions, particularly in relation to alcohol and drug services, which is a very small section of your portfolio? I think the legal marijuana issue fits into the public health section.

MS LE COUTEUR: On alcohol and drugs, I understand that all the services across the country have contracts with the commonwealth that expire in June 2017.

Ms Fitzharris: I would have to take that on notice. I do not know.

MS LE COUTEUR: My question was going to be: have you written to the minister to ask what is happening?

Ms Fitzharris: I spoke with the new federal minister yesterday at the Gift of Life walk. I certainly indicated that I am very keen to talk to him and my health minister colleagues about a number of issues around national partnerships, principally those that are expiring at the end of this financial year across a number of my portfolios. We have a health ministers meeting coming up at the end of this month, so I am sure that will be a topic of conversation there.

MR PETTERSSON: Last year the police drug diversion service was going to trial voluntary diversions for adults taken into custody for intoxication. How has the trial been going?

Ms Fitzharris: I think that is a question for ACT Policing.

MRS DUNNE: I would like some direction about where I should ask questions about the subacute hospital.

Ms Fitzharris: UCPH?

THE CHAIR: Maybe hold that and we can come back to you straight after the break.

MRS DUNNE: I have some general questions about finances, contracts and things like that. Do we do that under other matters at the end?

THE CHAIR: I think that would be a good time. There will be around about 30 minutes for general questions.

MRS DUNNE: Perhaps subacute is under rehabilitation? Is that where that fits?

THE CHAIR: How about we start with public health after the break and then you can ask about that in any of the sections that you would like.

Hearing suspended from 10.58 to 11.13 am.

THE CHAIR: We might get underway again. We will start with public health, which is a fairly broad section. We have a guest here who wishes to ask questions. I might go to Mrs Dunne first, as promised.

MRS DUNNE: No, I am relaxed. I will ask my questions when we get to rehabilitation.

THE CHAIR: Okay. With indulgence, we might go to Ms Lee, who has only a few questions.

MS LEE: Thank you, chair; I really appreciate it. Minister, my question is in relation to NDIS and community care. Yesterday, when we had annual reports hearings and the minister for disability was here, she mentioned that, in response to the requests for funding from the ACT government by bodies like SHOUT and TADACT, there were some discussions with your directorate. Could you update us on the progress of that, and moving forward?

Ms Fitzharris: I was not able to hear that particular conversation yesterday, but both Minister Stephen-Smith and I have been talking about these organisations. Within SHOUT, and the peer support organisations that are members of SHOUT, some of those do have a health interest. There are peer support groups for particular illnesses or particular conditions.

My understanding principally is that, of the 40-odd organisations that are members of SHOUT, some of which are very big organisations that are very self-sufficient, around four have a particular health focus. To the extent that they can probably be described as being around supporting people with chronic conditions, we will certainly look at other ways that they can be supported to continue their work.

Notably, the transition to the NDIS has left some organisations, as you would be well aware, that had previously had block funding in a difficult position with funding. It is a very worthwhile and important conversation to have about people who suffer from chronic conditions and how they are empowered to manage those conditions themselves and get peer support for the management of chronic conditions. So we will continue those conversations. There are other sector partners as well who are keen to talk with SHOUT and their member organisations about supporting them in the future.

MS LEE: Who are they?

Ms Fitzharris: Other community sector organisations that have been talking to

SHOUT, but I will leave it up to them—

MS LEE: As in non-government?

Ms Fitzharris: Yes. I will leave it up to them to continue those conversations. In the sense that the response to SHOUT has been one that Minister Stephen-Smith is leading, my office, my directorate and I will continue to talk to her about that.

MS LEE: Thanks, chair.

THE CHAIR: We will move up the line. We will go to Michael.

MR PETTERSSON: Page 18 states that the population health division will undertake work to establish a medicinal cannabis scheme in the ACT. Can you provide an update?

Ms Fitzharris: Sure.

MRS DUNNE: You did not read the press release this morning?

MR PETTERSSON: There was a press release? No.

Ms Fitzharris: Dr Kelly can talk in more detail, but this morning I announced that we will be opening expressions of interest for the medicinal cannabis advisory group. I have previously opened expressions of interest for the medicinal cannabis medical advisory panel. The difference between those two is the clinical medical advisory panel will be made up of clinical experts and the advisory group has a broader look at the implications for Health of establishing a medicinal cannabis scheme in the ACT. There will be some ex-officio members, which will include the police, but there will also be representatives more broadly from the community. That expression of interest opened this morning, so that we can establish those committees.

The government agreed to establishing a medicinal cannabis scheme last year. This committee, of which I was a member at the time, had some draft legislation referred to it by the Assembly which Mr Rattenbury put forward in 2014 or 2013. I came in about two-thirds of the way through that inquiry. The conclusion from that inquiry was that, although there was, among certain groups within the community, a high call for it and a need to offer compassionate access to medicinal cannabis, for the ACT to establish a scheme on its own would have been highly problematic. We needed the commonwealth to move, and they moved really quickly, fairly unexpectedly, and probably following the New South Wales government's lead. There has been a lot of community support and activism in New South Wales around one or two families, in particular, and a very active New South Wales parliamentary inquiry.

Once the commonwealth changed their legislation last year, and more recently, the commonwealth have agreed to look at importation of medicinal cannabis because it will take some time to establish effectively an industry in Australia. There are people who may wish to access medicinal cannabis legally now because they have already been accessing it effectively illegally. There is no certainty of supply. It is important to note that the scheme that we will be introducing here is one where medicinal

cannabis will be prescribed, but I understand that, even though the commonwealth has enabled people to now register to be a prescriber of medicinal cannabis, no-one in the ACT has yet sought to apply to become a prescriber.

From the government's point of view, we will have the expressions of interest. Nominees for both of those groups will be provided to me. I will take them to cabinet over the next couple of months. Meanwhile the work that Dr Kelly and his team are doing to establish the scheme as a whole, to provide advice both to the panel and to the group and then to the government as a whole, is underway. I will get Dr Kelly to talk to it in more detail.

Dr Kelly: I acknowledge the privilege statement. I apologise for my tardiness; I was giving an interview about this very issue, so it is front of mind. Thank you for your question.

The minister has outlined in quite a lot of detail what we are doing in relation to the two committees, so I will not go into that unless there are specific questions. I reiterate that the way new medicines can come into clinical practice takes a number of steps. It takes steps from the commonwealth government, in relation to their part of the regulation. I would summarise what happened with the commonwealth health announcements towards the end of last year as essentially dealing with the farm to the pharmacy. That was about supply of this particular medication, regulation around importation and so forth and/or setting up licences to grow what was previously an illegal product, and get it on the shelves of pharmacies.

The state and territory responsibilities in this area are really about the next steps: what happens from the pharmacy? How is it prescribed? Who prescribes it? For what types of issues? How will the use of this medication be monitored? Foremost in my mind, as the Chief Health Officer, is safety, quality, efficacy and effectiveness of those medications.

There is a role in education in terms of prescribers and the wider community about this new medication being legalised. Also, there is the regulatory component for which I am the delegate to the minister, under the Medicines, Poisons and Therapeutic Goods Act, to make sure that the people who should be getting this medicine on compassionate grounds to assist with their medical issues are the ones who are actually getting it. This is not about legalising marijuana; it is not about marijuana itself at all. It is a part of the cannabis plant, the cannabis component, which is what we need to work through.

Just to confirm what the minister said, you can go to the ACT Health website and see some information there, including a form for prescribers. So any doctor right now in the ACT could apply to be able to prescribe this medication, and we have a process for that. We will be guided more once these committees are in place in terms of the medical component and then, importantly, the wider social, legal and economic aspects of this scheme. But the barrier is not ours; the barrier, in fact, is supply. Having supply of this medication at medical grade in the ACT is still an issue.

MS LE COUTEUR: When do you think people in the ACT will be able to access medicinal cannabis?

Dr Kelly: Thank you for that question, Ms Le Couteur. From our point of view, from a regulatory point of view, they could do it today. People need to be having discussions with their usual care providers—doctors, their GP or others—to discuss it, and the doctor is the one who is able to request permission to prescribe. As the minister said, we have not had a single person come forward since this was announced several months ago.

The issue, though, is that part of the ability to prescribe is having access to the right supply, and that is still the problem. We are not able to do anything about that. The federal government, as the minister said, are looking at ways of expediting and improving importation. They have, as we understand it, under their new legislation—this is the farm to the pharmacy element—given a licence in an unnamed jurisdiction. It is not ours because they said they would tell us if it was ours. Under the federal government regime, they can make that decision without consulting other jurisdictions, which is interesting. However, they did undertake to tell us. They have not told us, so it must be another jurisdiction. But they have given one licence so far.

Ms Fitzharris: Or they break their word, but I do not think so.

Dr Kelly: Yes. So that will help. There is a time lag there, of course, in relation to doing these things, because this is introducing a new medication—in a slightly different way, but ensuring the safety and the quality of the medication are really important, and making sure that the right people get it at the right time. It is very similar to the discussions we have had about patient-centred care.

MRS DUNNE: Could I get some clarification? There is something I do not understand. You are saying that you are the delegate who gives permission to doctors to prescribe. Is that in this narrow case? I thought that the right to prescribe came with your provider number.

Dr Kelly: That is a very good point, Mrs Dunne, that I am happy to clarify. There are laws at the federal level around pharmaceuticals and there are laws at the jurisdictional level. The jurisdictional law is the Medicines, Poisons and Therapeutic Goods Act. What you are referring to is that a doctor has a prescriber number and they can prescribe a range of medicines.

At the federal level there are certain schedules, they call it, in terms of restriction there. Some medicines, in fact, you can buy over the counter from a grocery store; others are restricted to a pharmacy; others are behind the counter in the pharmacy; others require a prescription from a doctor. And there are others, what we call controlled medicines, or schedule 8 medicines, which require an extra layer of scrutiny. For us here, and in other jurisdictions around Australia, that is opiates—strong painkillers, morphine and the like, amphetamines used for attention deficit disorder and so on, and a couple of other ones, but mostly those two. The way we have handled this—it is slightly different in different states—and looked at this medicinal cannabis issue is to just incorporate that into that scheme.

MRS DUNNE: I see.

Dr Kelly: Our doctors in the ACT are familiar with applying for those approvals, and this will just be another one of those.

MR PETTERSSON: I have a follow-up on that. You have outlined a very high level of scrutiny of prescribing medicinal cannabis. Is that due to inherent medical risk in the medication? Is there something else being considered in the scrutiny?

Dr Kelly: The primary driver of that, as I just explained, is about the scheduling. The trigger for making this available nationally was the federal government's decision to take it away from the S9 category, which is a poison not to be used, highly restricted, illegal usually, to schedule 8, which puts it in the same category as controlled medicine: opiates, amphetamines and now cannabis. So that is the main thing.

The second thing, as I mentioned before, and earlier today on ABC radio, is that this is not about the legalisation of marijuana; this is a particular decision made by the government—and the minister can perhaps talk about that more—about a particular issue relating to a compassionate scheme for people when other medications are not working. There is some evidence that this will work to assist those people in need.

This is a live debate internationally. You would be aware, of course, that now 20 or more states in the US have gone down this path of either medicinal cannabis or, indeed, full legalisation of marijuana, and multiple other countries around the world have done so. At the moment in Australia that part is not on the table, but the medicinal cannabis part is. So my role as the regulator is to make sure that we follow that process from government and say, "This part's okay; that isn't." So what we do with those controlled medicines is, indeed, about quality, safety and efficacy, and looking for evidence of drug diversion, for example, inappropriate prescribing or inappropriate use. We do that already with opiates, of course, but this is just another example.

MR PETTERSSON: It was classified as a poison. It has been reduced in its scheduling classification. Are there any dangers to the patient from this as a medication?

Dr Kelly: In its pure form, cannabis, it seems to be safe. There is limited information on this. There is a live debate in the medical literature around whether in fact it is effective for the rather long list of things that some of the advocates say it is effective for. That is the main reason why we are having this advisory group. I am not an expert on marijuana or cannabis.

MRS KIKKERT: I am glad you are not!

Dr Kelly: I could use the Bill Clinton excuse but I will not! That medical advisory group is a group of experts in the medicine itself: the toxicology of the medicine, the pharmacology and all those things. It can give really strong indication and support about how one would decide which patients should receive it for what conditions. So that is a really important part.

With the other group that the minister announced today, the expressions of interest, it is an opportunity to discuss more broadly the community perceptions, the legal,

economic and social aspects of this, because it is quite a change. There has been a fair bit of media about, for example, our roadside drug testing, how this might affect that and what would happen to someone who has been able to start on medicinal cannabis—should they be able to drive or not? That is a live question and we would have to think about that in relation to the various laws.

MRS DUNNE: What exactly would be prescribed?

Dr Kelly: That is another live area. It is not clear. There is very little guidance from the national sphere on that. Unfortunately, we are doing this eight times around Australia. I think that is—

MRS DUNNE: Inefficient.

Dr Kelly: Inefficient and also opens the possibility for going off on different paths. I talk to the people in charge of this type of thing in each of the jurisdictions on a regular basis. We meet and so forth, and this is one of the hot topics that we talk about.

MRS DUNNE: So it may not necessarily be some sort of extract in a capsule or whatever?

Dr Kelly: Ideally, that would be exactly what it would be.

Ms Fitzharris: There are already products—you will be able to confirm—available under the PBS for certain conditions that have the active ingredient in them. They are already on the market. Wearing one of my other hats around the portfolio of Higher Education, Training and Research, and if I recall the discussion that the committee had when they were considering the legislation, one of the broader issues was that there was a bit of a chicken and egg situation, in that one clinical view might be, "Well, it's not effective," and the opposing view was, "Well, we haven't been able to try, and we haven't been able to access very good research yet because it's just not broadly enough available."

I know that particularly the University of Canberra has been looking at partnerships in being able to do research. There is potential for Canberra to play a role in working with researchers who are interested in this question about, over time, what the potential pharmaceutical uses for cannabis are that could become mainstream prescribed medications. I think that will take many years to develop. Certainly, within Australia, there has been the catch-22 of it being an illegal product, by and large, and not being able to do as much research, and then moving through the spectrum of clinical trials to make it an available prescribed medicine. But there is lots of experience in other countries that the advisory group will be looking at.

MRS DUNNE: I have a couple of public health questions, if I could.

THE CHAIR: Can we go to Mrs Kikkert first.

MRS KIKKERT: I have an easy one: how many people in the ACT suffer type 2 diabetes? While you are looking up the figure, what diabetes prevention strategies and programs does ACT Health run?

Ms Fitzharris: There will be programs within the hospital and within the community health setting, as well as with Diabetes ACT. I believe we have a contract with them to deliver some services. They also have a contract with the commonwealth, I believe. So they do some. Possibly Matt can talk on Diabetes ACT?

Mr Thompson: I can talk on that, and I am sure Dr Kelly can talk much more authoritatively about the prevention side of things than I can, and will in a minute. In terms of the treatment side of things, we have within ACT Health a comprehensive diabetes service that is about diagnosed people and about how to manage the diabetes effectively and treat exacerbations of the condition, which is a common feature of diabetes. More broadly in the ACT, we have a Diabetes Australia ACT contract that the minister has referred to. General practice is quite probably the major service provider in diabetes because, for people with stable diabetes, being managed by their GPs is almost always the most effective approach. But private sector specialists, specialist endocrinologists and specialist allied health and nursing clinicians, are also available to manage diabetes in the private sector.

MRS KIKKERT: How is the effectiveness of those programs measured?

Mr Thompson: In terms of the effectiveness of the programs, as ACT Health, we do not directly measure the effectiveness of the private sector and general practice options. Within our services, we monitor the activity of our units. We have a number of other performance indicators in terms of the diabetes service about how many clients they are seeing, how many group services they provide. It is largely around the activity of the services themselves and the ability to manage exacerbations and reduce hospitalisations associated with diabetes.

MRS DUNNE: Just to follow up on diabetes, in my understanding, the ACT has the highest prevalence of gestational diabetes?

Ms Fitzharris: I am not sure it is the highest, but we know it is rising, and that is a real concern. I am very interested in what we do about that; it has, obviously, immediate implications, while a woman is pregnant, for herself and the baby, but I think the evidence shows that the likelihood of the mother—

MRS DUNNE: Or the child.

MS FITZHARRIS: or the child having diabetes down the track is very high.

MRS DUNNE: This is, again, anecdotal, but with people who present for tests for gestational diabetes and who might be diagnosed with gestational diabetes, are they followed up afterwards and are their babies followed up? Are their babies considered high risk?

Ms Fitzharris: Elizabeth can talk to that.

MRS DUNNE: How is that followed up?

Dr Kelly: Whilst Elizabeth is coming, I may answer your actually quite difficult

question. The ACT rate of prevalence of diabetes is taken from the Australian health survey, which is a self-report survey run by the Australian Bureau of Statistics. The rate for the ACT is 4.3 per cent for diabetes. That is a combination of type 1 and type 2. Type 2 is by far the bulk of that number and is the one that is rapidly rising. That is related to obesity issues and other matters: nutrition, physical activity and, partly, age. I will talk to that after Elizabeth has answered the question about gestational diabetes.

The reason why I say it is a hard question is that one has to know that one has got it before you can report it, and one of the issues with diabetes is that it is silent for a long time. One of our challenges is that to find out the true number of diabetics in the community is not an easy thing. One of the ways we can is through, unfortunately, diagnosing women in pregnancy, because everyone in pregnancy is screened for that. I will pass to Elizabeth.

Ms Chatham: I acknowledge the statement of privilege here today.

Can you just repeat the question, please?

MRS DUNNE: I just wanted to know about the follow-up for people who are diagnosed with gestational diabetes. Generally speaking, it goes away after they have had their baby, but they are at higher risk of having a return of type 2 diabetes and their children are at higher risk, presumably, of type 2 diabetes as well. What is the follow-up for people who are diagnosed with gestational diabetes?

Ms Chatham: Women are followed up postnatally through the diabetic service at the hospital, and they will continue to be followed up until they are clear. They are given quite a lot of education to be alerted to signs and symptoms that they may want to raise with their GP once they have been cleared from their diabetes. Then there is communication from the hospital to their GP. That is for the women. Babies of gestationally diabetic women are cared for by the neonatology department, so they are cared for in hospital, and then are reviewed again post discharge, either by a neonatologist or by the paediatricians, until their sugars return to normal.

MRS DUNNE: How long after birth is the follow-up?

Ms Chatham: The follow-up is ongoing really, as long as the child becomes stable and is considered to be normal.

MRS DUNNE: But once they have been stable, once the mother and the baby have been stabilised, it is really up to the GP?

Ms Chatham: There is the maternal child health service that also screens the children up to age five as well. They also are looking for signs and symptoms and reinforcing that advice to the parents.

MRS DUNNE: Thanks.

Ms Fitzharris: But I think the broader concern about the rising rates of gestational diabetes and type 2 diabetes is real. I did not appreciate that we could not break down the two types. It is a question where, I think, given the national way of collecting this,

it might be difficult. It certainly goes to some of the themes around preventive health. Type 2 diabetes can be prevented. Awareness of the full health implications for your quality of life and length of life from diabetes is very significant. It often cannot be managed very simply with an insulin injection. It has significant health implications for people, for their quality of life and how long they might live. It will be one of those issues that we will be considering through the preventative health work that we do as well as the ongoing service delivery across the health system.

THE CHAIR: I have some questions in relation to maximising the quality of hospital services strategic objective, particularly in relation to the prevalence of staphylococcus infection rates at the hospital.

MRS DUNNE: Is that public health?

MRS KIKKERT: It is probably acute health.

Ms Fitzharris: It is acute.

THE CHAIR: Okay.

MS LE COUTEUR: But with the chair's indulgence.

MRS KIKKERT: You are allowed.

THE CHAIR: In relation to the sorts of strategies that are put in place to deal with those infections in the hospital, particularly in relation to what training is given to any cleaning contractors employed at the hospital and nurses in their role in cleaning wards—

Mr Thompson: I will start; I may need supplementation on the specifics of the cleaning contract. In terms of managing infections, it is all part of the comprehensive infection control program that we have across Canberra Hospital. A very significant aspect of it—and you can see that in the statistics that we have provided in the report—is hand hygiene. That is absolutely crucial. It is encouraging that over recent years we have seen a steady increase in the hand hygiene rates at both public hospitals in the ACT. That has been the focus of a very concerted effort. One is the education, and that is for nursing as well as medical and allied health staff, in particular, that we focus on when it comes to education and training. But it is also a process of auditing and information reinforcement. We have been running comprehensive audits to identify whether or not people are practising good hand hygiene and the extent to which that is translating into the overall hand hygiene results.

In addition to hand hygiene, it is essential that we have broader infection control policies and practices. That covers quite a broad spectrum of activities. One of them is what is called a septic technique: in other words, where minor procedures, in particular, are being done for patients, they are done in a way where there is not a risk of contamination and passing on of infection. Another aspect of it is, as you have talked about, looking at cleaning, ensuring that the cleaning standards are up to scratch and that, where there are risks of contamination from spills of body fluid and the like, they are very rapidly responded to. In a similar vein, it is about the use of

personal protective equipment, where indicated, for staff themselves.

So it is a combination. From the inspection control point of view, one, of course, is to ensure that patients do not receive infections. But also part of it is about just having staff themselves not receiving the infection from patients, because, of course, if they do, they are at risk of passing it on to other patients and family and friends. That is a broadbrush indication of the range of activities that we undertake.

In terms of the cleaning contract specifically—

Ms Kennedy: I currently have responsibility for the ACT Health domestic environmental services contract. That contract is provided by ISS Global and has specific requirements for them to meet what are now the ACT Health cleaning standards. They are based on and adopted by and from the Victorian healthcare standards. They outline quite clearly what is expected in relation to cleaning a health facility that is delivering clinical services.

THE CHAIR: Is there some sort of assessment ongoing as to whether they are meeting the standards?

Ms Kennedy: Correct. There is a regular audit regime. The audits in the clinical areas are conducted in conjunction with the clinical staff; they do joint audits. Those audits are reported monthly.

THE CHAIR: What if a particular patient were to report something, concerns about the cleanliness of their hospital room? What sorts of mechanisms are there for getting feedback from people using hospital services?

Ms Kennedy: They can report immediately through our consumer feedback process. If they are still an inpatient, somebody will go and speak with them about their concerns. Of course, they can also report it to the nursing staff in the area, who will contact the cleaning provider immediately via the help desk. So there is immediate response available on any issues that are raised.

THE CHAIR: What role do nurses have in cleaning compared with the contractor? Is there any role at all for them to be involved in that?

Ms Kennedy: The nursing staff will contact the contractor if something requires cleaning.

Ms Feely: Excuse me, may I just clarify, chair: do you meant the nurses actually physically doing the cleaning?

THE CHAIR: Physically.

MRS KIKKERT: Changing beds? Would that be one of them?

Ms Feely: Not ISS, but the actual nurses doing the work. There is a breakdown. Marina, I might get you to come up and talk about the nursing staff, but in relation to the physical cleaning of floors, that is not a nursing requirement.

MRS KIKKERT: Do the nurses change beds? Is that part of their job role?

Ms Kennedy: I will let Marina talk about the nursing role.

Ms Feely: This is going to get definitional. You will notice that we do not have Ms Ronnie Croome, who is the ACT Chief Nurse. She is currently on bereavement leave, so she is not here, but Marina is representing the nursing fraternity.

Ms Buchanan-Grey: I acknowledge the privilege statement that has been provided this morning.

Sorry; who asked the question? I apologise; I did not catch it.

THE CHAIR: I did.

Ms Buchanan-Grey: The nursing staff do not physically clean the clinical environments. They are responsible for ensuring that the clinical environment is safe and tidy and kept clean in that regard. They will wipe down medical devices and equipment that they use in a day-to-day setting, particularly in between individual patient care, to reduce the risk of cross-contamination of infection. But they will not physically take out a mop and bucket and clean the ward environment. They will change beds and linen for patients on a regular basis and as required throughout the day, but the basic cleaning of the ward environment is left up to the hospital assistants and the ISS contracted cleaning services.

Ms Fitzharris: I acknowledge, for the benefit of members of the committee and some staff, the previous chair of the committee, Dr Bourke, who had a very strong interest in hand cleaning over a number of years, I think. He used to ask the questions on hand cleaning. So a nod to Chris in that context.

MS LE COUTEUR: As we are on acute health, can you give us an update of the trial of publicly funded home births to date. How many have we had so far?

Ms Fitzharris: Admittedly, the first one got some quite good—

MS LE COUTEUR: I heard about the first one. Maybe there have been more?

Ms Chatham: I am delighted to tell you that we opened the books to bookings in October last year. We have had two babies born, and both have been very successful. One was a baby boy. I cannot tell you the sex of the other one. It was just a week ago, and it went really well. So we are really delighted.

MS LE COUTEUR: Great. Clearly you think the pilot has been successful, from your comments. Is it planned to continue it?

Ms Chatham: There is a formal evaluation process. At the moment it is a three-year trial and there are evaluation points two times during the three years. It is far too early to say, but we are very delighted with the two births that we have had, and the women have been very happy with their experience.

MS LE COUTEUR: Are you considering expanding it? At present it is only for second babies or you have had a normal vaginal birth before. Have you considered particularly expanding it to first-time mothers?

Ms Chatham: The eligibility criteria during the pilot stage are quite rigorous. What you have said is correct. Any change to criteria would be done after the evaluation process has been undertaken.

MS LE COUTEUR: So that is after the three years?

Ms Chatham: Yes. There is a midpoint, and we will look at it then, but it is within that framework of the evaluation. There is a midpoint evaluation at 18 months and then a final evaluation at three years.

MRS DUNNE: What are the criteria for getting on the program?

Ms Chatham: I am really happy to provide them to you, but I have not got them on me now.

MRS DUNNE: That is fine.

Ms Chatham: There are clinical and demographic criteria, but I can provide them to you.

Ms Fitzharris: One of the criteria is how far you live from the Canberra Hospital. How many are registered on the scheme?

Ms Chatham: At the moment we have got six more women booked to have home births. There are places for two women per month.

MS LE COUTEUR: Is six the capacity? I do not know, obviously, how many months we are talking about.

MRS DUNNE: Two per month is the capacity.

MS LE COUTEUR: Yes, two per month, but six could be capacity or it could not be capacity.

MRS DUNNE: Technically speaking, 18 should be capacity.

Ms Chatham: Two a month, but if someone comes off the home birth program, we can move someone onto it. If they have to go to the hospital for some reason, we can put another woman onto that program. So it is two women who are choosing to birth at home per month.

MS LE COUTEUR: But you currently have spare capacity in the program?

Ms Chatham: Yes.

MS LE COUTEUR: Have you had any feedback from the home birth lobby group?

Ms Chatham: Yes, we have had feedback directly and also we have done formal consultation with them.

MS LE COUTEUR: And what are their views?

Ms Chatham: They are delighted that ACT Health has started to look at home births, but they have expressed concern about the quite rigid eligibility criteria at this time.

MS LE COUTEUR: Is insurance one of the issues? I remember when I was in the Assembly before, and obviously the Greens have been pushing for this for a long time, insurance seemed to be the number one issue. Is it still the number one issue?

Ms Chatham: It is not the number one issue. It was a barrier. It is a barrier we have got over and we are working with the insurer to provide a service that they feel comfortable with us providing. They were a barrier once, but they have come on board and are happy to work with us to deliver this service.

MS LE COUTEUR: Great.

MRS DUNNE: There are a range of diseases that you pick up through the heel prick test. I am sorry; I do not have the list with me. I was written to recently in relation to Rare Disease Day and given a suggested list of other things that could be added to the list. Is there any discussion about extending the screening in relation to the heel prick test?

Ms Chatham: There is ongoing discussion at a federal level across all the jurisdictions about what tests are done.

MRS DUNNE: That is really a federal decision. It is funded federally?

Ms Chatham: Yes. It is a federal discussion. It is funded federally. Each jurisdiction contributes to a commonwealth pool of money to do the work, so it is decided federally what tests are on and off. I have just forgotten the rare disease they are looking at right now. You are right: there is a particular one they are looking at at the moment. We would fully support any increase in funding for the screening program in relation to that heel prick test.

MRS DUNNE: I might put a question on notice with the list of things that I was given and then you can come back to me.

Ms Chatham: Yes. In our discussions with the jurisdictions, ACT Health have supported moving forward to increase the scope of that screening tool.

MS LE COUTEUR: I have a public health question—and I refer to page 52—and it relates to hoarding. There is a cross-directorate exercise that you are going into. Where are you up to with this? I am aware that it is a significant issue.

Ms Fitzharris: It is, and there were some changes to legislation last year. To some

extent there are broadly two components: there is hoarding where there is a public health risk and there is hoarding where there is not a public health risk. The Chief Health Officer's role is around where there is a public health risk, and that is where my role comes in as well. There are clearly a number of specific examples in the community where they are not assessed as having a public health risk and they are more broadly issues with hoarding. Some are well-known to members of the Assembly. The coordination group is really important to work through all of those as well as work with individuals around hoarding behaviour.

Dr Kelly: I am going to flick pass to the acting executive director from the health protection service, mainly because he has been very closely involved with this matter, including the legislative changes and dealing with some of these really quite complex issues. I pass over to Mr Barr.

Mr Barr: The hoarding and case management working group was formally established as a result of legislative changes passed in the Assembly last year. However, the body itself had actually been working previously as a collaborative forum for a number of years. It involves members from our emergency services, the Health Directorate, adult mental health, the Community Services Directorate, TCCS—it is not TAMS anymore—and Access Canberra. The idea basically is that we understand that with the complexities of many of these circumstances they do not fit neatly in a box where all of it sits with one agency.

The forum works in a collaborative way so that, if the principal issue associated with a premises is an insanitary condition, which is our responsibility under the Health Act, then we will take the lead in dealing with that, using our legislative responsibilities et cetera, and other agencies will support us. Quite often, because of the complexities, there will be a role for some of the non-government community service agencies that are part of our working group or CSD, mental health et cetera to support both the person we are dealing with in the circumstance and the action we may take.

Other circumstances, as the minister has already identified, do not constitute a public health risk. Probably a really good example of that is the stockpiling of whitegoods on a premise. Again, because of the functionality of the forum, if it comes to the attention of one of the agencies, we share the information and we look at who is best to resolve that. For instance, in a recent example, whitegoods which were hoarded on territory land were dealt with very simply under the provisions of the Litter Act. TCCS took the lead in undertaking that action. Because of the relationship that we had managed to build with the person who owned the premises, we were also able to assist them in the removal of some of the material they had collected on their own lease.

In relation to dealing with the lease itself and the accumulation of material on the lease when it is not insanitary and not a fire hazard then that is for Access Canberra. But, again, we all work together to provide the most appropriate combined government response to those circumstances.

MR PETTERSSON: The cross-agency task force, from all accounts that I have heard, seems to be working quite well. Have you had any successful cases yet where hoarding has been dealt with?

Mr Barr: Yes, we have had a number of successful cases. At the end of last year we instituted an order under the Public Health Act using the new provisions that the Assembly passed last year to take clean-up action.

MRS DUNNE: My constituents are very grateful.

Mr Barr: We took clean-up action in relation to a person who has a food hoarding disorder. Again, the group successfully dealt with earlier this year the accumulation of whitegoods on public land in north Canberra and has made significant progress with the occupant of the premises in dealing with the material on their own lease. Often it is a collaborative arrangement. The person may have difficulty in disposing of the material. We can sometimes provide transport to assist them or we can provide assistance with disposal and the costs associated with that to remove the hazard.

There are a number of other properties we have been working with. With support and advice, there was one in the inner south where the occupant cleaned the material and removed it so it was no longer considered a hoarding property. Again, it was an insanitary condition, a public health risk one. There have been some others in the inner south where, for instance, by engaging with the leaseholder of the premises rather than the tenant of the premises, the leaseholder has been able to institute actions to remove the material.

MR PETTERSSON: You mentioned that in most of these whitegoods hoarding situations there is not a public health risk.

Mr Barr: That is correct.

MR PETTERSSON: I have had conversations with several people and they report things like a large number of rats in the street, snakes and pools of water. What is the threshold for considering it a public health risk?

Mr Barr: A good example is that if water collects in the whitegoods and mosquitoes breed in it, it is a public health risk. In that circumstance, the person does not necessarily have to remove the whitegoods to remove the public health risk. They merely only have to remove the habitat where the water collects for the mosquitoes to breed. As I said, it is often a really complex area. That is why, for instance, in that circumstance, the Public Health Act is not the most appropriate tool to use there. We certainly engage with them about: "You've created a public health risk here by doing this," and they close the lid, they tip it out and they upend it so water cannot collect in it anymore. That public health risk disappears.

Ms Fitzharris: There is a code of practice being developed under the legislation that was passed last year. Do you want to talk about that?

Mr Barr: Yes. The code of practice is designed to provide advice and guidance to the Chief Health Officer and the other parties involved in dealing with hoarding and insanitary conditions. The draft code of practice was circulated in December for consultation with all the key stakeholders. We are now finalising the final draft in close consultation principally at the moment with the Human Rights Commission and the Justice and Community Safety Directorate. As you can imagine in these sensitive

cases, there is a balance of how we exercise our functions as a regulator with due regard to the human rights of both the people who are affected by the insanitary conditions and the person who creates them. But we are expected to finalise the code of practice this month.

MR PETTERSSON: Will that be publicly available?

Mr Barr: Yes.

MR PETTERSSON: Are there any other time lines for work in this area that would be of interest to people?

Mr Barr: The case management group meets regularly. We meet basically on a monthly basis and out of session by exception if there are specific instances where the whole group does not need to deal with it. Again, I will refer back to one of the whitegoods circumstances. The group dealt with it and, once we established that TCCS was the primary lead in dealing with that, with support from Access Canberra and Health, we convened a smaller working group out of session where the key players came together to ensure that we worked consistently and in a coordinated way to mitigate the risk associated with that.

MRS DUNNE: I have some questions on Aboriginal health. Does that come under public health?

THE CHAIR: Yes.

MRS DUNNE: In relation to the bush healing farm, I presume that this is the item on page 206, "Aboriginal Torres Strait Islander residential alcohol and other drug rehabilitation facility"? Is that the bush healing farm? It says that it was expected to be completed in August 2016. Has it been completed? Is it operational?

Ms Fitzharris: The building itself has been completed. The access road to it is under construction.

Ms Feely: By May.

Ms Fitzharris: Ongoing discussions with service providers are underway at the same time to finalise the service delivery arrangements.

MRS DUNNE: So you will have a contract with the service provider, a service delivery agreement and an access road all by May?

Ms Feely: The access road is scheduled to be finished by May. To allow some leeway, I would like to say June.

MRS DUNNE: June.

Ms Feely: We will be working on the model of care and finalising the service delivery elements over the next three or four months. All things being equal, June.

MRS DUNNE: In the reporting period, the full expenditure was $8½ million and change out of an expected $11.7 million. What is the final budget of the project going to be?

Ms Fitzharris: I assume there is a final part of the budget in this financial year—2016-17.

Ms Feely: We can hear from Shaun.

Mr Strachan: I can confirm that the total budget was $11.731 million. The expenditure year to date at this particular point in time is $9.4 million. It is anticipated that the full budget will be utilised in terms of fostering and sponsoring all costs associated with the build and the ancillary aspects associated with the access road.

MRS DUNNE: So $11.73 million. It says $11.79 in here. There has been an 18-month or two-year delay. What has been the cause of that? Have you changed the scope of the project? Have you increased the size of the project? What?

Mr Strachan: I refer you to page 206. In relation to the—

MRS DUNNE: Sorry, I was reading the line above it. I take it back.

Mr Strachan: So, just to clarify, it is published at 11.731.

MRS DUNNE: It is; sorry, yes. Thank you, Mr Strachan. Apart from the access road, what has been the reason that the completion has taken 18 months more? Have you changed the scope of the project or what?

Mr Strachan: Could I just clarify? Is that in relation to the construction or in relation to the service?

MRS DUNNE: All of it. It was supposed to be up and running about 18 months ago, from my recollection, and it has sort of gone on and on.

Ms Fitzharris: I am not sure, and we can take that on notice, but the funding profile has it over this period of time. Unless anyone is able to answer—

MRS DUNNE: This is a saga that is as long as *Ben-Hur*.

Ms Fitzharris: Yes, I know. I know.

MRS DUNNE: On notice, then, could we have a time line? This goes back to about 2008, from my recollection. If we could have a time line on that, that would be great.

Ms Fitzharris: Sure. We can take that on notice.

MRS DUNNE: Also in Indigenous health, on page 25 you talk about the Aboriginal and Torres Strait Islander health plan. What areas will the government be including in its strategic priorities? All of those that are there on page 25, or are there some that you are going to concentrate on more?

Ms Fitzharris: Dr Bourke and I last year announced, I believe in April, some early consultation on the plan. As well, there is about to get underway some federal work on Aboriginal health. Matt Richter can talk to that in more detail.

Mr Richter: I acknowledge the privilege statement that we have here today.

Firstly, in relation to the land, we have undertaken consultation and a fair amount of underpinning research work. Where we are at with the plan is that it is important that we implement Aboriginal and Torres Strait Islander health policy in an integrated and coordinated way. It needs to embed in all the services and everything that we do if we are going to try to have a meaningful impact on closing the gap in life expectancy and other strategic targets.

What we want to do is make sure that the priorities that we have talked about in the plan and that we have consulted on integrate into work such as the clinical services framework aligned with the national framework that is going on through COAG and the national Aboriginal and Torres Strait Islander plan so that we can make the most of opportunities to leverage and intersect with those planning opportunities.

In terms of focus, it is important that we focus on particular areas at particular times whilst maintaining that holistic effort. We have not yet identified whether we will focus particularly in the ACT on any one of these areas outside of mental health and social and emotional health and wellbeing, which is continuing as a priority area for us. Nationally, we have agreed, through the standing council on health, that there will be a focus over the next couple of years on cancer in Aboriginal and Torres Strait Islander health. So we will be focusing on work here. As we roll forward with clinical services framework planning, we will get better ideas within our own service structure as to where we may have gaps and needs in service delivery.

MRS DUNNE: Also, I notice—I am not quite sure if this is you, Mr Richter, or someone else—that in tobacco control, there is a project which is being funded through ATODA to look at strategies for reducing smoking amongst pregnant and parenting Aboriginal and Torres Strait Islander women. How did that go to ATODA? How did that come about? Does that cross over the work that is being done by Winnunga in that space?

Mr Richter: I will refer to my esteemed colleague Dr Kelly.

Dr Kelly: Thank you, esteemed colleague. Thank you for your question, Mrs Dunne. On smoking in general, in the ACT we can be very proud of our achievements over the past 20 to 25 years in rapidly and enormously reducing smoking prevalence in the general population. Where we are at at the moment is leading the country in relation to that in terms of prevalence of smoking. But within that are some difficult stories. It is a time where we need to really look at who amongst our population are at higher risk of developing and continuing this behaviour of smoking, which is, as we all know, very harmful to health. One of those areas is in our Aboriginal and Torres Strait Islander community in general, particularly in young women and, most importantly, from our point of view in terms of health risk, young Aboriginal and Torres Strait Islander women who are pregnant.

That was seen from the Chief Health Officer's report to be a priority area. It is the use of that information which goes to guide our ACT healthy grants program. When we put out expressions of interest for that program, which we do annually for about $2 million of funding to the community sector for specific grants, that was one of the things we underlined, and we asked people to please come forward with suggestions about how to deal with this issue.

Through the process—which we have been doing for many years and which is all very transparent; it includes consultation with the community, and there is a process which goes up to me as the decision-maker and then to the minister for her to announce these things—ATODA was successful with that particular piece of work.

MRS DUNNE: So, unlike other grants programs, you can say, "Come to us with proposals, but we're interested in X, Y and Z, and you might like to think about those as well." If no-one had come forward with a project in that space, what would you have done?

Dr Kelly: Certainly it was work that needed to be done, so we would have had to work out another mechanism.

MRS DUNNE: You would have had to find another way of doing it?

Dr Kelly: Yes. Some years ago—we have had the health promotion grants program going for a number of years—a previous health minister suggested that we made it more strategic and more related to big picture needs. We reflected on that last year and produced a report, which I am happy to table with the committee, which looked back over the past three years since that decision was made. Interestingly, about 90 per cent of the funds went towards healthy weight, which was a big issue for us. Most of the rest was smoking and alcohol. It seemed to work. We were able to engage with the community and say, "These are the things where we really want to hear your ways of dealing with them," but guiding it so that there are more than just small grants here and there, with relatively large grants like the one that you mentioned with a specific purpose related to the objectives of the directorate.

Ms Fitzharris: In addition, in the last round of grants that we did, we asked for a focus on healthy ageing. We announced those grants late last year or early this year. One of those went to Alzheimer's ACT for a program that they want to run for their dementia clients called "Fill the bucket". That is quite a significant grant to Alzheimer's ACT. That round was particularly focused on healthy ageing. But, again, these are some of the sorts of issues that we will be considering in a range of different ways and through the preventative health forum, bringing in particularly the big issues of smoking and tobacco use, obesity and alcohol and drug use.

THE CHAIR: I encourage members to move to cancer services, if possible, to questions about that.

MR PETTERSSON: I have one. What methods are currently being used to promote participation in breast screens?

Ms Lamb: Thank you for your question in regard to breast screening. The ACT breast screen service has a range of initiatives that they are undertaking to try to increase the number of women choosing to have a breast screen. Our key focus of work in the recent year has been working with GPs, trying to get them to encourage women to attend and giving them all of the information about the benefits of screening. We have also been working with workplaces where we have opportunity to go into workplaces where women of the target age group of 50 to 69 are so that they get the information within their workplace as well.

MR PETTERSSON: I am noting that, for that cohort, participation has remained steady. What are the challenges of engaging with that particular cohort?

Ms Lamb: We have had an increase in our participation rate in the past 12 months. We have increased up to 58 per cent, which is getting closer to the 60 per cent target. This year we undertook a research survey looking at why women were choosing not to attend breast screening and identifying what some of the barriers were. Within that, a lot of it was incorrect information and just being busy, not having time and not putting that as their first priority. Our strategies now are going to be targeting those areas that women have identified.

MRS DUNNE: You get a reminder. Once you are in the system, you get a reminder. But for people who are coming into the system, the people who are sort of hitting the magic age but who do not present, is there some way through census data, electoral roll data, et cetera that you can make approaches to them? Things like bowel cancer screening, pap smears and things like this are commonwealth ones. You have magic birthdays and you get a little present from the bowel cancer screening people. You also get reminders for pap smears and things like that. Have you looked at interventions where you contact the people who have not contacted you?

Ms Lamb: We do now have access to the electoral roll and send out invitations to women, when they turn 50, to come and join the program. We will then also follow that up, but if they do not attend, we will send a reminder. We have a range of different reminders that we send out to women who may have come for one screen and then in two years time have not come back again. We will send them out an invitation to rejoin the program at that time. We have been using that avenue to try to increase our participation.

THE CHAIR: Are there any other questions on cancer services? No. We will move to rehabilitation, age and community care, which we may have already touched on.

MRS DUNNE: If I could ask, first of all, for a run down on where we are with the subacute hospital. I notice the roof has started to go on.

Ms Fitzharris: In terms of infrastructure itself, yes I believe it is all on track. Both the hospital and, importantly, the access road and the duplication of Aikman Drive as well are on track for completion in 2018. You can really see it starting to take shape now. We expect it to be on time and on budget.

Mr Mooney: The question again was: what is the program status of UCPH? I can say at this stage, as the minister has said, it is progressing very well to be on track. We

will be opening in the middle of 2018. From a construction point of view, the project is reaching a very definitive milestone with the crane being taken down later this month. In the last few minutes I was looking at pictures on my phone of most of the roof on the inpatient unit, all the RAAC areas and the last remaining area, the mental health area. As I said, it is a significant milestone with the crane coming down.

MRS DUNNE: On page 213 there is reference to the contract, which is a big sum, but also there is reference to a $49 million four-year contract for hospital maintenance which is also going to Brookfield. I was wondering: seeing that that contract was executed in November 2015, what is the contract for, seeing it appears to be a maintenance contract?

Mr Mooney: This particular project is being delivered under what is called a DCM—a design, construct and maintain—contract. In actual fact, there are two deeds, not contracts. Each of them was executed at the same time, on 19 or 20 November 2015. The first, the D and C parts, is with Multiplex. The M part, which is the deed that covers the provision of ongoing maintenance services both hard and soft surfaces at the facility once it is up and running, is a 25-year deed that has been set up with Brookfield Global Integrated Solutions, which is a sister company of Multiplex.

MRS DUNNE: I now see that they are slightly different companies with similar but different names. You say that this is a 25-year contract but it says here the expiry date is 2022.

Mr Mooney: The way the deed is set up, across hard and soft FM services, there is what is known as—

MRS DUNNE: Sorry?

Mr Mooney: Just to put it in perspective, hard FM—facility management—would be building maintenance. Soft FM would be cleaning, ward services, food.

Ms Feely: But not clinical.

Mr Strachan: If I can, I will just clarify exactly what services are actually in the contract. There are contract management administrative services, help desk services, distribution and patient support services, food services, cleaning services, building engineering services, material distribution services, security services, ground and garden maintenance and pest control. The hard reference is in relation to the core infrastructure side, and the soft is in relation to the ancillary services.

Mr Mooney: Going back to the actual date that you have picked up there, the first reviewable term in the 25-year period is after five years. That is where that comes from. The soft services are reviewed every five years, and the hard services have an initial term of 10 years and are then reviewed every five years thereafter. That gives the territory the opportunity to obviously maximise value for money.

MRS DUNNE: I am not sure who can answer this: when you contracted for the construction, it was always construct and maintain?

Mr Mooney: Yes. What we have done with this particular model—it was two deeds; there is what is known as an interface deed between the two contracting parties—is that we have mandated essentially within that arrangement whereby the FM, the facilities management provider, Brookfield Global Integrated Solutions, are integral in the design of the building so that we maximise the opportunity from a whole-of-life optimisation perspective. They have been working hand in hand with the builder throughout the process of final design.

Essentially the territory has a single point of contact with each of the contracting parties through critical phases. Currently it is with Multiplex, who are the D and C, the contractor doing the construction. As soon as we reach practical completion, that will hand over to the FM provider, Brookfield Global Integrated Solutions.

Ms Fitzharris: That is part of broader reforms around procurement.

MRS DUNNE: I am aware of some of those in school constructions and things like that.

Ms Fitzharris: And certainly along the spectrum, a public-private partnership with the courts facility as well as with the light rail. But one of the benefits of it is that you get that whole-of-life cost. The government can understand a whole-of-life cost over a budget beyond an estimates period of just four years. For example, when I visited the site late last year, the team was walking through the site and explaining the elements of the design of a hospital—and it is complex—and the fact that they know that they need to maintain this for the next 25 years means that they will construct it in a way that is best value for money for us as a client so that they do not do a cheap job.

MRS DUNNE: It has to be best value for money.

Ms Fitzharris: Yes, because they have to make it work for them. You do not get a situation where you might—I am not saying this has happened—well have, on any sort of project where you design something to look nice for a couple of years, the ongoing cost of maintenance to our assets as a whole, built assets and our natural assets, being a real long-term challenge for any budget. In terms of major investments, they have a stake in the game right from day one with design as well as with construction. It was interesting for me touring the site that it was something that they spoke quite often about, that they might have done something differently if they could have just walked away and left it beyond their standard sort of defects period for a construction.

MRS DUNNE: The $49 million seems like a lot of money but it is over 25 years beginning in 2018?

Mr Mooney: That period is over five years.

MRS DUNNE: What is the whole-of-life cost of the 25-year contract?

Ms Fitzharris: We will take that on notice in terms of today's dollars and the overall total cost.

MRS DUNNE: I had a series of questions related to the $49 million. I presumed that was over the whole life. Thanks. One of the questions is, and you might like to take this on notice: what is the capacity for rise and fall of the review dates?

Mr Mooney: The mechanisms are in the contract to look at all of the services. The reason why we chose five years was that is an industry standard in terms of being able to not only set something up—there are overheads when a contractor comes on board to do new services—but then also to get benefit out of that for both parties. So that five years is a sweet spot in the industry.

MRS DUNNE: And what capacity do you have to walk away at five or 10 or 15 years?

Mr Mooney: There are mechanisms within the deeds to do that.

MS LE COUTEUR: With regard to waiting time for ACAT assessments, what is considered appropriate and how long is it at present? Is it different if you are a hospital inpatient or if you are in the community?

Ms Fitzharris: Linda Kohlhagen is able to answer this question.

Ms Kohlhagen: I think I have got all the points of your question. It was around the ACAT assessments?

MS LE COUTEUR: ACAT, time for assessments, and is it different if you are in hospital or in the community? What is regarded as appropriate?

Ms Kohlhagen: The commonwealth set the priority for ACAT, and they have three levels. Priority one is ideally we should see someone within two days, someone who is at immediate risk. And that immediate risk is that they could be homeless or their family supports have fallen apart or they are clinically in need of support services around them. Priority 2 is someone that you should see between three and 14 days, and they are someone that you know needs services but obviously not immediately. And then there is priority three. The priority is set on your clinical need or your social need. It is not necessarily dependent upon if you are in hospital because ACAT also see people in a residential facility as well as in the community.

ACAT has transitioned to the my aged care program. We started that process in 2015 and we fully implemented it as part of the my aged care program now. It has been a little more difficult to actually get reportings as the commonwealth has worked through their processes around their systems in place. Just recently—literally in the past month or so—we have been able to see some internal records around how our performance is in comparison to the national. When I double-checked yesterday, we are comparable with the benchmark across the country as well.

We do recognise that when someone is in hospital ACAT is the first part of a very complex and—we have already mentioned it this morning—sometimes extended, not always but sometimes, journey as one transitions from an inpatient to a residential aged care place.

As we have also talked about, ACAT has a presence. We have staff that certainly work within the hospital. We have a process where every day the referrals are reviewed at 9 am so that we can prioritise the clinical caseloads and direct the staff accordingly as well. As we have touched on, we have the RACLN that can help work with the families once the decision has been made to transition to an aged care facility.

MS LE COUTEUR: How many people are actually seen or assessed, I suppose is the word, within those guideline times that you suggested?

Ms Kohlhagen: Sorry, I do not have that information. It is a little more difficult to get at the moment with the changes to the my aged care system as well. I know that—

MS LE COUTEUR: I notice it is in the annual report as one of the outputs.

Ms Kohlhagen: Yes. I did note, when I checked with our local managers yesterday, there are only 12 people waiting for an appointment to see an ACAT, and that is across the community. That is actually an incredible result.

MS LE COUTEUR: That is amazing. I am aware of instances in the past that were an awful lot longer.

Ms Kohlhagen: Fortunately we are fully staffed at the moment as well. We have got a range of casuals available if we do have some staffing issues as well. The changes in the my aged care program are quite significant. ACAT has also spent a lot of time talking to other service providers, to other health professionals across the organisation. They have a presence at, say, the seniors expo as well so that they are available to go and talk to whoever would like to hear from them as well.

MS LE COUTEUR: Continuing with seniors, can you provide an update on the dementia care in the hospital program? How far has it rolled out to date?

Ms Kohlhagen: It has rolled out to almost all of the inpatient units in Canberra Hospital. There are some inpatient units where it would not be suitable, say, ICU or in the high dependency unit. The inpatient rehab unit is a program of education and screening for cognitive impairment. In a rehab unit—there are other reasons that people have cognitive impairment; if they have had a head injury or a stroke as well—they will have some more specific types of screening and assessments that they have in place.

The formal project is due to roll up towards the end of this month. It is at the end of the contract of the moneys that we received as part of our participation in the national research. The chief investigator informally sent some of his preliminary results through last week and suggested it is very positive. The approach of actually providing this screening and using a cognitive identifier alerts people that probably we need to talk to people a bit differently, ie, that means we have shorter sentences when we talk to people, we probably do not ask as many questions that are wide open to a range of answers. It is a little more targeted. It works with support workers. We spend a lot of time talking to, say, kitchen assistants et cetera.

It has had a significant impact on reducing what we call avoidable incidents, people

who might get pressure injuries or pneumonia or those sorts of things. It is only early crunching of the numbers at point in time but he did say that it actually has been demonstrated to make a difference as well.

Whilst the formal part of the research is almost completed, we are certainly working with the quality and safety unit to be able to integrate it into business as usual but still have the targeted education and all the other support activities that we need.

MS LE COUTEUR: I assume this comes under this area still of rehab: I am concerned about the delays in handover when a patient is a hospital inpatient and is receiving specifically physio services—it may be others—and then they leave the hospital and go to ACT Health facilities. My experience is very vague. There is sometimes a significant delay between one and the other. Has this been addressed in any way?

Ms Kohlhagen: Actually I cannot recall that it has ever been raised as a complaint. I know that there were some earlier discussions around aged care facilities which Mr Thompson addressed. We do have a process within the division to monitor consumer feedback or service provider feedback as well. Certainly from a rehab setting, one of the great benefits of moving to UCPH is that the rehab team, which is currently—I think, I counted—in up to seven different locations, will be in the one facility. That will make handover much easier because you will get a physical handover from a team perspective and hopefully it will contribute to the patient and the carer experience as well.

We have discharge planning meetings that are consistent through the units and within RAC that we have what we call multi-disciplinary team meetings every morning where the teams—the medical staff, the allied health staff and the nursing staff—get together, talk about what activities they need to do that day but also to ensure who is providing and coordinating that transition across the different settings as well. We do not always get it right, but certainly I do not hear a lot of complaints around that. There have been concerns as well.

When I looked at the community services, in the past we have had waiting lists for our community-based allied health. I have been informed that at this point in time we do not have any waiting lists. We have processes where we prioritise people and then we book them into an appointment over the next few weeks as their clinical need or their functional need indicates.

MS LE COUTEUR: Hopefully it has been addressed now but I can certainly assure you that in the past there certainly has been. I am talking particularly about physio. We did not complain and the people around us did not complain. We had no idea where you would complain.

Ms Fitzharris: That was access to a physio at, for example, a community health centre or not a private physio?

MS LE COUTEUR: We ended up going to a private physio because it was six weeks to get into ACT Health. Talking to people around, we were not unusual in this situation. Every week you would ring up and, "Oh, no." It was an awfully long time.

Ms Fitzharris: Was that a few years ago or more recently?

MS LE COUTEUR: 2013.

THE CHAIR: I have some questions around the walk-in centres. How many people have been accessing each of the nurse-led walk-in centres in the ACT? I know there is a list of top presentations, and I was wondering whether that could be provided—perhaps on notice—the exact proportion that these represent of presentations to each of the walk-in centres?

Ms Fitzharris: Presentations to each different centre?

THE CHAIR: Overall, I think; that is what I would be after. I do want to know how many people are accessing each of the centres as well.

Ms Kohlhagen: I can give you some figures as at 31 January. At Belconnen—and I double and triple-checked this on the portal—it was 10,812, and Tuggeranong had one fewer—10,811.

Ms Fitzharris: That is year to date.

Ms Kohlhagen: That was to 31 January. There is a slight increase in the number of people that are presenting overall to those centres. When we first transitioned the walk-in centres to the community, there were more people who were attending at Tuggeranong, but as those figures suggest, it is fairly even now.

Ms Fitzharris: They have risen from—when they first opened, with the first one at the Woden hospital campus—15,237 in 2010-11 to now a total in 2015-16, this reporting period, of 33,713 at Belconnen and Tuggeranong, with plans to open three more, I think we see that the majority of people who come to the Belconnen and Tuggeranong ones tend to live in the nearby area. We have committed to three, in Gungahlin, Weston Creek and Molonglo valley, and in the inner north as well.

We expect that, with more, and with the increases to ED presentation that were talked about, across the system as a whole it will take some of the pressure off that. Certainly, between Gungahlin, Weston Creek, Molonglo and the city, the population projections in each of those regions show that is where the growth in population will be over the next 10 to 15 years. As Gungahlin slows, it will be Molonglo and Molonglo valley, a little bit in west Belconnen, but that will be able to be accounted for. But the city and the inner north have significant growth projections for population as well.

THE CHAIR: Do you have any sense of the numbers of referrals to other health services like the hospital that might have come from the walk-in centres, if they cannot be treated appropriately in the walk-in centre?

Ms Kohlhagen: Yes, we do monitor the redirections as well. This is an average across both. The numbers of redirections to a GP are around 12 per cent. There is a small percentage that goes to ED, around seven per cent. There are also a number of people who go to a GP and are told, "We'll put this plan into place, and then if you're

not feeling better or if you've still got a problem, come back and see me." So there is a small cohort like that as well.

We have, fortunately, received a grant and we are about to do some research into following people up so that when the clinicians provide a care plan or a discharge summary, so to speak, about doing X, Y and Z, we will track people to see why they might have gone and done A, B and C instead of what was suggested. That will help to inform the models into the future and the communication that we hope will be concurrently implemented as we establish and develop the new centres into the future.

THE CHAIR: What sorts of medications can be prescribed by staff at the walk-in centres?

Ms Kohlhagen: I would have to take that on notice.

THE CHAIR: That would be good. That is all I have on the walk-in centres.

MR PETTERSSON: I have a question on the geriatrician team.

Ms Kohlhagen: I could probably answer that one, too.

MR PETTERSSON: There were periods of staff shortages. What was the cause of that?

Ms Kohlhagen: There was a combination of issues. The important thing to note is that we are funded for 8.6 FTE at the moment and we are fully staffed, and we are fully staffed with registrars as well. So that is a great thing. That timing coincided with a number of people who retired, a number of people who decided to look at doing a different type of medicine and a number of people who wanted to go and work in a different area. Unfortunately, when you have a small team, when those things happen at a similar time, you do have staff shortages.

We have been able to recruit individuals from overseas. We have had a number of individuals from interstate, as well as some of our registrars that we trained ourselves who have chosen to stay with us. I think it reflects the fact that if you put the effort in to supporting your registrars and providing good training programs, and demonstrating that aged care is a positive area to work in, hopefully, you can attract clinicians to work in that area. But it is much better now.

MRS DUNNE: I have questions about accounts and contracts.

THE CHAIR: We only have early intervention to deal with. Does anyone have any questions on early intervention?

MRS DUNNE: I think I have asked mine.

MS LE COUTEUR: Yes, please.

THE CHAIR: We will move on to the broader section for anything else.

MS LE COUTEUR: The healthy weight initiative, mentioned on page 64, is obviously a whole-of-government program. How do you work with the rest of government?

Ms Fitzharris: Very well.

MS LE COUTEUR: Can you please elaborate on that answer, minister?

Ms Fitzharris: The project is led by a central agency, Chief Minister, Treasury and Economic Development Directorate, principally because it is a significant whole-of-government piece of work. The original towards zero growth policy was developed as a really comprehensive whole-of-government policy. It is five years old—

Dr Kelly: Four and a half. In October—

Ms Fitzharris: It is coming up to its five-year anniversary. The range of different policy work that has been done underneath that also intersects with every agency. For example, Education is promoting healthy food and healthy drinks in schools, the planning directorate is involved regarding the way we design our city, the way we move around our city, and there is Transport Canberra and City Services. There is a whole range. Every directorate in government had a contribution to the policy.

A lot of the delivery of the programs within it, which has changed over time as programs have matured and different focuses have been taken, is done through Health. The work around obesity, as with some of the work around smoking and alcohol and drugs, will also be part of the work that we do around the preventive health strategy, which the upcoming forum will be about. That is also recognition that the policy is now reaching the five-year mark.

There has been significant work done on researching how a whole-of-government program like this has worked, both for the staff within directorates and how it has been implemented over time. There are significant partnerships within the community sector and within the business sector now on delivering some of the programs under the healthy weight initiative.

MS LE COUTEUR: Do you have any idea which parts of it are working best or having most impact?

Ms Fitzharris: Paul might be able to talk a little bit about that. Removing soft drinks from schools is a really good thing to do. One of the other programs, for example, healthy choices, is a partnership with the Canberra Business Chamber, which started last year. They had effectively volunteer members who were part of the program. That program involved working with four different businesses, one of which was an IGA that had two locations, one in Kambah and one in Nicholls, around how they could provide healthier food and drink choices for their customers. There was a cafe involved in that, an IGA with two locations, Limelight Cinemas and the Hellenic Club. They all did interesting, different things, all got advice from Health and Nutrition Australia, and some marketing advice about how they could effectively better promote healthier choices in their venues. We did some work with them about

collecting data that helped to reassure them that if they made this choice their sales volumes and their margins were not going to go down. We have learnt some really interesting things from that trial, too. So that is a fairly new one. There is a whole range of different programs in high schools and primary schools, as well as a lot of work around walking and cycling, particularly with children. Paul, do you want to add anything?

Dr Kelly: To be honest, I could talk about it all day, but I will not. I will make a slight correction, minister; it was in October 2013, so it is coming up to its four-year anniversary. But, yes, it is well embedded.

As to your specific question, Ms Le Couteur, about effectiveness, the program itself was an across-government program and with the community, and was always seen to be comprehensive. It is difficult to point to one single thing and say that it has led to something. There was a progress report published in June 2016, only two years after the launch. It has shown some effect. We have reached zero growth, in fact, in obesity in children, and that seems to be holding steady. We have further to go in adults, and that will take longer.

In that long-term objective, we seem to be having some effect. With respect to specific programs, some of those were mentioned by the minister, primary school students, for example. This is talking about reach. You need to scale things up that are working, to have an effect at a population level. We had our fresh tastes program, which is a comprehensive settings-based program for children to support better nutrition choices. That has been rolled out into 63 schools, with 24,500 students and 599 teachers that have had some input from the program. There are plans to scale that up further.

There is the ride or walk to school program, which looks more at the physical activity component rather than nutrition. As of June 2016 that was in 52 schools, with approximately 20,000 students. It is further funded to expand again. It is very much linked—and this talks to the cross-government process—to the active streets program, which is around improving the safety around schools so that kids can be encouraged to take, and parents can be confident that their kids can take, an active travel choice to school. That started with a pilot in four schools. It has been funded to go out to 20 schools now. It is similarly the case in high schools, child care and early childhood centres. We are trying to take that whole scale with kids.

There is a range of programs happening in workplaces, including ACT government and the private sector. As the minister mentioned, a lot of this is about working with the community as well as with business. Other jurisdictions around Australia are looking at us to see how to best do that. We are being very innovative in relation to that.

This is a long-term project. This will not be turned around in just four years. As the minister mentioned, the next phase is to look at a preventive health strategy, and we will be having a forum about that in April to look at what are the next things to do.

MS LE COUTEUR: On that note, on the next page you have got the it's your move program, which may be regarded as part of this.

Ms Fitzharris: Yes, it is.

MS LE COUTEUR: How many kids are involved in it?

Dr Kelly: Thank you for your question. It's your move is into the high school period and particularly years 9 and 10. Around the world we realise that is a time when good habits that may have been built up in primary school age start to drop off in relation to nutrition, physical activity, sun smart, a whole bunch of preventative things. Anyone who has teenagers will know what I am talking about. It is a real issue for us as to how do we transition out of that early childhood to keep those healthy choices remaining the easier choices and the ones that people go to into adulthood.

We started with the project—it was actually a research project done with Deakin University in three schools—back in 2012-14. We very closely engaged with not only the teachers but also the students. The students actually were the ones that came up with the ideas of what they should do. In those three schools there were quite different approaches. We said, "Look, we're talking about healthy weight here. What would you like to do?" One of them took a path along mental health and wellbeing actually, but at all three schools it had a positive effect. None of the schools got fatter, shall we say. So that was a good thing.

MS LE COUTEUR: Did any of them get thinner?

Dr Kelly: Yes, two of them did. I am not talking about individuals here but the population in the school. So they did, yes, and in a very short period, and that has been maintained. We took that information and are looking to expand that and have been funded to expand that further into the future. But the other element, if I may just say, there is a learning package in there, and we are trialling that this semester with our colleagues in Education as an elective curriculum offering linked with the national curriculum. It has been signed off by the Education Directorate to be offered to kids in schools.

This is about that process of how they form something for themselves. There is a little bit of entrepreneurship in there—some of it is set up like the *Shark Tank;* I do not understand what that is exactly, but apparently that is a good thing. Kids will bring their ideas and be prepared to defend them. If it fails, they recognise how failure feels and how you leave that one and go off and do something else. That is the process they are taking. That has been really enthusiastically taken up.

MRS KIKKERT: When will that start and how long will the trial be for?

Dr Kelly: It has started now. It is an elective in a number of schools. I could get the details for the committee on notice.

MS LE COUTEUR: Yes, please, we would love to know.

Dr Kelly: But we are really excited about that. It is a combination with business and the Education Directorate and the kids themselves, because they are the ones who came up with the idea. We are really enthusiastic about that. Whether that will lead to

an obesity outcome, which is what we are trying to do in terms of prevention, we will have to wait and see. But certainly from that pilot project, it seems very hopeful.

MS LE COUTEUR: The live healthy Canberra website appears not to be functioning as yet. When is it likely to be?

Dr Kelly: I would have to check that and take it on notice. It has been functioning for quite some time out of the Chief Minister's directorate. That was part of one of the issues.

MS LE COUTEUR: I will double check, but the notes I have, which staff did in the past day or two, say it currently has only a "Come back soon" page on it. I will double check that.

Dr Kelly: I will take that on notice. It may have been a temporary phenomenon. But certainly that was one of the early things we set up. The minister is on the site now.

Ms Fitzharris: Yes, it is all right.

MS LE COUTEUR: Good, okay. Thank you.

Ms Fitzharris: I guess it is one of those challenges, the opportunity to have something that is whole of government, it is structured around the different themes: schools, workplaces, urban planning, social inclusion, food, environment and evaluation; so, all the programs that we have been talking about were linked to those.

Could I just mention two things: one is we took a commitment to last year's election to expand the it's your move program to more high schools, which we will be doing, as well as to provide more funding to the healthy weight initiative. That will be in that broader space around preventative health.

One of the common themes across all of these programs is actually gathering the data and the evidence to see how effective different programs have been: the measurement of kids in schools and has it actually affected their weight. That is an important part of gathering evidence about what works and what does not. I have visited a couple of the schools or events around it's your move. From memory, one of them was they thought their canteen was really boring and no-one wanted to be in there. So they ended up building with a local artisan furniture firm this really cool furniture for their canteen out of reusing, effectively, rubbish—crates and pellets. So they built furniture. Other ones had made sun hats and another one had a QR code where they could effectively check in on their ride or walk to school. It became a quite competitive thing amongst the students to see who could tap in the most. They are really exciting initiatives.

The *Shark Tank* one had one big forum where Mick Spencer, who was the Canberra guy that did pretty well in the *Shark Tank,* went and spoke to them about the entrepreneurial side of what he did. His leisure wear company, ONTHEGO, is very successful. He is a young Canberra guy, and I had the misfortune of speaking to high school students after this cool young guy did. He spoke to them about how you could be really entrepreneurial in this space and come up with ideas. There are so many benefits to that scheme with high school kids, it is really exciting. Whenever I have

been and seen them, they are really engaged and they are really proud of something they have led themselves and been able to deliver. That is why we will expand the program.

MR PETTERSSON: I note with great pleasure the high levels of immunisation in the ACT. Why are we doing so well and how do we compare to other states and territories?

Ms Fitzharris: Extremely high; I think the highest in the country. We do well generally. Our education levels have a bit to do that with and accessibility to services. That is the vaccination levels which are under the immunisation schedule. One of the other things I mentioned earlier was broadening access to immunisations, which was something that we did last year, notably, allowing pharmacies to deliver flu vaccinations more broadly across the community. Even though flu vaccination is on not the immunisation schedule; that is right, isn't it?

Dr Kelly: Some are.

Ms Fitzharris: Some are for some different groups. What we think has happened with that—and work is still underway to determine the success of that trial with the pharmacies—was that more people got the flu shot than the previous year, probably because more people that had not ever had it before were able to access it. Nearly 3,700-odd flu vaccinations were offered through pharmacies in addition to those offered in workplaces and IGPs and at the hospital. We will look at alternative ways to continue to deliver immunisations to the community, for example, through pharmacies.

MR PETTERSSON: Has the directorate in any way had to deal with misinformation campaigns in the past year?

Ms Fitzharris: Anti-vax sort of campaigns?

Dr Kelly: Yes. We are part of a national system in terms of vaccination. As the minister mentioned, there is the national immunisation program. That is essentially a commonwealth program which the states all sign up for and it is a cost-shared arrangement. The commonwealth, through its purchasing power, arranges the vaccines on the schedule to be purchased and delivered to jurisdictions. Then it is up to the jurisdiction to make sure they are used in the appropriate way.

A range of things have happened at the commonwealth level to increase vaccination, and one of the ones you have mentioned—the no jab, no pay—was introduced I believe early last year. We have our own local campaigns, again, looking at particular groups where perhaps the vaccination rates are less than optimal. Aboriginals and Torres Strait Islanders are one of those and certainly making sure that the gap is closed there is an important element.

Why are we so successful? I think a range of matters. The minister mentioned that we are healthy, wealthy and wise in general. Also we are public servants and we tend to do what we are told. That is part of it I think. There is a serious element to that because I think there are real issues, as you raise, of people that are anti-vaccination

and are conscientious objectors in that regard. That is not a big issue for us in the ACT as compared with some other states or some sections of states. It is a big problem in inner city Sydney or the northern rivers, but for us not so much.

It is more for us about convenience and access. That is some of the things the minister has talked about in terms of increasing access through pharmacy vaccination. Of those 3,700, there were 10 Aboriginals and Torres Strait Islanders that reported they got their vaccine through that pharmacy route, and there were 685 recipients who were 65 or over. Both of those groups would have been able to access through their GP free vaccine but for some reason had not done so. Many of the people, as we have found in other jurisdictions where this has been done through pharmacies, are getting the flu vaccine for the first time through this process. That is a great thing to do and we are looking, as the minister mentioned, to expanding that to other vaccinations through pharmacies.

THE CHAIR: We will move on to Mrs Dunne for broad questions about the whole of the portfolio.

MRS DUNNE: Where will I start? You have got a big fat report. I want to give the impression that I have read it, or some of it.

MS LE COUTEUR: Am I still on the list?

THE CHAIR: Yes, but Mrs Dunne flagged some questions before about infrastructure.

MRS DUNNE: I want to go to the issue of contracts. There is a long list of contracts on pages 214 and 215. There are quite a few that do not have amounts attached to them. Is there is a generic explanation why there are not amounts attached to those lists? For instance, the panel for supply and delivery of orthodontics, prosthetics-associated componentry and medical-grade footwear has nothing attached to it, as is the case for the other panels for supply and delivery et cetera.

Ms Fitzharris: It is because they are panels. The contract was to identify panels that are then available to be used for future service delivery.

MRS DUNNE: Actually they do seem to be—so they are mainly panels?

Ms Fitzharris: I believe so.

MRS DUNNE: What do they do? Do they become a list of preferred suppliers so that they do not contract to provide a specific thing but provide something when you need it?

Ms Feely: Exactly. That is spot on and in a price range that is sort of pre-agreed normally. It saves us going through the entire tender process. We usually have a tender to get on to the panel. It is just for ease of access and to limit the lengthy tender process having to be done every single time. Once you are on a panel, the department is entitled to approach people on the panel—whether it is one, two or three—to get a quote. Then we can take their services from that panel.

MRS DUNNE: The financial report begins on page 131. There is a note on page 165 which refers to the debt of Medicare ineligible patients and the collection rates. Who are Medicare ineligible patients? What is the procedure for attempting to collect debts?

Mr Thompson: The way that public hospital arrangements operate in Australia is that all eligible Australians are able to access the services free of charge. If you are not Medicare eligible—

Ms Feely: All Australians are eligible.

Mr Thompson: Yes, there are Medicare eligibility criteria, which to a very large extent comprise all Australians. There are some minor exceptions, but they are set by the federal government. If you are Medicare eligible, there is no charge for use of public hospital services. If you are not Medicare eligible, then there are charges.

Frequently people have insurance to cover that but, at times, people are uninsured. What we have is a situation where if someone has no insurance cover and they are Medicare ineligible, we will charge them a fee for the use of the services. From time to time, for financial hardship reasons predominantly, they are unable to pay. That is where we start looking at either payment arrangements or the extent to which we are going to write off the charges.

MRS DUNNE: So you provide them with the service and then bill?

Ms Feely: So no-one is denied service.

MRS DUNNE: No-one is denied service. Thanks. In relation to employee benefits, on page 112 there is a list of people who are subject to the attraction and retention incentives. Could you explain what the columns A, B and C refer to in that table on page 112? Can you talk me through the circumstances in which someone would attract a retention initiative?

Ms Feely: An ARIn is a process whereby it is an attraction and retention allowance. Here in the medical workforce—probably more so in the medical workforce and then less so in the public sector side of the health service—over the years people have been granted these ARIns. They used to be called SEAs; they are now called ARIns.

MRS DUNNE: What is an SEA?

Ms Feely: Semi-executive allowance.

MRS DUNNE: Yes.

Ms Feely: They are now called special employment allowances. They are now called ARIns. I think they were probably more prevalent in past years when we were building up the medical workforce and needing to pay above and beyond award entitlements to attract and then over time retain various medical work staff or various executives. That is what an ARIn in base terms is. I will ask Patricia O'Farrell to

come up. She is the ED of HR. Again, there are a number of individual ARIns.

MRS DUNNE: Then there are groups and then there are employees. I wanted to get the difference between individuals and employee groups. Presumably, there are particular categories of people who—

Ms Feely: Yes.

Ms O'Farrell: ARIns, as the director-general has said, have been used for a range of staff. We use them quite often for medical staff. That has been historically a way to be able to attract medical staff to Canberra. We benchmark against other jurisdictions to ensure that we can remain competitive and ARIns are used for that purpose. At times ARIns will be negotiated for an individual practitioner or an individual employee. At other times they will be negotiated for a group of employees who are doing similar work.

MRS DUNNE: Thanks. I wanted to get my head around what that table meant. You have 14 groups that would make up a total of 162 employees. But then it also says in column A that you have got 201 on ARIns. I am trying to work out the discrepancy between 201 and 162.

Ms O'Farrell: We have got 201 individual ARIns and then 14 group ARIns.

MRS DUNNE: Yes, but you have got a total of 162 employees on ARIns.

Ms Fitzharris: So your question is: how can you have less?

MRS DUNNE: Yes.

Ms O'Farrell: The total is 363.

Mr Thompson: To step you through, they are all employees. ARIns, by definition, apply to employees. Group A is those employees whom a single ARIn covers and no-one else. The second column, group B, is the number of ARIns that cover more than one person, ie, the group ARIn, and 162 is the number of employees covered by those 14, and 363 is 201 plus 162.

MRS DUNNE: Excellent, thank you.

MS LE COUTEUR: Can I go back to the website. We must be talking about different things. Because I have got live healthy here and it says, "Please check back for launch of live healthy Canberra." That is what we were talking about.

Ms Fitzharris: Yes, we were just talking about that.

Dr Kelly: I have got further information. Apologies. There is a healthy living and there is—

Ms Fitzharris: Yes, which is why I looked up.

Dr Kelly: Which is where you looked it up. The minister reported on this before. That is the website about the whole healthy weight initiative. It gives information on the various programs which you can link into different parts. The live healthy one is actually a specific task under the healthy weight initiative, which was to develop and maintain a web-based information resource for workplaces, primary care providers and the community about opportunities to improve physical activity and nutrition levels.

We have been doing that as a group but also specifically with the Capital Health Network. That is the one that is under construction at the moment. Apologies for misleading the committee, chair. We just want everyone to live healthily and there is a whole bunch of ways. But that is what that one will be.

The idea of that is to make it easier for people to find these many different various programs that are around the place that would be available for physical activity and nutrition advice, for example, here in Canberra. That has been work we have been conducting through this period. It is undergoing consumer testing and feedback at the moment. We hope that by April it will be live.

MS LE COUTEUR: Possibly this should have gone in aged care, but I am not sure it did. How many people in hospitals have advanced care plans? How do clinicians actually find out that the person concerned has one?

Ms Fitzharris: Sorry, could you—

MS LE COUTEUR: Advanced care plans; I know that they are primarily for older people, they tend to have them. But it is not just older people.

Ms Fitzharris: A lot of that work has been done with the Health Care Consumers Association, but we can certainly take that on notice, yes.

MS LE COUTEUR: In the hospital, how does someone find out that their patient may have one? If they do find it out, can they find it out if you do not have electronic health records? We are really unsure how they actually work, or do they, in fact, actually work, I guess?

Mr Thompson: They do, but there is improvement. There is no foolproof way at the moment of knowing whether everyone has an advanced care directive, because that needs to be brought to the attention of the hospital prior to its being able to be recorded. But we are able, one, to incorporate the advanced care directive within the clinical record. So while we do not have a universal electronic clinical record, what we have is a system whereby paper records are scanned into what is called our KRIS system that is searchable. People can look up the advanced care directives.

We can also include it as an alert on the patient administration system so that anyone who is having contact with this patient receives that alert that says there is an advanced care directive in place for that patient and they should look it up. The final way that we can do it, and it is done, is that where it is known that there is an advanced care directive and an alert has been noticed, it can be printed out and put within the paper record for that particular episode of care. As I said, none of that is

foolproof, but those are the different ways that it can be brought to the attention of clinical staff.

MS LE COUTEUR: Do you have any idea how many of your patients have them?

Mr Thompson: I would need to take that on notice.

MS LE COUTEUR: It may be a fairly small proportion still. Again, this might be even harder: have you any issues where you are not confident that what was in the advanced care directive is what the patient currently wants or, conversely, is radically different from what you think would be appropriate? What issues are you having with this?

Mr Thompson: The latter is much more complex and sensitive. That is really a matter that needs to be worked through very carefully with individual patients. In terms of the currency—if I understand correctly that is the first part of your question?

MS LE COUTEUR: Yes. The currency and also the understanding. It may be current—or reasonably current—but the person who did it may not have had a very good appreciation of the likely options for them.

Mr Thompson: There are two parts. One is that irrespective of the presence of an advanced care directive, there is the opportunity for clinical staff to work with and to hold discussions with patients and their families as to whether it is current. Frequently there are sort of different circumstances envisaged by an advanced care directive. Clarification of the understanding of exactly what is expected in certain circumstances is something that clinical staff will discuss with and work on with patients and families at times.

The other thing is that we are actually looking at a more sort of comprehensive research program across the hospital and being linked by one of our intensive care specialists to look at how we can improve generally, one, the coverage; two, the awareness; and, three, the sort of observance of advanced care directives within the hospital.

MS LE COUTEUR: Thank you.

THE CHAIR: Mrs Kikkert.

MRS KIKKERT: My question is about the administration of propofol. These questions relate to a letter dated 17 February 2017 from Ms Fitzharris about nurse-administered propofol following an ABC report on the matter. On 23 November 2016 Mrs Dunne wrote to the minister about an ABC report on nurse-administered anaesthetic drugs. You replied on 17 February 2017 indicating that the relevant drug is propofol. You said that the practice ceased in January 2016 pending a review. However, the letter provided no information on the progress of the review or whether any decisions have been taken in relation to the practice. Minister, is the practice of nurse-administered propofol still in suspension, and what is the status of the review?

Ms Fitzharris: It is still suspended. I think Nicole will be able to give an update on

the status of the review.

Ms Feely: There are a couple of elements to it. The college guidelines—anaesthetists, ED and gastroenterologists—are very clear that nurse-administered propofol is against the guidelines. On that basis, we do not allow nurse-administered propofol in TCH or across the ACT. That said, there is a general understanding around the system that in many places it could be being administered in that way. We want to see whether we could upskill our nursing staff to get them to a skill level where the administration of propofol would be safe and, secondly, look at a research program under the guidance of anaesthetists in relation to in what conditions it might be safe for nurses to do that. However, saying that, until our college guidelines are changed—and part of these things I have just spoken about will be to try to persuade the college to change their guidelines—I will not authorise nurse-administered propofol at TCH. I hope that answers that.

MRS KIKKERT: Yes, absolutely. When the practice was in operation, did any patient suffer any adverse effects from the practice that could have been avoided if the drug had been administered by appropriately qualified specialists? If they did, what were the side effects?

Ms Feely: I might give that to Mr Thompson, but I would say that there may have been a near miss, but there were no known major incidents.

Mr Thompson: I will preface this by saying that in the administration of anaesthetics across the board there are incidents, whether the anaesthetic is administered by a fully qualified anaesthetist or another staff member. So the short answer is yes, there were some incidents. But in relation to that, we have reviewed it and we do not believe that there was any indication that the practice was inherently unsafe. However, what we have done in observing the guidelines, as the director-general has said, is say that this is about improving safety so, irrespective of what has been our experience in the past, currently the guidelines say that nurses should not be administering it, and we do not allow administration of it by nurses.

MRS KIKKERT: Of course.

MRS DUNNE: How many incidents were there?

Mr Thompson: I need to take that one on notice.

MRS DUNNE: Were the incidents the thing that alerted you or alerted the hospital to the fact that it was being administered by not appropriately qualified practitioners?

Mr Thompson: It was drawn to attention by an anaesthetist who raised concerns following a near miss situation.

MRS DUNNE: What do you mean by "near miss"?

Mr Thompson: Sorry?

MRS DUNNE: What do we mean by "near miss"?

Mr Thompson: A near miss situation is where, if there had not been an immediate alternative intervention, there could have been an adverse health outcome. There was no adverse health outcome in respect of that particular incident. That is what I mean by "near miss". It was drawn to the attention of the ACT Health executive by an anaesthetist raising concerns about the scenario. That is where the review process commenced, and the decision ensued to change the practice.

MRS DUNNE: What was the time frame between the specialist raising it with administration and the decision to cease the practice?

Ms Feely: We would have to take that on notice, but as soon as Ian was made aware of it, we discussed it and the practice was ceased. It was not so much because of any immediate safety risks but because, as a director-general of the ACT health system, if we have college guidelines, they are what we follow. There is a very strong view amongst many of the gastroenterologists that nurse-administered propofol is a safe procedure. I just echo Ian's comments that it is a practice that had been operating here for a while and is operating in other places around the country. But as a director-general, it is my view that if we have college guidelines, that is what we must follow irrespective of the views of the particular clinicians. We are in the process of encouraging them to work out how we can go back to the colleges to maybe change their mind in relation to this particular guideline. But until it is changed, we abide by the guideline.

THE CHAIR: I have some short questions; then we will have to end.

MS LE COUTEUR: I have to go.

THE CHAIR: I want to ask about the commonwealth grants on health. My understanding is that the federal government announced cuts to health funding in the 2014-15 budget. I wanted to get a breakdown of what that has meant from financial year 2014-15, over the forward years from that period. And, separately, a change was negotiated for around $50 million additional, making up for cuts, with a net adverse outcome, in April 2016. If you could provide us with forward estimates for those same four years with that funding included, that would be useful. I also wanted to ask where those cuts have fallen in the health system and how that is affecting our ability to finance the health system.

Ms Fitzharris: In that 2014-15 budget, I think the impact over the forward estimates for ACT Health was around $250 million. They were also announced, I believe, from memory—if necessary I will stand corrected; I was not in the Assembly at the time—in the commonwealth budget, which gave us very little time to plan. We did in that instance have to move fairly quickly with our own budget. Our Chief Minister at the time made the decision that, despite the extent of the commonwealth cuts—people will recall that it was a budget that was filled with cuts across a number of community services, health services, and legal and justice services—the impact on patients receiving care in that next financial year was going to be too significant for us to ignore.

There have been further cuts since then, including really material cuts to dental

services. And although we have rolled over some of our dental service funding, we are still waiting to hear from the commonwealth as to where they are going to go on a number of other national partnerships. I mentioned one or two around screening. We expect that we will hear more about that at the ministers conference coming up and in the federal budget. We could perhaps take it on notice around the specific volume of cuts, unless Trevor can answer some of those right now for you.

THE CHAIR: And perhaps it is the different areas. You mentioned dental and screening. Are there other areas that particularly were the focus of those grants?

Mr Vivian: I acknowledge the statement.

I did not fully hear the question, but can I summarise what I think the question was about, and if I have got it wrong I am happy to be corrected. I think you are sort of saying that we have reductions of funding from the commonwealth and you are asking how that is impacting on health. Is that a summary of it?

THE CHAIR: Essentially, but I was after the specific figures across each of the financial years, and then with the change. So it is about what the original agreement with the commonwealth was. And when they made the cuts, they came back with the extra $50 million. What has changed since then?

Mr Vivian: We will take those questions on notice and give the exact figures. But what I can tell you is that the way that health is funded is through a funding envelope. Our funding envelope keeps us having constant funding. As funding from the commonwealth goes up or down, we get either more funding from the ACT government or less funding. What I am trying to say is that those changes in the commonwealth funding levels have not reduced our funding envelope.

Ms Fitzharris: We have had to fill some of that gap in order to provide a continued level of service with continued growth. One other change was around the way that we negotiate our payments for services we provide to New South Wales residents. Previously I think the commonwealth did some of that negotiation on our behalf; now we do that direct with New South Wales. Is that right?

Mr Vivian: That is correct, yes. That means that ABF—as it changes from the commonwealth, that flows through to us, but if the commonwealth reduces the funding levels the ACT government increases the funding levels, so we have a constant funding envelope.

THE CHAIR: That is not very sustainable over the long term if there are constant cuts and then we have to make up for the funding. What measures have been taken to address that issue? We would need to take that funding from elsewhere within the budget, I am sure.

Ms Fitzharris: Yes, and there is the certainty of funding over the longer term on a number of fronts, with education funding under the Gonski review as well as health funding, particularly for public hospitals, and a range of other national partnerships. This current agreement runs out in 2020, and that is not very far away to understand the future of funding for public hospitals in Australia for all jurisdictions. If the cuts to

us were around $250 million in the outyears, since the scale of other health systems across the country is much more significant than ours, the overall impact would be in the billions.

There needs to be work done this year by the commonwealth to identify a process. I would not expect that the specific detail would be available for 2020 this year, but the commonwealth needs to identify at least a process for us to agree on how public hospital funding is going to continue beyond 2020, because with the recruitment of doctors and nurses, there is extensive planning; it is very long term. Every single budget is seeing pressure and in every single health system the demand is growing. We both need to do things to make sure we can have better and shared incentives at the preventative, primary and subacute care, particularly where the commonwealth funds acute care services, but the incentives need to move away from hospitals and we need to prevent people being in hospital in the first instance.

MRS DUNNE: I have just one very quick question, which is an administrative one. On the Legislative Assembly contact list, there is someone listed in the Deputy Chief Minister's office as a health adviser. Is that correct?

Ms Fitzharris: I do not believe so, no. No, there is not. I think I know why that is, but I would have to take that on notice. There is no health adviser in the Deputy Chief Minister's office.

MRS DUNNE: It just seemed a bit clunky. Somebody pointed it out to me the other day.

Ms Fitzharris: I think I know why that is, but I will have to check it.

MRS KIKKERT: So why is it?

Ms Fitzharris: I will have to check it.

MRS DUNNE: Okay.

THE CHAIR: Thank you. The committee asks that answers to questions taken on notice at today's hearings be replied to by close of business five business days after the uncorrected proof *Hansard* is issued. Members' written supplementary questions relating to annual reports will need to be provided to the committee support office within seven business days of the uncorrected proof transcript becoming available. If the committee support office receives any supplementary questions, they will be forwarded to directorates. Answers to supplementary questions will need to be provided to the committee support office five business days after receiving the questions. When a proof *Hansard* is issued, that will be forwarded to witnesses to provide the opportunity for them to check the transcript and suggest any corrections. I now formally declare the public hearing closed. Thank you for attending, minister and officials.

Hearing suspended from 1.33 to 3.31 pm.

Appearances:

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

Health Directorate
Feely, Ms Nicole, Director-General
Thompson, Mr Ian, Deputy Director-General, Canberra Hospital and Health Services
Aloisi, Mr Bruno, Acting Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
O'Farrell, Ms Patricia, Executive Director, People and Culture

THE CHAIR: Welcome back to the hearing of the Health, Ageing and Community Services Committee on the 2015-16 annual reports for the Health Directorate and the ACT Local Hospital Network Directorate.

I remind witnesses of the protections and obligations afforded by parliamentary privilege, and draw your attention to the pink privilege statement that is before you on the table. Could you please confirm for the record that you have read and understand the privilege implications of the statement. I remind witnesses that the proceedings are being recorded by Hansard for transcription purposes as well as being webstreamed and broadcast. Could each witness acknowledge, when they first come to the table, that they have read the pink witness statement.

Before we proceed to questions from the committee, would you like to make an opening statement, minister?

Mr Rattenbury: Yes, thank you, Chair. I will make a few brief remarks. I am very pleased to be here today as the first dedicated Minister for Mental Health in the ACT. This is recognition by the government, in creating this portfolio, of the significant incidence of mental health issues in our community and the importance of having a strong system to address that, because we see that many people in their lifetimes will experience a kind of mental health disorder. It is estimated that around half of Australians will have that situation in their lifetimes, and that underlines the importance of having a strong system, the right system and a system that is focused on people.

We have seen almost one in seven young people aged between four and 17 assessed as having mental health disorders in the previous 12 months. Again it gives us a sense of the scale of the issue and the importance of having a good response. Certainly, in my previous portfolio as the Minister for Education, it was raised with me by principals on a very frequent basis, the concerns they had about the mental wellbeing of their students.

Certainly, suicide is still a leading cause of death for 15 to 44-year-olds in Australia. Despite years of government effort, growing awareness and breaking down taboos on the subject—and we know that that has been challenging—that continues to be the

case. That is why one of my priorities is to develop a new set of targets to reduce suicide and self-harm in our community. I am happy to talk about the rationale behind doing that, if you wish. I think this will support a new, stronger and more focused approach to prevention than actually naming a target; being explicit about it, and dealing with that difficult topic in an open way.

The other key priority for me in the area of mental health, and it is a key item in the parliamentary agreement, is to establish an office for mental health, which will be client focused and designed to reduce the sometimes confusing and fractured journey of people experiencing mental health concerns and, importantly, for their families, their carers and their advocates as well.

I will be happy to take more questions on those topics and on any others that the committee wishes to raise today, as will the officials, with their on-ground expertise.

THE CHAIR: Thank you. I want to ask some questions around adolescent mental health. I have certainly heard from some of my constituents concerns about the need to send young people with mental health issues interstate for treatment. Obviously, that means they are also away from friends and family, which is not ideal. Could you comment on this, and on how it demonstrates the need for further work on building adolescent mental health facilities here in the ACT?

Mr Rattenbury: Yes, certainly. That gap has been identified. There is a range of mental health services available to adolescents in the ACT. There is a number in the territory, but there are circumstances, particularly in severe cases, where at the moment young people do travel out of the ACT. I agree that that is a problem. Certainly, a key commitment that was made during the election campaign by the Labor Party was to expand the size and range of services within the Centenary Hospital for Women and Children, specifically to include a dedicated child and adolescent mental health unit. Planning for the expansion of the women's hospital is now underway. It commenced earlier this year. It is expected that the new facility will be operational in late 2019. That specific facility is designed to close that gap. In the meantime there is a range of services currently available, including both government and non-government services.

THE CHAIR: Do we have any sense of how many young people during that reporting period were being referred to interstate services?

Mr Rattenbury: I do not have that to hand, so I will take it on notice and check that.

MRS KIKKERT: What is the incidence of borderline personality disorder in the ACT?

Mr Aloisi: We would have to take that on notice.

MRS KIKKERT: You might like to take this on notice, but perhaps you can answer it: given the nature of this usually long-term mental health condition and that it is difficult to treat because it does not generally respond well to medication, what specialist services are available to sufferers?

Mr Aloisi: One of the programs we have at the moment is an adult dialectical behaviour therapy program, or DBT. DBT is recognised as one of the evidence-based treatments for borderline personality disorder. It looks at approaching several of the issues associated with borderline personality disorder such as increasing distress tolerance, looking at emotional mood regulation, and providing people who experience borderline personality disorder with the necessary skills to manage stressful situations better. Acknowledging that a number of people with borderline personality disorder have a significant history of trauma, it is basically a skills-building program.

MRS KIKKERT: How many clients are you currently seeing?

Mr Aloisi: I do not have that number.

THE CHAIR: I notice that the target of 120,000 occasions of service under the adult mental health program was exceeded, which is excellent to see. This was partly due to the establishment of an addition to the Gungahlin community health centre. Can you tell me a little bit more about that? I am also interested in general about region-specific programs that you have in place.

Mr Aloisi: Gungahlin mental health was initially established as a satellite team of Belconnen mental health. So we started off with a part-time service. Through 2015-16 we have developed a fully-fledged service out there. At Gungahlin mental health we provide a number of specialist mental health services, psychiatric outpatient appointments and clinical management services. Basically, we provide a range of specialist mental health services there.

THE CHAIR: This is a broader question: do you think a region-based response is the best way to do it—having services in each of the town centres?

Mr Aloisi: If you are asking about the benefits of having that sort of system, one of them is efficiency. For example, if you have a consumer living in Tuggeranong but they wanted to, for example, access services in Gungahlin, if you are responding to that person, particularly in crisis situations, you would have efficiencies there that you would lose because of the distance that you have to travel. Another primary reason for having the catchment-based system is around allocation of resources. For example, if you had a large proportion of the population seeking to access services in one centre then that would make it difficult to service all the people of that region.

Ms Feely: It is about a hub and spoke, too. The whole concept of how mental health runs means there will be tertiary services that need to be centralised because of the nature of the type of service being delivered. In relation to the spoke, though, part of the CSF discussion will be around that exact issue—looking at what should be in a tertiary setting, a general hospital setting, a specialist hospital setting, and back out into the community. As I said this morning, that is the nature of the discussion. For the patient, it is about having the right place for the treatment to take place, whether it be tertiary, general or back out into the community. Part of what we are talking about is looking at the various centres, care closer to home and patient-centred care. We cannot get away from the fact that certain treatment modalities must be in a clinical setting in a hospital.

MRS DUNNE: I will go back to my perennial theme for the day and ask about the data in the annual report and the ongoing problems with the 2014-15 mental health data and some gaps in the previous AIHW and ROGS reports. Minister, what is your understanding of the extent of the problem in relation to data relating to mental health, and how have you been briefed on it? Is mental health data part of the review, and what is your role in that review?

Mr Rattenbury: I know there has been extensive discussion about this already, and I do not have anything particularly unique to add to that, other than to reflect on the fact that the mental health data is impacted, as some of the other data is. The review of it is being done as part of the same package. The director-general is leading that process. It would be fair to say the directorate has been quite up-front in coming to me and advising me of the problems. Whilst it is clearly not ideal, there is a fairly aggressive program in place to respond to it, and I think that is appropriate.

MRS DUNNE: In the case of mental health, what sort of data are you collecting and what is it used for?

Mr Rattenbury: As you can see from the annual report, there is a whole array of indicators. They are used in broad terms for two purposes. One is to measure progress annually, or lack of progress. That is a key measure. The other is obviously in a long-term sense a degree of strategic planning. Do you want to go through in detail what is collected?

MRS DUNNE: Yes, I would not mind a bit more detail.

Mr Thompson: Essentially data is collected on service activities and service outcomes and to provide future demographic and demand projections. It is used, as the minister has indicated, for the purposes of monitoring day-to-day service delivery and it is used for service planning. It is used for decisions associated with allocation of resources as well as the longer term strategic planning. In a broad sense that is the purpose of the data.

You will see, of course, from the annual report the sorts of data that are used on a regular basis in terms of accountability indicators. When it comes to the more strategic planning side of things, as the director-general has already mentioned, the clinical services framework is an example of the work that we are doing in that space. The data that will relate to mental health within the clinical service framework will be data that relates to the current use of services, information about population and demographic changes, how those population and demographic changes are expected to influence service delivery in the future in terms of demand as well as shifts in the mode of service delivery, and, at a broader level, translation into the expectations for the range of services that we need to provide and the number of clients that will be accessing those sorts of services.

MRS DUNNE: I am just thinking this over. I am sure you have been thinking about this for a long period of time as well—probably longer than me. The fact that you are now having a root and branch review of data, does this mean that you can go back and actually analyse whether you are collecting the right data? Also, is it logical? We have

reporting requirements to the Productivity Commission, the Institute of Health and Welfare, the federal funding bodies et cetera. Would it perhaps be a reasonable approach to say, "Well, what do these people need, and is there anything that we need in addition that we can hang off that?" If you are having a root and branch review of data, will it be a root and branch review of data?

Ms Feely: To be blunt, I and my team are in the middle of trying to reform ACT Health. We have got issues everywhere. The data issue is incredibly frustrating because we are having to turn our mind back to issues that both my ministers have inherited and, in fact, so have I. When we talk about a root, I want to get right to the bottom and kill any issues with the reliability of our data once and for all.

Part of exactly what you have discussed is what we need to look at. We need to be very clear about what we need to collect as far as data is concerned to meet all our national obligations. We need to be very clear about what we need internally so from a performance perspective we can actually run the health services properly. And then we need to be very clear in relation to the warehouse how we are actually doing that. There will probably be some retraining of staff.

This is not my area of expertise, so I will look to my head of IT, Peter O'Halloran, who can talk on it in much more detail. But a lot of this is also about how staff collect data and how they enter data. When we talk about root and branch, I am talking about getting right back to basics so we will never be in this position again where we have any doubt about data. So that is why there is a government-led review of governance. We need to review the warehouse and what all that looks like and what is being collected through there, and then at the same time we need to be able assure that we continue business as usual.

In discussions with the AIHW, they have been fantastic and been very supportive of us. One of the issues that is becoming apparent is that smaller jurisdictions are being asked to report on exactly the same amounts of things as the larger ones, so is there a way we can consolidate that sort of data. There are lots of discussions taking place through the system to make sure data is only being collected where it is absolutely necessary to actually improve the performance of the patient journey and to improve quality.

In a nutshell, we are going right back to basics: what is collected, why is it collected, how is it extracted, is the warehouse actually stable enough to support us moving forward? All those questions will be put back on the table because the reform process in ACT Health is too important to allow us to be constantly pulled back to this sort of issue. We should have stability and assurance of our data. It should just be a given as we move forward.

Mr Rattenbury: The other thing in that space is—and Mrs Dunne, you have been here long enough to know this—we have a few indicators through our own annual reports that are not very useful. In the portfolios I have looked at as a shadow over the years and in the ones I am and have been responsible for as a minister, there are some indicators that I feel like we just collect because we do and they have been there for the whole time.

MRS DUNNE: Because they always have been, yes.

Mr Rattenbury: And I am not sure they tell the Assembly anything very useful either. I put an invitation to the committee: if there are indicators you think are not valuable or ones that might be there instead, I am quite open to that. We then have to have a conversation, because I have also seen committees express concern that indicators are dropped.

MRS DUNNE: And we like continuity so we can say, "Yeah, gotcha." I am being quite candid.

Mr Rattenbury: That is true; we have all been in those discussions.

MRS DUNNE: We have all done it. But sometimes it is reasonable that indicators disappear. It is difficult then to compare things over time, but I think that—

Mr Rattenbury: I am also keen to see indicators that reflect more on outcomes than on inputs.

MRS DUNNE: Yes.

Mr Rattenbury: It is a cliche, but there is not much value in saying how much of something we have put in. That does not tell the minister or the committee anything about what we have achieved.

MRS DUNNE: That is right.

Ms Feely: Data for data's sake means nothing. It has to be directed to the outcomes and the performance we actually want across the health service.

Mr Rattenbury: Do you want to go into that warehousing issue or do you just want to move on?

MRS DUNNE: No, I think my brain might freeze or something ridiculous.

MS LE COUTEUR: Minister, you started off by reflecting that 50 per cent of us are likely to have some mental health issue during our lifetime. When this happens, to what extent is it likely to be related to external circumstances? I am thinking, using the Australian vernacular, of drought and farmers' suicide. This statistical relationship is, unfortunately, well-known. How much data does ACT Health collect about the circumstances of its clients, apart from their immediate presentation: that the life circumstances in which they find themselves are relevant to the fact that they are involved with mental health issues?

Mr Aloisi: There would not be, I would imagine, any way of collectively saying what particular stressor impacted on that individual. When we see someone, as part of our assessment we will document that information. If it was coming from a relationship break-up to an extreme circumstance or a disaster, it would be captured in the medical record. It would not be captured as an individual factor, although we may look for trends, such as if we realise we have got a number of referrals that are related to a

particular event. As a general rule, we would not have any way of capturing information as to how many people were reporting that their mental health was attributable to a specific factor.

MS LE COUTEUR: Possibly it would not be put that it was attributable to a certain factor. On my reading of it, it would be more on the basis of trends as social circumstances got worse, you could say. The latest thing I read was from a younger person about, "Basically, the world is falling to pieces. Therefore, my anxiety rate is going up." They took this as a larger statement, not just a statement about themselves. How much are you seeing of that? If you are seeing it, what you are doing about it?

Mr Rattenbury: You mean social determinants in that sense?

MS LE COUTEUR: Exactly. I was refraining from saying that but, yes, social determinants of health. How much are you seeing that?

Mr Aloisi: Say, for example, it was a socially determined issue such as accommodation, education or something like that then I suppose we would look for those trends: has it been reported? Then if there was a particular issue in terms of, say, availability of accommodation then that might be something that we would explore.

MS LE COUTEUR: I guess a specific one which presumably you are exploring a bit is in relation to the older person's community mental health team. You are looking at a bunch of people whose common feature is age and generally living in residential care. Is that where you are finding that age is a determinant of mental health issues? That is possibly what you are saying there?

Mr Aloisi: Yes. I think in recent years we have found a growth in our demand on the older person's mental health service. In response to that we have increased our resources in those areas. An example of that would be a more recent initiative where we have a consultation service that looks at people in the older person's mental health inpatient unit. It reaches into that unit and helps support them into residential aged-care facilities. Where those trends are identified, we look to bolster our resources in those areas.

MS LE COUTEUR: Do you do work in the residential aged-care facilities? I read about the demarcation between the commonwealth and NDIS et cetera.

Mr Aloisi: Yes, we certainly do. We would provide clinical in-reach into those residential aged-care facilities; the same service that we would provide anywhere else in the community.

MS LE COUTEUR: Possibly not, but anyway. As someone who has had parents in those facilities for a long time, there are a lot of very unhappy people there, to put it mildly. I have read that it is partially a demarcation dispute and partially just giving up on our older people.

Ms Feely: I hear what you are saying. As part of what we need to do under the clinical services framework, we have started discussions with some of the providers of aged-care services here in the ACT with a view to seeing what services could be

delivered by ACT Health in the residential aged-care sector to not only—to be honest—look after the patients in the aged-care sector but also be a method of stopping people bouncing straight back into the acute sector.

Those discussions are only just in the preliminary stages, but it is part of what we want to do under the clinical services framework. When we talk about the right care for the patient in the right place, it is about Muhammad and the mountain. Maybe we start going out into the residential aged-care sector more in a planned and considered way so we can actually make sure that those patients are getting the right care that they need in the ACT from the public health sector and also, hopefully, stop the midnight ambulance being called to bring someone into ED. That is on our agenda. It is part of the discussions that we need to continue, and it is recognition of what you were saying. Is it a demarcation area? It can be an us and them situation but, from my perspective, keeping people in the right place and not in beds in the acute sector when they maybe do not need to be in beds in the acute sector is in my interests, as the Director-General of Health.

We are also looking at what hospital in the home services can be delivered to people in residential aged care. It is actually fascinating, not just in mental health but across the board. It is about resources and it is about the willingness of people to enter into new models of care. If we keep the patient and quality issues at the centre of this discussion, what is right for the patient is something that we need to more openly consider.

THE CHAIR: I have some questions in relation to the Mental Health Act 2015 and, in particular, what experiences mental health consumers and families have had since the introduction of that piece of legislation.

Mr Rattenbury: Do you have any particular observations?

Mr Aloisi: I suppose one of the major elements of the Mental Health Act was looking at having more involvement and participation from carers in terms of the treatment of their loved ones. One of those would be, for example, the requirements under the new legislation to keep identified carers and families informed. At the moment we are in the process of doing our evaluation of the Mental Health Act. So we will get some more qualitative and, hopefully, quantitative answers out of that.

Generally, what we are seeing is an increase in the revocation of psychiatric treatment orders. That is one of the things we have seen. Obviously that has a benefit in terms of reducing restrictions upon people. That is definitely one of the observations we have had. In terms of the flow of information to carers and having carers actively involved in the care of their loved ones, that is definitely something that we would hope the new act would achieve.

MRS KIKKERT: On page 48 it states:

> Achieved 100 per cent of all detainees admitted to the AMC having a completed health assessment within 24 hours of detention.

A similar record had been achieved for the young people entering Bimberi. Does this

health assessment cover substance addiction so that the AMC can treat people with substance abuse issues appropriately?

Mr Aloisi: Yes, it is part of that assessment. It would be a comprehensive assessment that would look at physical health concerns, alcohol and drug concerns and mental health concerns. It is that comprehensive assessment of a person's health status.

MRS KIKKERT: Does the medical record for each detainee contain a health assessment and a treatment plan for substance abuse issues?

Mr Aloisi: Yes, there would be a section of documentation around alcohol and drug use as part of that assessment.

MR PETTERSSON: The secure mental health unit has just recently opened?

Mr Aloisi: Yes.

MR PETTERSSON: How have operations been going?

Mr Rattenbury: It has gone very smoothly so far, for a new facility. It was officially opened on 22 November and the first patient came the next day. There has been a gradual increase in numbers; currently we have seven detainees there. The first four detainees were male. We have now received some female detainees. I guess there has been a series of events to try to build that up. We had a community open day prior to the opening of the facility. It was the one time members of the community could go through and see what is there, because once it is an operating facility that is clearly not going to happen.

The sport facility is now open as well. There is a football court and the like at the facility that are now fully open. At this stage we have had no significant issues arise at the facility. Colleagues, it has just been pointed out to me—you will have to forgive me, as a long-term corrections minister—that I have referenced clients as "detainees". I meant patients.

MRS DUNNE: I did notice that. I was going to let it pass, but—

Mr Rattenbury: Please let me offer my apologies. It is very habitual of me.

MR PETTERSSON: It is quite okay. You mentioned occupancy rates for patients.

Mr Rattenbury: There is no coming back from that one, is there?

MR PETTERSSON: You mentioned that there are seven people being treated at the moment—

Mr Rattenbury: Yes.

MR PETTERSSON: and that the first person came in on the first day. Is there a reason—

Ms Feely: The day after the opening.

MR PETTERSSON: Yes. Is there a reason that you have not reached capacity yet? Are you slowly building up or have you just not had patients present themselves?

Mr Rattenbury: I would say it has been a combination. The intent, first of all, was to start in an orderly way. There was a range of potential patients in the community who had been identified as possibly suitable for Dhulwa. Some of them have ended up somewhere at the AMC, for example, or they have perhaps been released from custody and have gone into a community care stream for mental health support rather than needing to be in a secure environment. It has been determined to some extent by who needs to come; it is entirely a medical decision as to who goes there.

MRS DUNNE: Could I ask about the entry points, then?

Mr Rattenbury: Yes.

MRS DUNNE: When you used the "D" word before, I initially did not blink, because I am presuming that some people do actually come from the AMC.

Mr Rattenbury: Yes, they do.

MRS DUNNE: But what are the other sorts of entry points?

Mr Aloisi: The other entry points would be broadly anywhere in the community. It could be someone, for example, who might be in the adult mental health unit. It could be someone who is in the community. In terms of admission, that might be more of a sort of preventative step. That person might be decompensating in their mental illness. That might be a measure to prevent further decompensation to have that person in a secure environment.

MRS DUNNE: Decompensation is not a term I am familiar with.

MS LE COUTEUR: Decompensation?

Mr Aloisi: Sorry, a deterioration in their mental health status.

MRS DUNNE: What are the circumstances in which someone would move from the adult mental health system into the secure mental health system?

Mr Aloisi: Sorry, could you repeat the question?

MRS DUNNE: What are the circumstances in which they would go from the Woden campus to the secure system?

Mr Aloisi: The circumstances would be that it would be indicated that their level of care needs have increased and that they cannot be safely managed within the adult mental health unit. Generally, you would find that that person might present with certain risks that cannot be managed within a locked unit, which the adult mental health unit is. They would be the type of circumstances. They might be either

presenting risks to themselves or risks to others. Therefore, in order to keep that person safe they would be transferred to the Dhulwa.

Ms Feely: Could you explain about the assessment part of it?

Mr Aloisi: I will explain the assessment process. What would happen is that the person would be seen by the forensic mental health service. They would do an assessment. Then what they would do is that they would make a referral to an assessment panel, which is made up of a senior clinical and operational leadership group. They would make assessment as to whether that person meets the criteria for entry and then decide whether that person could be perhaps safely managed in another environment or whether they would need to be admitted to Dhulwa.

Mr Rattenbury: There is an underlying premise there of the least restrictive option possible, of course.

MRS DUNNE: Yes. When they are in Dhulwa, is there a necessity—I honestly do not have a view about this; I am asking what the current thinking is on the subject—or a need to segregate detained people, that is, people who come from the AMC from other inmates or clients?

Mr Rattenbury: No, there is no distinction once they are in Dhulwa as to their correctional status, for want of a better expression. They are very much treated on a medical basis once they are at Dhulwa.

MRS DUNNE: Thanks.

MS LE COUTEUR: On page two hundred and whatever it is—

MRS DUNNE: But you have got 99 choices.

MS LE COUTEUR: It is page 225, but you do not really need the numbers. There is a whole heap of accountability indicators. They are all service contacts. Pleasingly, they are all exceeded. Bearing in mind what you said earlier about the importance of measuring outcomes, not just inputs, do you have any way of measuring whether people are getting better as a result of these contacts, the actions of ACT Health, or just that there was a contact?

Mr Aloisi: There are things that we would look at. We have outcome measures that are collected. For an individual who sees mental health, they would develop what we call a recovery plan. That outlines their goals for treatment. These would be a range of treatment goals, beyond medication. They would include things like goals around accommodation, employment, education and things like that. So they are used as a measure on the individual level to see whether the person has met their goals for the reason why they are seeing our service.

MS LE COUTEUR: Would you be looking at putting those in some aggregated form out as an output of some sort so that we can see not just that you talk to—

MRS DUNNE: You have admitted 4,000 people, but you know—

MS LE COUTEUR: Yes, I mean, they are all service contacts here. You did lots of things, but is there some way that you can report on your achievements, apart from just doing things?

Mr Rattenbury: I think we will take that as a comment and, in light of that earlier discussion, give that some consideration. I am not sure how easily defined that is, but it is a fair question and we will take it as some feedback to consider.

MS LE COUTEUR: Yes. It is a question that—

MRS DUNNE: But it might also be something to do with the annual report directions. It may be a more systemic issue than just this report.

Ms Feely: In a mental health context there is not the situation of: if you have broken your leg and you have been treated, your leg is better. But in mental health sometimes it is not as easy to be that definitive in relation to the outcome.

MS LE COUTEUR: I was assuming that that was the actual issue, that you would say, "Look, Ms Le Couteur, it is very hard to actually determine if we have succeeded in fully treating this person." That was the answer I was more expecting, actually.

Ms Feely: It is a good question. It is exactly the sort of question we need to think about in relation to the data we are we picking up. But, yes, it is worthy of consideration. I just do not have a perfect, nice answer.

MRS DUNNE: I have a couple of questions more about the future than the past. Mr Aloisi, Ms Feely and I have had conversations about the office for mental health and the thinking, six weeks ago, about where you were. Could you give the committee a bit of a feel for where you are in your thinking on what the office for mental health might look like?

Mr Rattenbury: Yes, I would be happy to. I guess I have a couple of objectives. They are not sort of formally stated objectives yet per se. I will give you a sense of what I think is important. We want to make sure that we have a mental health system in the ACT, not a sector. Understand the distinction. I think there can be a lot of moving parts, but I want to make sure that it is a seamless experience for people who are coming to the mental health sector—the cliche that there is no wrong door, but knowing where to go, where to seek the support. I think there are obviously strong efforts to achieve that at the moment, but our sense is that we can improve coordination. A lot of additional money has been put into mental health services in recent years and we need to make sure that money is being well spent.

I do not think it is a case necessarily of more money at this point in time but making sure we are making the best use of the services that are available. Clearly, an important consideration is to identify both any gaps or overlaps in service. Having a high level of coordination is really probably the number one objective in the space.

What we are doing at the moment in terms of your question around progress is that, across Australia and New Zealand in particular, there are a number of different

approaches to how mental health commissions and offices of mental health are being put together. One of the pieces of work the directorate has been doing for me is to look at those different jurisdictions and identify what those models are and, I guess, what the feedback is on them; what seemed to work well and areas that perhaps have not met aspirations.

That is the first piece of work. Obviously, having a strong discussion with the community is going to be an important part of that. Once we have done some internal work, my intention is to go to community with some sort of discussion paper to get the conversation going. It won't be a blank piece of paper. I think that is too broad, but to sort of say, "Here are some approaches we could take." We could seek some feedback at that point in time.

MRS DUNNE: Another future issue is the future of Brian Hennessy House.

Mr Rattenbury: Yes. As you know, there has previously been a decision to close Brian Hennessy House. I, like all other members of the Assembly, have received a range of representations around that. I have asked the directorate to provide me with some further advice on that. My number one focus is to ensure that each of the clients who accesses Brian Hennessy House has a suitable option going forward.

We have three main cohorts of people at Brian Hennessy. I think it would be fair to say that there are different options for each of them. Some, through an active rehabilitation, will potentially go to UCPH when it opens, because there will be a mental health section of the UCPH. Some may transfer to Dhulwa. That might be a more suitable opportunity for them. Others may go into the community. I need to make sure that every person in Brian Hennessy has a suitable option before it can close.

That is where I am at at the moment. I do not have any more definitive answer than that, other than to be clear that whilst the decision has been taken, it is not going to be just followed through for the sake of it, that there must be a good option for people.

MRS DUNNE: By that, you are saying that it is not going to be closed until at least the end of 2018? If you are looking at transitioning people out of there into the University of Canberra public hospital—

Mr Rattenbury: Yes. Your point is a fair one. I do not have a specific date in mind at the moment. It is much more driven by whether we have dealt with everybody, rather than sort of having a particular date. But you are right around the opening of UCPH, yes.

MRS DUNNE: But also, you have not revised the decision to close it. The decision to close is still going ahead? Or is that interpreting too much?

Mr Rattenbury: It is probably interpreting too much at this stage. I have asked the directorate to give me very clear advice around the status of everybody who currently resides in Brian Hennessy or may reside there in the future.

MRS DUNNE: Yes. It is also a pretty old, drab building. That is part of the issue, I

suppose.

Mr Rattenbury: That is an issue. I think there are two primary issues. One is the physical state of the building and the other is the appropriateness of the model of care. My advice is that having the three cohorts that I spoke of earlier in one single environment is, from a model of care point of view, not a good one going forward. It is not the way things are done these days, that we need to move on from what has historically been the case in that spirit of getting better at doing this as we move forward.

MRS DUNNE: Thanks.

MRS KIKKERT: I refer to the 2015 Auditor-General's report into rehabilitation of male prisoners. The Auditor-General stated that a number of stakeholders reported concerns about the provision of methadone to detainees, that methadone was provided to detainees who did not require it and that methadone doses were increased with little consideration. What actions have been taken to address the concerns of stakeholders about the operation of the methadone program at the AMC?

Mr Aloisi: One of the things that we have been looking at is changes to our assessment process around methadone. Currently we are doing a quality improvement activity, looking at our methadone prescribing at AMC. Some of the things that we are considering, I suppose, are the assessment processes that will underlie inducting someone into the methadone program. They will be making it a bit more of a comprehensive type of assessment. They are things we are looking at. Things that we are talking about there are nursing assessments to support a medical assessment, for example.

One of the things we have already completed in regards to work at the AMC is actually putting in a delay in terms of assessment by a medical officer for the methadone program and commencement on the program. That allows an opportunity to gather more sort of collateral information in terms of assessing someone for the program.

They are a couple of the changes. One of those is a change we have already made and the previous one, the former one, is one that we are considering.

MRS KIKKERT: Do all the detainees at the AMC receiving methadone have a management plan?

Mr Aloisi: They should have a management plan. If someone started on a methadone program, they should have a plan that talks about their involvement in the program, yes.

MRS KIKKERT: You are not sure or they should?

Mr Aloisi: I would have to confirm.

MRS DUNNE: Is the methadone program at the AMC designed to just maintain people or is it designed to wean them off opiates?

Mr Aloisi: Largely it is designed for maintenance. You can use methadone for withdrawal but primarily it is used at the AMC as part of a maintenance program. That is effectively looking at it from a harm minimisation perspective about reducing the likelihood of someone relapsing into illicit drug use.

MR PETTERSSON: I was wondering if you could help me with something. On page 49 there is reference to the consultation and liaison service. What is that exactly?

Mr Aloisi: Sorry, I missed that one.

MR PETTERSSON: On page 49, it states:

> The Consultation and Liaison Service expanded to provide after-hours support seven days a week.

Mr Aloisi: The consultation liaison service is a clinical service that operates at the Canberra Hospital and provides psychiatric in-reach support to all the other wards at the Canberra Hospital, with the exception of the adult mental health unit and the mental health unit in the short-stay unit. Effectively if you had someone, for example, in an orthopaedics ward who had a significant mental health issue, then that service would visit that person in the ward and they would contribute to the treatment of that person in terms of their mental health needs.

MR PETTERSSON: It refers to "provide after-hours support seven days a week". Do I take that to read 24-7 or do they still—

Mr Aloisi: No it is not 24-7. No, extended hours, seven days a week.

Mr Rattenbury: It is a recognition of the fact that people often will come in with a serious physical injury but they have either got an underlying mental health issue or perhaps even the underlying mental health issue has led to the injury. But they first must be treated for the severe physical injury. That is the point there.

MRS KIKKERT: I am quite aware of the amount of pressure and the stress that staff go through in treating patients with mental illness. What sort of support do they receive or what sort of training do they receive on an ongoing basis?

Mr Aloisi: The types of supports they would receive include various forms of formal support and formal supervision arrangements. A lot of staff would have a supervisor. In terms of other supports available, like any other staff member of ACT Health, they would have access to employee assistance programs. Currently across ACT Health we have a range of staff wellbeing-type programs that are accessible to all staff.

MRS KIKKERT: Is that staff wellbeing a workshop that staff can do?

Mr Aloisi: I suppose I am talking about an overarching framework that might include a number of, for example, training programs. It would include training programs. It might include information about things like stress management, sleep, hygiene, all those sorts of things.

MRS DUNNE: And what about an employee assistance scheme, a sort of access off site to mental health services?

Ms Feely: Yes, we have that as part of the normal package. Minister, through you, Ms O'Farrell can also speak about training for staff on how to manage aggressive behaviour, how to manage patients and family members who are maybe causing some angst in the workplace. There are lots of elements of how we look after them. You are right; it is a difficult environment and an increasingly difficult environment. That is also not just confined to mental health; it is an issue across the health service.

We put a lot of effort into respect in the workplace, both from a patient perspective but also very importantly from family and visitors towards staff. We do not tolerate poor behaviour. But in a mental health setting, it is usually a different issue, because they may not be not cognitive of the fact that they are behaving in a way that may be unacceptable.

Ms O'Farrell: In addition, as well as programs that help staff deal with aggression by patients, we also have other programs that help support staff. We have programs that help them deal with precarious trauma, because really working with disturbed patients can lead to an impact on the staff dealing with them, as I am sure Mr Aloisi would testify.

MRS KIKKERT: Are these programs free?

Ms O'Farrell: Yes. They are part of what we would call our my health program. We are about to launch a website that actually incorporates the my health program as well as some of the resources and supports we have for improving culture within the organisation. We are really looking at having a dedicated intranet site that deals with providing supports, both in terms of physical and psychological health in the workplace. We also include things like compassion fatigue seminars, suicide prevention workshops. We are really trying to look at supporting staff who are under pressure, because they are dealing with challenging patients.

MRS KIKKERT: Are you meeting the demands of the staff? Is there a waiting list?

Ms O'Farrell: In terms of being able to provide those programs? No, we are able to meet that demand. Obviously, we always are keen to do more, but those programs are readily available.

MRS KIKKERT: You are always keen to do more. Is that based on feedback from staff that they want more?

Ms O'Farrell: I think when I say we are always keen to do more, we are always looking at ways that we can support our staff and we are looking at ways to improve the culture in the organisation to ensure we have got a safe workplace for our staff and are obviously offering safe, quality care for our patients.

THE CHAIR: I have some questions about the role we might have in early intervention prevention programs, particularly in the schools. I know that the federal

government is still finalising their mental health framework and there are a range of funded programs, including the early childhood kids matter schools program. What role do we have in that space as an ACT government?

Mr Rattenbury: Those programs are run by the education department and not the health department. I have some knowledge of them from a previous life. If I remember correctly, primarily the rollout is done in the ACT. I would put the safe schools program in that similar vein. You will have seen of course that the ACT government has now decided to fund that program ourselves because of the restrictions that were put on it by the federal government. Our view was that it was a very valuable program and the restrictions that were being put on it were not appropriate.

Certainly in my time as education minister, I was given very strong feedback from staff that they really valued the program, that students got a lot from it, and that was why we took a decision to continue with that program. But I have had very positive feedback about both the minds matter and the kids matter programs. There is a view that they are successful, worthwhile programs.

MR PETTERSSON: But we do not have anything specific within Health that goes into schools to do that or works with schools? It is mainly an education directorate-led program?

Mr Aloisi: I think we are involved in the understanding and responding to the feelings and behaviours in schools program and we do that in partnership with the education directorate.

Mr Rattenbury: To go back to Mrs Dunne's earlier question about the office of mental health, I think that we need to recognise that mental health issues have both a clinical element and what I would loosely call a social element. I think it is very important that mental health services are delivered in the ACT in as joined-up a way as possible.

Certainly in the Health Directorate, the Community Services Directorate and the JACS Directorate in a lot of the justice areas, there are increasing levels of collaboration on and recognition of the crossovers between the areas that those directorates are responsible for. I think one of the positive things that the Australian government has brought about at the moment is better attempts to operate less in silos and more recognition of the flow-through in some of the programs, that the people who are accessing services out of CSD are probably also accessing services in Health. We need to make sure that we are dealing with them more effectively and in a more joined-up way.

MRS KIKKERT: I have a question about dental care at the AMC. Do all detainees at the AMC have access to emergency dental care?

Mr Rattenbury: I just want to check. They do have access to dental care.

MRS KIKKERT: How long does it take? They do have access to emergency dental care?

Mr Rattenbury: Sorry, I am just trying to check. Yes they have.

MRS KIKKERT: They do have access?

Mr Rattenbury: Yes.

MRS DUNNE: But if someone has an abscess on their tooth or needs a root canal or something, how often does the dentist visit?

THE CHAIR: Can you take that on notice, because I am not sure that it is in the minister's portfolio for this session.

Mr Rattenbury: It is.

MS LE COUTEUR: It is.

THE CHAIR: For this session?

MRS DUNNE: Corrections and justice health are.

Mr Rattenbury: Justice health delivers those services. I guess what I can say is that we do have a waiting list at the moment. I am not happy about that and I have actually asked the Health Directorate to look at something of a blitz in the jail to catch up, because we have some issues around it. I think you had a discussion earlier today about dental services, I heard. Just as we do in the public environment—people do not come to their appointments for a range of reasons—the dental time when the dentist is there is not used as effectively as it might be. So I am working with the team to see how we can improve that.

MRS KIKKERT: How often does the dentist attend the AMC?

Mr Rattenbury: Do you remember?

Mr Aloisi: Not off the top of my head.

Mr Rattenbury: We will have to take it on notice. I think I know the answer, but I will have to go and check, I am afraid.

MRS KIKKERT: That will be great, thank you.

Mr Rattenbury: But it will be more often if I have anything to do with it.

MRS KIKKERT: That is great. Nobody likes a toothache.

Mr Rattenbury: Exactly.

THE CHAIR: There being no other questions—

Mr Rattenbury: Here we go, the wonder of modern technology. Twice a week, the

dentist comes. And for urgent dental matters there is a prospect of transfer to hospital. In the extreme examples, in the very severe examples, that is a possibility.

MRS KIKKERT: You will look at making that a little more frequently?

Mr Rattenbury: Yes. As I said, there is something of a waiting list at the moment and I am not satisfied with that. I think dental health is a very important area and it has a significant impact on people's general quality of life. To have people having to wait too long is not acceptable, in my view.

THE CHAIR: Thank you for coming along, minister and officials.

Mr Rattenbury: Thank you.

THE CHAIR: I remind officials in particular that the committee asks that answers to questions taken on notice at today's hearing be replied to by close of business five business days after the uncorrected proof *Hansard* is issued. Members' written supplementary questions relating to annual reports will need to be provided to the committee support office within seven business days of the uncorrected proof transcript becoming available. If the committee support office receives any supplementary questions, they will be forwarded to directorates. Answers to supplementary questions will need to be provided to the committee support office five business days after receiving the questions. When a proof *Hansard* is issued, that will be forwarded to witnesses to provide the opportunity to check the transcript and suggest any corrections. I now formally declare the public hearing closed.

The committee adjourned at 4.29 pm.