LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING AND COMMUNITY SERVICES

(Reference: Annual and financial reports 2016-2017)

Members:

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

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 15 NOVEMBER 2017

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

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 20 May 2013

The committee met at 9.30 am.

Appearances:

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

Health Directorate
Feely, Ms Nicole, Director-General
Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
Richter, Mr Matthew, Acting Executive Director, Policy and Stakeholder Relations

THE CHAIR: Welcome to today's hearing of the Standing Committee on Health, Ageing and Community Services. This is the first public hearing of the standing committee on the 2016-17 annual reports, referred to it by the Assembly on 26 October. The committee is inquiring into the annual reports referred to it and will report to the Assembly by the last sitting day in March 2018.

Today the committee will hold hearings on the Health 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 implications of the statement?

Mr Rattenbury: Thank you, yes.

THE CHAIR: I remind witnesses that the proceedings are being recorded by Hansard for transcription purposes as well as being webstreamed and broadcast. Please note that the committee requires answers to questions taken on notice to be provided within five days of receiving the uncorrected proof transcript. I also remind members that questions today should relate to the 2016 annual report as far as possible. Before we proceed to questions from the committee, minister, would you like to provide an opening statement?

Mr Rattenbury: Yes, thank you, chair. I will make a few brief remarks this morning. It has now been a full year since I became the Minister for Mental Health. It has been a year in which I have developed a much greater understanding of mental health services in the territory. It is also a year in which we have made good progress in implementing the government's agenda.

Before I speak in detail about a few of those specific items, I would like to place on record my thanks to all those involved in the provision of front-line clinical services and those who support them. The provision of mental health services is hard work. Both the services we directly provide and those we fund will help people and their loved ones at some of the most vulnerable times of their lives.

Our service providers overwhelmingly do an excellent job in what are very hard circumstances, but without question there are times that things go wrong. No

healthcare system gets it right every time; and when it does go wrong, service providers do their best to make matters right and learn what needs to be learnt to prevent it from happening again.

How those times when it goes wrong are reported or commented upon is something that I have reflected on quite a lot, particularly in this portfolio. It is, of course, appropriate for questions to be asked and for those issues to be scrutinised. As the responsible minister, I recommit here to being as transparent and as honest as I can be on these matters.

However, it is worth remembering that for every case where things do not go right, there are hundreds of interactions with clients that go well and deliver the service that is required at the right time and in the right place. As such, I do feel it is important that, when there are questions to be asked or inquiries to be made, they are done in a way that respects our dedicated and talented workforce. This is because the atmosphere in which questions are asked has a demonstrable impact on the clinical workforce morale.

Having said that, let me touch on a couple of specific issues that I think will be of interest to the committee. In November 2017 an updated electronic clinical record system was implemented into mental health, justice health, alcohol and drug services. The new system will enhance our clinical reporting capabilities for inpatient and in-community episodes of care and help to develop multidisciplinary communication pathways for those treating patients.

The child and adolescent mental health services, CAMHS, implemented the choice in partnership approach intake model in the past year to address access to CAMHS services. It offers face-to-face appointments for children, young people and their families who are concerned about mental health issues. The choice in partnership approach intake model ensures that anyone has the opportunity to speak to a clinician face to face to obtain assistance, regardless of the severity of their issues and within a short time frame. This approach reflects a "no wrong door" philosophy and promotes timely access to services which we consider to be particularly important for young people often experiencing their first episodes of mental health concern.

In the justice health space a quality improvement activity regarding the opiate treatment program was completed and a clinical procedure was developed and implemented in alignment with the national guidelines for medication assisted treatment of opioid dependence 2014.

In addition, as I think members will know, we have now implemented the new technological system for methadone dispensing, called idose, which went live in the AMC at the end of August. Idose is a computerised method to dispense doses of methadone and suboxone using iris scanning and biometrics technology to accurately identify people. We believe it also delivers significant efficiencies for staff time and helps reduce the chances of human error.

Dhulwa opened nearly a year ago and is an important addition to mental health provision in the territory. I would like to congratulate staff on bedding down the new model of care and on the provision of a service that has not been offered in the

territory before. Dhulwa is a complex and challenging place to work. The patients have complex health needs and staff are continually striving to provide the best possible care, with a strong rehabilitation and recovery ethos which focuses on helping the whole person and not simply treating a mental illness. Since the opening of Dhulwa there have been 17 patients admitted and eight of them have now been discharged.

Through the parliamentary agreement the government has made a commitment to expand the size and range of services in the Centenary Hospital for Women and Children, which is planned to include a dedicated child and adolescent mental health unit. This is something that I know the community has a particular interest in. Planning for that expansion is now underway. We expect the facility to be operational by early 2020.

In 2016-17 there have been additional intensive and specialised support services for older people delivered through the expansion of the existing older persons mental health community team. This expansion enabled further assertive case management and clinical care to help people remain in the community as well as providing additional mental health support for people in residential aged-care facilities and those older Canberrans who are transitioning from an acute mental health inpatient setting.

While it is important to recognise those successes in the system, I also acknowledge there are a number of challenges. The issue of respect and acknowledgement of the dedication of our staff, as I mentioned earlier, is inextricably linked to our ability to recruit and retain the workforce we need to deliver the services.

As has been discussed recently, there is a nationwide shortage of psychiatrists in public mental health services, and in the ACT we are not immune from this issue. This poses a significant challenge that ACT Health has been proactively seeking to address, with a significant national and international recruitment effort to fill vacant positions. The directorate has also established a medical workforce working group to develop a workforce plan incorporating analysis of current and future need, recruitment and retention strategies.

Briefly, regarding the Moss review, ACT Health are working collaboratively with Corrective Services to respond to the recommendations and conclusions that arose from that report. Particularly for Health, this is about developing a partnership with Winnunga Nimmityjah Aboriginal Health Service to provide services within the AMC.

Also regarding the AMC, the health teams operating in the centre are facing pressure when it comes to providing health services due to the increasing number of detainees. That is a matter where strategic planning is now underway to enable improved provision of those services across a number of areas. I am happy to discuss that further.

I should briefly mention Brian Hennessy Rehabilitation Centre, which was planned to close following the opening of the University of Canberra public hospital. With respect to the mental health rehabilitation services, those services were planned to transition from BHRC to the hospital. An options analysis looking at the longer term accommodation needs of the cohort of long-term residents of BHRC was completed

in 2017 and it identified gaps in the market for long-term supported accommodation. I have therefore deferred the closure of BHRC for up to four years whilst suitable accommodation can be appropriately identified.

Our plans are in progress for the transition of some BHRC residents—some to the University of Canberra public hospital, where they will be in rehabilitation programs, and some into suitable accommodation in the community, supported by community sector organisations, with specialist in-reach mental health care provided by the ACT's clinical staff. ACT Health are also working on a forward plan regarding both the future uses of Brian Hennessy and how to improve access to supported accommodation options in the community.

I suspect you want to ask questions about the office of mental health, so I will not speak to that too much. I am happy to answer questions on that.

MRS JONES: Given that now we only have 20 minutes left.

Mr Rattenbury: Mrs Jones, we have heaps of time. Let me leave you with that snapshot of a few issues relating to the areas we are going to discuss for the next hour.

THE CHAIR: Thank you, minister. I want to launch off by asking you about the response to the Moss review. In particular, it is mentioned in the report, as you mentioned in your opening statement, that justice health services is working with corrections and Winnunga Nimmityjah Aboriginal Health Service to integrate a model of care into the AMC. What will the model of care look like?

Mr Rattenbury: It will very much reflect the work that Winnunga does now. The key finding from the Moss review was that we should work with Aboriginal-led organisations that have that cultural frame that will better enable Indigenous detainees to seek help and to get better support, and I guess my view is to do things differently. In a sense we have so many Indigenous detainees that we need to look at ways we can more effectively work with them, and Winnunga offers something, we think, that will add to our system.

THE CHAIR: Will they have a permanent presence at the AMC?

Mr Rattenbury: That is the intention. We are still discussing the details with Winnunga, but our intent is that they will operate a full service and that they will be a unit within the AMC, if I can put it most simply.

THE CHAIR: Do we know how many people will be working through the AMC?

Mr Rattenbury: In terms of the number of patients or the number of staff?

THE CHAIR: Number of staff.

Mr Rattenbury: That, again, is still to be determined. We are thinking about the best way to work with Winnunga, whether to start with a large service or start with something a bit smaller and build up, and that is the conversation that is ongoing in a series of discussions now. Similarly, we are unsure how many patients will avail

themselves of the service. It will not be a requirement, if you are Indigenous, to attend the Winnunga provided service. You will be free to choose whichever service you want. So we are not sure how many detainees will choose to go to Winnunga. That is part of the thinking about how to build the service up.

THE CHAIR: Will it have any effect on existing health services in terms of the number of staff that operate those services in the AMC?

Mr Rattenbury: That is not determined at this stage, but, with the growth in detainee numbers, we are under such pressure that I do not envisage a situation where we would reduce the number of staff. Frankly, we need as many as we have at the moment. Again, not knowing how many detainees might go to the Winnunga service, there will be a little bit of seeing how it goes. But I would not expect a reduction in staff numbers.

MRS JONES: Minister, referring back to your introductory remarks with regard to the methadone program, I have a couple of quick questions to ask. The first one is about what happens at the entry point when people are put into the AMC and they have their health assessment. If someone during that period states that they have an opioid addiction, what is the process of verification for that, or is that simply taken at face value?

Ms Bracher: When people are inducted into the AMC, we do a full health screen, which includes an alcohol and drug screen. At that point, detainees may disclose that they have an addiction that they are receiving treatment for in the community or they may say that they have an addiction that they are not receiving treatment for in the community but would like to start in the AMC.

The pathway is different for those two people. The pathway for the first cohort is that we validate their participation in the opiate treatment service with the alcohol and drug service at building 7; then we have their prescription faxed across and we continue what they are receiving in the community that has been prescribed. Our medical staff will also do another reassessment to make sure that it is okay for that person at that time. Our idose system, though, is now an electronic system; we can check in idose if somebody has been receiving care in building 7 for their addiction.

MRS JONES: Before going in?

Ms Bracher: At the point of going in, yes. If somebody has not been on an opiate treatment service in the community, our new process is that we have a further screening assessment done by our assistant director of nursing. Then the person sees an alcohol and drug nurse for a full alcohol and drug assessment. Then, and this usually within 24 or 48 hours, the person will see the GP out at the Hume Health Centre for a prescription, based on the full assessment that the nurses have provided to the doctor and what the doctor assesses and finds at that particular point in time.

MRS JONES: Is the doctor free to make contact with anyone on the outside of the prison system to verify what has been said?

Ms Bracher: Certainly we make contact with other health providers that the detainee

says have been involved in their health care.

MRS JONES: Are they able to contact family or friends if they want to, to check the story?

Ms Bracher: With the consent of the detainee we could.

MRS JONES: Finally, on the new system that has been implemented—

Mr Rattenbury: You mean idose?

MRS JONES: Yes, idose. In particular, I want to ask about the moveable machines. I understand that there are five machines that are attached inside each unit, but then there are portable machines on trolleys. Would the machines be recalibrated every time they are moved?

Ms Bracher: Absolutely.

MRS JONES: So that is part of the standard procedures?

Ms Bracher: Yes. In fact, the stand-alone machines are calibrated before we start dosing every time.

MRS JONES: Every day?

Ms Bracher: Every day.

MRS JONES: And after every move? For example, if you go from one cottage to the next.

Ms Bracher: Absolutely they will be. The stationary machines are also calibrated every time we start to dose.

MRS JONES: Excellent. I know there are lots of requirements in that space. Also, in relation to the answer to question 603 on notice, I have a question about the cost of these two trolleys. They are about $9,000 per trolley. I just wondered why that expense. Are they painted in gold?

Ms Bracher: No, they are not painted in gold.

MRS JONES: Encrusted in diamonds?

Ms Bracher: They have the computer system embedded.

MRS JONES: In the actual trolley?

Ms Bracher: In the trolley. And they have been manufactured so that the idose dispensing unit can be part of that trolley.

MRS JONES: I know it is actually screwed on.

Ms Bracher: Yes.

Mr Rattenbury: It is not just a trolley.

MRS JONES: We do not want anyone running off with the methadone. I understand that. Finally, can you give me a breakdown of how many inmates are on methadone, broken down by age group? If you cannot do that now, can you take that on notice, because that is quite important. We have very high levels of methadone users.

Ms Bracher: There are in the order of 130 detainees currently on methadone and suboxone at the AMC, but I cannot provide that to you by age group.

MRS JONES: On notice though?

Ms Bracher: We can look into that on notice.

MRS JONES: Thank you.

MS LE COUTEUR: Is this technology being expanded elsewhere, to Dhulwa and to the other drug and alcohol facilities in the ACT?

Ms Bracher: In fact, it has come in the other direction, Ms Le Couteur. It has been used at building 7 for a number of years in our alcohol and drug service; it was implemented at Dhulwa when we commissioned that service last year, and the commissioning into the AMC has taken just a bit longer because of working with corrections to do that safely.

MS LE COUTEUR: I understand there are new antiviral medications for hep C available under the PBS. Are these new medications now available to the inmates at AMC?

Ms Bracher: Absolutely. We have treated 113 detainees who are hepatitis C positive since the availability of those antiviral medications. For over about a year that has been happening. Professor Levy, who is our clinical director out there, has provided advice to the national Clinical Directors Forum. We are pretty much close to the leaders in Australia for the proportion of detainees that we have access to to treat in the ACT and have actively treated. It is in the order of millions of dollars that we have drawn down in medication management.

MS LE COUTEUR: That means millions of dollars in the cost of the medication, but that comes from the PBS? It does not come from the ACT?

Ms Bracher: That is federally funded. The commonwealth government made a decision to fund, free of charge to states and territories, antiviral medication for hepatitis C in prison.

MS LE COUTEUR: Have you got figures for what the rate was before and is now for hep C?

Ms Bracher: For hepatitis C, yes we do.

MS LE COUTEUR: Take it on notice if it is not obvious.

Ms Bracher: I would probably prefer to take that on notice. The rate now is less than a couple of per cent; the rate previously was in the order of 30 per cent. But I would prefer to take it on notice and try and clarify the actual figures with the committee.

MS LE COUTEUR: That would pretty much indicate that there are no other strategies needed from a hep C point of view to control hep C in the prisons.

Ms Bracher: Hepatitis C management nationally is part of a harm minimisation approach. For any health care, any illness, our preference is to prevent the illness rather than to treat it effectively after a person has got it.

MS LE COUTEUR: I was just wondering what that meant in terms of there being an ongoing push for needle exchange within AMC and whether this meant any changed views on that.

Mr Rattenbury: I think Ms Bracher's comments are right: we should still be seeking to prevent the transmission of diseases where we can. This antiviral medication—whilst the commonwealth is paying for it, which is terrific—is expensive. We should be seeking to not need to use it where possible. The government's view remains that we should be implementing a full suite of harm minimisation measures as well.

MRS DUNNE: I would like to talk about the escapes from custody that we have seen via the Canberra Hospital in the last 18 months or so. Has there been a security review in relation to the hospital and detainees? If so, what was the outcome, in general terms?

Mr Rattenbury: The escapes that have taken place have all had different individual circumstances, so we looked at them individually. In terms of one particular method, one area of concern, we have now made physical changes to the building. There was a spot identified where people were able to scale the building. Barriers have now been put in place to prevent that. That has removed that opportunity for escape. Others have related more to issues of the transfer of people. And there are issues that we are looking at further.

MRS DUNNE: There was one instance where one of the detainees had mental health issues and escaped. Was consideration given to placing this person at Dhulwa rather than taking him to the hospital?

Mr Rattenbury: I am just trying to think about the incident. We are getting onto an individual here, Mrs Dunne; I am just thinking about how to answer this question.

Ms Bracher: I can speak from a principle perspective, if you like.

MRS DUNNE: Yes.

Ms Bracher: If a person is in the AMC and has a mental illness that requires an

inpatient admission, we have two options. One is Dhulwa and one is the acute mental health unit. We do make a clinical decision based on the bed availability but also based on the needs of the person and on the needs of the cohort that are in both those units, on where is the most appropriate place to be. If we are worried that the person might also have physical concerns, we would always send the person to the Canberra Hospital, say to the adult mental health unit, and have their physical health needs stabilised as well as their mental health care.

MRS DUNNE: There are also issues raised in the community about the delays in making it known that there have been escapes. On a couple of occasions, one in August, the responsible ministers did not know for a couple of days. That was also the case in the July escape. What is the protocol for briefing ministers about escapes from custody?

Mr Rattenbury: I think we should clarify that. I know that Minister Fitzharris was in a meeting when you asked about an escape. I was briefed on that matter as it was a matter relating to a mental health patient. I was aware of it. I had not had the opportunity to speak to the Minister for Health, but I was aware. The responsible minister had been briefed.

MRS DUNNE: According to my reading of the events, with the case in July you were not advised for a couple of days after the escapes. Is that the case?

Mr Rattenbury: Which one are you referring to in July?

MRS DUNNE: There was one on 29 July which, from my reading of reports, you were not advised about for a couple of days after the escape.

Mr Rattenbury: I am not sure which reports you are referring to. I am happy to take that on notice.

MRS DUNNE: If you could take it on notice.

Mr Rattenbury: If you can let me know which reports you are referring to.

MRS DUNNE: In relation to three escapes, there was one escape on 29 July this year, one on 16 August and one last year. I cannot remember the date off the top of my head. For those three escapes, if you were the responsible minister at the time, when were you briefed?

Mr Rattenbury: I will give you that detail on notice.

MRS JONES: Minister, on the matter of transferring prisoners to hospital, has any thought been given to transferring them to a secure hospital unit in another state? I have recently been told that Victoria, and possibly New South Wales, has these units—because its hospital system is so big—which are secure units for other types of medical issues, not just mental issues. You would then not need to have as many personnel with them for the whole period of their—

Ms Bracher: Many of the bigger prisons in the other states do have in prison a

hospital, if you like.

MRS JONES: Sure. But I am talking about the secure units within the actual hospital system, not within the prison system. I understand we probably cannot afford those other beds.

Ms Bracher: Certainly. We have in our forward planning, and work with corrections to have, a secure design for the new emergency department. That is being forward planned, so that we can—

MRS JONES: But not general surgical? There are no plans for that?

Ms Bracher: No.

MRS JONES: Or to transfer people interstate to general surgical wards that are secure?

Ms Bracher: No, transferring ill people interstate in a custodial sense is a fairly—

MRS JONES: It is too difficult?

Ms Bracher: significant challenge and a fairly significant risk. We probably would be more concerned about the person's wellbeing than transferring them.

MRS JONES: Sure. It is better than having them run off.

Ms Feely: At this stage, on behalf of Health, I would like to acknowledge the superb support we get from ACT Policing, who tirelessly come and support us when we have people who are not where they should be.

MRS JONES: Of course. We love ACT Policing.

MR PETTERSSON: This may seem a bit of a strange question. The forensic mental health services began supporting the Mental Health Commission and Australian Federal Police fixated threat assessment team. Could you expand on what that is for me?

Ms Bracher: Yes. We have been part of a cross-government committee that has looked at fixated threat. The definition of "fixated threat" nationally is somebody likely with a mental illness and through that mental illness who has a fixation on a public figure and puts that public figure at risk.

In the ACT the AFP have a local territory working group. We are part of that working group, to look at strategies and processes to manage people with mental illness who might have a fixated threat. We have one of our very experienced mental health forensic psychologists seconded to the AFP, working with them, doing the assessments for the AFP and then connecting with our service, should that be needed.

MR PETTERSSON: You might not be able to answer this, but how many instances of individuals being identified through this program have there been in Canberra?

Ms Bracher: I cannot answer that question.

MR PETTERSSON: Understandably; thank you.

Hearing suspended from 9.58 to 10.13 am.

THE CHAIR: We will now be focusing on mental health services, Output 1.2.

Mr Rattenbury: Before the break Mrs Dunne asked me a question about when I was advised of certain escapes from custody. I now have that information. I will quickly share that. There were two incidents from the Canberra Hospital campus. One was on 16 August. I was notified by text on the day that he was escaped and I also received a written caveat brief that day. For the second incident, which was on 29 August, my office was texted immediately and the formal brief arrived in my office on 31 August, just as a function of a weekend. But certainly the text notification came through.

MRS DUNNE: 16 August to 31 August?

Mr Rattenbury: No, 29 August. Two events: one on the 16th, the second on 29 August.

MRS DUNNE: Sorry, 16th. Yes, okay.

Mr Rattenbury: A formal brief arrived on the 31st but there had been an earlier text notification.

MRS DUNNE: The 31st; yes, okay.

Mr Rattenbury: The third matter was a fellow who was at Dhulwa. He was on escorted leave at the time. That was on 10 July. There was a delay in notification there. That delay was actually to Ms Bracher. That is because the staff were seeking to find the gentleman involved. They were using their contacts in the community. They put their energy into finding him. They did not notify as they should have. I was notified immediately, once Ms Bracher knew. Staff in that incident have been reminded of their responsibilities. They at one level sought to do the right thing in seeking to use practical responses to find him but failed to notify as they should have.

THE CHAIR: I will kick off with a question in relation to the Mental Health Advisory Council. I was wondering what the progress was on the work of the council since its establishment in April?

Mr Rattenbury: Yes, the council is now under way. We have a full suite of appointments to that council, so all of the positions are filled. They have had three or four meetings now. The initial ones were confirming their terms of reference and some of those practical matters. Certainly I have met with them at least twice.

An example of some of the practical things they have done is the release of a conversation starter on the office of mental health. I gave that paper to the members of the Mental Health Advisory Council and the Ministerial Advisory Council before

releasing it, as a way of harnessing their expertise and as a peer review of the work we were doing. I have asked them to play two primary roles: one is to be proactive in bringing matters to my attention; the other is to respond to matters that I seek their views on.

THE CHAIR: Do they have an established work plan yet?

Mr Rattenbury: They are developing their work plan at the moment. I expect to see that soon. When I last saw the chair they were due to have a meeting and discuss it. I have not had an update since then.

MRS KIKKERT: My question is in regard to the office for mental health. On page 40 it says that the government will provide a total of $2.9 million to establish the new office. When will the office for mental health be fully operational? I note that in your ministerial statement on 12 September you state that "there have unfortunately been some unavoidable delays in progressing formal consultation on this initiative". What were the unavoidable delays in progressing formal consultation on the office for mental health?

Mr Rattenbury: In terms of that figure you cited from the budget papers, just to be clear, that is the expenditure over four years. That is the full forwards expenditure. Your second question was?

MRS DUNNE: Delays.

Mr Rattenbury: No, there was another one before that. Anyway, I will come back when I remember it. In terms of the delays, I guess there were several things that went on there. Predominantly it was internal work, looking at other jurisdictions. I asked for some briefing on what other jurisdictions were doing as part of developing our conversation starter. I wanted to make sure that, as a range of other jurisdictions have done this, the ACT does not reinvent the wheel. That information took longer to get to me than I had hoped. That was your second question: when will it start?

MRS KIKKERT: Yes, the operation.

Mr Rattenbury: It will start on 1 July. Whilst the delays—

MRS KIKKERT: Is it 2018, 2019?

Mr Rattenbury: In 2018. Whilst there is some frustration at that delay, certainly from my point of view I have not stood still during that time. I have had a lot of conversations with community organisations. A lot of informal consultation and discussion has gone on. We have continued the conversation through that period.

MRS KIKKERT: Okay, great. Thank you.

MS LE COUTEUR: What was the gap that the Mental Health Advisory Council was designed to fill?

Mr Rattenbury: I might ask Ms Bracher to answer that. Simply, it was formed last

term, before I was the minister, and she might know the background better than I.

Mr Richter: I acknowledge the privilege statement, chair. It was established under the new Mental Health Act 2015. The intent is to provide another mechanism to the elected government, the minister, for advice from the community. It is so that there is another pathway to the minister; it is not just through the bureaucracy that government can receive advice on matters pertaining to mental health. It also gives the minister another mechanism to seek advice from whoever is on that committee, on whatever he may wish. It is quite open. He can ask the committee for advice on any matter that he would like. It would seem that it is not so much addressing a gap as a strengthening of the provision of good, holistic advice to government to make decisions on mental health matters.

MS LE COUTEUR: Are there any projects that it is actively going to be involved in or is it for just very high-level advice?

Mr Richter: The work plan of the Mental Health Advisory Committee is subject to that Mental Health Advisory Committee. We do not direct them as government. The minister has given them some direction, as he indicated before, in terms of what he would like to look at.

MS LE COUTEUR: Can they get involved in program delivery at all?

Mr Richter: No.

MS LE COUTEUR: Or is it all very high level? For example, do they say, "We think there should be more emphasis on this or that"?

Mr Rattenbury: It is not intended that they would deliver programs. The group is quite diverse, and most of them are involved in some other service delivery organisation, whether it is a community one or private provision of services. There is no intention that they deliver programs themselves.

MS LE COUTEUR: I was not thinking that they would actually be delivering programs, but they might have detailed commentary on a particular program, saying that something is working or not working because of whatever.

Mr Rattenbury: Certainly.

MS LE COUTEUR: That was where I was going: whether it was all very high level or going down to that level of detail.

Mr Rattenbury: There is certainly nothing to stop them. If there was a particular program—perhaps if the government was taking a decision on whether to continue to fund something—we might seek their views. I cannot imagine that they would be involved in formal evaluation per se; it would be more in that advisory role rather than a formal evaluation.

MS LE COUTEUR: How many meetings have they had so far and how often do they meet?

Mr Richter: They have had four meetings. I will have to take on notice how often they meet exactly, because that is subject to their work plan. There is a minimum requirement in the legislation for them to meet four times a year, but they may choose to meet more than that if they determine that they want to do that.

MS LE COUTEUR: Thanks.

MRS DUNNE: Minister, I have a range of questions in relation to adolescent mental health, but I would like to preface them with a case study that I have become aware of. I have checked this with the parents of the person concerned. I have rephrased it so as not to identify the person and the rephrasing has been checked with the parents of the person concerned.

This young person comes from Canberra. I will call him Jack. He did very well at primary school and had impressive career aspirations. About the time he entered year 7, Jack developed significant mental health problems, including severe depression and anxiety. Jack's parents were unable to access adolescent psychiatric services in Canberra and resorted to services interstate. After several unsuccessful attempts to get Jack admitted to the Canberra Hospital, they managed to have him admitted to an interstate hospital. By then, he had been assessed as being at crisis point and at risk of self-harm and psychotic behaviour.

Apologies for being unable to provide the care Jack needs in Canberra did not help Jack or his family as a whole. In getting a referral to the child and adolescent mental health services, Jack waited for several months after being discharged from hospital interstate before getting an appointment with a case manager. He was given promises of wraparound services that did not materialise in his case, because of a lack of resources, and received only limited, inadequate professional support.

This is not from the family a criticism of the professionals involved, but they were pressed and the professional involved with Jack only worked 3½ days a week and had 22 people in their caseload. Jack reports to his family, and that has been reported to me, that he does not see the point of continuing with the treatment because it is slow and he does not see progress. He and his family are losing hope.

This is a different case from the one that was recently reported on the ABC. So in the last two weeks there have been two spectacular cases of adolescent mental health failures where people have had to go interstate at great expense to themselves. The services that are not being provided here are being provided interstate. I am not entirely sure of the extent to which, when you talk about a national problem, our staff issues are worse than they are elsewhere.

Minister, why are Jack and his family facing a brick wall in terms of services that he needs to help him recover and get back on track—in the first instance—and why are there repeated examples of people being turned away from very limited mental health adolescent services in the ACT?

Ms Bracher: I think it is fair to say that our child and adolescent mental health service is stretched. We have a child and adolescent mental health service that has

grown over years, with government investment, but we still do not have sufficient clinical staff to home visit as significantly as we would like. The current government has made a commitment to a dedicated adolescent unit, in recognition of a service that needs additional support in order to care for all of the children and their families that need that care.

I would respectfully like to say that I have never experienced my staff sending somebody away if my staff believe that that child is at risk based on their assessment. I want to acknowledge that that could be quite different from the perspective that the family has around their concern for their child. I am not sure about the dates with regard to the intake into our child and adolescent service from the inpatient care that that young fellow received interstate. But with our CAPA model, if there is a child coming from interstate, the child is seen in a continuum without a gap and the child is monitored.

MRS DUNNE: In this case, the child waited a number of months between discharge and seeing a professional through the CAMHS system.

Ms Bracher: I am talking about our system; I am unable to speak about an individual. If there is a young child and a family in distress now, out of session I would be happy to hear their name and do some follow-up.

MRS DUNNE: I understand that the family has also written to the minister, but I will talk to you about the case. Minister, in your opening comments you touched on the fact that we are stretched and that you have a recruitment strategy in place. Would you like to elaborate more about the recruitment and retention strategy, what parameters you have around measuring its success and in what time frame?

Mr Rattenbury: Certainly. As I said earlier, there has been both a national and an international recruitment effort to bring people on board. In terms of the number of staff that we have lost in recent times, a commensurate number of staff, or equal number of staff, have been recruited, although not all have yet commenced. I do not have the exact numbers to mind, Mrs Dunne, but it would be in the order of about 13. So far, seven or eight have come on board, and several more are coming in the coming months.

However, it does continue to be a struggle to bring them. That is why we have now established, as I also said earlier, a dedicated workforce strategy group to look across the spectrum at what we need to do. I think we need to produce more people in the ACT system; we cannot be constantly looking outside. We need people to want to come to Canberra or people who would like to be in Canberra. For all that this city has improved in recent years, it is still not the coolest place to come to. Professionally, it is not the biggest jurisdiction, so some people see it as having professional limitations.

I have started a piece of work nationally, through the COAG health ministers process, to have work undertaken on a national workforce strategy. So it is also being looked at at that level.

MRS DUNNE: In a related story, Dr John Saboisky was reported on the ABC on

29 October, talking about these issues. He claims that 15 psychiatrists have left the system in the last 15 years and eight in the last five years—that is private psychiatrists. When you are talking about recruitment, you are not talking about recruitment to private practice; you are talking about hospital recruitment?

Mr Rattenbury: Yes, I am talking about recruitment into the public sector. I did note in that interview that Dr Saboisky made a very interesting observation where he said that one of the issues for private practice was that the conditions were so attractive in the public sector that he saw a challenge in people being in the private sector. I thought that was a very interesting observation. As the minister, I am not sure how to interpret it, because it kind of speaks well to what we are trying to do in the public space but obviously that private shortage is problematic.

MRS DUNNE: Is the shortage just in psychiatrists or is it also psychologists?

Ms Bracher: From time to time we have challenges across our mental health workforce. There are mental health nurses. With psychologists, currently we have an intern program, an intake program and a registrar program to be part of our service that local graduates are finding very positive. So the situation with psychologists is actually positive at the moment. From time to time we have gaps in social work as well and gaps in occupational therapy.

MRS DUNNE: When you say from time to time, you have said you are out recruiting psychiatrists, but where are we with psychologists, both in the public sector and the private sector? I have had reports that people cannot see psychologists and psychiatrists in the public sector and that the appointment books are also quite full in the private sector.

Ms Feely: Mrs Dunne, if I may just jump in, we do not recruit in the private sector.

MRS DUNNE: No, but you must have some idea about the workforce.

Ms Bracher: We are working very actively with Capital Health Network, who are a coordination point for some of the psychology services in the private sector and community. We work very closely with them and try to join up our services. But in terms of the numbers, that is a market-driven environment.

Ms Feely: In relation to the psychiatrists, in relation to the shortage, we are trying to now work with the ANU to look at how we can package recruitment for psychiatrists. For example, rather than ACT Health working on a recruitment plan to bring ANU closer, we look at how we can package, for example, research and training opportunities along with maybe offering opportunities to have a private practice as well as public. So when people come to Canberra we are presenting an entire lifestyle opportunity, and with many psychiatrists the opportunity to do research is very attractive. So we are trying to look at how we recruit in a different way, and in that way we will be able to look at the private requirements as well as meeting our issues in the public system.

MRS DUNNE: What sort of time frame are you putting on your recruitment? Are you setting a time frame that by X date we need to have found those seven or

10 psychiatrists that we need?

Mr Rattenbury: I had not thought about it in that way, but I guess we have a frame that says we have immediate recruitment going on; we have had constant recruitment rounds in the last couple of years. That seeks to fill that short-term strategy. Then a more medium to long-term approach is the—

MRS DUNNE: The one that Ms Feely has talked about.

Mr Rattenbury: The sort of thing Ms Feely has been talking about. It is also about just trying to boost the workforce over time.

MRS DUNNE: The other thing about this—and this is something that I can really relate to—is that Jack's parents, who are both employed, professional people in the ACT, have complained to me about the major difficulties they have in navigating what they see as a complicated and piecemeal mental health service. That is a constant message that I get from people across the medical scene in the ACT. I have said it about myself. If I am a 15-year legislator and I cannot negotiate the health system, there is something wrong with it. If two highly paid professionals cannot negotiate the mental health system for their child, there is something wrong with the system. How are you addressing those issues of what seem to be complications and bureaucracy that make it difficult, in addition to the shortages, to access the system here and which make it more attractive to spend a lot of money and take your child elsewhere?

Mr Rattenbury: That is feedback that I have heard as well, that people find it complex.

MRS DUNNE: What are you doing about it?

Mr Rattenbury: We are getting there. You spent 60 seconds asking the question.

MRS DUNNE: Okay.

Mr Rattenbury: I am being honest about the fact that it is feedback that I also get. At a time when people are most vulnerable in their lives, it is the time that it needs to be the most simple. That is what we are striving to achieve. Certainly, the intent behind the office of mental health is to drive an approach that links everything up. I made the comment this morning, and I have said it publicly, that I think we have an excellent mental health sector in the ACT—there are a lot of people doing good work—but I do not know that the system works as well as it might in regard to people navigating their way through it. The idea of having the office of mental health is to drive that coordination and have that constant oversight in the system so that that is improved.

The other part of it, at a broader health level, of which mental health is part—and Ms Feely can add to this—is the territory-wide health services framework which, again, is designed to improve the flow-through in the system.

MRS DUNNE: Does this mean we are not going to see a joined-up system this side of July next year?

Mr Rattenbury: I do not think that is a fair characterisation. I think people are doing a lot. I think we have quite a good system but we also have room for improvement. I cannot be any plainer about it. I am not going to sit here and say it is all good, but I am certainly not going to sit here and say it is all not working. It works quite well most of the time but there is definitely room for improvement.

MRS DUNNE: In the space of adolescent mental health and the feedback I am getting, having regard to this case study and the case that was in the press in late October, the feedback that I get from school principals is that mental health issues are their number one issue. It is not education and it is not pedagogy; it is mental health.

Mr Rattenbury: Correct.

MRS DUNNE: I have been getting the same feedback. I vividly remember the first time that a school principal took me aside—it was in January 2014—to complain about adolescent mental health services, and from their point of view it has not got any better.

Mr Rattenbury: Having spent time as the education minister last term, I hear that feedback as well. That is why the government has taken a series of steps already to put more resources into schools. There are commitments to have more school counsellors over the full term. The first ones have already been added and there will be more in each budget cycle. In this last budget we put more money into headspace in the ACT because that is targeted at young people. So there are pieces of work going on. Organisations such as Menslink are operating in that space. We need to think about mental health as a spectrum, and for a lot of young people those early intervention mechanisms at the school level are quite important. The two case studies you cite are both quite acute, at the more acute end of the spectrum, and that is where the staff shortages particularly become an issue.

Ms Bracher: Mrs Dunne, just recently the federal government released its fifth national mental health plan, and there are eight priority areas in that. One of those priority areas is joining up the service system. The federal government has acknowledged across the system that this is an issue across all states and jurisdictions, and we are actually no different. That is not a defence of how the situation is. We absolutely, in terms of our commitment to the fifth national mental health plan, will be prioritising work around joining up the system with our community organisations, our public mental health services, and in fact Capital Health Network and the shared planning that we are doing with Capital Health Network on commissioned mental health services.

MR PETTERSSON: Dhulwa opened about a year ago. Could you provide me with an update on how things are going?

Ms Bracher: We opened about a year ago and we admitted nine or 10 patients in the phased approach over the first six or eight weeks from opening. We did that quite consciously. Those people were transferred in from our community, from the adult mental health unit and from the prison environment, based on their need. Many of those people have stabilised sufficiently that they could go back to the community, or more likely back to the prison and receive mental health care in the prison

environment if they have a custodial order in place.

There have been in the order of 19 people admitted and about eight or nine of those have been discharged from the unit. We have stabilised many of those people. Many of them have started their hepatitis C management in Dhulwa. Many of them have had their physical health checks, women's health checks and men's health checks, that these people have not had access to in their previous circumstance. As well as the mental health care and stabilising their psychosis and their significant, complex mental health challenges, we have been able to stabilise their physical health.

MR PETTERSSON: Have there been any teething issues with a new facility, a new service?

Ms Bracher: There are always commissioning issues with a new facility. We are working through those with our infrastructure group. That is part of a post-commissioning period. There will be a post-commissioning evaluation, usually at about 18 months post opening. That is standard practice for infrastructure projects. There have been commissioning issues. We have had to do some work on some locks in the bedroom areas, so we have done that. Another area is computers for the consumers to access, so that, when they are on their rehab program, they can access the internet. You can appreciate that there are fairly significant security requirements around that, so we are still working on that.

MR PETTERSSON: You said eight people have been discharged?

Ms Bracher: In the order of eight; eight or nine. I can check that number.

MR PETTERSSON: How many of them went back to AMC?

Ms Bracher: Most of them. I can take on notice the exact numbers.

Mr Rattenbury: Eight have been discharged, according to my notes, but we do not have the breakdown to AMC. We will have to take that on notice.

MR PETTERSSON: Why not? Thank you.

MRS DUNNE: In relation to Dhulwa, what was the pre-occupation commissioning? How long a period was there between completion and first patients, and what commissioning work was done in that time?

Ms Bracher: There is a building commissioning period that the consultant does. They go through and test that all of the things that they have built are up to the standard that they believe. Our health infrastructure program goes through and also tests, and our clinical service went through and tested. That is at a point where—I think the language is building occupancy; we get certification of occupancy at that point.

We provided the director-general, through both deputy directors-general, clinical and corporate, with advice that ACT government could take ownership of the building. I cannot remember the date, but that was in about early October last year. At that point we take ownership of the building and our clinical teams can go in and do their

training and learn how to use the building before the first patient comes in.

MRS DUNNE: How long was that period?

Ms Bracher: That was about a five-week period. Some of that we did in the unit and some of that we did in training facilities away from the unit.

MRS DUNNE: You got your certificate of occupancy and you took possession in October. When was the first patient admitted?

Ms Bracher: 22 November.

MRS DUNNE: So it was quite a short turnaround.

Ms Bracher: It was a five or six-week commissioning—a five-week commissioning period, yes.

MRS DUNNE: Where are we with the beds that are going to be rolled out in this financial year? When will they be rolled out?

Ms Bracher: We have provided advice to the minister. The intention was to commission those beds, the additional seven beds, in October this year. With our psychiatry workforce shortage and the skilled workforce in forensic mental health nursing, we provided advice that we would like to delay that into next year.

MRS DUNNE: Next calendar year?

Ms Bracher: Next calendar year, yes. Our anticipated time now is around April next year. We are currently out to market with a specialised recruitment company to do national and international searches for those staff, to bring them on board. Our clinical director for forensic mental health left at the beginning of this year. We have recruited a new clinical director and he does not start until December. We wanted him to be in place prior to bringing on the additional beds.

THE CHAIR: We will finish on mental health. Thank you for coming along. We will continue with acute services and Minister Fitzharris.

Appearances:

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

Health Directorate
Feely, Ms Nicole, Director-General
Bone, Mr Chris, Deputy Director-General, Canberra Hospital and Health Services
Murkin, Ms Jane, Deputy Director-General, Quality, Governance and Risk
Norris, Mr Lynton, Deputy Director-General, Performance, Reporting and Data
Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
Richter, Mr Matthew, Acting Executive Director, Policy and Stakeholder Relations
Vivian, Mr Trevor, Chief Finance Officer
Mooney, Mr Colm, Executive Director, Health Infrastructure Services
Kohlhagen, Ms Linda, Executive Director, Rehabilitation, Aged and Community Care
Brady, Ms Vanessa, Executive Director, University of Canberra Public Hospital and Canberra Hospital and Health Services Program
Kelly, Dr Paul, Chief Health Officer and Deputy Director-General
Chatham, Ms Elizabeth, Executive Director, Women, Youth and Children
Wood, Mrs Mary, Deputy Director-General, Innovation
Lamb, Ms Denise, Executive Director, Cancer, Ambulatory and Community Health Support
Kennedy, Ms Rosemary, Executive Director, Business Support

THE CHAIR: I will not reread the opening statement, but I will invite the minister to provide an opening statement.

Ms Fitzharris: Thank you very much, chair and committee members, for having me appear this morning on an exciting day. I would like to make a brief opening statement, just to put on the record the significant achievements of ACT Health over the last financial year, particularly in their significant efforts to keep our community healthy and well. I would like to acknowledge the efforts made by doctors, nurses, allied health professionals and the many ACT Health professional and administrative staff that support them in providing a high level of health care to Canberrans, and those notably, too, in our surrounding region. These achievements are reflected in the latest annual report.

There are some notable achievements for the reporting period that I would like to highlight: the expansion of Canberra Hospital's emergency department, with completion of construction in December last year and the final nine new beds opening in July this year; the establishment of a medicinal cannabis scheme in the ACT, including the formation of two expert committees to provide high-level advice for the scheme; completing the upgrade of the helipad at Canberra Hospital in January this year; progress on construction of the new subacute hospital at the University of Canberra, which will give Canberra its first dedicated rehabilitation hospital while also providing a world-class training facility for our future health workforce; and significant improvements in access to imaging services. As well, there have been significant achievements in the mental health portfolio, which you have just heard

about from Minister Rattenbury.

Our hospitals and health services continued to perform well against a range of the directorate's strategic objectives and priorities over the 2016-17 reporting period, including record levels of elective surgery, improved performance in the ED, a mean bed occupancy rate of 86 per cent for ACT public hospitals, and continuing to meet our target of assessing 100 per cent of emergency dental clients within 24 hours. Other benchmarks where our public hospitals continue to perform better than their targets included hand hygiene rates—I give a nod to Dr Bourke, who previously had a strong interest in this area—hospital acquired infection rates, unplanned return to hospital within 28 days, and unplanned return to the operating theatre.

Often within our health system the focus is on tertiary hospitals and the community health services that help people when they are sick, injured or hurt. While we will continue to provide high quality health care when and where Canberrans need it, we are also having a real focus on thinking about the health of Canberrans more holistically.

My new title of Minister for Health and Wellbeing, announced earlier this year, demonstrates our commitment to look more broadly at prevention and helping Canberrans live healthy and active lives. We backed this up in this year's budget with a $4 million commitment to a range of initiatives to assist Canberrans. I am excited about this work because I believe it will create more and better pathways for Canberrans to live higher quality, longer and healthier lives. It also builds on significant and positive progress previously made through the towards zero growth policy and the healthy weight initiative.

In the last financial year there have been several key pieces of work completed aimed at reducing the burden of chronic disease in our community, including the rollout of over half a million dollars to community organisations to help reduce age-related chronic disease factors and promoting healthy lifestyles for older Canberrans through the healthy Canberra grants; and $1.3 million in health promotion funding grants to support projects that aim to reduce people being overweight and reduce smoking and alcohol-related harm and support healthy, active ageing in the ACT.

I refer also to businesses from across Canberra partnering with 80 ACT primary schools to support healthy learning environments through the fresh tastes program; the introduction of the newly developed curriculum "entrepreneurs, it's your move", which encourages high school students to generate and test their own innovative ideas for healthy lifestyles; the expansion of the pharmacist vaccination program so that Canberrans can now receive whooping cough vaccinations as well as flu vaccinations from local pharmacies; and the introduction of new smoke-free areas, including public playgrounds and also most recently transport waiting areas.

The previous year was a particularly busy and challenging year on a number of issues. Notable among them was the system-wide data review. This is an important piece of work. It is progressing very well and I am grateful for ACT Health's swift and proactive response.

ACT Health has also responded to the challenges exposed by the Grenfell Tower

disaster to provide robust advice on managing the issue locally, with the safety of our community at front of mind. ACT Health also responded to the electrical switchboard incident at Canberra Hospital in April this year and managed the incident well, again with the safety of patients and staff at the forefront of their actions. Influenza also impacted Canberrans and their families significantly this year. ACT Health staff rose to the challenge to provide expert and increased care.

Looking ahead, we continue to reform the territory's health system to better meet the needs of Canberrans now and into the future. In September the draft territory-wide health services framework was released and expressions of interest opened for an advisory group. I note that you had some discussion about this in your earlier session. In addition to the clinical services planning work, ACT Health is also developing the new ACT health quality strategy. We aim to be the safest healthcare system in Australia, delivering high quality, effective and efficient care. The quality strategy will focus on delivering person-centred safe and effective quality of care, and I look forward to further work on this in the coming months.

In the coming year ACT Health's focus will be on the operational commissioning of the new rehabilitation hospital at the University of Canberra, planning works for the expansion of the hospital in the home program and delivering a new nurse-led walk-in centre for the Gungahlin community. Significant infrastructure programs were announced in this year's budget and will also continue to be progressed, including the early forward design and planning for the new surgical procedures interventional radiology and emergency centre at Canberra Hospital.

The delivery of healthcare services to the community is one of the most important areas of service provision for any government and their community. The ACT government recognises this and has made significant investments in our health system and services over the last 16 years. The territory-wide health services framework, the preventative health strategy, the quality strategy and the system-wide data review are some of the priorities for ACT Health that will inform the strategic direction for healthcare delivery now and into the future.

We are renewing and reforming so that we are ready to meet the demands as our city continues to grow. We are not alone in this endeavour. Again, I wish to give special thanks for the work of staff at ACT Health, as well as our community and private sector stakeholders who we partner with to keep our community healthy and well. With that I am happy to take questions from the committee.

THE CHAIR: Thank you, minister. I will kick off. Could you update the committee on the progress of the subacute hospital at the University of Canberra?

Ms Fitzharris: Certainly. Would you like to understand the build and the services that are provided there?

THE CHAIR: Yes. Also, can you elaborate on how it might affect services at the Canberra Hospital and the broader health system?

Ms Fitzharris: For those of you who have to travel past it, I note two aspects of my portfolio which are important. One is the Aikman Drive duplication, which is very

important in order to access the hospital and provide increased access to and from the growing Belconnen town centre. Work is obviously ramping up now to undertake the commissioning work and allow people who will be working there to have the training and skills that they will need to open the hospital. In terms of the build itself, it is very much on track to open midway through next year, we expect. I will hand over to Ms Kohlhagen and Mr Mooney.

Ms Kohlhagen: I might talk a little bit about the services and the commissioning part first and then I will ask Colm to talk a little bit about the build as well. As we have mentioned, this is Canberra's first subacute facility and it is well on track. One of the wonderful things that this facility will enable us to do is to bring together our subacute rehab services from across the ACT in the public system. This includes our inpatient units that are based at Canberra Hospital, our community subacute teams that provide a range of services in the community health centres, and a small amount of service that we provide at Village Creek as well. The ACAT team that is currently based at Canberra will be put into a purpose-built facility. We will be able to have staff that will go across those different areas and we will be able to provide the community, and the patients, more importantly, with the opportunity and the ability to provide better care across what we call the care continuum.

Patients could be admitted to our day programs specifically from the community and/or will be referred from our inpatient acute areas at both Calvary hospital and Canberra Hospital. We also could have people who are in the acute areas that may go into the day program or transfer straight into what we call our ambulatory services.

We have established what we call our CHASERs team. This is a small team of rehab physicians and a rehab nurse who can proactively work with our colleagues in the acute wards to look at people who may benefit from rehab to work through with the treating team as to what is the best type of rehab, whether it is an inpatient stay or whether it is the day program or an ambulatory service. That has proven over the last 12 months to reduce our length of stays and reduce the time between being referred to a rehab team and being admitted to a rehab service as well.

We are hopeful that the new facility—not just the facility but actually the way that we will deliver care—and our staff there will be able to pull people out of the acute units more quickly and, more appropriately, that people will be able to receive their care in a purpose-built facility that has been specifically designed to meet their clinical needs at that point in their journey.

MS LE COUTEUR: This facility specifically for rehab and aged care—I am not sure what is happening with—

Ms Fitzharris: And mental health.

MS LE COUTEUR: And mental health.

Ms Feely: There are 20 beds for mental health.

Ms Fitzharris: Yes.

MS LE COUTEUR: I admit I am not quite sure what is happening with the proposed new rapid routes, but I do know that it is not on the current 300 route. I think this is particularly challenging, given its expected clientele, who presumably tend to have longer stays in hospital. Certainly for aged people, both their immediate family and their friends may well be getting to stages where a long drive to somewhere that they are not familiar with, which will be the case for most of the people, presumably, is something that is seriously challenging and perhaps not possible. What are you doing as far as public transport access to the new hospital is concerned?

Ms Kohlhagen: There has been a lot of discussion with ACTION for a number of years. It is very true that, whilst rehab is for all ages, all adults, predominantly it involves an older person and often visitors are a similar age as well. There has been lots of discussion with ACTION around what the bus stops and the bus routes would be. There is a bus stop that is being specifically designed and placed at the University of Canberra hospital. Importantly, it is covered; we have gone right through. It is not only where the bus stop is, but the entrance from the bus stop into the hospital is covered. There are areas where people can sit along the way so that they can take a break. We are mindful that it is quite a long distance that people might have to walk; we have been very thoughtful as to how we can break up those walks so that people do not get too exhausted.

We have also done a lot of thinking around the role of a concierge and our volunteers within the facility to help people. If elderly people or visitors are dropped off at the front entrance, there are seats for people to sit on. Hopefully, we will have volunteers to help people go and access those areas where their friends and relatives are staying. We have designed a space where we can, hopefully, subtly hide the wheelchairs; we all hate those things when we see them at entrances of hospitals. We can make sure that they will not clutter up the space. Hopefully, we have thought through all of those things.

MS LE COUTEUR: I hope wheelchairs are not disguised too much; I quite like seeing them. I had my mother in a wheelchair for a very long time, so it is welcoming to see them.

Ms Kohlhagen: Yes, and a significant number of people who access rehab will use some sort of mobility aid. There has been quite a lot of thought in making sure the corridors are wide enough to accommodate lots of additional mobility aids. The facility has what we call a centralised equipment store underneath, so instead of having the wheelchairs and bits and pieces like that in the wards or in the corridors, they will be stored downstairs. The intent is that it is as clutter free as we can possibly make it.

Ms Fitzharris: Can I add a comment on transport? There has been significant work underway for a long time, and it goes to the point of having a dedicated, purpose-built facility. The objective is that people who need rehabilitation that might have day services are not travelling to lots of different places throughout the territory. So there is one central location for that. At the moment, the services are distributed around the territory. Particularly if you are a carer, you will now be going to one place. A lot of thought has gone into the transport needs, and we continue to work on improving the community transport and flexible bus service. We can expect to see more

improvements in those services over the coming years.

Ms Kohlhagen: Just to add to that, the facility will have a cafe installed in the grounds, and there are a lot of what we call patient quiet areas scattered throughout the facility, both in the day program areas or the ambulatory areas and within the inpatient units. So there are opportunities if people have travelled and they want some quiet time and to get a cup of tea or coffee. They have been purposely built into the facility. As the minister has said, particularly people who go for a day program will spend a considerable period of time there, and a number of those will come with their family members or carers.

Ms Fitzharris: Do you want an update on the actual build itself?

Mr Mooney: We are reaching a significant milestone in the next week in terms of completion of the construction phase of the project; we are expecting to get formal completion next week, on 21 November. That is a contractual milestone. It represents the culmination of a lot of work on this particular project, going back over six years. In terms of the actual build, we are talking about over 500,000 hours building this hospital over the last couple of years. Of that 500,000 hours, 55,000 are training hours for new apprentices and things like that, so a lot of significant work has gone in to ultimately deliver what is approximately 30,000 square metres of hospital space.

So we are ready in terms of the construction phase. Then we go into what is known as a caretaker phase, which will take us into the middle of February of next year, before we go into pre-operational commissioning work that a lot of Linda's area will be gearing up for in July of next year.

MRS KIKKERT: My question is in regard to language barriers at the emergency department. Is there a particular strategy to ensure that emergency department doctors, nurses, staff and patients have a clear understanding of what is happening when somebody is presenting?

Mr Bone: I accept the statement. Usually they use interpreter services for people presenting from non-English speaking backgrounds. If it is really urgent critical care, we try to access someone with that language. We prefer not to use staff for interpreting purposes, and we prefer not to use family members, but if we need to, to get immediate care, that is what we do. Our strong preference is to engage with the interpreter services.

MRS KIKKERT: How quickly are the interpreters there to help out?

Mr Bone: I would need to take that question on notice.

MRS DUNNE: Do they use actual interpreters or the telephone interpreter service?

Mr Bone: We use both.

Ms Feely: If it is an emergency, you normally have to get someone on the telephone. Again, it is not perfect, and it is better to have someone standing there, but the interpretation can be received very quickly if there is a clinical need for that to happen.

Then it will depend on availability at the other end of the phone, but we would access that as fast as humanly possible, because we need to for a clinical reason.

MRS KIKKERT: How many interpreters are there?

Ms Feely: We will take that on notice.

MRS KIKKERT: All right. Are there any ED employees whose command of English is such that it could be misunderstood by patients or their family members, particularly when they are stressed by the reason for their presentation?

Mr Bone: All of the professional staff, doctors, nurses and allied health workers, who work in the emergency department are registered with AHPRA. To get registration with AHPRA, if you are from a non-English speaking country, you have to pass English assessment criteria. All of the professional staff who work in the emergency department should be able to be understood, in terms of both speaking English and comprehending English messages.

MRS KIKKERT: Has there ever been a case where patients or family members could not understand a staff member's English?

Mr Bone: Not that I am aware of. I can take that on notice. Maybe looking at complaints would be our source of that, but I do not have that information at present.

MRS KIKKERT: Can we see a copy of the English test that you have to give to employees?

Mr Bone: It is not something that we as ACT Health run; it is a national registering authority.

MRS KIKKERT: It is a nation-wide thing?

Ms Fitzharris: Yes.

Ms Feely: And just to clarify, the interpreting service is not a health-only service; it is an interpreting service that people from across the territory would be able to access to find interpreters. Again, it is not something we as a department control in relation to employment.

MRS KIKKERT: But you have access to it.

Ms Feely: We have access to it, yes.

Mr Bone: We contract them.

MS LE COUTEUR: Many of your staff obviously have languages other than English Do you use those informally or in an emergency? I have certainly heard of this being done, and I was wondering if that could be a useful strategy.

Ms Feely: If we are in an emergency situation and we need to find an interpreter, the

preference is not to use family or staff because of the risk of the interpretation being incorrect, which could have some serious ramifications back into clinical care. But if we could not find an interpreter and we did not have anyone around who was a family member and it was urgent we would use whatever we could to get someone to interpret, but always with that understanding that the risk is that the interpretation is not what it should be and that that may have a clinical risk attached to it.

MS LE COUTEUR: Assuming your patient has been seen by ED, you have done your interpretation and they have now been admitted, how do you manage the ongoing care when their language is not English?

Ms Feely: Subject to privacy rules, and making sure there is an identified carer that has been authorised by the patient, in a non-urgent situation the interpretation between the patient, the carer and the clinician in a less stressed environment would be used. If someone is in hospital for weeks, the carer then plays a very significant role in interpreting.

To my mind, there is a difference between the clinical risk that sits immediately when we are trying to determine what sort of care somebody needs, and then the ongoing issue as to whether or not they are happy, comfortable and their needs are being met. All those sorts of issues can then be dealt with by a carer. But where there is a serious clinical issue that needs to be discussed the preference is to try to get a qualified interpreter to come in.

MS LE COUTEUR: Do your qualified interpreters have any specific knowledge not of medicine but of all the terms that are likely to be used in your conversations? You have got to talk a lot more about the body than an interpreter would have to deal with in a general conversation, so they must be a bit specialised.

Ms Feely: May I ask Matt Richter to come up and answer that, minister?

Ms Fitzharris: On the Health website there is quite a lot of information about how we are a multicultural community and how to access interpreting services. A lot of the feedback we get goes to Ms Le Couteur's point: sometimes even if you are an English speaker you may need to translate health-speak. I think everyone is seized of health-speak.

MS LE COUTEUR: And the acronyms.

Ms Fitzharris: Yes, AHPRA is a case in point.

Mr Richter: The minister's point about conversations between clinicians and consumers at the first point is where we start, and it is an important one. Acronyms and medical jargon can cause an issue at any time, so there is a lot of work that is undertaken through the health system nationally to improve both consumer literacy, so they can understand better what is being said, and how our clinicians talk to consumers so that a better conversation happens.

In this space, in terms of interpreter use, it is a national system. We pay to use the system. We have worked really hard over the last few years to increase interpreter use

across the board. We have increased our use by 129 per cent from 2013 to 2017, which is really good, reflecting better support for our people with non-English speaking backgrounds.

In terms of specific training around medical terminology, they do not undertake specific training around medical terminology, but they do receive training around how to ask questions in specific instances that may be related to an industry term. So an interpreter could be used in health care, law or other arenas in the economy, all of which have their own suite of jargons and specific terms, and interpreters are well trained to identify when someone is using a specific term—to clarify not with the consumer but with the professional on the other side what that term may mean in a more simple fashion and to communicate that through to the consumer.

MS LE COUTEUR: Thank you. What I was actually going to ask about was the geriatric unit, which is on page 47. I believe it has only six beds. What has the occupancy rate been for that? Does it have a waiting list?

Ms Fitzharris: I will bring Ms Kohlhagen back up as well.

Ms Kohlhagen: Thank you for the question. That refers to what we call our geriatric assessment planning unit, so it is only six beds. We do have a 26-bed acute care of the elderly unit, which is currently being refurbished, so we have transferred that unit to level 4B, another ward in the hospital, and it has reduced to 20 beds. We have a subacute geriatric unit, which was 18 beds, and the six beds are located on the same unit as our subacute unit, so we have a lot more than six geriatric beds.

MS LE COUTEUR: Good, and they are normally full, I assume?

Ms Kohlhagen: Absolutely, yes.

MS LE COUTEUR: And am I correct that you still have the issue of finding beds in nursing homes or other parts of the community to discharge your patients from there?

Ms Kohlhagen: Yes. In our geriatric assessment planning unit, which we call GAPU—we like our acronyms, with the SAGU as well—we take people directly, where possible, from the emergency department, and they stay in that unit probably for 24 to 48 hours. We have rejigged our nursing staff, so we have a clinical leadership position in that unit. We have, obviously, the geriatricians and the registrars who work there, so it is hopefully better for the patient that they get that more intensive geriatric assessment sooner and in a geriatric unit where the nursing staff are specifically trained to treat geriatric patients, and the allied health staff are working in that unit as well.

From the GAPU unit, they will transfer either to our acute geriatric unit or to our subacute unit. Only a very small number of them may go home from that unit as well. Yes, the issue about transfer to residential aged-care placement is still an issue. I believe that on both of our geriatric wards at this point in time there are seven people waiting for placement. That was as of yesterday. I cannot tell you how long they are waiting. Some people only wait a few days; for some it is a little bit longer.

The challenges of transferring people and the reasons that people may stay in hospital are quite complex. They are related to personal choice, the specific type of unit or a bed that is available in a residential aged-care facility. We have a residential aged-care liaison nurse that works very closely with the patient, with their permission, their family and the aged-care facility, to help facilitate that challenging journey to access residential aged-care places within the community.

MS LE COUTEUR: How long can people stay in the hospital while they are trying to access an aged-care bed?

Ms Kohlhagen: As long as they need to.

MS LE COUTEUR: Can you be a bit clearer around "need"? Say your family lives in Gungahlin and you can find a bed in Tuggeranong and it is going to be three-quarters of an hour drive. Is it possible for a family to say, "Yes, it is a bed, but this is seriously not going to work for us"? Can the person then stay in hospital longer? I do speak from some experience of trying to find suitable aged-care accommodation.

Ms Fitzharris: Yes. I am aware—and correct me if I am wrong—that other jurisdictions do have limits in terms of accepting a place if a place is made available to you. There is a spectrum from, "You must take it." We are at the other end of the spectrum. But I think it is important to note—and this is across the delivery of ACT funded and commonwealth funded services, across primary care and also residential aged-care facilities—that there is work, and a pilot program with the Capital Health Network at the moment, around the issue of people who need to make the move from their own home into a residential aged-care facility, but also, importantly, the people who are already in residential aged care but come into hospital, and whether they can go back into residential aged care. There is a lot of work underway to make sure that as many people as possible are able to stay either in their own home or in their residential aged-care facility, to prevent them coming into hospital in the first place, and that is another part of the puzzle.

Ms Kohlhagen: Further to what the minister said, our policy asks people to nominate three places that would be suitable. The clinicians talk with the family and the individual and say that, even if you choose or are transferred to option 3, there is always the ability, once you are in one facility, to transfer. I know it is not easy, but you are able to do that. At this point in time we do not say, "You must take that." We strongly encourage people, and work with them, to find a facility that suits their needs, and those needs range from their clinical and functional needs to location—where they would like to live and where their family and friends are located.

MS LE COUTEUR: As you would be aware, the number of homeless older people, particularly older women, is getting higher. What do you do in the situation where someone does not come from a stable home? Do you discharge people into homelessness?

Ms Kohlhagen: No.

MS LE COUTEUR: Would that be all across the hospital or—

Ms Fitzharris: Across all of the services, yes.

Ms Kohlhagen: Yes.

THE CHAIR: On page 128 it says that the new national system for prioritising access to home care has negatively impacted on the availability of packages for patients when discharging from hospital. What is it about those reforms that has had an impact?

Ms Fitzharris: Apart from significant loss of funding? One, it is a transition to a fairly significant new system, but my understanding is that there is a national queue that sort of exists, which everyone goes into. There is not a lot of transparency around waiting times on that or where you are in the queue, or information. So partly it is: is the system designed well? Even if it is designed well, is it working well? Given that it has only been since the beginning of this year—

Ms Kohlhagen: February, yes. The packages are portable, so the intent is that if you received a home care package in New South Wales you could bring that with you if you moved to the ACT, instead of waiting on an ACT package as well. What it does mean is that, from the end of February when this system was introduced, people have to wait in a queue—and that queue is across the country—to access a home care package. We have done a lot of discussion with our clinicians and social workers within the organisation to make sure that they are aware of that and they can then talk to families about what their options are, how they can access additional support and what that means.

It is early days. We are monitoring it very closely for the long-stay patients and people that may be dependent on these type of services, particularly the high level home care packages, to be able to be transferred home safely.

THE CHAIR: You said you did not discharge anyone to homelessness, which is great.

Ms Kohlhagen: Yes.

MS LE COUTEUR: If they came from homelessness or a home that they could not go back into, where do you find beds to discharge them to?

Ms Kohlhagen: We would work very closely with ACT Housing particularly to find suitable accommodation. The cohort that sits within my division within rehab and aged care often need a modified or adaptable house as well, so that brings an additional challenge to work with our Housing colleagues.

We also work, under the NDIS, with people who might share accommodation—their care packages and/or the appropriate supports or environment. So we work closely with their advocates. If people do not have families, we consider: do they have capacity? Can they be their own guardian and make their own decisions? Do we need to have an advocacy group that could work with them advocate on their behalf? So there is a range of options.

One of the important things when they come into our units is to talk about discharge planning from an early stage so that, if that might be an issue or that is going to be a concern, we can work with them as well.

MS LE COUTEUR: Thank you.

MRS DUNNE: My initial question is about the system-wide review of ACT Health data. Minister, is the review on track to be completed by 31 March?

Ms Fitzharris: It is, very much, yes.

MRS DUNNE: What is the expected expenditure on the system-wide data review?

Ms Fitzharris: We will take that specific question on notice unless there is someone who can specifically answer that. There will be the review process itself. There will then be the things that we do to implement the recommendations of the review. Those we do not know yet. We know some of them but we do not yet know the full picture.

MRS DUNNE: I was thinking about the actual review itself.

Ms Fitzharris: The cost of the review itself? Yes, I will take that one on notice.

MRS DUNNE: In relation to data supplied to the Institute of Health and Welfare that becomes part of the ROGS data, what is or was the deadline for 2017 data health sets to the Institute of Health and Welfare?

Ms Fitzharris: Mr Norris recently joined ACT Health from the National Health Funding Body. In that capacity he was sitting on the review panel but has recently joined ACT Health.

Mr Norris: In relation to the ROGS report we have supplied data to the AIHW for the next report. That goes through a number of iterations. The report gets released early next year. At the moment of verification with the other states and territories around the measures, some of that gets provided directly to the Productivity Commission; the other gets supplied directly to the AIHW. But that is on track for inclusion.

MRS DUNNE: That is on track. So there will be no NAs next year in February?

Mr Norris: For 2016-17 data, that is correct. But for 2015-16 there will be a retrospective application of the new data, governance and standards subsequent to the ROGS report. At this stage the 2015-16 will still be NA.

MRS DUNNE: So the stuff that was missing at the beginning of this year will continue to be missing?

Mr Norris: Correct. And we will work—

MRS DUNNE: Will that ever be updated?

Mr Norris: Yes, it will.

MRS DUNNE: When will that be updated?

Mr Norris: That will form part of the subsequent submission for the next ROGS report for 2017-18 to correct the time series.

MRS DUNNE: We will see that, hopefully, in February 2019?

Mr Norris: If I can provide the data or replicate the tables I will look to do that and work through with the minister and the director-general on how their stats can be provided. Essentially we are stabilising data definitions and governance, and applying those over the 2015-16 data so that there is continuity of measurement across the years.

MRS DUNNE: The data that was missing in February 2017 still does not exist or is not available?

Ms Fitzharris: It is important to note that the February 2017 ROGS report is from 2014-15.

Mr Norris: It is 2015-16.

Ms Fitzharris: There is 18 months of it

MRS DUNNE: Yes, I know. But the data that was missing from the February 2017 ROGS report is still not available.

Mr Norris: It will not be provided in this year's ROGS report. The focus has been on correcting the data, governance and standards for 2016-17. Once that is stabilised and we are going through that process with ROGS, that will then subsequently be applied over the 2015-16 report.

MRS DUNNE: That will be back-cast eventually?

Mr Norris: Eventually, yes.

Ms Fitzharris: Eventually.

MRS DUNNE: But probably in 2019?

Mr Norris: Correct. And if there are other ways to provide that information I will work with the director-general to provide it.

MRS DUNNE: In relation to the gaps in the data, Minister, there was a briefing to the outgoing minister on 14 October 2016. The director-general briefed Minister Corbell on data release and missing or problematic health data. Mr Rattenbury, as the Minister for Mental Health, signed off on his copy of the brief in November 2016. It seems from the FOI that neither you nor Mr Corbell ever signed off on that briefing. Why was that?

Ms Fitzharris: Sorry; 14 October 2016 we would have still been in caretaker mode.

MRS DUNNE: Yes, but did you ever see that briefing?

Ms Fitzharris: Not to my knowledge, but I will take the question on notice.

MRS DUNNE: A brief went to Mr Corbell on the 14th. Yes, I know it was the last day before the election. Mr Rattenbury has signed off on his version of that brief.

Ms Fitzharris: Mr Rattenbury would not have received that on 14 October because he was not the minister for—

MRS DUNNE: He may not have received it on 14 October but, according to the documents that I have received under FOI, he signed it off on 24 November. It would seem to indicate that you would have at some stage seen that.

Ms Fitzharris: Is there a number on the brief? That would be helpful and we can track that one down.

MRS DUNNE: I do not have it here, but I can go back and check that. I am happy to do that.

Ms Fitzharris: As I have mentioned on a number of occasions—if we are going back in history on this matter—it first came to the attention of the previous health minister in relation to the quarterly performance reporting. The subsequent work that was done was specifically on the quarterly performance reporting. That is just one piece of a very extensive number of reports that ACT Health does and provides to various bodies for different purposes, but notably including AIHW and the National Health Funding Body, for both funding purposes and data collection and reporting purposes.

The system-wide data review, of course, includes the quarterly performance reporting data, but it became a much wider, indeed system-wide, review in early 2017. Our focus expanded beyond the quarterly performance reporting. I am just not sure what the title of that brief you referred to was.

MRS DUNNE: I will get that for you and I will get the number. But when you do answer the question on notice can you give an explanation, if you did not see that briefing, for why you did not see that briefing of Mr Rattenbury's if Mr Rattenbury did?

Ms Fitzharris: Okay, sure. I will take that on notice.

MRS DUNNE: Also on the matter of briefing: on 13 January the Director-General of ACT Health sent a ministerial briefing about the missing data from the ROGS report. That briefing said that the data was missing and that it would be made available. It is clear that that has never happened. Mr Rattenbury signed off on that before the ROGS data came out, but you were on leave.

Ms Fitzharris: I was on leave, yes.

MRS DUNNE: You signed off on it sometime afterwards. Did you ever chase up at that time the missing data that the briefing said that you would be provided with, which is now, according to Mr Norris, not available?

Ms Fitzharris: I am not sure. I will have to take that on notice. Without it in front of me it is hard to answer the question. On the day of my return, which I think, from memory, was 14 January, I was briefed that there was gaps. I had seen that media reporting while I was overseas, that there were gaps. Over the course of the next week, in discussions with Health, I firmed my view that, rather than do report by report—because there are simply so many and it is such an extensive system-wide issue—we needed a system-wide review. I was not going to respond to this issue report by report by report; it needed a system-wide focus. That is exactly what we did.

MR PETTERSSON: I have a question about the new expanded emergency department. I am hoping someone can tell me about the fast-track area.

Mr Bone: At triage, patients who are assessed as most likely to not require admission to the hospital are allocated to that area. They are seen by the doctor and nurses within that area, with the intention that those patients are highly likely to be discharged from the hospital from that area.

MR PETTERSSON: Have we seen any benefits from this introduction?

Mr Bone: We have. It has freed up the area in the acute space so that we can see the patients who have got more complex issues. It has also allowed us to look at how we manage our workforce so that when we are looking at what our work force is for the day we can allocate those to the appropriate clinical areas. There are quite strong guidelines developed by the head of department and his deputy around the types of patients that go into that space. They provide guidelines for the people at triage. With those patients, we endeavour to get them through in a much timelier manner than if they were in the main acute area.

I guess it builds into the premise that in the emergency department we have complex patients and those who require urgent care, the category 1 and 2 patients. The complex patients tend to sit in category 3. They sit in the acute part of the department. That is, if you like, a part of the business that keeps the large part of the workforce on their toes. And then in the other part of the business, parallel to that, is the concept that we would manage the patients who will be going home through the discharge stream in a parallel process.

MR PETTERSSON: Could you expand for me who the patients are who are referred to as fast track?

Mr Bone: I would need to take that on notice. I would have to consult with the clinicians to get that.

MR PETTERSSON: One of the other things I noted was that there has been on average a 10 per cent growth in emergency presentations year on year. Do you put that down to anything in particular? Is it a growing population, or are people just

choosing to go to the emergency department first?

MRS DUNNE: The population is not growing by 10 per cent.

Mr Bone: I am not sure that it is the growing population. But the age of the population is changing and as people get older they develop more health issues. So that may be part of the issue that people present to the department. There are broader health concerns. This year in particular we have seen a very difficult winter season with influenzas coming in quite early and staying quite late. It is a difficult issue. Also we have got more children in the community and we have seen a growth in the paediatric component of the emergency presentations as well.

Ms Feely: I think it is also a sign of the respect that the people of the territory have for the care they receive in the ED. People become because they know they are going to get the full treatment in relation to all their pathology and imaging and they know that they will get care both at Calvary and at TCH that will deal with their issues one way or another. So many people are prepared to sit, if they are not an emergency, and wait for two or three hours to make sure they get the fulsome, all-up, taxpayer free care in the emergency departments rather than wait on a list to see a GP. I put it down to the fact that there is a lot of respect for the care that is delivered to the people of Canberra and the surrounding regions by our teams in both EDs across the hospital.

MR PETTERSSON: How do our emergency departments compare to emergency departments around the country in terms of presentations?

Ms Fitzharris: Most broadly, every jurisdiction is seeing increased presentations. We are "same, same but different" in some ways. We are a major tertiary hospital not only for Canberra but for the region as a whole. We are really seeing that across the region, and people being aware of the level of service that is provided at Canberra Hospital, which is greater than any other hospital before you get to Sydney. There is increased pressure around the flu season and the winter season, with retrievals from around the region as well over the winter period. All services have seen increased presentations.

Mr Bone and Ms Feely both reflected on not only older people but also people with more complex and chronic conditions. The feedback I get from clinicians is that often people are presenting with more complex issues. That is the experience I have shared with health ministers around the country, which is why recently health ministers have agreed to three key things to shape health reform over the next decade. One of those is the right care in the right place at the right time. The second one is a real focus on prevention and helping people manage their health over their lifetime, which goes to issues of health literacy but a lot more than that. And the other is using data to inform our decision-making.

Increasingly we are having a very strong focus on prevention here, and people understanding their own health and understanding the services that are available to them. We have two emergency departments in the territory. We see some people driving past Calvary. They do not need to drive past Calvary. They can get very, very, very good care at Calvary. So we are working on ways to inform different members of the community about the services that are available at Calvary and working with Calvary to improve and broaden the types of services that we can access there.

Our waiting times are coming down. There has been an investment in funding from the government in terms of expanding the footprint of the ED and also the number of staff that are in there, as well as ongoing changes to the flow within the emergency department, which I think goes to the category 5 results being very strong. Do you want me to add anything to the reform within the ED?

Mr Bone: The indicators for the reporting period are that our category 5 numbers have decreased, which was part of a broader strategy to keep people who do not need to be in an emergency department but can get alternative care with their GPs or other health providers, while we have seen a growth in categories 2 and 3 in particular.

MR PETTERSSON: Three more ambulance bays seems like a small number, off the top of my head, but does that make a big difference in the operations of the emergency department?

Mr Bone: Yes, it does. Ambulance presentations only make up a small number of the presentations overall each day to the emergency department. It is an irregular pattern. Previously we had limited access for ambulances to offload patients. And it is not just the offloading of the patients; they have then got to prepare the van for the next use, so it actually takes quite a while for the vans to come in, make sure the patient is handed over appropriately, then prepare the van for its next job. So having greater access through the three bays means that we can move patients through that process more quickly.

MRS DUNNE: Emergency waiting times for categories 2 and 3, and to a lesser extent 4—I note the vast improvement in category 5—are still below target and still below the national average for 2, 3 and 4. What other strategies are in place to address the targets and come up to speed with the national average?

Mr Bone: The targets against the Australian triage rating scales are targets set by the professional bodies. There are a number of strategies. Category 2 and 3 are the acute part of the hospital. This is part of a systems issue; it is not just an emergency department issue. We can look at the work of the emergency department and the system in three parts. We have got what we can deal with in the emergency department from start of care to end of care. Then we have the admit to the ward process, which is where the whole system has got a role to play in dealing with getting patients through into the inpatient wards. The other part is creating capacity in the inpatient wards by getting patients appropriately and safely discharged.

Our target is in each of those three areas to improve our performance, and in particular categories 2 and 3. Those patients may require admission into the ED short-stay ward or into the hospital. Getting the hospital cleared up is about going to the far end, which is about creating discharge capacity, creating beds. Without beds we do not get patients out of the ED, so it slows down our capacity to see people in the ED, meeting those time frames. The more patients we have in the ED, the more—

Ms Feely: Pressure on—

Mr Bone: I was trying to get the right word; pressure is good.

MRS DUNNE: Pressure is one that we understand.

Mr Bone: It means that we cannot get patients into the department from the waiting areas and other areas to be seen in a timely manner. That is our challenge. It is about getting the back end of the hospital to discharge patients safely and appropriately and move the patients out of ED, and that gives us our capacity to do churn in the department.

MRS DUNNE: If the patient is in the short-stay ward, are they technically admitted, or are they still in accident and emergency?

Mr Bone: Both, technically. There is an actual criterion, which is a national criterion, for admitting a patient into the short-stay ward of the emergency department. They tend to be patients who have got to stay for less than a day, who require ongoing care or are awaiting results or whatever. They are admitted into what we call the EMU at the ED. They are under the care of the ED consultants and they will be discharged from that ward.

MRS DUNNE: Are they admitted?

Mr Bone: Yes. They are admitted into SDA care.

Ms Feely: But still in ED, not transferred to the wards.

MRS DUNNE: The biggest problem seems to be category 3. You are sort of coming close in category 2. Are there particular strategies in place for addressing the substantial shortfall in category 3?

Mr Bone: Category 3 is the most difficult group to deal with.

MRS DUNNE: And the biggest.

Mr Bone: It is the largest group. Also predominantly it is people with more than one presenting complaint. They may be people with chronic diseases who have got an acute exacerbation of one of their chronic health conditions. It is a matter of how we get them in, get the team in ED to work them up and then get, if required, the admitting teams—the teams that are going to take over their care in the hospital—to come down and see them and to get them into the hospital. So this is, again, not just an ED issue; this is a whole of systems issue. That means that we need to get patients out of the hospital so that we can create capacity in the hospital.

As part of the government's investment in nursing, we have created nurse navigators in the hospital who work with the multidisciplinary teams to get people prepared for discharge, keeping it in people's consciousness there. We need to do these steps in a planned way so that patients can get out in a timely manner. It all feeds into the process of how we get patients safely discharged so that we can clear the ED of those complex patients in category 3.

MRS DUNNE: Is there a strategy to address what seems to have been in the past—

and you may have addressed this—a propensity for GPs to advise their patients, when they have an exacerbation of a chronic disease, to go and present to accident and emergency rather than send them to a specialist or whatever? I have personal experience of people being told, "You need to be in hospital and you need X, Y and Z. Go and present to accident and emergency." Those people probably have infections that they do not need exacerbated any further by being in ED and that we do not want to spread around in ED. Are there strategies for addressing the use of accident and emergency as a sort of shortcut for admission when people's chronic conditions become exacerbated?

Mr Bone: There is no easy solution to this, unfortunately.

Ms Feely: Or answer. We would never discourage someone who has been referred by a GP. If a GP thinks this individual needs to be cared for through ED, we would not discourage that. There are pathways that we are trying to work with, through Capital Health Network and the GPs, to show them different ways through the system. I want to hand back to Chris.

Mr Bone: Through the chief of clinical operations, we have done a lot of work with the Capital Health Network, bearing in mind that they do not represent all GP practices in the territory, though they access a number of them. How do we assist GPs and work with GPs to manage patients safely in the community? There are a number of options. Hospital in the home is an option; it keeps people out of hospital. There are, I think, 300 health pathways that are being signed off by the Capital Health Network and ACT Health that provide a guideline for GPs and others working in primary health care on how to deal with different health issues. There is quite a structured process.

Hopefully, if we can get more engagement in that space then that will mean that more people can be supported in the community. When they actually come into the emergency department or have a referral to outpatients for specialist follow-up, we will know that they have had a sequence of steps taken that provides the best care possible in that primary healthcare space. But, as I say, it is not a quick fix.

MRS DUNNE: I know health is a very complex area, but 300 different pathways seems uber-complex.

Mr Bone: Correct. Internationally, these pathways were developed originally in New Zealand. They were referred to as the Canterbury pathways. They have good, well-validated recognition. If you are in the community and you have a patient presenting with heart failure, you look up the heart failure pathway and then there is a step-by-step guide about how to link that patient to the appropriate services.

Ms Feely: It is part of territory-wide planning to look at the concept of the centres. We work very closely with GPs to use these pathway concepts so that, hopefully, we can guide the general medical and nursing professions, and people in the ACT and the local New South Wales district, on a pathway to eradicate the issues you were mentioning before. This is about confusion in the system and no-one knowing where to go. This is what the territory-wide planning process will try to alleviate.

MRS DUNNE: Are these nurse navigators generalists or will they have specialist knowledge? They might be chronic lung disease nurse navigators or diabetes nurse navigators.

Ms Feely: In the ED?

Mr Bone: We have navigators in ED which have a different function, which is to keep people on their toes and to check that patients are having follow-up procedures in a timely manner.

MRS DUNNE: All professional whip crackers.

Mr Bone: Yes. Then you have navigators in the wards who are the links in the discharge process and trying to pull together all of the processes that are required to get a patient prepared for discharge and get their care coordinated.

MRS DUNNE: What about entering the health system, entering the hospital system?

Mr Bone: There are navigators, as I understand it, with the Capital Health Network, but I do not know what their role and function is. I would have to take the question on notice.

MRS DUNNE: Okay; thanks.

THE CHAIR: I want to follow on from Mr Pettersson's questions regarding the emergency department. The report notes on page 97 that ACT Health has achieved significant improvements in outpatient waiting lists for medical imaging services. I was wondering whether you had the numbers on the improvements in waiting lists.

Mr Bone: Could I take that on notice? I just cannot put my fingers on it straightaway.

THE CHAIR: Yes.

Ms Feely: With the eradication of the majority of the waiting lists down to zero, for medical imaging I think you can now get an MRI in five days.

THE CHAIR: It says here that all of the different diagnostic imaging can be accommodated within two to five days. I am just wondering what the improvement has been for each of those. Secondly, it also mentions that this came about as a result of the reforms to the emergency department. I just wondered whether you could highlight the specific reforms that had an impact on medical imaging in particular?

Mr Bone: In 2016 a desktop review was undertaken of the medical imaging department and recommendations were made to the DG at the time. As a result of that, there were changes made in the workforce structure, the reporting lines and the leadership in the department.

Ms Feely: As in the—

Mr Bone: Yes, 38 per cent.

Ms Feely: It was under me at the time, that implies.

Mr Bone: Sorry, under the current DG. As a result of that, the new leadership team was given very specific targets of what to meet. We had very long wait times for MRI, in excess of six months; we had long waits for CAT scans, both for outpatients and inpatients; and we had long waits for other modalities, including ultrasound and X-rays. It would be fair to say that, at the time, access to the medical imaging department from the ED for actually having investigations undertaken as part of the process of the patient being managed in the emergency department contributed to long delays in the department.

As a result of a number of strategies, we have reduced the wait times; in most modalities, there is no wait time. In particular, in neurology, in the inpatient part, we have reduced the length of stays by up to three days for a large cohort of patients, because they can access CT machines in a timely way and get their reports done on the Friday so that they are not waiting over the weekend for ongoing care and the results of CAT scans. In terms of MRI, there has been a really strong drive to drive the wait times down. If you now require an MRI and it is urgent, we can get you in within about 24 hours. If it is semi-urgent, we can get you in within a week, five days.

Ms Feely: Two to five days. Paediatrics?

Mr Bone: We have a deliberate focus on paediatrics. We had long waits for paediatrics because they require an anaesthetic to have their procedures done when they are going into MRIs and CTs. We had long waits for that. We had a deliberate focus on reducing the paediatric wait list down, and we continue to monitor that.

THE CHAIR: Excuse my ignorance, but are any of these diagnostic imaging services available at Calvary hospital?

Mr Bone: Yes; Calvary has ultrasound, X-rays, CT and MRI.

Ms Fitzharris: There is a very significant improvement in access to services—more quickly as well.

We talked a bit about nurse navigators. There is also work that we are in the beginning stages of, an election commitment from us around chronic care navigators and patient navigators. Patients are being empowered to navigate their own way through the system. That work is being done with—

MRS DUNNE: I would like to see that.

Ms Fitzharris: That is being done with healthcare consumers who are expert in this area. We are looking at implementing that election commitment soon and working closely with healthcare consumers on that.

THE CHAIR: Does the increase in the use of medical imaging that is reported on page 98 just reflect the increase in the number of patients presenting at emergency, or is it reflecting an increased use of particular diagnostic imaging modes?

Mr Bone: I am sorry; I missed the start of the question.

THE CHAIR: The increase in medical imaging reflected on page 98 of the report—what does that reflect? Is it just an increased number of patients or is one particular diagnostic imaging process being used more as a result of medical advancements? What is driving the increase?

Mr Bone: It would be reducing the wait lists. An issue we have now with minimal wait lists is how we continue to maintain these figures. Say we have a lot of people waiting and we have pulled them in, plus there is the increased presentation at the hospital through the emergency department and getting our patients through in a more timely way from the inpatient setting. All those factors lead to increased numbers. I am not sure what that will look like this year because we have got our wait list down. We still have to look at how we keep the department focused on doing its core business.

Ms Feely: The improvements that have been made in relation to access to our imaging services have been done in concert with the clinicians. With a lot of this, our ability to improve access and improve flow-through is because of a change in work methodologies and thinking outside the square in relation to how we can move patients through the ED.

A simple example was to designate spots for X-rays in an ED day. Rather than having to call and wait, we knew that at 10 or 12 those slots were available. It has not been without its tensions, but we are really grateful that the medical imaging team have worked with us to change the way they operate and allow us therefore to increase access to these services for the people of Canberra. It could not have been done without the good working relationship with the medical imaging department.

Ms Fitzharris: There is broader work, nationally, in the Medicare benefits schedule review, around a whole range of different procedures, of which a few are diagnostic. It is around what might be happening nationally across a whole range of things. There are more than a couple of imaging-related reviews under that significant national review.

THE CHAIR: What is the implication of that? Will it mean that people can get imaging done outside the hospital instead? Is that the idea?

Ms Fitzharris: The review was charged by the previous federal health minister to look at thousands of different MBS procedures and see if they matched current clinical expertise around what was being recommended. That is a very lengthy and significant review. I think there are close to 6,000 different items being reviewed.

It is iterative. They have released a couple of reports for consultation and a couple of recommendations. It might be that there are some things where the clinical evidence shows that perhaps that is not the best treatment available and there are new and better models of care for certain procedures.

MRS KIKKERT: My question is in relation to page 198: fire maintenance at the

Canberra Hospital. Does the $1.1 million payout from insurance for the switchboard fire in early April reflect full compensation for the damage caused by the fire? Why is the switch fire on 5 April minimised in the ACT Health annual report?

Ms Fitzharris: We might take that one on notice.

Mr Mooney: Yes. I need to clarify that. The switchboard fire that I believe you are alluding to was in early April this year. The final insurance claim for that has not been settled. That is still a work in progress. That is why I have taken that one on notice.

MRS KIKKERT: Thank you. Will the upgrades to the building 2 and building 12 switchboards be completed by June 2018 and February 2019 respectively?

Mr Mooney: We are working through that at the moment. Within the program of work we have to allow for planned interruptions to services. At this point we are planning to complete everything by quarter 1 of 2019.

MRS KIKKERT: Are the switchboard upgrades being performed on budget?

Mr Mooney: Yes. They are being provided within the overall UMAHA program budget.

MRS KIKKERT: Why was the contract to upgrade the hospital switchboard signed days after the fire?

Mr Mooney: That was a coincidence. We had a process that we were working through—quite a lengthy procurement process—that had final negotiations to be clarified with the successful tenderer. As a coincidence, that particular week we were in the process of signing off. I had just agreed with the then deputy director-general who the actual preferred tenderer would be and that we would be formalising it that week. As I said, I can categorically say it was just a coincidence. We had come to the end of the procurement process.

MRS KIKKERT: Irish luck?

Mr Mooney: I would not say that. I do remember very distinctly that, after the conversation I had with the particular person to say everything was fine, about half an hour later I got a phone call. So it was purely a coincidence.

MRS KIKKERT: When was the problem with the hospital switchboards first identified and placed on a risk register?

Ms Fitzharris: I have given a number of statements. We are very happy to answer these questions, but there have been significant statements made previously on this.

Mr Mooney: Going on from what the minister has said, in terms of the particular switchboard that you are referring to, that would have been put on to the extreme risk register, following the work that was done by ACON in their condition audit report that had input from a variety of reports, one of them being the Brooks Marchant report, that had identified that the electrical main switchboards in building 2 and building 12

were problematic from the point of view of being a single point of failure within the system.

Following on from the ACON report, we used that document to support the UMAHA—upgrade and maintain ACT Health assets—appropriation that came down in the 2016-17 budget. We started work, in terms of the process of getting a contractor on board to do the replacement jobs, in early 2016, with the process to engage a consultant to work to develop the specification that would be required to be put in place to replace the various boards.

MRS DUNNE: I am glad we got to the risk register because I love to ask questions about risk registers. The answer to question on notice No 607 tells the Assembly that the health infrastructure services risk register was established after the ACON report. Mr Mooney has just said that the switchboards went on the risk register after the ACON report. Was there an infrastructure risk register before the ACON report?

Mr Mooney: The health infrastructure services risk register was put in place when health infrastructure services was created, which would have been in July 2016.

MRS DUNNE: That is what the answer to the question on notice said, but what happened before? Was there a risk register for health infrastructure, however described, before July 2016?

Mr Mooney: There was an asset register primarily used for tracking all equipment assets from a financial point of view.

MRS DUNNE: Can I take that as a no? There was not a risk register for infrastructure before July 2016?

Mr Mooney: In relation to projects, we would have project risk registers, primarily, and we would have an asset register.

MRS DUNNE: Did the hospital risk register include risk to failing infrastructure of any sort before July 2016?

Ms Feely: May I take that on notice? I can answer this in a slightly different way. As a consequence of the recommendations going to government about the maintenance of the actual site, I initiated the risk register to be updated following the ACON report. I was looking at the whole concept of risk; we have elevated it and we have now appointed a new DDG, quality and risk, who is here today—Jane Murkin, who has come from Scotland. So we have elevated the concept of risk and quality.

As part of the discussions with government about the infrastructure at TCH—ACON, UMAHA—that have informed the basis of an ongoing risk register for the management of the risk on the infrastructure side across the organisation, we then have the issues of risk at the hospital.

MRS DUNNE: This question is really about what the status of risk was. How was risk assessed before July 2016?

Ms Fitzharris: I appreciate that question; I am not in a position to answer that. The most important thing is that, following a range of different policy decisions in the previous term, the ACON report was commissioned and the risk register was established. So the baseline now is very comprehensive and has informed the UMAHA investment from last year's budget and will continue to inform ongoing upgrades as well as our planning for future new infrastructure not only within Canberra Hospital campus—although particularly there—but also across the territory as a whole.

The baseline now is very comprehensive. Going forward, we have that to work with. That is the most important thing from my point of view, but we can take on notice what existed before that informed the decision-making. Clearly, there were some gaps, and that is exactly why the DG had commissioned that work. It was established and now the baseline is very comprehensive and is being addressed by priority.

MRS DUNNE: In relation to the risk register as it currently exists, how is it managed to ensure that it is a living document?

Ms Fitzharris: That is a very good question.

MRS DUNNE: I am glad you agree that I ask good questions.

Ms Fitzharris: Sometimes.

MRS DUNNE: You may not agree with them.

Ms Fitzharris: No, that is important; and there is a good answer, too.

MRS DUNNE: We will see.

Mr Mooney: The health infrastructure services risk register is an active document, readily reviewed. We have two levels of governance meetings within health infrastructure services. There is the health infrastructure operations working group, which is an endorsing group that is made up of members of the Health Directorate and treasury—both finance and project management elements of treasury—and then we have the business support and infrastructure executive committee, which is an approving committee in terms of governance structure.

At both of those meetings an update on the health infrastructure services risk register is provided, whereby we outline how many active risks we have and how many have risk control action plans in place. These documents are used essentially by the teams. For example, within the facilities management area, that group is across all aspects of the health infrastructure services risk register so that when work orders come in through our asset management system they can refer to the risk register to make sure that they are prioritising work. If there is a risk that is there, they can close off elements of the risk.

As you will appreciate, because of the live and dynamic environment that is the 24/7 space that we work in, we have a live and dynamic risk register. That helps the whole planning process. With planning, it is really about trying to provide visibility

for what is invisible at the moment. That risk register provides the team and me with the ability to brief the DDGs, the DG and ultimately our minister.

MRS DUNNE: Is the risk register elevated out of the health infrastructure area into wider management? Do you have oversight of the risk register?

Ms Feely: Yes, by exception. I can see the issues, and then, on a regular basis, I review it with the executive team. For example, Mr Bone, through the hospital, about six months ago did an immediate review of all the risks associated with CHHS and is now having an ongoing risk management strategy. I cannot look you in the eye and say that we have every single risk covered, but the whole concept of management of risk, mitigation of risk and plans to make sure that those mitigation strategies are in place is now an active way that we manage across the system.

MRS DUNNE: So the health infrastructure risk—

Ms Feely: It comes up through Karen.

MRS DUNNE: Yes, but there is also a wider, across-the-board risk register as well. How old is that?

Mr Bone: At the CHHS level, the hospital and house services level, once a month we have our corporate team members come in and talk about issues that we do not necessarily have oversight of on a day-to-day basis from our operations perspective. Colm brings the risk register, the top 10 risks that sit in infrastructure. All of the senior directors of the hospital have seen that risk register in the last three months. As a result of that, in one way ED has raised a question around the top 10 risks for the hospital, which is part of a review we are currently doing with quality governance and risk, through Jane Murkin's team. We are expecting to have that back on track within the next four weeks.

MRS DUNNE: So there are risks outside that may or may not include infrastructure?

Ms Feely: Yes.

MRS DUNNE: So we have an infrastructure risk register and we now have it operational across the board, across not just the hospitals but the health system.

Mr Bone: And health services.

Ms Feely: The health system, and we will shortly have—

MRS DUNNE: How old is that? How old is that, Ms Feely?

Ms Feely: Six months it was reviewed.

Mr Bone: The risk register from an operations perspective pre-dates my coming into the position. There has been a risk register from an operations perspective. The EDs have divisional risk registers, and they have been running them for a while.

MRS DUNNE: The executive directors as opposed to the emergency departments.

Mr Bone: Yes, the executive directors.

MRS DUNNE: Thank you. Just for clarity.

Ms Feely: Jane Murkin is the new head of quality and risk, and we will shortly have a quality strategy that will have indicators in relation to risk. I will let Jane speak on that.

Ms Murkin: In relation to strengthening governance and risk management across ACT Health, we are taking a very proactive approach in reviewing all of our risks, as Chris Bone has already outlined, and Nicole. It aligns with the work in relation to the accreditation of standards. We have undertaken a map and gap exercise to look at the governance 1 standard in relation to the Australian commission on safety and quality. We are continuing to strengthen and review risks but also come up with our top three risks from the hospital system, and also from infrastructure, which will be brought into one corporate risk register which Nicole, as the Director-General, will have oversight of.

As I am sure you would appreciate, we are continually mitigating risks and looking for opportunities to put in place strategies and improvement activities to lower the risk and make sure that we are proactively looking to continually strengthen and improve governance and risk management across ACT Health.

MRS DUNNE: What is the timetable for the completion of that?

Ms Murkin: The map and gap activities in relation to governance and work in preparation for reaccreditation against the standards in March 2018 have been completed and have been discussed at a strategy and governance meeting as well as a tier 1 quality and safety meeting.

Ms Feely: The strategy meeting is a DG meeting with all the DDGs. A tier 1 committee is the tier that is usually chaired by our deputy director-general and which I usually attend but do not chair. So there are two levels of meeting.

Ms Murkin: The corporate risk register will be with Nicole by the end of November.

MRS DUNNE: The corporate what, sorry?

Ms Murkin: The corporate risk register, which will include risks that have been elevated. What we have also put in place is opportunities for education and training for both of our executive directors and other clear leaders across the organisation, to help them understand their roles and responsibilities in relation to risk and the mitigation of risk.

MRS KIKKERT: Can I just go back to my initial question about the data here? The switchboard fire damages claim was $1.1 million; however, you mentioned that that claim is not finalised yet. That raises a few issues for my curiosity. Is this a typo or a prediction of how much it might cost or could there have possibly been a switchboard fire that we do not know about?

Ms Fitzharris: No. I think you take it to 30 June 2017. The process will likely take a bit longer than that financial year to settle insurance claims.

MRS KIKKERT: Yes.

Ms Fitzharris: We might have some more specific information. We might be able to bring someone else up.

Mr Vivian: I acknowledge the privilege statement. Our financial statements are accrual financial statements. The fire occurred in April. Because the event occurred in the financial year, we have to report an estimate of revenue to come in and actually get the accruals matching the expenses. It is as simple as that. I am also taking the question on notice, and I will get the detail behind it, but that is not a mistake. I do not think it is a mistake; I think it is just reflecting the accruals.

MRS KIKKERT: What do you base it on?

MRS DUNNE: You have anticipated $1.1 million in insurance. How do you work that out?

Mr Vivian: That is why I will take it on notice and get the calculations of how it was estimated.

MRS KIKKERT: But in order for you to have calculated $1.1 million, it would have been based on something. So on what?

Mr Vivian: Absolutely. It will be our insurance area. I will get the information from them as to how that revenue was estimated. As you could imagine, it is more appropriate to include an estimate of our revenue for an event that occurred than to basically record it in the incorrect financial year. It is as simple as that.

MRS DUNNE: I want to go back to the issue of professional whip crackers. It seems to be a prevailing theme. In estimates, Ms Feely, you talked about a sort of one-off, two-year boost to the executive to help the executive keep on track for the reforms—

Ms Feely: They are not the nurse navigators.

MRS DUNNE: They are not the nurse navigators but the professional whip crackers that we talked about in estimates. Where are we in that cycle? You said that was a two-year cycle. Are these people recruited?

Ms Feely: They have all, over the last year, been recruited to. As we move through the process, we are now reviewing their actual roles. It is still with the initial idea of them being a resource that is focused on reform and not day-to-day operational issues. However, I would respectfully say that, in relation to the government priorities across the health service, we are of the view now that we need more people with specific project management skills rather than just keeping things moving. We are in the process of looking at a review of the job description to make sure that we have people who not only understand the health system but also understand the Prince

methodology and straightforward project management.

MRS DUNNE: Sorry, did you say Prince methodology?

Ms Feely: Prince, yes. It is a method; it is not my area of expertise. It is about looking at people who have those specific skills. We have also split the innovation department into the health services program, a territory-wide program, and a government and policy branch. The idea at the moment is that everyone sits under the health services program. Vanessa Brady, who is sitting back over there, has oversight of running from the project concept all the operational requirements and now the infrastructure requirements. They are to be delivered between now and 2022 or thereabouts.

Those innovation managers are being aligned under that position. We also need people now to help drive the territory-wide process, so one of those individuals will now move to territory-wide. We have also moved some more people in under data; that has arisen as an issue which I was not expecting a year ago when we started doing this work. We are moving more people into data. We have also given more support to finance, because, in moving through in the review, there are governance issues that need to be uplifted and moved through.

So the role has changed slightly, but it is still the concept of having a group of people who are not bogged down in day-to-day operational matters who are there to work to support the DDGs and me to make sure that the reform process moves forward. It is still moving forward; I think they are all recruited at this stage. But that is an ongoing process.

MRS DUNNE: As you described it during the estimates hearing, it seemed to me to be in a sense someone who was shadowing you or a deputy director-general to say, "Keep your eye on the ball."

Ms Feely: Yes. When we are reviewing, yes. On a day-to-day basis, the executive team in the hospital are running things, but also their day-to-day demands mean, and history has shown me through my experience in working in health services, that the day-to-day operational requirement nine times out of 10 take priority over reform.

That is why I refer to them as a whip cracker. As we have an executive, every project, every initiative and every government priority has an executive sponsor, and implementation plans are outlined. The innovation partners—I call them the whip crackers—have to make sure that the delivery against those government priorities is not being put second down the list here because we are trying to fix an issue over there. So their role still is the same.

MRS DUNNE: But their reporting lines are somewhat different?

Ms Feely: No. Initially there was an innovation department or division, and they were all under that. What I was saying before is that that division has now in effect been split into three groups because of the size of the programs, from the government priorities area, from territory-wide planning and also from revisiting the policy and government work that has been required—and, of course, supporting the minister in her role as chair of AHMAC. They are still sitting there, reporting under what is in

effect probably the old innovation role, which is now called the health services program.

MRS DUNNE: How many actual staff are the innovators, and at what level?

Ms Feely: Five.

MRS DUNNE: That was a four, was it not?

Ms Feely: Five at the 1.3 level.

MRS DUNNE: And it has always been five?

Ms Feely: Yes, it has been.

MS LE COUTEUR: At the top of page 49 it says the ACT government announced additional funding in 2017-18 re stroke services. This is unfortunately something that is very dear to my heart. I am wondering what you are planning to do, given that in my most recent family experience the issue was that the patient did not get to hospital quickly enough for the diagnosis to be made quickly enough for there to be any point in it.

Ms Feely: In recognition of the importance of a timely delivery of stroke services, the government has allocated funds for us to increase the breadth of what we provide by way of stroke. It is going to be dealt with through the territory-wide process. We are looking at the whole concept of neurology, mind and brain and all the issues associated with that. Specifically in relation to stroke, we are looking at a service that is currently being run through Calvary. It is an interventional stroke unit. What we are trying to do is to make sure that we have one point of access in the system for stroke. I always use myself in this example. If I am having a stroke, I want to know that I am going to be brought into an area that will assess whether I need some headache tablets, maybe a Bex and a bit of a lie-down because I have just got a bit of a headache, or—

MRS DUNNE: Bex is not on the PBS scheme.

Ms Feely: I know that. Or whether I need to be thrombolysed very quickly, need to be straight in to the cath labs to remove a clot, or whether time has elapsed and as such I am not in a category that can appropriately be thrombolysed and am moving more into the rehab phase. That is a very blunt way of looking at it. The neurology department with the team at Calvary are working very closely to bring all this to fruition and to life. It is a critical example of what we are trying to do through the territory-wide planning. You get treated with a multidisciplinary team who immediately will be ready to make a decision as to your treatment. The issue about not getting there in time will eventually need to form part of a community engagement process and a community information path to talk about the signs of stroke—"Don't wait" and that sort of thing.

MS LE COUTEUR: In this case I diagnosed my husband about 30 seconds after it happened. It was abundantly clear what the problem was.

Ms Feely: And he did not get treated in time? I do not want to go into your personal circumstances.

MS LE COUTEUR: I do not mind, but—

Ms Feely: Okay. That is the idea of the stroke service. It is operating in the majority of respects now. It does still need some refinement, but we are working very closely with—

MS LE COUTEUR: Given that timeliness is so acute.

Ms Feely: That is the immediate assessment when you arrive at the facility.

MS LE COUTEUR: At a fundraiser at Bunnings they were talking about equipping an ambulance to do scans at the point when the ambulance came. I was wondering if that is where we were going.

MRS DUNNE: That is certainly Victoria's policy.

MS LE COUTEUR: When I read this, that is what I thought you were going towards.

Mr Bone: I am unaware that we are planning to purchase an ambulance with a CT scanner. I am aware of the product. I was made aware of the product about 12 months ago after a member of the staff had been to an international area looking at diagnostic imaging equipment. I was informed by the news the other night that Victoria has bought one of those. It does allow you to make clinical judgements on the road as to the point of recovery of the patient. But we are actively not pursuing that at this time.

MRS DUNNE: You are actively not pursuing it, or not actively pursuing it?

Mr Bone: Not actively pursuing it.

Ms Feely: That said, it could be something that can be presented to government as part of the two, five and 10-year plans in relation to territory-wide planning. Right now, no, it is not an issue. It is more that if you have had a stroke—and, again, I am not a clinician—there is a time frame for going from here to there. If you can get to treatment quickly, we can still treat you. It is not a case of: "You have your stroke and that's it; you're finished." There is still a window of opportunity, particularly in relation to whether you can be thrombolysed. It is 12 hours. People are now looking at whether it is six hours, 12 hours or 24 hours. The literature is moving on this.

We are actively looking at providing the best world-class service we can in stroke. We are pretty much there now. By January we will hopefully have ironed out the last remaining administrative and political issues, and then we will certainly have a very, very good service. If I am having a stroke: "What is happening? Get it fixed." So we will get it fixed.

MR PETTERSSON: I note that in the budget it says that the government will undertake a feasibility study and early forward design for a range of facilities, which

includes expanded north side hospital facilities. What is the expected time line for that process?

Ms Fitzharris: The work is effectively a commitment we made last year. The early work was funded in this budget. As we know, there is a growing population on the north side. We are in the early stages. Obviously Calvary hospital is part of that conversation as well.

Ms Brady: We are currently undertaking the scoping study of the north side general hospital. That scoping study is an internal document that will be completed by later this calendar year. It will then be subject to review and decision as to how we would move forward with the findings of that scoping study.

Ms Fitzharris: It is looking as well at the future needs on the north side. Many things are intimately linked to the territory-wide health services planning. It is the constant iterative nature of services planning and infrastructure planning, and they are intimately linked, as well as what we understand about what the needs are on the north side and how it complements the overall offering we have of health services right across Canberra.

Hearing suspended from 12.28 to 2.01 pm.

THE CHAIR: We are now focusing on rehabilitation, aged and community care, output 1.4, and cancer services. I will kick off with questioning. On page 126 of the annual report it says that presentations at the walk-in centres at Belconnen and Tuggeranong continued to increase over the year. To what extent have they increased and what are the reasons that the presentations might have increased? Is it because of growing awareness of the walk-in centres as a place to go to treat minor illnesses or are there any other reasons?

Ms Fitzharris: Linda Kohlhagen will be able to answer these questions. There are a range of different reasons, but one of the things we see is that the local community where the walk-in centre is located is the most likely to come to the walk-in centre. In your region, if you live in Belconnen, I think the highest presentations are from the Belconnen region, and it is the same for Tuggeranong.

There continues to be growing awareness of what members of the community can go to the walk-in centre for. Once you have been once, you know of their value. People are becoming more aware of where they can best access the service that meets their needs. In some instances it might be a walk-in centre, their GP, or it might be an emergency department. We have just had another round of social media work around "Did you know that this is what you can go to a walk-in centre for?"

Ms Kohlhagen: Further to what the minister has said, our numbers are continuing to increase. We think that is also partly related to the communication that has gone out to the community more recently. There is also very strong word-of-mouth. If you have had a very good experience, you actually tell people that you have had a very good experience. There is that type of communication among the community, and they discuss the service they get. In our division a significant number of people write to us saying that they very much appreciate the service and are very complimentary

towards the holistic care and assessment that they get in the walk-in centre.

THE CHAIR: We might have had this conversation before: if they are presenting again—a repeat presentation—are you able to track that in the system?

Ms Kohlhagen: Yes. For every person who presents, there is an entry made in our clinical records. There is a record of care that they keep. We do not routinely run reports on the number of people that might have presented once or twice. We have people that might present several times throughout the year, but they would present potentially for very different things. You might have sprained your ankle once or had a laceration another time. You cannot always link that the re-presentations are related to the same incident. There is a small minority that might re-present if they have a wound or a laceration that needed to be re-dressed. We could certainly look at it, but the majority are one-off episodes of care.

THE CHAIR: The top presentations are listed in the annual report. Are you seeing changes in any particular presentations over time?

Ms Kohlhagen: No, they are fairly stable. Upper respiratory tract infections continue to be the most prominent reason why people present, followed by wounds and laceration management and musculoskeletal. It is also reflective that the community are aware of what you can receive from the walk-in centre. That has been fairly stable.

THE CHAIR: What about the top presentations that are in need of referral? Do you have an understanding of that?

Ms Kohlhagen: I would have to take that specific question on notice. We do have referrals. We send what we call a summary of each episode, with the patient's permission, to their GP. There are some presentations where it is a natural and appropriate place to suggest to an individual, "If you're not feeling better or this hasn't improved in X number of days, go and see your GP as well." We would need to do some analysis of that, so I cannot give you that, unfortunately.

THE CHAIR: With the communication to the public on what the walk-in centres can and cannot do, if you have a large number of people coming in for a presentation that cannot be dealt with by the walk-in centre, that may need to be—

Ms Kohlhagen: No. If we looked at the reasons that people may not present, I cannot tell you exactly what they are, but we can certainly have a look and see if we can give you the reasons that people may be presenting that we actually cannot manage. That is very important information that is part of the communication that you would use with the community, and on our website et cetera as well.

MRS DUNNE: There was information in answer to a question on notice that said that, on average, you referred three to four people a day up the medical chain. You do not have the information on the types of conditions or whatever it is that causes you to refer to a GP?

Ms Kohlhagen: There are a number of reasons that you would get referred to a GP.

MRS DUNNE: Or accident and emergency.

Ms Kohlhagen: Yes. It may be out of scope or you might need to be further reviewed in several days time. I do not have that level of detail with me at the moment; we would have to get it for you.

MRS DUNNE: I am happy for you to take this on notice: three to four a day is still the referral rate?

Ms Kohlhagen: Yes. The redirection rates have been fairly stable over the last several years, which is good. The other things that have remained fairly stable are what we call the median time of an assessment and the median time that people wait. That is really good to see as well.

MRS DUNNE: If we are talking about things being stable, is the $180 for the presentation still stable?

Ms Kohlhagen: That is a good question. The costs are slowly coming down. Obviously, if there are more people presenting to the walk-in centre—and the numbers when I looked at them last night have again increased over what has been written in the annual report—that will reduce the cost of the episode of care over time. We are doing lots of work with our colleagues within outpatients to look at the types of services that we could provide in addition to what the walk-in centre currently does to ease the burden across the health service more broadly. We met with the AMA and representatives of the college of GPs only last week to talk to them about what we could do collaboratively with them.

MRS DUNNE: Does the walk-in centre do immunisations?

Ms Kohlhagen: No.

MRS DUNNE: Would that be something that you would—

Ms Kohlhagen: That is certainly something we have discussed, but immunisations, certainly for children, are part of the child's development and a normal part of the health and wellbeing of the child. We believe that should be part of the work that they still do with either specialised nursing teams to support children or one's GP. At this point that is probably not something that we would look into.

MRS DUNNE: That is not something you would consider, so you would still keep it with the community health nurses and GPs?

Ms Kohlhagen: Absolutely; yes.

MRS DUNNE: Do you run immunisation clinics elsewhere in the health system, at health centres?

Ms Kohlhagen: We would, but I am probably not the best person to answer.

Ms Fitzharris: As Linda was saying, the level and types of services provided at the

walk-in centres are something that we are specifically looking at, particularly with our commitments to have three more walk-in centres—Gungahlin, the Weston Creek region and the inner north. There are a variety of views about the increased range of services that walk-in centres could provide. Immunisations is one, screening is another, as well as some pretty productive conversations recently with the AMA and the college of GPs about additional things that could assist particularly local GPs in their own work. I think that is a very positive conversation that we are having.

Dr Kelly: Could you repeat the question, please?

MRS DUNNE: It was just a follow-on in relation to immunisation. Apart from going to your GP, do maternal health nurses still provide clinics and where are they?

Dr Kelly: I will leave some of that for my colleague to answer. Firstly, in terms of vaccinations, there are a range of options in the ACT, and they have expanded recently. The majority of vaccinations, including childhood vaccinations under the national immunisation program, are done through general practice, but there is a very important and large component done through the maternal and child health clinics for childhood vaccination. Adult vaccination occurs almost exclusively in general practice. In the last year we have introduced vaccination in the pharmacies—

MRS DUNNE: Yes, for flu.

Dr Kelly: which has been an excellent thing for flu and for pertussis vaccine, whooping cough. Flu vaccines have increased markedly this year—more than double the number of flu vaccines through pharmacies than occurred in the first year of operation. That demonstrates a need and also that people are becoming more aware of that option. With the pertussis vaccine, which was introduced by the minister earlier this year, there has been a good uptake of that as well.

Ms Fitzharris: What about school-based—

Dr Kelly: Yes, of course. Thank you, minister. The school-based programs are also run through Ms Chatham's area. There are maternal and child health clinics for the young kids and then there are a number of school-based programs, which are again done through the immunisation nurses who work with Ms Chatham. I will pass to her for the operational components.

Ms Chatham: Thank you for the question. We provide, alongside our maternal and child health services, which are across the whole territory, immunisation clinics at all those sites. Those sites are in the community health centres; they are in the child and family centres, which are run by the Community Services Directorate. We also have some stand-alone MACH sites at Florey, Ngunnawal and Lanyon. All of those sites run immunisation services.

MRS DUNNE: And they run regular—

Ms Chatham: Regular, yes.

Dr Kelly: I will add one more. There is also a private sector approach for flu vaccine

in particular that can be run through businesses. By "business" I would include major commonwealth departments, for example. That service is run by the private sector.

Ms Fitzharris: And the ACT.

Dr Kelly: The ACT as well, yes.

MRS DUNNE: Do you record the take-up of flu vaccine? Has the rollout to pharmacies increased the take-up or has it just displaced the source—where people get their vaccines?

Dr Kelly: Under the national immunisation program there are a number of high risk groups within the community that are able to access free vaccination. That does not include the cost of a GP visit, but the vaccine itself is provided free. Through the health protection service those vaccines are distributed around the ACT, mostly to general practice, as mentioned. Those high risk groups include people over the age of 65, Aboriginal and Torres Strait Islanders, young children and people over the age of 15, young children and adults with chronic diseases that make it more likely to have severe flu, and pregnant women. The program within pharmacies was designed not pick up those that could access the free vaccine but rather to open it up for people who, for other reasons, would like to have the flu vaccine.

We have asked pharmacies to collect that information. Our information back from pharmacies is that the majority of people that come for that service have either never had a flu vaccine before and/or are not in those high risk groups. There are some that choose to get the vaccine from the pharmacy, even though they could access that free vaccine, because in the end it costs about the same.

THE CHAIR: We will come back to public health. We are not dealing with public health at the moment.

MRS KIKKERT: Okay. My question is regarding page 39. You have promised $12.1 million for the new purpose-built facility for Aboriginal community health services. Can you provide an update on where you are at with this funding and progress in the last six months?

Ms Fitzharris: I myself and Minister Stephen-Smith have met with Winnunga Nimmityjah Aboriginal health and community services organisation on a couple of occasions to talk about how we progress this, because this is money to upgrade and potentially expand their facility. Those have been really productive discussions. There are a range of land planning, health services planning and procurement issues that we need to work through with them. We are in close contact with them very regularly, because this is a priority, to enable them to continue some work that the government had previously funded to upgrade the facilities at Winnunga.

Mrs Wood: It is basically a design and construct project. It is at the stage which you would expect, which is that we are discussing with Winnunga the governance and the joint planning, and the feasibility of the sites in particular.

MS LE COUTEUR: Minister, you are probably aware that the Weston Creek

Community Council have written to the Treasurer as part of the budget consultation process. One of the things they identified was a new health centre for the Weston Creek region. Do you have any views on this?

Ms Fitzharris: Yes, to the extent that, as I mentioned earlier, we have the commitments to three new walk-in centres: Gungahlin, Weston Creek and the inner north. The funding in this year's budget really starts the work on all three of those, but the sequence in which they will be delivered is Gungahlin, Weston Creek and the inner north. So at the moment the plan is for a walk-in centre. I am aware that the Weston Creek and Molonglo community have also talked about the need for other community-related infrastructure. That is a conversation I think we need to have across government, because collocation of child and family centres, community health centres and walk-in centres is possibly optimal. We would need to look at the specific needs of the community.

MS LE COUTEUR: That is really where I was going. I appreciate that there already is the commitment to the walk-in centre, so I am confident that that will be delivered, but it is about the rest of it. What is happening with that, particularly bearing in mind that, as you would also be aware, there is a draft Territory Plan variation for Cooleman Court, the area in which potentially it would be delivered? It is in the very early stages and there is no commitment at this stage to doing anything apart from the walk-in centre?

Ms Fitzharris: That is right.

MS LE COUTEUR: And the walk-in centre will be actually delivered in—

Ms Fitzharris: We expect that it will be delivered in this term, but the precise timing is something that we are still working through.

MRS DUNNE: Let us go back to the issue of the refurbishment of the geriatric care ward, which was touched on this morning. After the UC hospital opens, where will the geriatric beds be? There are acute and subacute beds and six assessment beds. Where are those going to be situated after UC comes online?

Ms Kohlhagen: We have at this point in time 44 geriatric beds based at Canberra Hospital. That includes the six GAP—geriatric and planning—unit beds that I spoke about this morning. We also have 26 acute care of the elderly wards. This is where people who are very medically unwell would be admitted to. The length of stay in those units is around nine or 10 days. It is a fairly short length of stay. Our subacute unit is located across the corridor. That is nominally 16 beds.

The plan for UCPH would be to have the service that we call the older persons rehab service. They are people who are currently going to Calvary Health Care at Bruce. These are people who have had, mostly, some sort of orthopaedic accident or have broken their hip or got pubic rami fractures. It is that type of patient that we plan to have admitted to UCPH when we open next year. There are a number of outliers, the geriatric outliers who are on "other acute" across the board. There may be a small number of patients who are in the SAGU unit who might benefit from going to UCPH as well.

MRS DUNNE: SAGU? All these things that end in "U" make me think of SNAFU all the time.

Ms Feely: Unit is usually the last word.

Ms Kohlhagen: That is the sub-acute geriatric unit. They have a slightly longer length of stay. It is important when we look at our acute geriatric service that you can have access to a small number of subacute beds for the people who are in the acute units who may need one for a couple of days, not the length of stay that you would have at UCPH.

To support the establishment of the University of Canberra public hospital we have done a lot of work looking at the admission criteria. We will go through a process which I have talked about, another acronym, CHASER, the Canberra Hospital Assessment Service for Early Rehab, which is our rehab physician and nurse. They will work with clinicians across the organisation, both at Canberra Hospital and at Calvary, to identify people of all adult ages, including the older person, who would benefit from going to the facility.

MRS DUNNE: Can I just cut to the chase? Will the 44 geriatric beds currently at the Canberra Hospital remain at the Canberra Hospital?

Ms Kohlhagen: Yes. Those people often need a lot more. They need a geriatrician but they need a lot more, potentially, other clinicians who are around. So they are better placed at an acute facility.

Ms Feely: It is acute versus the rehab type.

MRS DUNNE: There is acute, subacute and rehab. Subacute does not include rehab?

Ms Kohlhagen: It includes a component of that. In that unit we also have people—

MRS DUNNE: There are never clear categories in health.

Ms Kohlhagen: When we are working through who will go to UCPH, we will only transfer someone there who might need to stay in hospital for five or more days as an inpatient. With the subacute unit that we have and that will remain at Canberra Hospital, people will be in that care type for only two or three days, hopefully, after their acute care episode. We have a nice continuum.

MRS DUNNE: A step-down sort of process.

Ms Kohlhagen: Yes. And the other way it can work is a step up. You might be admitted from the community to UCPH and then, if you become more unwell or need more specialised acute care, we have developed lots of processes that are in place to be able to safely transfer you to the acute facility.

MR PETTERSSON: I have some questions about discharge planning and the new national system for prioritising access to home care. Can someone explain to me how

that is negatively impacting patients?

MRS DUNNE: There was some discussion about that morning, was there not?

MS LE COUTEUR: There was, yes.

MR PETTERSSON: Insofar as it related to hospitals?

MRS DUNNE: Yes.

Mrs Wood: Do you mind repeating the question?

MR PETTERSSON: We have a new national system for prioritising access to home care. We have patients who are waiting longer for home modification services and supported accommodation. Can somebody explain to me why that is? I do not know anything about the system.

Mrs Wood: What page are you looking at, specifically?

MR PETTERSSON: Page 128, discharge planning.

Ms Kohlhagen: This is in relation to people who may be dependent on the NDIS for support?

MR PETTERSSON: I am assuming they are waiting for NDIS packages to come through. What happens in the meantime?

Ms Kohlhagen: That is a good question. There are four stages within the NDIS process. The first stage is a request for access. This is for under 65s only. When we have a patient who we know will have a significant level of impairment that will require the support of the NDIS, we strongly encourage the family and the individual to put in a request for access so that they can start the ball rolling fairly quickly. Hopefully that happens very early during the person's admission. People who are in rehab could be there for six weeks or longer. Hopefully the patient is moving through that process of trying to access the NDIS and have their eligibility considered whilst they are still undergoing rehab.

There is a period of time. It is fair to say that there will be some people who are remaining in hospital because they have not got their NDIS-specific supports. We have three of them in our rehab ward at the moment. They are all in there for slightly different reasons. These are just general reasons. They might not have completed their planning process and been allocated a package. We have examples where people have their package but are waiting for quotes from builders, because only a limited number of builders in the ACT are NDIS providers, or they are waiting for specialised equipment that is to be ordered, or to be reconsidered as part of their plan.

Whilst they are still going through their active rehab, they can do that concurrently whilst they are working through the NDIS process. If they have come to the end of rehab, we work very closely with them, and with our CSD colleagues and NDIS officials as well, to try to expedite that process as best we can. But there will be some

people who have to remain in hospital whilst they are waiting. Some families have chosen to self-fund some of the mods if they have an extended period of time and it is still going to be quite a long time before they get their support. We have a short-term loan scheme. If people are still waiting for their package to be approved, we can lend them, at no cost, certain types of equipment that will help them get home, and they can wait until their package has been approved at home. But there are a small cohort who will, unfortunately, remain in hospital.

THE CHAIR: My question relates to the work that is being done on the cancer centre to improve the new inpatient area, building 3 at the Canberra Hospital. I was wondering what the thinking is around that and how it will improve the quality and access of care for patients.

Ms Lamb: We are very excited about the opportunity that the refurbishment of our inpatient cancer areas will bring for our patients. The aim of the refurbished areas is to provide a much more specific environment for the care of patients, whether they are a haematology patient or whether they are a medical oncology patient. We will provide a higher level of single rooms, which is a much better model of care for people who have some type of compromise with their immunity, and also improve the facilities to allow families to be part of their care. We are aiming for a two-stage approach. The first will be to renovate the area of 14A, which was previously an outpatient area. That will be renovated, and our haematology ward will move into that first. Then we will renovate the current 14B for the medical oncology area.

Ms Fitzharris: And connect through to the cancer building.

Ms Lamb: The aim is also going to be that the wards which are down at the end of building 3 will have a walkway across to the cancer centre, therefore bringing a much closer connection to the outpatients and inpatients, and flow of people between.

THE CHAIR: Can you give me a picture of what sorts of things, when they are coming into the inpatient area, they are coming there for, in particular?

Ms Lamb: There can be a range of reasons for admission. Often for our medical oncology patients it is as a result of the treatment that they have received as an outpatient. For most medical oncology and radiation oncology patients, most of their care is done as an outpatient. Sometimes they will get side effects from their treatments that require them to be admitted, have a different type of treatment and get to a level of being able to go back home. For haematology, you have a much more acute admission: often someone will be diagnosed with leukaemia and they will come in acutely unwell from that diagnosis and then go through a treatment plan in that way.

THE CHAIR: Will there be a certain number of beds? Has that been established? Is that work being done at the moment?

Ms Lamb: The work is being done at the moment from a planning perspective. We aim to move into the area with our current number of beds, which is 44. But we will work towards having some growth capacity within the area, given that it is a significant area that will continue to grow.

THE CHAIR: You mentioned that support is being given to families in the new centre. How is that being achieved? Through the design of the refurbishment?

Ms Lamb: Through the design. With the actual patient rooms, there will be space for family to be able to stay with their relative or the person that they are caring for. That will be similar to the women's and children's, with some ability to separate. If the patient does not want to see their family for a small period of time, they can have some separation and vice versa. There also will be dining room space and bathroom facilities for carers and the family to utilise.

THE CHAIR: Has a rough time line been given for the development of that project?

Mr Mooney: The program of work has started already with a procurement process that is currently out to market for the principal consultant to be engaged to do the detailed design, to get it to a point where we have a reference design that can be used for a DA application but also be used to go to the construction tender. We are in that process of both design and then construction tendering next year. As Denise has said, there is a staged approach to this work. We will do 14A first, and then 14B will follow. As to the time lines, at this point in the program we are looking at the middle of 2019 for 14A and the back end of 2019 for 14B at the moment.

There is a lot of work in relation to building 3 that we are doing in preparation for that as part of UMAHA as well. A lot of this stuff, as we have found through UMAHA, is a program of work that has to be covered off. We know we are, as much as possible, doing futureproofing activities as part of upgrades, bearing in mind other areas of the campus that we are dealing with, so that we are not doing duplicated work or aborted work.

MRS KIKKERT: My question is in regard to page 45. It mentions that new service funding agreements were finalised for Winnunga and Gugan Gulwan Youth Aboriginal Corporation. Could you please give us a brief summary of that?

Mr Richter: We hold service funding agreements with both Winnunga and Gugan Gulwan for a range of services. The agreements run until 2019. Winnunga are funded for services such as primary care services, which are GP-type services, maternity services, some dental services and AOD services. We also put some funding into their social health team, which is a very good service.

At Gugan Gulwan we have a range of services as well: a number of AOD services again; some sexual health services targeting youth; and the street beat service, which you may or may not be aware of, where they go out into the streets in the evenings and meet people and talk to them about different issues and connect them up with services. That is very successful. There are some preventative health services there as well.

MRS KIKKERT: How often do they go out and do the street beat?

Mr Richter: Every weekend.

MRS KIKKERT: How many staff do that?

Mr Richter: I can take that on notice in terms of the specific staff. We do not mandate how many staff they have to have; we just have an agreement with them about how often they go out, and we have a target for how many people they can try to reach.

MRS KIKKERT: What is the target?

Mr Richter: The target is that we want them to get out every weekend and at least have conversations. We break it down into different types of groups. For example, 50 individuals around sexual health is something that we focus on.

MRS KIKKERT: How long do they spend out there?

Mr Richter: I can take that on notice.

MRS KIKKERT: For street beat.

Mr Richter: It is a few hours in the evening.

MRS KIKKERT: Are these volunteers or paid staff?

Mr Richter: Paid Gugan Gulwan people.

MS LE COUTEUR: I am not sure if I am asking about community care or not. On page 47 you are talking about a publicly funded homebirth program. That is in the community, but I am not sure if it is community care or whether it is health care.

MRS DUNNE: Page 37?

MS LE COUTEUR: Page 47.

MRS DUNNE: It is on page 99 as well. I had a question on that. I missed it on 47.

MS LE COUTEUR: You got further along than me, Mrs Dunne. Basically, I would like to know how it is going. I know that the original issue was around insurance, and I wonder how you are going from an insurance point of view.

Ms Chatham: The pilot program for homebirth is going very well. The insurance issue has been resolved so that we can run the pilot program for a period. It is a three-year pilot. We have had eight babies born in the homebirth program, two boys and six girls. We have 10 people booked in the forward months to have births at home.

MS LE COUTEUR: Are you oversubscribed?

Ms Chatham: No, we are not oversubscribed.

MRS DUNNE: How many did you anticipate?

Ms Chatham: We anticipated two a month.

MRS DUNNE: How long have you been operating?

Ms Chatham: I will have to quickly look, but I think it—

MS LE COUTEUR: It commenced in early 2017.

Ms Chatham: The take-up has been slower than we hoped, and we believe that is around eligibility criteria to meet the requirements of the insurer. We have quite sensible but narrow clinical criteria. There are also criteria around distance from the hospital.

MRS DUNNE: Are first births—

Ms Chatham: No first births, only second and subsequent births. We have a desktop audit evaluation due early next year; there may be opportunity to discuss with the insurer flexing or looking at different eligibility criteria, but that will not happen until we have thoroughly reviewed and evaluated the current service.

MS LE COUTEUR: So that would not happen until the end of the three years?

Ms Chatham: After our desktop audit evaluation, which is happening early in the new year, we will put to the insurer some changes to the criteria. Whether they accept them or not will be up to them; they may or they may not. They did leave it a bit open that at the midway audit point we could re-look at the eligibility criteria. One that will not change is the distance at which the ambulance is set. The ambulance have set a very clear 20-minute retrieval process from their ambulance point going out and coming back, and it is quite limited around Woden.

MRS DUNNE: So it is limited to Woden?

Ms Chatham: Around the Woden hub.

MRS DUNNE: The test is that you have to be able to get from an ambulance station to the house and back to TCH.

Ms Chatham: Yes. It is only being supported through TCH at the moment, not Calvary.

MS LE COUTEUR: Would that be something that could be fairly easily changed? I understand that you can have a baby at Calvary.

Ms Chatham: You can have a baby at Calvary; that is correct.

MS LE COUTEUR: They presumably would have the facilities there.

Ms Chatham: It is a model of care, but I think that once proven, tested and evaluated, that could be implemented if Calvary felt they wanted to do it at Calvary in the future, as well as TCH.

MRS DUNNE: Have you any assessment of the cost per delivery and how that compares?

Ms Chatham: We get a DRG funding. We receive a DRG or a costing for a vaginal birth.

Ms Feely: DRG is a unit measure of cost. A DRG can be a birth, and it has a cost attached to it. I will not frighten you by going through all the detail.

Ms Chatham: All the women at home are having a normal vaginal birth. We get the same funding for a normal vaginal birth at home as we do in a hospital.

MS LE COUTEUR: Mrs Dunne's question I think was not around funding but what it costs you, as distinct from the funding.

MRS DUNNE: What is the actual cost?

Ms Chatham: I do not have the figures here. Cost in the staffing of it? Is that what you mean?

MRS DUNNE: You have had eight births. What do those births cost compared to a birth in the hospital? I am not asking what you are funded for. Is there a difference in the cost?

Ms Chatham: There would be a difference in the cost. They are not using an inpatient bed so there would be a significant decrease in cost. The woman is not taking up a ward bed with food, linen and nursing and midwifery staff to care for the woman. There would quite a difference in cost. That is part of the evaluation, and their costing analysis is within the evaluation, yes.

MS LE COUTEUR: You would be fairly confident that the homebirths are a cheaper program?

Ms Chatham: Yes, I would be. I would be confident in saying that, yes.

MS LE COUTEUR: As I would have expected.

Ms Feely: The cost is not the main issue here. It is about providing access to patients and also making sure we manage the risk of the birthing process with the mother and baby.

MS LE COUTEUR: I am heavily in favour of homebirth.

MRS DUNNE: I cannot imagine why anyone would want one. We balance each other out.

MS LE COUTEUR: My questions are not trying to suggest that you should not be doing it.

Ms Feely: I am not trying to be difficult. I am saying that, in making a

recommendation to the minister, cost would be one element of what we are looking at here.

MS LE COUTEUR: Sure.

MRS DUNNE: Have a look at it the other way. If it was more expensive then it may be something that mitigates against continuing the program. But, Ms Chatham, you are saying that, although you have not done the sums, your belief is that it is less expensive.

Ms Chatham: Without the sums, I believe it is less expensive, for the reasons I have given you. But there will be a cost-benefit analysis as part of the final evaluation at the end of the pilot program.

MS LE COUTEUR: I assume that, given the smaller numbers, you have a fairly good idea of the satisfaction.

Ms Chatham: Yes.

MS LE COUTEUR: You are smiling, so hopefully you would like to speak on that.

Ms Chatham: I would say that the women who have experienced a homebirth under the care of ACT Health are highly satisfied with the care delivered. We have had no transfers into hospital. That is probably a reflection on very tight eligibility criteria, particularly not having first time mothers in the scheme.

MS LE COUTEUR: Have you had any comments from the rest of the family, who in some ways might be more affected by it being a homebirth versus a hospital birth, given that the mother will be involved regardless of what happens?

Ms Chatham: No, but as part of the evaluation we will be doing focus groups with the women and their families about the experience of the care, because it very much does involve the families. We did have one complaint from a neighbour.

MS LE COUTEUR: One complaint from a neighbour. The screams I guess.

Ms Fitzharris: We could try Access Canberra for that one.

MS LE COUTEUR: I will leave it at that.

MRS DUNNE: I will go to the other end of the spectrum and raise the difficult issues. This year in the flu season we saw 16 elderly people die of flu in nursing homes. I suppose this brings in a general discussion of a pretty bad flu season. What percentage of aged-care workers and healthcare workers do you know are immunised? I do not know whether you know the issue with aged-care workers.

Ms Fitzharris: No. In fact I do not think we do. It is subject to quite considerable work nationally around aged-care facilities. I think the commonwealth is looking at two issues in particular: the availability of potentially a different vaccine for people over 65 for the next flu season; and, secondly, how to significantly improve

immunisation rates amongst staff within aged-care facilities.

MRS DUNNE: I suppose the other question is—I do not know whether this falls under your purview, Dr Kelly, or whether it is a commonwealth issue—the extent to which residents in aged-care facilities are immunised.

Dr Kelly: To the point you made first: this has been a very severe flu season. We have seen many more cases and the flu season has lasted for a longer time. We have seen almost double the number of admissions than that of previous seasons.

MRS DUNNE: That is pretty much national?

Dr Kelly: That has been reflected in the national picture. The people that are ending up in hospital, at the severe end of the spectrum, have been mainly older people—that is again the same nationally—and young kids. They are the two big groups that have been hospitalised. Over the last few years the Health Protection Service, which works under my area, have done a lot of proactive work with aged-care facilities here in the ACT, including encouraging them to notify us when they have outbreaks of influenza-like illness. During the flu season that is mostly flu. Also to look at pre-preparing—

MRS DUNNE: It is not notifiable?

Dr Kelly: It is notifiable. We get most of our notifications from laboratories. But here we are trying to shortcut that by saying, "Okay, now we've got a few cases of flu in this aged-care facility." As you know, that is a very high risk area for a whole range of reasons. High risk people mobile around the area very easily spread infectious disease. If we can be involved in what to do about that in those closed settings early on, we can—and have in the last couple of seasons—limit the number of patients. Despite having a very severe flu season, with large numbers of particularly older people being admitted to hospitals, our work with aged-care facilities has led to the same number of admissions and the same number of deaths as last year. I think that is a major step forward. There is more to do.

I think your question about the immunisation of staff is a big one. Part of our pre-preparation has been encouraging that. But staff of aged-care facilities tend to be very mobile. They are often from non-English-speaking backgrounds. They tend to be low paid. Some of them have rather strong beliefs about vaccination, particularly around flu. It is a challenging area. If you look across the aged-care facilities within the ACT some of them have close to 100 per cent vaccination of both residents and staff; some are as low as zero. There is a wide range there. There is definitely work to be done to improve that.

Aged-care facilities are a commonwealth responsibility, so it is difficult for us to mandate these things. But the commonwealth would have the power to do that in terms of the accreditation of aged-care facilities, for example. The minister has already mentioned the other thoughts about a vaccine which is stronger, if you like. Older people tend to have a lower response to the vaccine in terms of immunity. Introducing something like that could also have an effect.

MRS DUNNE: So not necessarily a different strain but more immunisation,

essentially?

Dr Kelly: Yes, that is right. So the antigen, the part of the vaccine which is effective and causes the immune system to respond, would be the same, but the amount of the antigen or other ways of strengthening that immune response is what is being considered. Those vaccines were not available—they are not licensed—in Australia for this flu season. But there is certainly work in the federal area—we are involved with that—looking at what to do next flu season.

MRS DUNNE: Can I sum up what you said, Dr Kelly: although the flu season was bad, the death rates out of aged care this year were no different to what they were last year, this flu season from last flu season?

Dr Kelly: Yes. I can give you the exact figures, if you like. Since 1 July, which was around the start of the flu season this year, up until October there were 15 outbreaks in ACT residential care facilities, affecting a total of 289 residents and 78 staff. This resulted in 28 hospitalisations and 18 deaths. That was very similar to what we found in the previous season, when the circulation of notifications was way less and the number of total admissions was way less. I think that shows that, whilst we are still having a problem with older people getting flu, aged care is—

MRS DUNNE: Aged-care facilities are not a hotbed for outbreak.

Dr Kelly: That is right, yes. In comparison to the rest of Australia that is a very good result.

MRS DUNNE: Good. Thank you.

MR PETTERSSON: I have a question about clinical trials for cancer patients. How many patients are currently in these trials in the ACT?

Ms Feely: I might have to take that on notice. I cannot tell you off the top of my head how many clinical trials are actually cancer—

MR PETTERSSON: Take it on notice.

Ms Feely: Just in cancer or generally?

MR PETTERSSON: Just in cancer. If you are trying to increase patient participation in these clinical trials, how do you do that?

Ms Lamb: Clinical trials are offered to all patients, if there is a trial that is currently being undertaken within ACT that is suitable for their particular type of tumour or blood cancer. There are some that will not be run in the ACT because we do not have enough numbers of patients. Those people will be provided with information in regard to whether there is a trial being run in Sydney or Melbourne, to give them that opportunity, if they wanted to access that.

Ms Fitzharris: There is quite often strict eligibility—about being eligible for being in a trial. We might not have the right people eligible for a particular trial.

Ms Lamb: There are a significant number of clinical trials being undertaken within the ACT.

MR PETTERSSON: You are not specifically doing anything to increase patient numbers, where there are suitable people to take part in trials, or encourage them to do so?

Ms Lamb: Certainly, any time a patient comes in, particularly in their first consultation, and when it has been identified what their plan of treatment is, they will be provided with information at that point as to whether or not clinical trials are available for them. There is an active provision of information at that initial consultation.

Ms Feely: All clinical trials go through extensive ethics committee approval. They have to be funded. The concept of how we get people under trials is as Denise has said. It is also about making sure that there is knowledge of the trials, and getting consent for patients to be involved. There is a consent process, there is a human ethics process and there is a funding issue. This is all run through our clinical trials unit at the hospital.

To that extent, the minister has just reminded me to talk about our new research strategy. Professor Ross Hannan, who is a leading researcher in cancer, is the executive director of the research unit at Canberra Hospital. He is leading, with our policy unit, a review of our strategy for research. We are looking at a multiplicity of issues in how we can increase both the participation and the level of excellence in research.

There is this type of work on what the clinical trials unit does and how it is peer reviewed. For example, we are setting up a new subcommittee, with oversight from the ANU, UC and ACT Health, so that we can make sure that the clinical trials unit is at a level that is peer reviewable and actually getting the results we are looking for. We are looking at how we can make a dedicated time for clinical researchers to be involved in clinical trials, looking at a new biobank issue, looking at how we run the mouse facilities, looking at the library, looking at we can attract world-class both clinical researchers and medical researchers to the ACT. It is actually very exciting.

It is something we need to do in conjunction with the ANU and UC. We are hoping to be able to wrap that up by the end of the year. We have a draft and it is close to being finalised. Mary, can you add anything more to that? It is an exciting piece of work. I would like to see us driving research as a discipline through the entire ACT Health hospital system because it creates a culture of inquiry, a culture of innovation, and allows us to use a fantastic resource, which is our patients, to improve clinical care.

Mrs Wood: About $14 million is spent on in-kind subsidies or support for research activities in ACT Health. That is largely the time spent by clinicians on research, which is obviously sanctioned through various governance mechanisms, including the ethics committee that Nicole has mentioned. There is a clinical trials governance committee to ensure that the trials proposed not only meet ethics standards but also have some underlying strategic direction, and so that we have priorities that

ACT Health are supporting rather than just idiosyncratic projects that reflect particular individuals' interests but which are not necessarily strategic.

In addition to the in-kind support, there is a $2.1 million budget for the office of research, which is for direct staff costs for the executive director, the deputy and their staff. There are all sorts of operational costs that lie beneath that unit, including animal health and various operational units.

Ms Feely: Mr Bone has just pointed out that all cancer patients are offered a trial if possible.

Mr Bone: If it is appropriate. As Ms Lamb was saying, for everybody who comes in, if you meet the criteria for a trial you will be offered a place in the trial. When the trials are approved, the clinicians look at the known demographics of patients, where we get our cancer patients from and the historical data that feeds into it, and they will identify a number of people who would fit into each trial that we could reasonably do.

If there was an expectation that there was a low specific cancer incidence and we would expect to do 200 or 300 people, the trial would not go ahead because we could not meet those numbers. You balance your known demographic—that is, the patients with cancer—against the number of people required for the trial, against very specific clinical criteria, if we cannot go out seeking more patients for trials in general.

MR PETTERSON: One of the things that was mentioned earlier was people travelling interstate. If you are travelling interstate to participate in a clinical trial is there any support for you?

Mr Bone: Through the IPTAS we provide assistance for families who have to go interstate. So there is financial assistance through the government.

MR PETTERSSON: For clinical trials?

Mr Bone: Yes.

Ms Fitzharris: We have an update on the street beat program, if you would like to have that right before the break.

THE CHAIR: Yes, sure.

Mr Richter: The street beat program requires two trained youth workers, one female and one male. They undertake night patrols two nights a week at risk times in risk locations. Risk times are generally on Friday and Saturday night, and we leave the risk locations to Gugan to work with their communities to identify. They are out from 7 pm to 11 pm on those nights.

With the services they provide, they are there to provide appropriate contact information in relation to a range of health issues, from contraception to prevention of STDs to blood-borne viruses, smoking cessation and any other relevant health issue that may come up. They link up; so they provide diversionary services. They also provide transport for young people who might be at risk of getting into trouble with

police that night. They provide training for their staff to deal with comorbidity issues where you might have someone with a complex mental health or AOD issue. So they have training to deal with that situation, should it arise.

MRS DUNNE: Chair, while we are getting an update, could I get an update as well, please? In relation to the questions I asked this morning about Ms Feely's briefing to Minister Corbell on data, the TRIM number was Min16/1168. I was slightly wrong. The critical date was 14 October, but it was actually signed off by an official on 9 October. The question was: Mr Rattenbury saw that after he became minister, so did you, minister, see that? If so, did you sign it off, and if not, why not?

THE CHAIR: We will break for afternoon tea.

Hearing suspended from 3.01 to 3.17 pm.

THE CHAIR: We are on alcohol and drug services, public health services and early intervention prevention.

Ms Fitzharris: We have a couple of updates from the previous session.

Ms Feely: I would like to clarify my answer, Mrs Dunne, in relation to the innovation partners and how many there actually are employed. I said there were five and they all had people in them. Two of them have been re-advertised and we are in the process of moving through.

The next issue was when I talked about the health services program, the territory-wide program and government and policy. That is out for consultation at the moment in relation to a restructure on the corporate side. Technically we are still operating that, but Mary Wood is still the head of innovation. That is just to clarify.

Mr Bone: I had two questions on notice to answer. One was in relation to complaints related to a lack of understanding by people of non-English-speaking backgrounds. RiskMan is a system where we log, amongst other things, all of our complaints. Our review of the RiskMan system for 2016-17 found one complaint related to communication difficulties relating to language.

A second question on notice related to the conditions that would be seen in fast track. I will not go through them all, but needless to say the guidelines are that it is a single system. Examples of what that might look like are simple limb fractures in patients who are mobile; musculoskeletal soft tissue injuries; simple wounds; vomiting and diarrhoea; ear, nose and throat complaints; cellulitis; deep vein thrombosis; dental; or isolated rashes. There are a number of others, but that gives you a sense of the sorts of single systems that would go through fast track.

Ms Feely: Chair, in relation to cancer trials—

MRS DUNNE: Systems, not symptoms?

Mr Bone: Systems, yes.

MRS DUNNE: I am confused, but okay.

Ms Feely: Chair, I have one more in relation to the question on notice about how many cancer trials there are. We have 160 clinical trials across the ACT operating at the moment, of which 70 are cancer trials.

THE CHAIR: My question is in relation to the powers that are available to make public areas smoke free and exactly how those powers work.

Ms Fitzharris: They are new; they were passed in the Assembly last year. Rather than having to have new legislation each time an area is declared smoke free, it is a declaration that needs to be agreed by the Chief Minister and the relevant minister. At the moment that is me. Playgrounds were the first one; the second one, in October, was public transport waiting areas.

There was broad consultation on tobacco control which asked the community about their priority areas for becoming smoke free. That clearly indicated widespread support for smoke-free public areas and then some priorities within that. In each of the two declarations we have made under the new legislation, we have done additional community consultation to gauge community support, which has consistently been extremely high.

THE CHAIR: The two areas I think you mentioned which are now smoke free were children's play equipment and public transport. What has been the community response to the declaration?

Ms Fitzharris: Good so far. Certainly around public transport it was something that not only comes up in terms of tobacco control and making Canberra smoke free; it was one of the areas that public transport users have a view on as well—that it makes it a less than pleasant public transport experience when you are standing at the interchange surrounded by second-hand smoke. We have seen that around the country. While its primary role is public health, a secondary objective was to make public transport more enjoyable for people in Canberra.

THE CHAIR: And Access Canberra have responsibility for the compliance enforcement side of things?

Ms Fitzharris: Yes.

THE CHAIR: Do they report back to you about what actions they have undertaken?

Ms Fitzharris: Yes, but we can take some questions on notice around that. I cannot recall the playgrounds specifically, but with public transport waiting areas the first approach is community education and awareness raising. At the interchange in particular you will see that there is information available, including on the ground, that it is a smoke-free area. There has been a lot of information within the buses themselves that transport waiting areas are smoke free. And at, I think, 100 of the most utilised bus stops there is information that now public transport waiting areas are smoke free. They will not permanently be there, but they will be there during the introductory phase.

THE CHAIR: So there are signs around.

Ms Fitzharris: Yes, and if you are a regular public transport user you would have seen it on internal screens within the newer buses.

THE CHAIR: Is the Health Directorate looking at making any other areas them smoke free? Shopping centres have come up for me; people raise it at Cooleman Court in particular, just outside shopping centres where people go into the shops.

Ms Fitzharris: Right.

Dr Kelly: On the feedback from the community, as has been mentioned, there was overwhelming support during the consultation phase prior to the introduction. In terms of post introduction, I have had anecdotes given to me but no actual collection of the number of people there might have been where enforcement might have happened. In general terms, the approach that Access Canberra has to all of these matters is to educate, to engage and then to enforce only when required. Some of the anecdotes I have heard are that the general public feel freer to have that conversation with people who might be smoking where they had not done before. I think a lot of it is about talking to people rather than enforcing it.

In terms of the next steps, we are very proud of our anti-smoking efforts over the last 25 years here in the ACT. We lead the country in many of the indicators for that. It is about 10 per cent of the population that smoke now. Whilst it is important to continue with that wide scope and to make sure we do not lose those gains of a non-targeted approach to smoking, I think now is the time to concentrate on that 10 per cent. We have quite a few programs looking, for example, at smoking and pregnancy, particularly with young pregnant mothers, young Aboriginal and Torres Strait Islander mothers and the Aboriginal and Torres Strait Islander group altogether and other high risk, highly vulnerable groups such as those that are affected with mental health issues. The next phase of tobacco should probably be more targeted at those groups whilst continuing to look at potential for other regulatory reforms. At the moment there are not any specific new areas for that.

THE CHAIR: Do you have programs targeting school-aged young people?

Dr Kelly: Yes, definitely. One of the other reforms that happened during the period of the last annual report was the inclusion of vaping and other e-cigarette products, essentially handling them the same as cigarettes in terms of our legislation. We know from information gathered overseas and also here in Australia that that is an entry point for young people. We know that e-cigarettes and other vaping products are seen as cool, interesting and so forth. That is why the decision was made by the ACT government to include e-cigarettes. Essentially, everywhere that cigarettes are restricted, the same applies for those types of products.

THE CHAIR: And that is informed by the TGA guidelines? Is that right?

Dr Kelly: Yes. The World Health Organisation and Australia's National Health and Medical Research Council are very clear in their guidelines in relation to that. Whilst

there is some debate in the public health literature that e-cigarettes are probably a safer way of delivering nicotine than traditional cigarettes, that is the wrong counterfactual when you only have 10 per cent of people that are smoking, in my view. If 90 per cent of people are not smoking anything, why would you introduce a potentially harmful product like e-cigarettes into the community in those sorts of settings?

Others will argue that e-cigarettes can be used as a quitting tool for people that are currently smoking, and there is no restriction for that under the legislation in the ACT, but we have been very clear on no advertising. Wherever cigarettes cannot be smoked, e-cigarettes also cannot be used, now including bus stops, interchanges, playgrounds and internal settings, with the same idea of the second-hand smoking issue but particularly in relation to the re-socialisation of that behaviour for our younger people.

MRS KIKKERT: My question is in regard to page 66. It is about the multicultural and diversity health policy unit. It says:

> … culturally and linguistically diverse communities is captured, the Quality, Governance and Risk Division will collaborate with the Multicultural and Diversity Health Policy Unit.

However, minister, I have been informed that this policy unit has discontinued. Is that correct?

Ms Fitzharris: There has been a restructure within the policy area. But certainly in terms of the advice that is provided and the increasing focus on our more diverse community, particularly the multicultural community, there is a different approach, and that is embedding that knowledge about the specific needs of multicultural communities within all aspects of health service planning and delivery. We can probably have Matthew speak more to it. It is actually strengthening. The way that this has been designed is to strengthen knowledge and understanding across the health system as a whole, as opposed to having it focused in one area. The objectives are still being met, just in a different way.

Mr Richter: The minister is correct. We have restructured. No, it has not been abandoned; it has been incorporated into our broader policy setting function.

MRS KIKKERT: All the volunteers that worked there before, are they still there?

Mr Richter: We do not have volunteers that work for us; we have employed staff. So to talk about the unit, the unit—

MRS KIKKERT: At the policy unit?

Mr Richter: Correct.

MRS KIKKERT: They are paid staff?

Mr Richter: Paid staff, correct. We had a small multicultural policy unit before of a couple of people—three FTE who worked hard and did a very good job. What we are

doing now is taking what they do and broadening it through all our policy work. If we are going to deliver patient-centred care, we need to do patient-centred policy, which means thinking about what all patients need at all times, including people from multicultural backgrounds.

We are doing things like thought leadership streams where people who know lots about multicultural health issues will work on all our projects, whether it is something over here in primary care or even in Indigenous health. We are working across all projects to embed that thinking and understanding, and up-skill all our policy officers in terms of the issues that multicultural people may face in accessing health care. We are aiming to produce more out of our multicultural policy thinking than we did before.

MRS KIKKERT: Because you wanted to strengthen this whole policy unit, you discontinued—

Mr Richter: We are not discontinuing multicultural policy. We are continuing it.

MRS KIKKERT: The unit, the actual unit—you are discontinuing the unit. You are just restructuring it to something else.

Mr Richter: On an organisational chart, yes, they do not exist, but they still exist in the team. They just do not have a structural unit, so we can work more broadly outside of units.

MRS KIKKERT: Can I just clarify that the team that was working within the policy unit are still currently working there?

Mr Richter: They are still working there, yes.

MRS KIKKERT: Okay.

Mr Richter: And we are still doing the work we were doing before, but we are doing more work than we did before. We want to do more work in the multicultural space than we were doing before. For example, we are about to try to kick off a new project looking into the experience of chronic disease in the Chinese community in Canberra, as a start under the national chronic conditions framework, which we have worked on nationally and we have endorsed in the ACT. We really want to get a better understanding of different communities' experiences with chronic conditions. We know the approach and the cultural approach to chronic conditions is very different in terms of prevention, treatment and accessing care. We have not done that before. We have done nothing in that space, really. We are really moving into it strongly now, as an example.

MRS KIKKERT: Was there any time during this policy unit that any volunteers worked there?

Mr Richter: No.

MRS KIKKERT: No, okay.

Ms Fitzharris: There are a lot of volunteers at the hospital.

MRS KIKKERT: But specifically this policy unit.

Mr Richter: Not in the policy unit.

MS LE COUTEUR: On page 71 you have the ACT Health sustainability strategy, which it says is designed to assist ACT Health to meet the impact and challenges of climate change. Can you tell me more? It does not give us a huge amount of detail about the actions or strategies you might be taking under this. Can you give us more information?

Ms Fitzharris: Rosemary Kennedy will be able to answer this question. Lots and lots of solar panels on the roof and car park.

MS LE COUTEUR: I would like more information about your health sustainability strategy. Very specifically, is it just health care or does it cover what the whole community should do? Does it cover private health care or is it focused just on your specific service delivery?

Ms Kennedy: The strategy is predominantly focused on Health. It was renewed in 2015. We had a strategy from 2010 to 2015. In 2015 we then renewed the strategy to 2020. It is designed for the health directorate in relation to infrastructure, as well as our ability to address the government's carbon neutral framework. It is designed to reduce our carbon emissions across the board. It also focuses on capturing, if you like, the hearts and minds of our staff to think about sustainability in the broader sense. This can also include what we are doing in the workplace, what is happening around our transport, how we build buildings that are more energy efficient et cetera. That is the main thrust of the strategy.

MS LE COUTEUR: Is it very much inward looking: how you run your own operations? It is not about, say, climate change—it is going to be hotter; you should drink more or any of those sorts of things?

Ms Fitzharris: Climate change impacts on public health, but yes.

Ms Kennedy: It does look at adaptation in relation to climate change, so it certainly sort of incorporates our colleagues within Health, which is population health, in relation to how the healthcare service can adapt to climate change challenges.

Ms Fitzharris: Yes, so it is probably fair to say that the focus is on ACT Health. That is one focus. Dr Kelly can probably talk to you a little bit more on the climate change impact on the Canberra community's health, what sorts of work we are doing and the heat effects.

MS LE COUTEUR: I would be very interested to hear more about that, Dr Kelly.

Dr Kelly: I thought you might be.

Ms Fitzharris: While Dr Kelly was wearing another hat, I think ACT Health, under the previous minister, had a specific focus because the previous minister was also the minister for the environment and climate change. He took that opportunity to really focus on energy use and transport, and waste within health services is fairly significant as well.

MS LE COUTEUR: Waste is seriously an issue for Health, I would have thought. We will talk to Dr Kelly.

Dr Kelly: In addition to looking within our own house then outside, of course climate change would be one of the major challenges for public health into the future, if not the major challenge. Locally we are very involved with the whole-of-government work in this area. We are contributing to particularly the climate change adaptation group, specifically looking at increasing community resilience to extreme heat as one of the very local manifestations of that global problem. Other extreme events and how the health service and health system more broadly can respond to those is another area of interest within the emergency preparedness area.

Earlier last month or the month before, we launched AirRater. It is an app that is now available to people around the ACT. It allows people to self-report on their symptoms in relation to asthma and hay fever. Then, after a few times of reporting, it will give warnings directly to the users in relation to pollen counts, air pollution and heat. All three things are related to climate change, in fact. Indeed, the thunderstorm asthma event that we saw in Melbourne around this time last year demonstrated how severe it can be and how rapidly it can happen. Our AirRater is part of the response to that.

We regularly monitor and report on air quality in the ACT. We have contributed to the emergency plans around storms, heat management and the health emergency plan. We engage proactively across government, as I mentioned, to make sure that the public health components of climate change are addressed and included.

MS LE COUTEUR: You mentioned extreme events. What sorts of events are you modelling—what sorts of temperatures? Are you modelling 45 degrees, 50 degrees, extended periods of time at those sorts of temperatures?

Dr Kelly: Extreme heat has both of those elements in it. It is particularly night-time temperature which is the concern. A number of days of heat during the day, not cooling at night, and a number of days consecutively, are the ones that have been demonstrated around the world to be associated with particular health effects for vulnerable people, elderly and others with chronic diseases.

They are the ones we are most concerned about and we work very closely with our colleagues in the ambulance service and others across government, predicting those events and then giving warnings about them and responding where required. We saw several of those events last summer. One in particular was also associated with the potential for power outages. Those sorts of things add to the complexity. A lot of planning has been put into place around Australia and here in the ACT for those types of events. Severe storms is the other one, and thunderstorm asthma would be a component of that.

MS LE COUTEUR: Have you looked at extra hospital admissions for extreme heat events? Have you quantified in any way the short-term likely impact on the health system?

Dr Kelly: Not directly, no, but we do work with national authorities. I am a member of the Australian Health Protection Principal Committee of AHMAC. Certainly, it is one of the things that we discuss on a regular basis. In fact we had a briefing from the Bureau of Meteorology a couple of meetings ago in relation to that. We rely on our colleagues interstate and we extrapolate that to the ACT.

MS LE COUTEUR: Given that you have not done any work for the ACT and given that the ACT's health system does not have an abundance of spare beds, would it be safe to say that as extreme weather events increase we could have problems?

Dr Kelly: Certainly, as extreme weather events increase, the likelihood is that there will be more admissions to hospital. Part of my role is to look at that and to see ways we can mitigate that, to relieve the health system from having to cope with those sorts of issues.

MS LE COUTEUR: You said you were thinking of ways to mitigate. I am wondering what you are thinking of here.

Dr Kelly: At a global level there are things that could be done.

Ms Fitzharris: Let us start there.

MS LE COUTEUR: Maybe ACT Health is very powerful, but possibly not at a global level.

Dr Kelly: I do not think we are going to change some of those things. Realistically, prevention is better than cure. Looking at ways of mitigating by starting to decrease emissions and so forth would be an important element. Locally, there are things that we can do with public messaging around what to do in times of heat and, importantly, what not to do. So do not go out in the heat of the day and run a half-marathon, especially if you are not that fit. There are those sorts of things.

Also we have done work with colleagues across government in relation to those very vulnerable people who are at home and who have to rely on equipment that requires electricity—oxygen concentrators, for example. We are also looking at where our heat refuges are. In times of extreme heat, if people do not have air conditioning in their house, for example, where could they go? That sort of work with the Community Services Directorate is an important component of that.

There are a range of things that we do in preparation for what used to be called summer and is now called the disaster season, including those things to do with heat and extreme weather events. Those things are set up and we have had those meetings. My colleague Conrad Barr may be able to say more on the specifics, but that is where we are starting. Closer to the times when we can predict severe heat, for example, there are a range of things that we do across government, including public messaging. Once we are in that situation we also escalate that response. Depending on the scale

and length of it, that response also varies. Of course, with all of these things there is a recovery phase and an evaluation of how we went so that we learn as we go.

MS LE COUTEUR: You talked about heat refuges and CSD. Should I ask them about that, when they appear tomorrow, or should I ask you? Where are they likely to be? Are we talking about the malls of this world?

Dr Kelly: It is probably best for CSD to answer that, but in general terms public buildings, and shopping malls in particular, are there, as well as some of our other infrastructure which has air conditioning and is large enough to take that. We very rarely, if ever, have had to use them, but that is certainly part of the potential response.

Ms Fitzharris: And planting more trees, as you know.

Dr Kelly: And planting more trees.

MS LE COUTEUR: Absolutely planting more trees. I could talk a lot about other responses.

Dr Kelly: There are a lot of responses, of course; you are the expert.

MS LE COUTEUR: There are other questions to ask. Minister Fitzharris mentioned waste as one of the sustainability issues that you have been looking at in particular.

Ms Kennedy: Our overall waste has increased but our recycling has also increased. Although there is a slight increase in waste to landfill, it is commensurate with the overall increase in waste. The overall picture is that we are recycling more and we still have more recycling to do.

MS LE COUTEUR: The overall picture, as someone who visits hospitals occasionally, is that everything seems to be incredibly well packaged and—

Ms Feely: And single use.

Ms Fitzharris: Disposable—

MS LE COUTEUR: Yes. I can see the clinical reasons for it, but there seems to be an awful lot of waste. Is ACT Health aware of or pushing in any way actions within the health industry to try to reduce the amount of packaging, which must be a major part of your waste, I would think?

Ms Kennedy: It is. We are trying to roll out how to recycle as much of that waste as possible, in relation to the packaging. Most of the product comes from overseas. Our ability to influence how that packaging is established is pretty minimal.

MS LE COUTEUR: Yes. You would have to do it with your colleagues, clearly.

Ms Kennedy: Yes. It is almost like a global industry now, in relation to the packaging of items. We still recycle or re-use a lot of medical instrumentation, but you are right, in that the volume of single-use items is increasing. We are focusing now on how to

recycle that, particularly those elements that are not contaminated with any biohazard.

Mr Bone: There are also very strict TGA requirements regarding single-use items in health care being re-used. There are really stringent controls that would almost make it prohibitive for us to reprocess and repackage single-use items.

Ms Kennedy: A great number of the single-use items also use recycled product in the production. For example, we have metal scissors and so on which have been made from recycled product but they are then disposable after use. So it is being recycled as part of the supply chain.

MRS DUNNE: I would like to ask about pill testing. I notice that in the annual report it says that the office of the Chief Health Officer has established a working group to look at the public health, legal and social issues related to pill testing. What work has that committee done? Is that Dr Kelly?

Ms Fitzharris: It informed the decision by government—last month, I believe—to agree that the STA-SAFE proposal which had been put to government earlier in the year was able to go ahead with the Spilt Milk music festival, which is on in about 10 days time. As you know, that has been something that they have been in discussions with the National Capital Authority about.

MRS DUNNE: It says on ACT Health's pill testing website that STA-SAFE has not proposed any changes to the legal status of illicit drugs in the ACT and that the possession, supply and use of illicit drugs would remain illegal. What was or is the thinking about how we get around this disconnect that possession, use and supply are illegal except in this tiny bubble. And—I have asked this question before—was there any proposal to in any way amend the law or suspend the law in relation to possession for the term of the Spilt Milk festival?

Ms Fitzharris: No. The proposal was put to the government, and the working group that was led by the Chief Health Officer's division incorporated input from JACS, as a directorate, as well as ACT Policing. It was considered and legal advice was provided. There was no requirement for us to change the law, and ACT Policing were involved throughout the whole process.

MRS DUNNE: What advice did we receive that there was no need to change the law?

Ms Fitzharris: We received internal legal advice.

MRS DUNNE: From whom?

Ms Fitzharris: From the Government Solicitor's office.

MRS DUNNE: The government solicitors have provided advice that there was no need to—

Ms Fitzharris: That is right.

MRS DUNNE: suspend or change the law—

Ms Fitzharris: I could not—

MRS DUNNE: to facilitate pill testing at Spilt Milk?

Ms Fitzharris: That is right, yes.

MRS DUNNE: I am quite surprised that we could do it under the present provisions in relation to possession.

Ms Fitzharris: Who do you mean by "we"?

MRS DUNNE: The territory—

Ms Fitzharris: Right.

MRS DUNNE: In that you would not have to suspend the laws in relation to possession. Possession is always a crime, so how do we get around that?

Ms Fitzharris: The question is around enforcement, but that is best put to ACT Policing.

MRS DUNNE: You said in answer to a question on notice or in response to a question without notice—I cannot now remember—that coordination with the commonwealth was through the ACT events coordination group.

Ms Fitzharris: Yes.

MRS DUNNE: To your knowledge, did anyone at any stage make representation to the National Capital Authority about pill testing at Spilt Milk?

Ms Fitzharris: The working group did incorporate Access Canberra as well as an event organiser, but, again, the request to hold the music festival was made by Spilt Milk. The STA-SAFE consortium was talking to the ACT government, but it was a proposal by them to provide a service at a festival run by Spilt Milk. Spilt Milk needed to do what they needed to do to get all the relevant approvals to hold the festival, so that was a matter for them.

MRS DUNNE: So there was no contact between the ACT government and the NCA about pill testing?

Ms Fitzharris: There was, as I understand, but I will take that on notice and clarify that there was some level of communication.

MRS DUNNE: Did you raise this with your colleague the federal Minister for Health at any stage?

Ms Fitzharris: Not prior to the announcement, no.

MRS DUNNE: Did you raise it after the announcement?

Ms Fitzharris: I had a very brief discussion that we were conducting. I know he was asked questions about it. In the context of health ministers meetings, I did say, "Obviously you would have seen this." He said, "Obviously you have seen what I said." We agreed that we had heard what each other had said.

MRS DUNNE: That is another way of saying "agree to disagree"? It was mooted earlier in the year that pill testing might be conducted at Groovin the Moo. Are there discussions about Groovin the Moo next year? And how do we address the issue that Groovin the Moo is an all-ages event?

Ms Fitzharris: We expect that STA-SAFE will come back to us, talk to us. The process that the government went through was to get all the information that we needed from our relevant directorates. There are available on the website a number of operational elements that we concluded would be necessary for a safe pill testing trial to occur. We expect that STA-SAFE will probably come back and say, "We would like to work with Groovin the Moo next year. Does the government's position still stand?" And we would consider any subsequent proposal from them.

MRS DUNNE: Would you have a different position on the basis that Groovin the Moo is an all-ages event?

Ms Fitzharris: We have not gone through that thinking yet.

Dr Kelly: I can add a few words to that. My group was tasked to work across government in a way to allow a supportive policy environment for a particular festival, which was the Spilt Milk festival, coming up in a couple of weeks. Some of the various elements that we looked at were generic, but many of them were very specific for that particular festival at that time. Another festival with, as you say, a different environment will need to also be considered. We did not consider that particular element in the discussions we had.

MRS DUNNE: For complete clarity, Dr Kelly, your remit was to create a supportive policy environment? Are you comfortable with those words?

Dr Kelly: For the Spilt Milk festival; that is correct. It was to put to government all of the issues. The ones that you have raised, the concerns that you voiced, were also looked at: the legality, what about police, how does that work, what would be the very specific way in which STA-SAFE proposed to do their work? We interviewed them in great detail about how they were proposing to do the actual testing. That was the advice that we provided to government. The view was to look at what would be the supportive policy environment from the ACT government's perspective for this particular festival and this particular type of—

MRS DUNNE: Thank you.

Ms Fitzharris: I think I need to clarify that. There were a number of recommendations put to government, having received the proposal. The government received the proposal and indicated that we wanted work to go ahead on it and that one of the options we wanted to consider was a supportive and safe environment. But

it was not the only option we asked to be considered.

MRS DUNNE: What were the other options you asked to be considered?

Ms Fitzharris: We said, "Have a look. Get all the relevant people that have an interest in this and can provide us with useful advice on this proposal." They are obvious: health, legal, policing and the events aspect of it. We asked, "What are all the issues involved in this proposal? What are the legal issues? What are the policing issues? What are the health issues? What would be the specific event-related issues?" In any environment where you ask for advice, there is the option to do nothing, accept the proposal or ask if there are any alternatives. An alternative could have been that the government could have run a service itself; that was not the decision that the government made.

MRS DUNNE: Would it be possible, on notice, to be provided with the terms of reference for the group?

Ms Fitzharris: There are a range of different proposals that the government gets. Many of them involve input from lots of different directorates or more than one directorate.

MRS DUNNE: I understand that.

Ms Fitzharris: There were not terms of reference as such.

MRS DUNNE: There were no terms of reference?

Ms Fitzharris: No.

MRS DUNNE: Dr Kelly used the expression "supportive policy environment". You kicked back from that a little.

Ms Fitzharris: No.

MRS DUNNE: I am just trying to get a feel for the remit of this committee and whether there is a written remit for this committee.

Ms Fitzharris: I do not believe so, but I will go back. There were, of course, updates through formal government decision-making processes, notably cabinet, saying, "We have received a proposal. What is the most appropriate way for the government to consider a proposal that has been provided to us?" When the proposal was finally provided to government, there was a working group established, led by Health.

In terms of its terms of reference or remit, I will take on notice whether there was anything specific that we can provide, but we really said, "We have got a proposal; we would like to know if it can work or if it can't. We need to have all the options in front of us to make a good decision." And we got that from the working group.

MRS DUNNE: Was that a cabinet-level decision, finally?

Ms Fitzharris: Yes.

Dr Kelly: Could I just clarify something, Mrs Dunne? What I was really describing is where the cabinet decision landed rather than what we were asked to do. What we were asked to do was to talk with the people that have been outlined by the minister, across government, to consider all of the legal, health and other matters related to this. They were our terms of reference, if you like, which were communicated to me.

MRS DUNNE: Thank you.

MS LE COUTEUR: In the context of festivals, Spilt Milk or any others, are you aware of any specific pills or substances circulating in the community that festival-goers should specifically be aware of? Spilt Milk is coming up soon.

MRS DUNNE: Probably all of them.

MS LE COUTEUR: There have been media reports particularly of overdoses in Newcastle linked to a specific batch of tablets.

Dr Kelly: What is actually circulating at the moment around town in various people's pockets, I cannot tell. The police keep some intelligence about that. We do have a very small program where we work with the emergency department at Calvary hospital to monitor people who come in with unusual overdoses to test for any drugs that are given forth at that time. But that is very piecemeal. What is actually circulating around is really a discussion with the police, and they may or may not answer that.

Ms Fitzharris: Earlier in the year a young woman presented to emergency and had become very unwell from taking a pill. That information was publicly provided as a public health measure to alert people not to take this particular pill, and there were images of it.

Dr Kelly: We shared that not only in the wider media but also very much through peer groups and so forth, and user groups, so we did use this as a harm minimisation strategy. Indeed, pill testing, from the health side of things at least, putting aside the legal components, is essentially harm minimisation. We do know that the majority of people who go to these types of festivals do take either drugs or alcohol. That is a fact. We do know that young people are dying at these types of festivals around Australia right now. That is a fact. We do know that, despite the best efforts of drug enforcement to decrease supply or decrease demand, we still need to have a harm minimisation component within the national drug strategy. This fits very carefully and clearly within that as a potential way forward. If we do not do anything then we will continue to get the results we currently have.

MS LE COUTEUR: They are clearly problematic; young people are dying. Given that, are you planning any proactive media or alerts before Spilt Milk, given that you will not be doing pill testing?

Dr Kelly: Not over and above what we normally do around the very clear message from the ACT government, which continues to be: "Don't do drugs." That is the best

way forward.

Ms Fitzharris: My understanding is that these messages are provided at music festivals anyway. A very important part of the pill-testing trial was that the act of the test does not take five seconds; it takes 10 to 15 minutes, so there was an intervention point at which trained staff, counsellors and others, would have the opportunity to say, "The only thing you can actually do to keep yourself safe is not to take this at all." They provide a lot of information, and then the person has some time to sit there and think about it. The point is that at the moment we know that people are dying. We also know for a fact that young people in particular have no idea what is in the pills that they are taking. This is providing information that they would not otherwise get.

MS LE COUTEUR: Absolutely. My understanding is that, where it has been done elsewhere, a lot of the people who have been told the situation decided, "No, I am not taking that."

Ms Fitzharris: That is right, yes.

Dr Kelly: That is very clear from overseas studies that we looked at as part of the proposal to cabinet. As a harm minimisation strategy it is not perfect—none of them are—but it does appear, wherever it has been measured, that people who have been involved with pill testing like this are more likely to make a decision not to take those pills, regardless of what the test shows, particularly if the test shows that it is not what they thought it was.

MR PETTERSSON: Do you have numbers on both of those scenarios: when someone gets their pill tested and comes back with a bad result and then bins it, and when people get less explicitly bad news about their pill but there is the intervention? Do you have numbers on both of those scenarios?

Dr Kelly: We did a literature review, quite in depth, from overseas studies, but this has never been done in Australia before. It has never been done here, so I do not have any specific data in the local context.

MR PETTERSSON: What about globally?

Dr Kelly: The literature review was part of the cabinet submission. If the minister agrees, then—

Ms Fitzharris: We can take that on notice. There were some provided in the public domain on the day too, when we made the announcement.

MR PETTERSSON: Can you update the committee on the progress of the medicinal cannabis scheme?

Dr Kelly: The short answer is that we have a medicinal cannabis scheme.

Ms Fitzharris: We have one and, as I mentioned in my opening statement, we have two advisory groups: a medical advisory group and a broader advisory group that includes a wider range of stakeholders, including the police and consumer

representatives. The relevant necessary commonwealth and local regulations are in place. There has been one application for—

Dr Kelly: Several applications—one agreed to.

MR PETTERSSON: What is the application process?

Dr Kelly: This was work that we were asked to undertake over the last couple of years. The minister made an initial announcement, I think on 4 August 2016, that such a scheme would be rolled out, so during the last period we looked again at how that could be implemented here in the ACT, as has happened in other jurisdictions in Australia and many other jurisdictions around the world.

To answer your specific question, we have a mechanism where any prescriber who is allowed to prescribe, for example, opiates or amphetamines, the other so-called controlled drugs, can also apply to me for approval to prescribe medicinal cannabis.

There are a number of specific components to allowing that to go ahead. The first is to gain what is called category approval: essentially, if the patient has this issue then this is an appropriate drug to use and go ahead with. That would be spasticity for multiple sclerosis; nausea and vomiting related to cancer chemotherapy; people with life-limiting illness, essentially likely to live for less than the next 12 months, with cancer, for example, with pain and anxiety and so forth, so palliative care type patients; and those with refractive paediatric epilepsy. Those are the well-recognised indications across Australia for this medication. That is the first tick.

The second tick is that the way the medicinal cannabis is going to be administered also is within agreement from the national authorities. We are not talking about smoking here; we are talking about particular pharmaceutical products with cannabidiol oil in them.

Once that application is made by a medical practitioner or a nurse consultant working within the palliative care space, it is considered and I would, as I have done on one occasion, give permission for that. Other applications can be made. If they are outside of those guidelines then one of the committees that has been mentioned by the minister, the medical advisory committee, would on a case-by-case basis look at that and see whether that would be allowable under the regulations.

MRS DUNNE: This is a commonwealth issue, but where are we in relation to supply of appropriate product?

Dr Kelly: When we first started to look at this, more than a year ago now, that was a particular issue. It remains somewhat restricted, but there have been advances in that over the last 12 months from the commonwealth's perspective. The Therapeutic Goods Administration has done work in relation to allowing certain products to be registered and to be imported into Australia. Whilst it still might be quite a short supply, the number of applications we have received has been low so far, so we certainly have not exhausted the supply.

MRS DUNNE: You said, Dr Kelly, that you have approved one?

Dr Kelly: That is correct.

MRS DUNNE: How many applications have you received, and how many are in the pipeline?

Dr Kelly: I know of another one. There may be more, but at the moment I only know of those two, one of which has been referred to the committee I mentioned and the other one I have signed off on.

MS LE COUTEUR: Do you have any idea how many patients have been prescribed and received their prescription?

Dr Kelly: One person. That is legally prescribed and legally receiving. I am aware that there are alternative ways of receiving this product—many ways, including through the internet, of getting the pills and so forth. They are generally more expensive. People who do that are actually breaking the law. There is the opportunity now to do this legally as long as they are within the criteria, as I have mentioned. I encourage people to talk to their medical practitioners to access the scheme.

MS LE COUTEUR: It sounds like it is very hard for a medical practitioner, though, if you have only had one successful applicant.

Dr Kelly: There are a number of elements there. Part of it is getting used to using this as a therapeutic. It is brand new. Most doctors have not come across it. So there is an engagement piece which we have had already with general practitioners, and I have another talk with pharmacists coming up in the next month or so. As the word gets out, I am sure there will be more applications. But the indications are that actually, apart from the palliative care space, there are quite small numbers of very specific indications. There could be a large number of applications but, in terms of allowing them to go ahead in relation to those four things that I mentioned, there are not a lot of people around like that.

MR MILLIGAN: I guess there is no real surprise as to where my line of questioning will be.

MRS DUNNE: Surprise us.

MR MILLIGAN: I will try to. Maybe the answer will surprise us; who knows? In relation to drug and alcohol services for the territory, in the annual report, on page 63, it states that the Ngunnawal Bush Healing Farm is due to start day programs as of August 2017. Have the day programs commenced yet?

Ms Fitzharris: Yes, they have. They commenced this week.

MR MILLIGAN: What was the hold-up or delay in those day programs commencing from what was scheduled here, being August?

Ms Fitzharris: I know that you recently visited, so I think you know the answers to a lot of these questions. With the opening of the facility, that started the process of

going through the application process and principally the screening of people who want to participate in the program. As with all programs, that takes some time. The first eight participants have started this week. Mr Richter can talk in more detail.

Mr Richter: We have started this week. We had eight client participants who were screened. Six turned up this morning and yesterday. We have had very good feedback about the participants over the last two days from service providers. They are highly engaged and very excited to be out there, and we are off to a good start.

MR MILLIGAN: During the screening processes were patients assessed for their mental wellness? Are they suffering from self-harm or the potential for self-harm? Have they been through a detox process prior to this? Were they part of the assessment?

Ms Fitzharris: Yes.

Mr Richter: Yes.

MR MILLIGAN: Were any of the results of that surprising? Were there more people who applied for the Ngunnawal Bush Healing Farm programs than you have currently received?

Mr Richter: Yes; that is correct. We have had a number of potential consumers go out there who have not met the criteria because they are currently actively involved in some form of high level AOD treatment or they are under some type of custodial order that prevents them from meeting the criteria there.

MR MILLIGAN: When possibly will the Ngunnawal Bush Healing Farm become a residential treatment facility? Is that planned in the future?

Ms Fitzharris: Yes.

MR MILLIGAN: Do you have any estimation as to when that may be?

Mr Richter: We are aiming next year to go back out into the market again to look for a provider to do the residential component. It will depend on what market appetite is there again, as it has been tested before. We are hoping to move to residential as soon as we possibly can, but there are those potential limitations on the way through.

MR MILLIGAN: When it gets to that point, hopefully, of being residential, will there be a model of care provided for treatment?

Ms Fitzharris: Yes.

MR MILLIGAN: A medical model of care?

Ms Fitzharris: No.

MR MILLIGAN: No? Just therapeutic and educational?

Ms Fitzharris: Yes.

MR MILLIGAN: Are there any plans for this government to honour its original promise made by Jon Stanhope to the Indigenous community to deliver an alcohol and drug residential rehabilitation facility?

Ms Fitzharris: There is a difference of interpretation about that. You have been there and spoken with members, and there are a range of different views in the community. If you could explain what you believe to be a medical model of care that would help us to answer your question.

MR MILLIGAN: There are obviously three different stages of treatment. There is a detox stage, which normally occurs in a hospital or a permanently built facility. The second stage is probably the most crucial, where patients get the psychiatric and mental health support but there is also medical treatment available during that period. Normally, that period can go for up to 10 or 12 months or longer. The services that you have provided here tend to be for the final stage of treatment. Feedback from the community is that it is that second stage that is missing here in the community. There is no local, specific treatment for the second stage of treatment.

Ms Fitzharris: And that is okay too. Katrina Bracher can probably answer some of these questions, but to the extent that a medical model of care is provided at the Ngunnawal Bush Healing Farm, on the day of the opening the United Ngunnawal Elders Council in particular said that their involvement to date had meant that they were very clear about what sorts of therapeutic services—reconnection to country, breaking the cycle, and types of services and programs—would be provided at the bush healing farm.

MR MILLIGAN: Obviously there was some sort of miscommunication with the Health Directorate when they approached Winnunga to develop the medical model of care.

Ms Fitzharris: Yes, that is right, and we have discussed that, and we know that. What new information would you like today?

MR MILLIGAN: I would like to know if the government is even considering delivering a drug and alcohol residential rehabilitation centre in the territory that is specifically targeted at Aboriginal and Torres Strait Islander people.

Ms Fitzharris: That is a different question from providing it at the bush healing farm.

Ms Bracher: We currently have a withdrawal unit on the Canberra Hospital campus where we do stage 1 of the active medicated withdrawal. All of the clients that go through that service are being connected with a community rehab program. We prioritise the intake into our alcohol and drug service based on the number of criteria, and being Aboriginal and Torres Strait Islander is one of those priority areas, as are pregnant women and a number of others that you could imagine. From time to time we have a number of Aboriginal people in that service and then a flow-on into the community services. We have an Aboriginal liaison officer that works with Aboriginal people in that unit and then continues with them into community as well.

Nicole, as DG, has asked me more recently to do some very early thinking on a number of dedicated beds within the Canberra Hospital withdrawal service that are focused on culturally sensitive care for Aboriginal people who need withdrawal. We have done some very early thinking on an Aboriginal workforce in that space.

MR MILLIGAN: Are you able to indicate how many beds are available in the territory as a whole for this detox program, roughly?

Ms Bracher: We have 10 medicated withdrawal beds on the Canberra Hospital campus and Mr Richter's area funds the community sector beds.

Mr Richter: We do. In the community sector we fund a number of organisations. Firstly, I will give an indication of the type of throughput that we see there for Aboriginal and Torres Strait Islander clients. It is approximately 12 per cent of the total occasions of service in our community sector that are delivered to Aboriginal and Torres Strait Islander people. That is, we expect, an underestimation because not everyone identifies. We did a snapshot survey a little while ago, on a day, going around and seeing who was in care, and the number of Aboriginal or Torres Strait Islander people in care on that day in our AOD rehab services was 24 per cent of the total clientele.

With total beds across the system, it is important to note that there are a number of beds. We have about 44 residential rehabilitation beds in the system, but residential rehabilitation is one component of rehabilitation. Counselling is critically important. We fund a lot of counselling out of our mainstream AOD services; also there are Gugan Gulwan and Winnunga for AOD specific Aboriginal and Torres Strait Islander services.

MR MILLIGAN: Between the different providers for the detox program, there are a little over 100 beds available, if you include all of the different providers of detox, not just the Canberra Hospital.

Ms Fitzharris: They are not all detox; 100 are not all detox beds.

MR MILLIGAN: In the last financial year I think there were around 67 Aboriginal and Torres Strait Islander people requiring a detox program of some sort. Does that show that there is a demand there, and that there need to be more beds provided for the community to go through this detox program?

Ms Fitzharris: Is that number 67?

MR MILLIGAN: Roughly around 67 Aboriginal and Torres Strait Islanders.

Ms Fitzharris: Where is that from?

MR MILLIGAN: In one of the reports. I could find out which one it was and get back to you.

Ms Bracher: Withdrawal is a process, and I think that is what you are alluding to.

There is an acute withdrawal phase, and I think that is what you are colloquially terming "detox". We call that "acute withdrawal". In our 10-bed unit we have a bed occupancy rate of around 70 per cent. At any given point in time about 11 per cent of those people identify as being Aboriginal and Torres Strait Islander.

Ms Fitzharris: Is your concern mainly around the acute withdrawal in a culturally appropriate setting?

MR MILLIGAN: The appropriate setting, yes.

Ms Fitzharris: That is the work that we are looking at now. With the opening of the bush healing farm, it is important to note that the availability of service providers has been a challenge in this area. The original request for tender for services at the Ngunnawal Bush Healing Farm received no responses at all, which then prompted ACT Health to approach ATODA and Winnunga. It is always a challenge to have the right service providers, but that area of acute withdrawal that is culturally specific for Aboriginal and Torres Strait Islanders is something we are doing work on now.

THE CHAIR: I am mindful of the time. My view is that, in the interests of fairness, we should close for today. Thank you for your time today, minister. 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 five 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. All answers and questions need to be provided in a signed electronic PDF form and an electronic Word copy. When the 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 4.22 pm.