LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING AND COMMUNITY SERVICES

(Reference: Annual and financial reports 2017-2018)

Members:

MS B CODY (Chair)
MRS V DUNNE
MS C LE COUTEUR

TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 16 NOVEMBER 2018

Secretary to the committee:
Mrs J Moa (Ph: 620 50136)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 20 May 2013

The committee met at 9.31 am.

Appearances:

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

ACT Health Directorate
De'Ath, Mr Michael, Director-General
Doran, Ms Karen, Deputy Director-General, Corporate Services
McLeod, Dr Margaret, Chief Nursing and Midwifery Officer

Canberra Health Services
McDonald, Ms Bernadette, Chief Executive Officer
Bone, Mr Chris, Deputy Director-General, Clinical Services
Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
Mooney, Mr Colm, Executive Director, Infrastructure Management and Maintenance
Hammat, Ms Janine, Executive Director, People and Culture

THE CHAIR: Welcome to today's hearings of the health, ageing, and community services committee. This is the last public hearing of the committee's inquiry into the 2017-18 annual and financial reports referred to it by the Assembly on 25 October 2018.

I acknowledge that we meet on the lands of the Ngunnawal people. I pay my respects to elders past, present and emerging and the continuing contribution of their culture to this city and this region.

On behalf of the committee I thank ministers and officials for attending today. I remind witnesses of the protection and obligations afforded by parliamentary privilege and draw your attention to the privilege statement before you on the table. Can you confirm for the record that you have read and understood the privilege implications of the statement?

Mr Rattenbury: Yes, I think all the officials are familiar with it.

THE CHAIR: Excellent. I remind witnesses that proceedings are being recorded by Hansard for transcription purposes as well as being webstreamed and broadcast live.

Minister, how did this year go for Dhulwa? I know a few hiccups were reported in the media. I am relatively new to this committee so this is a good chance for me to ask questions about it, but Dhulwa is also a relatively new establishment.

Mr Rattenbury: Dhulwa is just about to come to its second anniversary of official opening. It opened in late November 2016. There have been some difficulties this year with occupational violence but we are working very closely with staff to put in place

new measures and to reflect on the model of care. The incidents that receive public attention are related to one individual. Whilst I am obviously not going to discuss the individual specifically it has provided an opportunity to reflect on how we approach things and how staff collaborate around an incident like that.

Another thing that has been very good for Dhulwa this year has been the opening of the second phase of support services. Dhulwa has a more acute wing and a more rehabilitative and progressing wing, and we opened the first of the rehabilitation wings this year. That is in a nutshell where it is at.

THE CHAIR: So the 25 beds are across both those cohorts?

Ms Bracher: Dhulwa is a 25-bed facility. Stage 2 of Dhulwa brought us up to 17 beds opened. We initially opened 10 beds in the acute wing and then an additional seven in the rehabilitation wing. Our capacity now is for an additional eight beds.

MRS JONES: I would like to go to the topic of tobacco and smoking in the AMC. Minister, I know you have previously expressed support for a tobacco-free prison. I am also aware of the draft drug strategy action plan for 2018-21 which proposes it. Are you able to provide me with an update as to whether you have made a decision about whether you will be going ahead with that ban and, if so, when?

Mr Rattenbury: It is government policy to have a smoke-free prison but at this stage we do not have a timeline for the implementation of that.

MRS JONES: As I am sure you are aware, the CEO of Winnunga Nimmityjah Aboriginal Health and Community Services, Ms Julie Tongs, wrote in the press just recently her concerns over a potential ban. Do you share any of those concerns?

Mr Rattenbury: I think that is a very interesting article. I have had that conversation with Ms Tongs in person as well. I think she raises some very interesting points and I think that, as someone who runs a health service, she sees the dilemma in her own arguments. I will not speak for her; I see the dilemma in her arguments. Winnunga is running an extensive campaign to convince Aboriginal people to give up smoking, from a health perspective. But the issues she raises about power and contraband in the AMC are, I think, factors we also need to consider. One of the reasons we have not moved yet is to give us more time to think about those matters. But also there are other matters at the prison that I want to focus on: things like providing more employment opportunities and those sorts of things, which I think are part of moving to a smoke-free prison.

MRS JONES: Do you have any thoughts on the fact that we have a fairly high methadone rate in the prison and at the same time are talking about a ban on smoking, which is a legal and licit substance? Methadone obviously is on prescription. I wonder if the strangeness of the situation hits you as well with regard to that.

Mr Rattenbury: That is an observation one can make. I think they are unrelated questions in the sense that we need to deal with a smoking policy and we need to deal with the fact that we have a cohort of people who have a high usage of drugs when they come into custody. We need to deal with both of those health issues in their own

right.

MRS JONES: It has been put to me by former inmates that—and I am not suggesting this is coming from the top—there is a practice or a culture within justice health of encouraging inmates to take or increase their methadone doses while in custody. I would love to find out that that was not true, but that has been put to me. Inmates have said that staff want them doped up to keep them more subdued. That is what has been presented to me. I wonder what your thoughts are on that view or what you think might be able to be done about that.

Mr Rattenbury: I will ask Ms Bracher to give an update on the methadone program but what I can say on that specifically is that it is obviously not government policy, it is not management policy, it is not an acceptable position and it is not one that I condone. In terms of the methadone program—

MRS JONES: Yes but if that were the case—and it has been stated by at least a couple of people to me—then what can be done to look into that or to address that?

Ms Bracher: I have actually heard that as well. In addition to the comments that the minister makes, no health professional, in my view, would prescribe for that reason. We have very tight prescribing of schedule 8 medications and, as you know, methadone is a schedule 8 medication. We have done a lot of work at the prison over the past 18 months on our methadone program, and we have employed an alcohol and drug nurse out there over the past year. Part of the role of that alcohol and drug nurse is to do some really extensive pre-assessment planning with the detainee and ensure that for the people who are on the methadone program it is appropriate as a health intervention for an addiction. It is a harm minimisation approach to a health concern.

MRS JONES: Nonetheless we do have an extraordinarily high number of people—if I have been briefed properly, between 30 and 40 per cent, depending on the cohort—who are taking methadone daily. It would seem to stack up that potentially there is perhaps some practice in the facility that is not what you would want. How can we address that if that might be the case?

Ms Bracher: I am confident with the practice out there from a health perspective. The most recent number I have seen—and you are right: there is a large number—is that there are 105 people on methadone at the moment out of a prison population that is just short of 500. So we are at about 25 per cent of the population. That changes from day to day based on the muster and the people's needs. We have in previous estimates hearings and annual reports hearings also discussed that the number of people in other jurisdictions, when we compare the methadone proportion of detainees in other jurisdictions, also relates to the number of community placements for people on a methadone program for their through care. In the ACT we have no cap on that. We are a very progressive jurisdiction—

MRS JONES: But that is after people have left the facility, correct?

Ms Bracher: whereby we treat people's addictions based on their need, not based on a capped system. The other jurisdictions limit the number of people they put on a methadone program in prison based on who they can continue to provide care to out

in the community. That has other side effects. A harm minimisation approach to healthcare, if you do not minimise the harm, has other potential side effects: illicit use in prison, overdose in prison, blood-borne viruses and other things that we have discussed previously.

MRS JONES: I am not sure if my numbers are the same as what you look at, but I have only ever seen presented that prisons interstate are at the 15 per cent mark or below. So it is a significant increase, and also—

Mr Rattenbury: No, it was 105 out of 500.

MRS JONES: Not here. I said interstate. Ms Bracher said around 25 per cent, and what I have been presented with—

Mr Rattenbury: A hundred and five out 500 is closer to 20 per cent. Do you have a number in mind that should be an appropriate percentage?

MRS JONES: Victoria, I have been briefed, has between 12 and 13 per cent normally. I am just curious. I have been putting this point and I think it is a reasonable point to put.

Mr Rattenbury: I think the issue is that if you want to prescribe a specific percentage, you are then removing the individual decision-making of a medical professional to make an assessment of a person.

MRS JONES: I am certainly not suggesting there be a cap. I am suggesting that we ask ourselves the question, "Are we doing the best we can to keep people off it?" That is all. I think we have had this conversation a few times now.

MS LE COUTEUR: On page 38 you talk about bloodborne viruses and the treatment of people with hepatitis C in prisons. The report states that 157 people were treated last year. How many have we now got with hep C in AMC, and Dhulwa, I guess?

Ms Bracher: Are you happy for me to answer?

Mr Rattenbury: Yes, please.

Ms Bracher: We are very proud of hepatitis C management at the prison. In the 2½ years since the commonwealth has made available the antiviral medications in the prison, we have treated 173 people who are hepatitis C positive. We have about 12 people actively being treated at the prison at the moment. There are about another eight people that we know of who have hepatitis C but who are not suitable for the particular treatment. You need to be hepatitis C positive for three months, for example, before you can start on medication. So there are nuances around that. But less than two per cent of the population now is hepatitis C positive. At Dhulwa, we are hepatitis C free.

MS LE COUTEUR: Good. You are saying that now we have less than two per cent. What did we have before?

Ms Bracher: It was in the order of 20-25 per cent.

MS LE COUTEUR: Great.

Ms Bracher: It was a significant proportion of the population.

MS LE COUTEUR: That is a real success story, then.

Ms Bracher: It is. We are the national leaders. Certainly in the medical profession, that is recognised nationally.

MS LE COUTEUR: Do you have a situation where people can get reinfected after they have had the virus as the vaccine will not be effective the second time around?

Ms Bracher: People can be reinfected, Ms Le Couteur. Just to share some information, it is not a vaccine; it is actually treatment. We are not vaccinating.

MS LE COUTEUR: Sorry, I thought it was a vaccine thing.

Ms Bracher: It certainly can—

MS LE COUTEUR: It is a treatment; so they can get reinfected.

Ms Bracher: Reinfected and then be retreated.

MS LE COUTEUR: Is any reinfecting happening within the prison or is this happening outside and then people are coming back into the system?

Ms Bracher: Our reinfection rates are much lower. Partly, that is because the population in the prison has less hepatitis C to share. But from time to time there are people from the community who come in who are hepatitis C positive. We offer every detainee at induction hepatitis C screening. A large proportion of the detainees actually take that up. We know when people come into the prison whether they are hepatitis C positive. Then we move very actively to treat them if they are suitable for treatment.

MS LE COUTEUR: I assume that you do the same with Bimberi as well.

Ms Bracher: Yes, we do.

MS LE COUTEUR: Does this have any influence on the need or otherwise for a syringe sharing program.

Ms Bracher: I think an NSP is actually a broader policy perspective. When we were doing the work a number of years ago on—well, let me say this: when we reviewed our bloodborne virus data in the prison a number of years ago, the major concern was hepatitis C.

MS LE COUTEUR: That is what I thought.

Ms Bracher: I think, if I can recall the data, we have never had a transmission of HIV at the prison. Hepatitis B was not an issue at the prison, or not a significant issue; obviously, there were a couple of people. Chlamydia is the other bloodborne virus—sexually transmitted disease—that we screen for. So hepatitis C is by far the biggest concern. What we are saying now is that we do not really have a significant hepatitis C problem at the prison. Other than that, I am not going to make a policy decision for you.

MS LE COUTEUR: A good news story.

Ms Bracher: Yes, thank you.

THE CHAIR: I ask a very quick supplementary. How long is the treatment for hep C? Is it a one-off treatment?

Ms Bracher: Do you know specifically? I am thinking over about a three-month period. They see the nurses weekly at the prison. But for educative purposes, I can come back and provide the committee with just how we monitor.

THE CHAIR: That would be really interesting, thank you.

Ms Bracher: We have a chronic disease nurse who actually monitors all of the detainees who are on the hepatitis C program. I am pretty sure that it is over a three-month period. It is a weekly visit but I can confirm that with you.

THE CHAIR: Thank you.

MS LE COUTEUR: If a detainee was released before the end of the three months, I assume you have arrangements so that they continue in the community.

Ms Bracher: Yes, absolutely, with the gastroenterology clinic at the Canberra Hospital.

MRS DUNNE: I would like to get my head around the staff establishment in justice health at the AMC. You said that you have a drug and alcohol nurse and a chronic disease nurse. What is the overall establishment? What is the head count for staff?

Ms Bracher: The actual number I will have to take on notice. We have about 25, 26 nurses. That is in the primary care team. As that team grows, we are trying to specify their roles into focusing on alcohol and drugs, focusing on bloodborne virus or focusing on the broader primary health care. We also have a forensic mental health team out there made up of nurses, psychologists, social workers and doctors, obviously. That team is in the order of 15 people as well.

MRS DUNNE: On top of the 26 primary health care?

Ms Bracher: Yes, absolutely.

THE CHAIR: You have also just done a huge recruitment round during 2016-17. Is that correct? It was a recruitment push?

Ms Bracher: We do those often.

THE CHAIR: You mentioned in the annual report that there was a big push.

Ms Bracher: Yes, in 2016 that was very much targeted on the recruitment of nurses, allied health professionals, and doctors, for that matter, that we had need for at the opening of Dhulwa. For our community model of care in the mental health space, we grew our community mental health teams as well. We actually had a very significant recruitment drive in 2016 to bring on about 80 staff for Dhulwa. There were about 20 or 30 additional FTE that we needed in our community mental health. Yes, that was a big focus then, but it is a continual process of recruitment for us.

THE CHAIR: Did that include the new clinical director for justice health services?

Ms Bracher: Yes, that is right.

MRS DUNNE: Just following up on my question, on a normal day, how many people would be rostered on? You said that you have 26 in primary health care. How many would be there at the moment?

Ms Bracher: I do not know exactly. We have nurses who start at 6.30 in the morning. They start with early medication rounds for the detainees who need to come into the courts for their court process. We do work with corrections very closely on making sure that people have their medication for that process. Then we have the bulk of our day shift start around 8 o'clock in the morning. They come in 7.30-8 o'clock to prepare for their clinics and for the medication rounds. We then have staff start in the early afternoon so there is a clinical handover. That is fairly standard practice for nursing teams across health care. They do their clinical handover at that point. Then they stay in the prison until 8.30 or 9 o'clock at night.

MRS DUNNE: So it is not 24-7?

Ms Bracher: No, we have an on-call medical roster for the after-hours period.

MRS DUNNE: In a normal shift—one that starts at 8 o'clock or one that starts in the early afternoon—how many people would be rostered on?

Ms Bracher: There are three medication rounds going at any point in time. We always have two nurses on those. Then we have—

THE CHAIR: Registered nurses?

Ms Bracher: Registered nurses.

MRS JONES: In the mornings, are the medication rounds when people come into the medical centre?

Ms Bracher: The medication rounds are in the accommodation blocks.

MRS JONES: Right.

Ms Bracher: We go out to where the detainees are. Because of the number of accommodation blocks now, we have separated our medication round into three. It is actually three rounds. The nurses do that logistical activity with corrections support to the different areas. So there are two nurses at any given point in time on those rounds. Methadone management we do separately from the general medications so that we can concentrate very clearly on those schedule 8 medications.

MRS JONES: Two staff deliver that; is that correct?

Ms Bracher: Two staff also do the methadone management. That is standard nursing practice for any schedule 8 medication. Coming back to the health centre, we have nurse-led clinics in the health centre. We have methadone dispensed in the health centre. We have mental health nurses doing medications in the health centre and we have our chronic disease nurses seeing patients in the health centre as well. Then we have nurses who are supporting the GP clinics. It is a very busy clinic.

MRS DUNNE: What are the circumstances in which someone might get their methadone at the clinic rather than having it delivered in the rounds?

Ms Bracher: People who are newly inducted on to the methadone program come up to the health centre and have their dosing in the health centre. Sometimes if we are worried about a detainee, they come up to the health centre. With some of the blocks that actually do not have the i-dose facility to dose in place, we bring those people up to the health centre.

MRS DUNNE: This is a sort of cross-over question between corrections, health, mental health and the other parts of the branch that Ms Fitzharris has responsibility for. In the restructure, has there been any change in the reporting lines? This area looks after the adult mental health service. How has that split gone between Canberra Hospital and the other parts of ACT Health? I would just like to get a feel for whether there has been any change to the structure and where bits have landed as a result of that.

Ms McDonald: The split at the highest level was about ACT Health and Canberra Health Services being formed as two separate directorates or organisations. In terms of all the parts of Canberra Health Services, including our mental health services, which includes our justice health provision, those reporting lines have all stayed pretty much exactly the same except for the addition of a chief executive officer role, which is the role that I am currently fulfilling. We have added that to Canberra Health Services to oversee all Canberra Health Services that have been split off from ACT Health. These are the operational delivery of health services in a day, on a daily basis. They have all been put together into Canberra Health Services, so there is no separate division from mental health from that perspective.

MRS DUNNE: Okay; that is what I wanted to get. Because we are at that cusp, and Mr Rattenbury said you were comfortable about taking questions, where does the office for mental health sit in that arrangement? Is it with Mr De'Ath? And how do they communicate? I seriously want to get my head around what is going on.

Mr De'Ath: I acknowledge the statement. The office for mental health sits independently within the directorate. As you are aware, the coordinator-general for mental health is also coming on stream in early December. Mental health also has a policy unit within the policy area. And then there has been a lot of work done on our governance structures. Canberra Health Services has its own operational governance mechanisms; ACT Health has its operational governance mechanisms.

What we have attempted to do here is to be efficient and effective about this: not to create more cross-cutting governance in the middle, but to have cross-pollination, if you like, of membership on various governance things. What we are wanting to do is keep the operational activity and interface very engaged with the policy environment so that the intel is flowing backwards and forwards all the time.

MRS DUNNE: I will just absorb that; thank you.

Mr Rattenbury: Come back to it if you want.

MRS JONES: Is there a schema that you are working to for the set-up of the two separate halves of health and how they will interact? Is there some sort of plan or table that you can bring back to the committee?

Mr De'Ath: Thank you for the question. There are obviously very distinct organisational charts for the two organisations. One of the pieces of work that we are working on at the moment is very similar to the arrangement we have with Calvary, where we have formulated a significant agreement that has been in place for years that gets revised and reviewed. Ms Doran can speak to that in much more detail. We will be creating exactly the same sort of agreement that exists between ACT Health and Canberra Health Services. This is very aligned to what happens in pretty much all jurisdictions in Australia now: the department, if you like, has an agreement with various health services.

MRS JONES: So there is not a schema yet? You have just got the two organisational charts? Is that correct?

Mr De'Ath: There is a document that sits behind that, which I think has been made openly available, that describes the relationships between the two entities.

MRS JONES: Could you, on notice, provide that document to the committee, please?

Mr De'Ath: We absolutely can.

MRS JONES: Thank you.

Mr De'Ath: It is publicly available.

MRS JONES: Thank you.

MRS DUNNE: And the org charts?

Mr De'Ath: Absolutely. The same. I think they are publicly available; if they are not seemingly accessible, we will make sure you have a copy.

MRS JONES: Thank you.

Mr De'Ath: Could I add a bit more? It is actually not that complicated. It might sound a bit complicated but—

MRS DUNNE: You make it sound very complicated.

Mr De'Ath: Yes. It is actually pretty streamlined. I can make a general comment—Ms McDonald can speak for Canberra Health Services—that the separation has been a remarkably seamless activity. There are a range of things that we will still work through and work out as we go, but getting the governance right is absolutely critical to us. We have attempted to make that really efficient. We have had ongoing discussions with Canberra Health Services and with Bernadette and her staff as we go through, and that is shaping up very well.

MRS JONES: I have a question on justice health. From my conversations there has been some confusion about how the split will affect justice health. Are you able to explain any changes that have come about as a result of the split?

Mr Rattenbury: The answer is the same. The justice health team sits within the broader mental health team, so it is the same answer as the previous question.

MRS JONES: Going back to the previous question in a sense, I wonder if you could explain for me—I may have missed something—the reason for the split. Is it, as you mentioned before, Mr De'Ath, about being in the modern space of having policy and services separated, or was there a reason why it was more Canberra based for the change?

Mr De'Ath: I am happy to respond, Mrs Jones. Thank you for the question. Ms McDonald might like to respond to this as well. We have both come out of other jurisdictions in our careers where the arrangements we have put in place are very familiar to us.

I would make a general comment that I have led ACT Health since early April and up until 1 October I can say that it has been no small challenge to be leading an organisation that covers the full spectrum of health. As at 1 October, being able to dedicate my attention towards the policy environment, the corporate environment and the system line service planning and thinking, we are busier than ever in that space. Why? Because we are doing very dedicated thinking on that work now, which really should progress the system. The other comforting element of that for me is that I know that there is someone extremely competent, skilled and capable in the space of hospital health service management and leadership who is paying attention to all of the things. To be honest, I found it very hard to get to the full spectrum.

That helps understand or explain why, while all health systems are under considerable pressure, other jurisdictions are managing their health systems in a particularly targeted way. We have moved to that, and I think we are already starting to see some

of the benefits of that. I am happy to pass to Ms McDonald.

Ms McDonald: In terms of Michael's point about other jurisdictions, I come from a jurisdiction that is far further down the devolved governance track than anything that we have designed here in the ACT.

MRS JONES: That is the theory that this comes from, is it? Devolved governance?

Ms McDonald: I will not comment on that; I was not involved in that.

MRS JONES: I just have never heard it before.

Ms McDonald: Yes, the design. There is a lot around about devolved governance, and different jurisdictions have different models of governance of health services. Victoria is probably the most devolved of all the jurisdictions, and that is the world that I come from. I have some knowledge of other jurisdictions, but the Victorian system is where I grew up. I have provided health care myself but also led health services in Victoria.

The ability as a chief executive officer to focus on health service delivery and delivering the high quality, safe care everybody in my organisation seeks to do is a fantastic opportunity for the ACT and for the development of our health services going forward. That is really a dedicated focus of a chief executive: to bring an executive team, a senior leadership team and all our clinicians together as one organisation with one purpose and one focus, which is really about delivering high quality, safe patient care in a very supportive, respectful environment.

I would be very optimistic for the future of the design, having worked in a similar sort of structure in other jurisdictions. It is early days, and we are still developing our own organisational structure, which will not be particularly different from what we have right now because we have a very good approach to the provision of services and how we manage those services across the organisation.

One of the benefits of my role as the chief executive is that whilst I will have lots of input into policy direction and development, and the implementation of policy across the system, it is not my primary focus. My primary focus is working with my team on the delivery of health services. That is a shift, and a very positive shift, for the organisation.

MRS JONES: That is interesting. From our perspective, the reasons for the split perhaps were not so clearly advertised.

Ms McDonald: Happy to help.

THE CHAIR: We will move on to mental health. In your annual report, on page 79, you talk about the aggression and violence division framework. In the very last paragraph of that particular section, you talk about the monthly seclusion restrained review meeting, both qualitative and quantitative data. Can you expand on where that is at and how that works?

Ms Bracher: Within all mental health services across Australia there has been a significant focus on reducing restrictive practices, and seclusion and constraint are restrictive practices that we are looking to reduce. We have a strategic indicator in the budget papers that talks to our seclusion rate. Our way of monitoring that and moving our clinical services towards a less restrictive practice is to monitor through these seclusion restraint meetings. That is the governance context of that meeting. We have two seclusion restraint meetings, one at Dhulwa and one at the adult mental health unit, which also picks up some of the cases of seclusion that happen in the emergency department on the Canberra Hospital campus. They meet sometimes weekly, sometimes monthly, depending on the numbers of incidents that occur in that period of time.

We do a very detailed analysis and discussion of an individual case: what was the lead-up; what was the person's presentation? What were the lead-up triggers or incidents that might have gone into needing to restrain or unfortunately needing to seclude somebody? We do that level. That then informs tomorrow's practice for that individual. That goes into their clinical management plan and their clinical record so that if there is a particular trigger that was distressing for the patient yesterday we try very hard to recognise that and not do that tomorrow. The other component of the seclusion restraint meeting is looking at themes over time, our rates over time and themes that might require staff training or a different approach to our model of care.

That is what we do in both Dhulwa and the adult mental health unit. The one in the adult mental health unit has been running for nine or 10 years. The one at Dhulwa we commissioned about a year and a bit ago. We have consumer and carer representatives in those meetings from the two peak bodies, the Mental Health Consumer Network and Carers ACT, as well as clinical staff.

THE CHAIR: What systemic issues have been identified through these meetings?

Ms Bracher: Demand and the acuteness of the condition of patients who are coming in. To be fair, it is different in both units. In AMU it is really around the demand, the rapid churn of patients through the unit. High acuteness—that is what an acute mental health unit is. This is our intensive care unit, if you like, for the ACT. So that is the cohort that is there. That contributes. In terms of themes, that is one of them. Our recruitment of skilled mental health nurses is also something that, while it is not a contributor to seclusion, is one of the things that we have acknowledged. We need to do some training for our staff and to look at recruiting people with postgraduate mental health nursing qualifications. That is a recommendation. We do not just pull people with mental health qualifications out of Woolworths. That is a theme. Certainly a theme in Dhulwa is around our learning how to work in a forensic environment with people who have quite different needs from an aggression and violence perspective. What does least restrictive mean in a forensic unit? It is a different threshold to what least restrictive in an acute unit might be, or least restrictive in a community mental health team. We are learning there.

MRS DUNNE: Following up on the point you made about postgraduate training, part of the May review recommendations was that we need to grow our own. So where are we in terms of encouraging our own staff into postgraduate study, and what assistance is provided to staff to extend their study?

Ms Bracher: We have a postgraduate nursing program, which is a scholarship-driven program. We referred earlier in the hearing this morning to our concerted effort in 2016 to recruit staff into that. From 2014-15, or somewhere around there, I doubled the number of intakes into that program. We had about nine or 10 people each intake; the current intake has 19 people. We graduated 19 mental health nurses last year, and we—

MRS DUNNE: At what level? Is that a master's level or a graduate diploma or—

Ms Bracher: It is a postgraduate diploma on top of their nursing degree. We run that collaboratively with the University of Canberra. We graduated 19 and we currently have 19 nurses going through that program.

Mr Rattenbury: Further to that, Mrs Dunne, you will recall that in the review that was done of mental health services in the ACT it was recommended that we increase the number of staff, I think you are alluding to that. Off the back of that review I have asked for advice on a timetable and targets. As Mrs Bracher mentioned, we obviously cannot just suddenly produce people, but we need to be very deliberate in setting ourselves a long-term target for where we ultimately want to be, which, ideally would be 100 per cent. And I think it is important that we set some interim targets along the way so that we also send a signal to our staff that we are looking for those qualifications and that we collaborate with the university to make sure that the courses are being provided. We need to set that in train now so that we get to a point where we want to be in whether it is five or eight years is not clear yet but I have sought advice on that.

THE CHAIR: How long is the postgraduate course?

Ms Bracher: It is about 18 months. The staff work in a roster in our service, so they are getting on-the-ground experience in the mental health space, and then they do, I think, a day a week at the university in tutorials.

MS LE COUTEUR: Following up on your statement that you cannot pull people out of Woolies, which I know was a bit flippant, I thought you actually were starting to do that with the peer support workers. Have I got it wrong? I am not saying necessarily Woolies but that you are getting peer support workers who are from a wide range of other walks of life.

Ms Bracher: I did not mean to be flippant. Registered mental health nurses are highly skilled, highly qualified mental health nurses that we need in our workforce profile for a contemporary mental health service. They take a long time to train. That was the discussion around those people. In terms of peer workforce, you are absolutely right. We are adding a peer workforce to our workforce profile as a very important team contributor to the multidisciplinary team. We have had some scholarships for supporting some people through the cert III training to do that and then to have the qualifications to work in our recovery support officer roles, so to be there on the ground with the skilled nurses and doctors as part of a multidisciplinary team, fulfilling a different function from nursing.

MS LE COUTEUR: What sort of feedback have you had about that?

Ms Bracher: Very positive feedback. We work very closely with the consumer network on that. We have two projects, in fact, where consumers from the consumer network are employed in our service, one with the Chief Psychiatrist to work on informing both consumers who access our service and also our staff on the "my rights, my decisions" framework that fits within the current Mental Health Act as a flow-on out of the Mental Health Act for informed decision-making. And we have another peer support worker who is part of our project team implementing the redesigned community model of care. So we are employing people strategically. Then in the adult mental health unit we also have peer workers in the community mental health teams.

MS LE COUTEUR: The last bit you said about employment at the adult mental health unit sounded a bit more expansive, which sounds great. Particularly given the difficulty that you have in recruiting highly skilled, experienced nurses, is this a way of improving things for both the consumers and your workforce management? It seems like potentially a very positive move.

Ms Bracher: It is certainly a very positive move for the multidisciplinary team. New workforce can never replace the registered nursing workforce that we also need in a multidisciplinary team. To take us back to the point earlier, when we recruit general nurses into our adult mental health nursing profile, what we need to do is—there are people who want to work in mental health—support them and to grow their skill sets so that they can provide the really elite-level mental health nursing care that we need as well.

MRS DUNNE: What does the scholarship entail? Does ACT Health pay the HECS?

Ms Bracher: We pay their course fees. We pay a relocation allowance if they come here from interstate and they are employed by us. We also pay for them to attend the university.

MRS DUNNE: So on salary?

Ms Bracher: Yes.

MRS DUNNE: So that is part of their rostered time?

Ms Bracher: Yes.

MRS DUNNE: And the people who are doing the cert III?

Ms Bracher: We did a similar thing with that cohort; we paid for their CIT fees and their time to attend.

MRS DUNNE: Is the cert III a rolling program or one-off program?

Ms Bracher: It was a one or two-off program. We are not running it at the moment, but we certainly can. We are looking at that through our workforce management.

MRS DUNNE: That is also a substantial investment, so is there mutual responsibility, such as return of service or something in response?

Ms Bracher: Industrially we do not have a capacity to do return of service. I might not be the best person to talk about industrial relations law and the EBOs. But through recruitment processes we offer permanent roles. Some people move on because they move on but we certainly encourage people to stay. That is about the limit of our—

MRS DUNNE: I grew up in the time of bonded scholarships in another millennium, but it had merit.

Ms Bracher: Maybe I was in that millennium too because we have asked how we could do that. Strategically, even if they do not work for ACT Health, it is valuable for our community to have more trained expert mental health nurses.

MRS DUNNE: But there is a risk that we train them at a cost to the ACT taxpayer and somebody else poaches.

Ms Bracher: Absolutely.

THE CHAIR: But that is a risk with any employment.

Ms Bracher: That is right. The 19 people who graduated last year are all working with us this year.

THE CHAIR: Surely the more you support the workers the longer they will stay working for ACT Health?

Mr Rattenbury: In general, yes.

Ms Bracher: Yes, absolutely.

Mr Rattenbury: People's partners get jobs somewhere else and all those things, but in principle you are absolutely right.

Ms Bracher: It is fair to say that there is a very competitive process at the end of the post graduate nursing program for our teams to recruit nurses. They are the winners in the market.

MRS DUNNE: So whilst they are on their scholarships they are not permanent officers?

Ms Bracher: They have a two-year temporary contract, a long-term contract. Some of them are supernumerary in the workplace and some of them are employed into the RN1 positions, depending on the team they are in. For example, in the adult mental health unit a registered nurse can be on our general roster so they can be offered a permanent registered nurse level one position. In some of our more specialised teams we do not have level one registered nurses so we put them on a supernumerary and pay them as a registered nurse level one but we do not have a permanent position for them in that space.

MRS DUNNE: Does that mean their presence on the ward is on top of the rostered—

Ms Bracher: It is part of the roster.

MRS DUNNE: They are not in addition to the roster?

Ms Bracher: That is correct. In the adult mental unit, that is absolutely correct. In the community mental health teams they are supernumerary and will carry a very small clinical load. But because of the autonomous nature of community mental health work, we supervise them very closely.

MRS DUNNE: I might ask a question about ligature points. I could not go past without asking about where we are up to with the assessment of ligature points.

Mr Rattenbury: Yes. We especially got the right person because I knew you would want to know about this.

Mr Mooney: Your question was in relation to ligature minimisation?

MRS DUNNE: Where are we with the process? This goes back to 2017.

Mr Rattenbury: This is the doors at the adult mental health unit, specifically?

MRS DUNNE: It is the whole lot. There was a review in 2017. It was commented on in the accreditation in March. I asked some questions on notice. Then we had a conversation, probably in June or July. Where are we since then? There was a process of taking out the doors and putting in new doors. Where are we with that?

Mr Mooney: Primarily within the adult mental health unit and the Canberra Hospital we have, as at this point, removed all the ensuite doors in all the bedrooms. We have had an approved prototype room to identify all of the new ligature minimisation fittings that we will be putting in and also have approved the solution for the entrance door into the room.

As of 31 August, what we are describing as stage 2 is complete: ensuite removal of doors and then the prototype room confirmation. We are now going through the final stages of design to actually install the doors in the rooms. It is a very busy environment. One of the things that we have come up against in terms of the actual door design is that we are fitting two primary new devices, pressure sensors, on the door and also electrostatic vision panels. These panels are basically swipe activated.

MRS DUNNE: Like they have at—

Ms Bracher: Like the ones at the University of Canberra Hospital that you saw.

Mr Mooney: Yes, exactly. And also at Dhulwa. These improvements are things that we have identified for adult mental health. When that was first built, it was best practice. Obviously things evolve over time. We have taken the learnings from Dhulwa. We introduced them at UCH, where we removed the doors. Originally there

were ensuite doors in UCH; they were taken out. We have fitted pressure sensors on the doors and electrostatic vision panels.

There is a challenge with that retrofitting in a live environment. The pressure sensors are linked to the duress systems within the building. We have to hardwire them into the systems. We have 40 doors. All have to be fed back to a central core of the building. All that design from a security point of view has been done. We are planning to do the first doors, hopefully, before the end of this year and then a rollout thereafter with a program that must be completed by the middle of next year.

The reason for that is primarily the operational constraints. We are working closely with Tina's team to see how we can improve that lead time. Going to the experience that we have gone through with the ensuite doors, when we first started removal of them, the first ones were quite slow, but we then got into a rhythm and we were taking three doors off at a given time in a day. That is by moving people out of the room and then being able to move them back in later in the day. They would go to various sessions in the actual building so that they are not inconvenienced. Then they could come back into the room when it is finished.

We are going to take the same approach but, as you can appreciate, we are going to be removing a door and then installing a new door that is essentially all kitted out. We are going to be putting cabling into the roof space. We can be doing that in advance so that as much as possible we are making plug and socket installations. It is going to be a challenge in that space, but thus far we have worked very closely with Tina's team and we have a very good contractor on board who knows the space.

It is a difficult environment because of the nature of the consumers in that space and the level of occupancy, but our target program at this stage is to complete by mid next year. We will be looking to accelerate that as much as we can, obviously without compromising the safety of staff and consumers, or indeed the workers who are going to be in there.

MRS DUNNE: That is essentially the conversation I had with Mr Rattenbury several months ago, and we do not seem to have progressed except that we now have a finish time line. I understand that there are 40 doors and you are not going to take all the doors off at once or anything like that. But if there are 40 doors, how much actual work is there to take out the current door and replace it? For each of those steps, what is the elapsed time that is needed to take out, plug in and install the new door? Presumably it comes as a modular unit. Without demeaning it, you are popping one out and popping another one in. You are saying that you are doing the cabling ahead of time et cetera. What is the actual elapsed time to take out a door and put in another door?

Mr Mooney: That is not the critical path in the actual process. The challenge is that we have a very busy environment. With the design solution that we have, we have to knock out an existing door—that is all the frame as well—and build it back up.

MRS DUNNE: Is it the same size?

Mr Mooney: No. It is a new door.

MRS DUNNE: I know it is a new door. You actually have to make the hole bigger or smaller?

Mr Mooney: What is in there at the moment is a cat and kitten door. That is being removed.

MRS DUNNE: Sorry?

Mr Mooney: A cat and kitten door. That is a smaller leaf door. They are being removed. We are putting a pressure sensor across the top of one door. That then has to be hardwired back into the system.

MRS DUNNE: I understand that. But what is the time it takes to pop out the existing door and install a new door? Half a day?

Mr Mooney: No. In the first instance it is going to be at least a week.

MRS DUNNE: Per door?

Mr Mooney: Not per door. As I said, starting off, it will be at least a week of the actual program. Once we get into a rhythm working through it, as we found with the ensuite door removal which, relatively speaking, was much easier—

MRS DUNNE: Absolutely.

Mr Mooney: We will work through it, relatively speaking. Part of the challenge is that there is a mechanical installation but then there is programming with the connection of the door back into the duress system. Obviously we will be doing one door at a time. We have to make sure that we do not undermine the rest of the duress system in the building at the same time.

There are checks and balances that have to be done. As they say: measure twice; cut once. We do not want to have in any way a situation where we have unintended consequences in the building. We work very closely with Tina's team to make sure that the outcome that we arrive at is the solution of the installed doors but not at the expense of any safety issue.

MRS DUNNE: Could I just clarify—

THE CHAIR: We are running out of time.

MRS DUNNE: Yes, I know. Sorry. We have the 40 beds, but they are not all staffed. Or have we now moved up to fully staffing all of the beds?

Mr Rattenbury: It is fully staffed for the number of patients that are in there.

MRS DUNNE: At one stage we were appearing to be over occupancy.

Mr Rattenbury: There are always enough staff for the number of patients.

MRS DUNNE: Are there ever vacant rooms? And do you work on the vacant rooms if they are there?

Mr Rattenbury: Certainly we would if that were the case. That will ebb and flow, as these things do.

MRS DUNNE: Yes, I know. I just put on the record my concern at what seems, to an outsider non-techy person, a very long lead time for the completion of this work. I find it quite alarming.

Mr De'Ath: If I could make a comment, Mrs Dunne, there was a point in time where I made the exact comment you have just made. Colm will remember this because I had responsibility for this at the time and through the accreditation. To be fair, it was not until I went down there with Colm and had a look at actually what is involved in this sort of adaptation and construction that I understood it. I had assumed that it was a case where a door comes out and a door goes in with a pressure switch on and it is all very fine. But this is really complex. In fact, I am surprised that Colm has got it to about one week. I think that would be a great effort in terms of the complexity of the frame, all of the issues that go with a mental health facility and all the risks around how these doors need to operate and so on. It really is an engineering feat. And there is all of the electrical work that goes into it. I was quite astounded.

There is another very important element to this, and this is the very important role that the Chief Health Officer, Dr Paul Kelly, played as the regulator in terms of looking at, examining and commenting on the risk mitigation strategies that need to be in place in such a unit while you are working through the remediation works. Dr Kelly played a very critical role in there, and with the ACHS through the AC90 process, in determining that our risk mitigation strategies were sound. That is another very important element. While the work is complex and protracted, which the ACHS were across as we were working through these issues with them in terms of our accreditation, it is also very important to have the risk mitigation strategies in place and signed off. And all of that has taken place.

MRS DUNNE: Could I ask one last thing?

THE CHAIR: We are very much over time.

MRS DUNNE: All the other ligature points have been addressed apart from the doors?

Mr Mooney: They are in the rooms. The primary one was the ensuite door. We have confirmed all of the fittings that are going to be fitted into the rooms. They are going to be done at the same time as the doors. Each room will be taken offline.

MRS DUNNE: What other fittings are there?

Mr Mooney: There are, for example, hinges on the doors. It is going to be one continuous hinge. There will be pull-off curtain rails. There are various drain covers in the ensuites themselves. Door runners are being removed from the bedside drawer

units. It is things like that. They are all going to be done at the one time.

MRS DUNNE: So you are going to systematically take each room offline and do the lot now that you have identified all of those things.

Mr Mooney: Yes. I have to say, Mrs Dunne, that if we have opportunities where we work with Tina's team and there are opportunities to go in—soap shield dispensers are one thing that we will be putting in—we will be doing that ahead of time. We are just sorting out the supply of the particular consumable to complement the design of the unit that we have. Then that will be put in directly by our FM team members.

THE CHAIR: We will break for morning tea. We will be back at 10.45 for Minister Fitzharris.

Hearing suspended from 10.35 to 10.46 am.

Appearances:

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

ACT Health Directorate
De'Ath, Mr Michael, Director-General
Doran, Ms Karen, Deputy Director-General, Corporate Services
Kelly, Dr Paul, Chief Health Officer, Public Health, Protection and Regulation
O'Halloran, Mr Peter, Chief Information Officer
McLeod, Dr Margaret, Chief Nursing and Midwifery Officer
Bartholomew, Ms Carolyn, Acting Executive Director, Health System Planning and Evaluation

Canberra Health Services
McDonald, Ms Bernadette, Chief Executive Office
Bone, Mr Chris, Deputy Director-General, Clinical Services
Mooney, Mr Colm, Executive Director, Infrastructure Management and Maintenance
Hammat, Ms Janine, Executive Director, People and Culture
Chatham, Ms Elizabeth, Executive Director, Women, Youth and Children
Dykgraaf, Mr Mark, Chief of Clinical Operations
Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
O'Neill, Ms Cathie, Executive Director, Cancer, Ambulatory and Community Health Support
Talaulikar, Dr Girish, Executive Director, Medicine
Wood, Mr Daniel, Executive Director, Surgery and Oral Health

THE CHAIR: Good morning and welcome back. We will now move to health and wellbeing. Thank you, minister and officials, for attending today. Before we go to questions, I remind witnesses who are appearing for the first time to confirm for the record that you have read and understood the privilege implications of the privilege statement before you.

I will start, minister. This last year has been a very big year with lots of significant change, the organisational separation and all of that. Can you talk us through how that is going? What process was followed with the organisation transition?

MRS DUNNE: That is a question that probably relates more to the—

THE CHAIR: I ask it because it is included in the annual report.

MRS DUNNE: Alright; okay.

Ms Fitzharris: I acknowledge the privilege statement. I managed to catch some of the earlier hearings. I know that the separation was canvassed a little.

THE CHAIR: Yes, it was.

Ms Fitzharris: But I note also that a number of statements—I think probably three 15 to 20-minute statements—were made in the Assembly throughout the year. However, this an opportune time—six weeks into the separation of both organisations—for both Michael and Bernadette to reflect on that and also to reflect on potentially how things look for next year. As I have said many times, it is the start of two new organisations. We very much look forward in 2019 to being able to realise even more of the benefits of the separation, particularly with a dedicated focus on both service delivery through Canberra Health Services as well as system-wide management, in respect of which I do not think we have been able to fully harness all our potential in the ACT.

An example of where we can benefit from that is that earlier in the week at ANU we joined with ANU, the University of Canberra and a number of other organisations, including in the higher education sector, to talk about the enormous benefit we have here in the ACT with a large population within our borders, a similar population just outside our borders and the high-quality universities we have here that train a significant proportion of the health workforce, many of whom stay in Canberra and work in our public health sector.

We talked about being able to take that system-wide stewardship approach through ACT Health to bring all those parties together to form a new and what I think is a very exciting collaboration about how we integrate research, teaching and training directly into Canberra Health Services and Calvary Public Hospital, as well as with the staff in primary health care and in the private health sector. In the ACT we have opportunities that are unique in the country. This is just one example of the stewardship of the health system. I think we will see a further improvement in performance and quality of health services, particularly through Canberra Health Services, next year. I invite both Michael and Bernadette to comment further.

THE CHAIR: I am also looking at the 2017-18 annual report period leading up to the latest separation of health services.

Ms Fitzharris: Certainly, another significant part of this year was the accreditation process, which I think we discussed in the estimates committee as well. That was a different committee. We went into some of the issues that were outlined and highlighted in that draft accreditation report. We went through some of the reasons why some significant strategic and structural reform was necessary. We look forward to realising the benefits of that next year as well.

Certainly, a period in the annual report for 2017-18 was about working to address the issues outlined in the accreditation report. We then received an incredible, real turnaround. We had independent people come in March. They came back again three months later. They took an independent view of the improvements that had been made. They were saying that not only had all the criteria been met but also that some should seriously be considered to be nominated for further recognition.

Mr De'Ath: I acknowledge the statement. The minister referenced the accreditation process. It was actually very interesting talking to the surveyors about what they had

identified in terms of what they viewed as problematic around our arrangements as a health system and how that was different for them in carrying out surveys in other parts of the country; in other states and territories.

Of course, we put in place measures to get through the AC90 and militated against those. But that was a pretty comprehensive conversation with both the commission and the ACHS on what changes were also looming, which of course they were well aware of.

I will make a little more of comment about ACT Health specifically heading into post-separation. I will then hand over to Ms McDonald to make comment on CHS. For ACT Health, this is the opportunity to really shift a gear. The minister referenced the recent summit that was held with our strategic partners. That was a very significant event. As I have said since first stepping into this role, we have an opportunity in Canberra that is second to none. We have a teaching hospital; we have a medical school; we have some of the leading universities in the world; we have the John Curtin School of Medical Research; and we have an amazing workforce, all as a captive audience.

What we want to do now is to absolutely harness all of the collective energy, enthusiasm, knowledge and skill base to take us forward. It is ridiculous to think that ACT Health would create contemporary, world-leading policy independently of any of those partners. It is inconceivable to think that we would not be moving to put in place really sophisticated arrangements around workforce.

There is some history to that but the opportunity—with new deans of medicine at both of those universities, University of Canberra and ANU, coming on stream, with research people and with policy people lecturing in the space—to harness that energy, to work with those people and really take our health system to a new level is what ACT Health will be incredibly focused on, both the policy level and through to a practice sense. I will hand over to Ms McDonald.

Ms McDonald: I add to that in terms of, I guess, the other half of the coin in terms of running a health system and managing a health system, that is, managing the delivery of services. I talked briefly about that earlier today. I guess the opportunity for us is to really focus on our performance, to improve our performance and to have really high performance across our Canberra Health Services.

We have already started working to develop a timely care strategy, bringing together key parts of the organisation to really focus on timely care and access for all our community and patients coming into Canberra Health Services as well as really building on the solid foundation from AC90 in terms of our quality systems and our governance processes across the organisation.

Another huge aspect is actually starting to work on the culture across the organisation as well. I guess the opportunity is that we have good, dedicated leadership to Canberra Health Services in the restructure and the transition. That provides a very positive way forward for me and for the rest of the organisation.

THE CHAIR: Will that involve two annual reports in the future?

Ms McDonald: Yes, we are two separate organisations.

MRS DUNNE: Fantastic! I can hardly wait for that.

THE CHAIR: I am not sure if you are being sarcastic or—

MRS DUNNE: I am being sarcastic. Just for *Hansard*, I am being sarcastic.

THE CHAIR: In the past year we also heard a lot about cyber attacks elsewhere into health systems. What have we been doing over the last year?

Mr De'Ath: I invite Mr O'Halloran to address cyber attacks.

Mr O'Halloran: Good morning and I acknowledge the privilege statement. In the ACT government ICT environment, Shared Services is involved in most aspects of cyber security. Within ACT Health, we also provide ICT support for CHS. We are doing a number of other steps to look at how the health environment is different from the other aspects of government. For example, the 24-7 nature of our operations is quite different, as is the nature of the medical devices and so forth.

The key things we are looking at at the moment in terms of cyber security are focusing on the different attack points for medical devices and how we can isolate those from the network. We are doing additional work with Shared Services around how we provide better protection of end points and we are doing a lot of work around how we are actually going to be educating our staff to recognise if there is an anomaly, and what to do.

I am also pleased to advise that ACT Health has appointed a chief information security officer based on what came out of the budget for this financial year. That recruitment has been completed. He actually commences on Monday. He has formal qualifications in the area and has been working in healthcare IT for the past 10 or 15 years.

Secondly, we also do a lot of work with the Digital Health Agency around cyber security. We are working across jurisdictions. I note, for example, that when there was the WannaCry ransomware issue last year, ACT Health or the ACT was actually the first jurisdiction that was involved in coordinating a national response for how this was dealt with across Australian hospitals.

MRS DUNNE: Before the restructure was announced a lot of policy work was done in the territory-wide health services review and work was done to establish virtual centres. What has happened to that work? Has it been delayed or refocused in the context of the restructure?

Mr De'Ath: I think "refocus" is a very good word. A number of pieces of work were underway in various forms and various stages: a digital strategy, a workforce strategy, the territory-wide health services framework and so on. We have had a look at all those pieces of work and stepped back a little bit to ask how they fit into a broader framework. Territory-wide health service planning is part of an overarching

framework of how you think about all these things together.

In doing that we also had in mind taking the opportunity—I thank the minister for allowing us to have that time—to ensure that the look and feel of documents had greater coherence to them. We wanted to see greater alignment across those pieces of work.

What we have been working on and will be bringing to the minister in the new year is a package of information that sits under a broader framework which has in it things like digital strategy, workforce strategy and health service planning as part of the role of ACT Health as system steward going forward, and our new identity. That should be something that is much more meaningful to the entire community and the health workforce.

MRS DUNNE: So we should stop referring to some of the current documents?

Mr De'Ath: No, I do not think we need to stop referring to them; they are very good pieces of work but they sat a little independently of each other in some ways. We wanted to bring them together; it is not unusual that you end up in a situation like that. But putting an overarching framework on that will bring a lot of coherence and clarity for people to see the strategic direction on a number of fronts.

MRS DUNNE: Where are we with the approach to centres? That was touted for quite some time but we seem to have gone quiet on that front.

Mr De'Ath: At the moment we are not continuing with the centre model. As soon as I arrived the minister spoke to me and we had a lot of feedback particularly from clinical staff on their thinking about that. It was an evolving piece of work. We have stepped back from the centre model.

We have certainly kept with the specialty service plans which were pretty popular and still evolving. We have continued to go with that piece of work, but that will all be clear as we bring out the broader framework and that piece of service planning work.

MRS DUNNE: What would be covered by the specialty service plans?

Ms Fitzharris: This was canvassed in estimates as well. The territory-wide health services work is still very much underway around models of care with work between Canberra Hospital and Calvary hospital. A number of factors have contributed towards a significant advancement in that relationship.

A draft organisational structure was released in November last year and that was finalised subsequent to the accreditation and announcement around the separation. The centres were removed at that point and subsequent to that the structures were finalised for separation on 1 October. But the commitment to delivering territory-wide health services very much remains in the specialty services planning. I think we discussed this last time and we circulated an example.

MRS DUNNE: You did circulate an example.

Ms Bartholomew: I acknowledge the privilege statement. Mrs Dunne, could you repeat the question?

MRS DUNNE: What is the future of planning for treatment for particular diseases or classes of diseases? I am interested in the respiratory space, for instance. At one stage we were looking at a virtual respiratory centre but that has been discarded. Where are we with planning for delivery of services in a particular area and what might we see that is different in the future?

Ms Bartholomew: This is probably a joint question with work in the Canberra Health Services space. The service specialty plans are well and truly underway with 46-odd plans being developed. A common thread will link them to a general service plan for the territory for work that needs to happen across the whole service delivery.

The centres no longer being a part of the formalised restructure has not diminished the ability for the service plans to go forward, but with the commencement of Canberra Health Services—a different entity—we need to start working on how we transition from what we know the services want to do and need to do to how we undertake that.

MRS DUNNE: What is the timetable for this work?

Ms Bartholomew: The service specialty plans will be completed early in the new year, probably in the first quarter of the year.

Ms McDonald: In terms of the service specialty plans it is positive to talk to each specialty and clinician to understand what they see for the future and also add in the forecasting of data for demand in different disease-specific areas. I have had quite a bit of experience working with clinicians in service planning and everybody gives you a wish list of the things they would like to do, the new technologies, new procedures and all those sorts of things.

The sophistication is in working with every speciality, understanding what they look like, coming back to our forecast demand in those areas and then coming up with a Canberra Health Services territory-wide service plan that sets out our priorities, our time lines for working on these different areas and where we will move forward in this space.

A lot of fantastic groundwork has been done with clinicians. That is great because we need to speak to clinicians about these plans; they cannot be made in isolation with people who do not know the procedures or treatments that will come to the fore in a lot of these disease areas. Clinicians can have great input into that, and that is what has been occurring.

In terms of the 46 plans, we have to prioritise because we cannot do everything straight away. That is impossible; no government can do that and meet all those needs. We need to work with our clinicians to prioritise where we want to go with our specialties, our treatments and our procedures. That takes quite a bit of work but I hope to get my teeth into that work in the early half of next year.

MS LE COUTEUR: This is a question unrelated to organising the health department.

My understanding—

MRS DUNNE: I think they are all related to that.

MS LE COUTEUR: No, I think this one is not. My understanding is that the health department is discharging people into homelessness. I have spoken to the people at Safe Shelter. They say that they are getting people discharged from Canberra Hospital to them. Safe Shelter is by definition homelessness. I am talking about the Safe Shelter that is organised by the church. Can you comment on what you are doing to reduce this problem and what impact it has on patients who are discharged into homelessness?

Ms Fitzharris: They are being discharged into Safe Shelter?

MS LE COUTEUR: Yes. Safe Shelter has told me that that is where they are being discharged to. Mrs Dunne has the same information. We believe that this is happening.

Ms McDonald: I am not aware of the discharge destinations for all our patients, obviously. If that is occurring, it is not something that has been raised within the organisation. I am in week six, so I would suggest that we take that on notice. I do not have the details or the numbers of patients who may or may not have been discharged to Safe Shelter. We would have to look at that. I know that our policy is that we would always discharge to wherever the safest environment is for patients. We would need to look at the particular circumstances that you are talking about to investigate if that is happening. And I am very happy to look at that and shift anything that we need to shift if that is occurring. The safety of our patients is always our priority. I would like to take that question on notice but I would need more details.

MRS DUNNE: I am happy to provide the detail of the cases that I have dealt with.

MS LE COUTEUR: I do not have details of cases, because I got the numbers from Safe Shelter, but I suggest that if someone were to ring Richard Griffiths they would be able to find out some numbers and details of that. Maybe we could take it, for the purpose of discussion, that while we are not sure exactly how frequent it is—

THE CHAIR: Mrs Dunne, you said you would provide it.

MRS DUNNE: For clarity, the person I dealt with was not actually discharged to Safe Shelter. They were discharged even though they were homeless.

Ms LE COUTEUR: They did not even go to the Safe Shelter centre.

MRS DUNNE: They were discharged in a bit of bush behind the Belconnen Markets.

Ms Fitzharris: We will take it on notice. I know that ACT Health is involved in broader pieces of work being undertaken in Housing ACT and the CSD. I believe there is some work underway to look at issues around this in a policy sense. Perhaps if we can provide more information to you in response to the question on notice we can cover off both.

MS LE COUTEUR: I am concerned. While some policy work is no doubt a good thing, I would not have thought we needed a lot of policy work to decide that discharging into homelessness was a bad thing. So I am concerned—

Ms McDonald: I think we need to clarify whether we are discharging to homelessness. In discharging a patient there are different options. A patient can be physically well and ready for discharge and not provide information that they are homeless. They may provide an address they had a long time ago in their data. You have got to be aware that not every staff member is checking where a patient is going to when they leave the hospital if they are physically and medically well for discharge. I am not excusing it by any stretch of the imagination but in some cases our staff would not be aware that a patient is homeless if a patient is not declaring that and there is no clear sign that that is occurring.

Any patient who has ongoing medical needs and those sorts of things and needs follow-up that we are aware of, we would always refer to our social work department and to our clinical nurse coordinators to make sure that the discharge destination was safe and that that person could be discharged, especially those who need to be picked up by family members and transported home and those sorts of things.

We discharge thousands of patients every week. We do have discharge policies, and the safety and care of our patients is uppermost in all my staff's minds. We need to be careful; we do not condone that, but there might be circumstances where staff are unaware of the home circumstances of a patient. Where a patient does not want to disclose that or does not want to take advice, we may provide options, saying, "We would prefer that you not be discharged, because you do not have a home to go to or you do not have a supportive or a safe environment to go to," and patients can still choose to be discharged or discharge themselves. There are lots of different circumstances upon discharge.

I am very happy to take the question on notice in terms of the particular details here and also to follow up within the organisation to check if we are aware that that is happening or if we are not, and what the circumstances might be that we could improve on to make sure that it is not occurring. But we recognise that people are autonomous. They can make their own decisions and they can choose what happens with their discharge. We cannot forcibly keep somebody in a hospital bed, if they do not want to be there, because we do not feel they have the right home environment to go to. It is a balance that we need to work through in every clinical situation with every individual patient.

Mr De'Ath: I have a comment from a former life in CSD working in this space. I will not speak for that directorate but there is a cohort study you may be aware of that is underway, looking at some of the more challenging cohorts of people in the homelessness side of the housing space. I think that is very important work which provides information on this. I do agree that a case by case examination is absolutely critical and important. One of the most challenging things I felt in the homelessness space at times, which may be a factor in what we are talking about here, is that there are some people who at a point of time in their lives choose that path. If indeed that is the case, that would be a very difficult thing for the system to be managing at discharge where they were continuing to choose that path.

MS LE COUTEUR: Where people are not choosing this but were homeless before going to hospital, what do you if they do not have a home to go to but they have become no longer clinically sick enough that you would normally regard them as a patient? What would you do with them then?

Ms McDonald: It is very similar for anybody who has needs to be met post their acute phase episode in hospital. For example, we get elderly patients who come in who, when they leave us, need to go into residential care but were not in residential care before. So we have our social work and our care coordinators who work with families to find the next location for those patients and get them into residential care. It is the same sort of situation if we are aware that a patient is homeless. Then we would use our social work department and our team to find options for accommodation post hospital.

I can honestly say, hand on heart, that I doubt that any of our staff would push a patient out the door knowing that they were homeless unless they had set up some sort of, even temporary, accommodation for that person to go to post their hospitalisation. We have systems and services within the organisation to help manage the social circumstances of patients post hospitalisation, and they work very hard to try to do that.

They are also working within a system of whatever is available in terms of capacity in the community. There may not always be availability of accommodation that would be suitable for the person, and sometimes the patient themselves may not like the options that they are being presented with. They have a say in that as well. But we do have services within the organisation that will help manage those social circumstances for patients post discharge.

MS LE COUTEUR: Getting back to policy, have you looked at the additional cost to the health budget if people are discharged into inappropriate or no accommodation? I am a lot more aware of it from the aged care point of view than from the younger people's point of view.

Ms McDonald: That would be pretty complex, because it could also involve the impact on a lot of people who are very unwell who need to be in a hospital. So that is quite a complex sort of question. There is a lot of work across government. From ACT Health I expect an even richer contribution to whole-of-government policy work, with the separation about collaborating on the policy side and on the operational side, around how we contribute to being part of the solution for a number of different groups of people in our community, and homelessness is obviously one. Many of these things have an element of social determinants of health that we often have a number of conversations about as well. There is increasing and quite deep collaboration across government on these issues.

Mr De'Ath: We have very strong linkages to ACT Housing, so our people are constantly engaging back and forth on a range of these sorts of issues, not just in a policy sense but also in quite an operational sense. The linkages are strong.

MS LE COUTEUR: We probably should stop at this point, but I just point out that

page 79, the mental health part, talks about accommodation being an issue for discharge.

Ms McDonald: I think you are talking about step-down mental health facilities as—

THE CHAIR: Mr Rattenbury was here earlier.

MS LE COUTEUR: Yes, we did not have enough time. I would have gone to that but we did not have time for that.

MS CHEYNE: I have questions about HR policies and about attraction, development and recruitment. I see that there are a few ARIns current in ACT Health. Is there a breakdown of how many ARIns are for men and how many are for women?

Ms McDonald: I will ask Janine Hammat, our executive director of people and culture, to join us.

MS LE COUTEUR: What is an ARIn?

MS CHEYNE: It is an extra bit of money.

MRS DUNNE: It is attraction money. It is some sort of incentive.

MS CHEYNE: I learned about them in EPSDD.

MS LE COUTEUR: So they are not specific to Health? Are they across the ACT government?

MS CHEYNE: No, they are not.

Ms Fitzharris: Are ARIns across both organisations or Canberra Health Services in particular?

THE CHAIR: Before you commence, Ms Hammat, can you acknowledge the privilege statement?

Ms Hammat: I acknowledge the statement.

MS LE COUTEUR: Excellent, thank you.

THE CHAIR: Thank you.

Ms Hammat: Sorry, what was the question again?

MRS DUNNE: First of all, what is an ARIn?

MS CHEYNE: What is an ARIn? Is there a breakdown of how many ARIns are for men and how many are assigned to women? Then, perhaps, how many ARIns are in one side of the organisation and how many are in the other?

Ms Hammat: An ARIn is an attraction and retention incentive. It is a mechanism that is in enterprise agreements that allows the organisation to pay over and above the rate that is specified in the agreement. There is a fairly rigorous process that one needs to go through to justify an attraction and retention incentive. There are a number of attraction and retention incentives in Health. Most of them are for medical staff.

There are quite a few for health professionals and very few in other categories. One of the reasons for that is because one of the major things that you look at when determining whether an ARIn should be paid is market forces. Often with medical professionals, those market forces might be from other jurisdictions or, in fact, they are from other jurisdictions.

The same tends to go for health professionals. In other categories of employee, for example, nursing or administration, the market forces are not as prevalent in terms of the fact that other states tend to pay similar wages. In fact, I think with nursing we may be a little ahead of most others. In terms of the numbers, the vast majority, as I said, are with our medical staff. I do not have a breakdown of male and female, but I am sure we could find that information. I am just looking at the information that is in front of me at the moment. Sorry, do you have the numbers there?

Ms McDonald: No.

Ms Hammat: There are 321 staff in ACT Health. Canberra Health Services has 311. Most of them are for clinical staff: health professionals, medical staff.

MS CHEYNE: I do not know whether this is a question better directed to Minister Rattenbury. Something that we have talked about before is retention of psychologists and psychiatrists. Is there any indication of how many ARIns are given to those? I think there was discussion earlier about how we train them up here but then they go back to Sydney or Melbourne.

Ms Fitzharris: Can we provide a breakdown? We can probably provide a breakdown.

Ms McDonald: We could.

MS CHEYNE: Yes, only if there is a way to provide a breakdown that does not compromise privacy. If there are only—

Ms McDonald: Absolutely.

MS CHEYNE: two people working in one place and one person has an ARIn and one does not—

Ms McDonald: I am sure we have the information that we can provide. In terms of psychiatrists, we have recently done a piece of work to implement an attraction and retention incentive for psychiatrists so that we can advertise that amount in the remuneration when we advertise those roles.

MS CHEYNE: Okay.

Ms McDonald: We are certainly very hopeful that that will improve our efforts in relation to attraction and retention.

MS CHEYNE: That is very encouraging. I ask about the staff and wellbeing workshops and programs. I notice that the total number of participants is 2,500. However, with the lack of breakdown there, it could be that the same person is participating in every single program. Given the numbers of staff there are—2,500—and taking into account that some staff probably participated in more than one program, it seems to suggest to me that maybe more people could be participating in some of these programs. How are some of these programs, particularly the emotional wellbeing ones, advertised or promoted among staff? Are staff encouraged to attend? Are they given the space and the opportunity to attend in work time and not chastised for taking some time away from their day-to-day job to attend these programs?

Ms McDonald: I can talk to that. I talk from an overarching high level in terms of all staff training across the organisation. The programs that you are questioning us about are part of a suite of programs across the organisation. Staff training ranges from all the mandatory quality and safety training that staff have to do right through to clinical training—competency training for clinical competency—and our HR-type programs.

There is a multitude of training requirements on all our staff. The challenge in delivering the training and in encouraging staff to attend is to find the balance between our still needing to deliver this service every single day and maintaining our staff levels to deliver the patient care, which is our priority, obviously.

MS CHEYNE: Yes.

Ms McDonald: But we must also find a way that we can meet all the staff training needs, not just the ones that you have talked about but also their quality and safety and their clinical competency training that they need to do on a regular basis.

MS CHEYNE: Yes, that is a tough balance, isn't it?

Ms McDonald: Yes.

MS CHEYNE: Patient care is paramount but good patient care relies on your staff also feeling well and supported.

Ms McDonald: We are looking at that in terms of what are the priorities across the organisation. In my experience every year we make more and more things mandatory for staff, but what we have to do is find innovative ways to deliver that training: what can we do online, what can we do on apps, what can we do face to face and how do we prioritise that across the organisation so that we minimise the actual time away from care? But we also need to make sure that we meet all the needs that you are talking about to make sure that the care is great, that we are delivering, but then that the staff are looked after themselves, that they are challenged, inspired and growing in the training that they are doing as well.

Janine and I have talked about this in terms of creating a sort of training and education governance committee that really does look at the most innovative ways to deliver the

training to maximise staff attendance. We certainly would not discourage people at all from going to training. Whatever they need, we want to encourage and support that. But, as I said, that is the balance; so we are looking at how we do that in a better way.

Ms Fitzharris: You might have seen earlier this week, I think it was, that the various professional bodies also encourage this. There was a report this week about the College of Nurses and a program called NurseStrong. It is a national program that a number of local nurses were participating in. I think they were filmed doing star jumps while at work. It was on the local news this week. That is another example of professional bodies noting the importance of staff health and wellbeing.

MS CHEYNE: Specifically, what is the Red Cross health services blood challenge?

Ms Fitzharris: What page is that?

MS CHEYNE: It is page 126.

Ms Fitzharris: My memory is that it is something that the Red Cross offer to encourage—

MRS DUNNE: There are different organisations.

Ms Fitzharris: Yes. Different organisations come in and say—

MRS DUNNE: "We guarantee you X number of people who will donate on a regular basis."

MS LE COUTEUR: Yes. They had a public service challenge.

MS CHEYNE: Yes. I am just checking that that is what it is.

Ms McDonald: I am not sure, to be honest. It is early days for me; I can go and have a look at that. I will take that on notice.

MS CHEYNE: I am just interested. Does that really count for a wellbeing workshop or program? That is my question. It more sounds as though people are doing it—

MRS DUNNE: Community service.

MS CHEYNE: out of the goodness of their heart.

Ms Fitzharris: If it is that people are donating and there is a challenge to get increases in donations, some people value that highly. If we can encourage and support them to do that, then yes, it does contribute to their wellbeing and their feeling of contributing to the community.

MS CHEYNE: Yes, if they are being given that time to do that.

Ms McDonald: Yes.

MS CHEYNE: If you could confirm that, that would be lovely.

Ms McDonald: We will.

MS CHEYNE: I have some questions about annual leave. At the Canberra Hospital, what is the average annual leave balance for nurses?

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

MS CHEYNE: That would be good. What measures are in place to encourage employees, particularly nurses, to take leave?

Ms McDonald: I can talk in general terms, and Marg can talk specifically about nurses from last year. In general terms we encourage all staff to take leave, but it is the same as finding the balance with the service delivery. Every ward has a CNC—a clinical nurse consultant, a nurse in charge of the ward—who manages rosters. They have a role in rostering staff across the wards.

In all our services there is a nursing roster, and within that there is a requirement that they understand how many people need to be on leave at any one time and how they balance those leave requests of nursing staff to deliver the roster and the service, but also have enough time so that people can take their leave. Also then, there is the balance of people taking their leave when they would like to take their leave, because they all have family commitments and different things on at different times. That is a traditional approach to how we apply leave. In the EB, nursing staff have a leave entitlement. We encourage people to take leave, and I will increasingly encourage people to take their leave on a regular basis.

You would understand that some people like to hold their leave so that they can take a big chunk of time away, but we would encourage people to take their entitlement in regular leave, because it is good for their wellbeing. It re-energises them and it helps us with a healthy workforce. If you want to talk more specifically, Marg can talk to that.

Dr McLeod: I accept the privilege statement.

THE CHAIR: Thank you.

Dr McLeod: Each nurse has an annual conversation with their manager, a performance review, and leave entitlements or leave plans should be considered during that discussion. Anyone with a long period of leave that they have not taken would be strongly encouraged to book their leave on an annual leave planner to ensure that they are fresh and can do their job and look after their own health and wellbeing. So it is about taking leave and, as you mentioned, Bernadette, not accruing it. Working for very long periods of time is discouraged, but we really need to balance that with the service needs, and each unit has an annual leave plan to work that out.

MS CHEYNE: How do people go about applying for leave? I understand that it is a balance with the service delivery, and I assume that whether leave is granted or not might be related to whether a person can be covered.

Dr McLeod: That is right.

MS CHEYNE: How does that work?

Dr McLeod: They put in a formal request to the nurse manager. There is a nurse manager in every unit or every area that looks after a certain number of clinical areas. They put in a formal request. They might do that years in advance, or at short notice if it is required. Then the nurse manager looks at the leave balances for all the staff, and where there are opportunities to release staff to go on leave, that is booked into the annual leave planner. If there is not a space when the staff member wants to go, there might be discussions about considering another time of the year.

MS CHEYNE: Are there some areas where leave requests are regularly rejected because it is difficult to find people to cover them because of the nature of the work?

Dr McLeod: I would not say regularly rejected. Every effort is made to accommodate staff requests, but there has to be balance with the service needs as well. Staff members have the opportunity to personally negotiate or have conversations with their colleagues to see which spots on the leave planner might be able to be freed up if someone particularly needs to get away.

MS CHEYNE: What annual leave balance do we have to try to ensure that nurses have no more than X number of days, for example? Is there a limit where, if they get 40 days or 50 days, we go in and say, "You've got to take leave and we will make it happen for you"?

Dr McLeod: The DONs and the managers of the clinical units can check on the leave balances and really identify the staff members who have not taken their leave for a very long period, and personal conversations are held with those individual staff members to see if their leave could be taken, as I said, so that they can be refreshed but, as far as I am aware, there is no set number of hours.

MS CHEYNE: On notice would you get that average annual leave balance for nurses? Are you also able to take on notice the highest number of days that someone has?

Dr McLeod: Certainly. That information would be available.

MS CHEYNE: The background to my question is that anecdotally I have heard that there are some nurses who have more than 50 days and, when they have put in requests, for years they have been rejected. I very much appreciate that balance. I expect that in some places it is very difficult to negotiate simply due to the nature of the work. But I am very keen to know what more can be done to ensure their own wellbeing and not having burnout. I think it is part of that broader attraction, retention, development conversation too.

Dr McLeod: Certainly.

Ms McDonald: Just as a point of clarification for you, to add to the discussion, often

there are terms used such as "excess annual leave" and there are often definitions but they are unique. They are different. For nursing, it may be different to doctors, to other health professionals and those sorts of things. There is not a standard, from my understanding, excess annual leave. "If anyone above 50 days is excess, we have to do this". They are different concepts there.

We also have to understand that there are complexities in annual leave. I might work full time for 10 years and accrue a whole lot of leave and then I will drop down to two days a week. When I go on leave I only ever use two days a week of leave. For me to actually then use up my leave takes a long time. There are complexities and that is just one small example in terms of somebody who may look like they have got huge amounts of excess annual leave but they are only working part time. They are actually going to take forever to get it down. But they still get their leave, those sorts of things.

MS CHEYNE: Conversely, I think that there are examples as well where people at a very junior level bank their leave and then they take it five years down the track when they have been promoted a few times and it is worth a lot more to them.

Ms McDonald: Yes, that is right.

MS CHEYNE: And they get paid a lot more to take that leave?

Ms McDonald: Yes.

MS CHEYNE: Which has a budget impact too?

Ms McDonald: Yes. We are happy to take those questions on notice and provide that information for you, recognising that annual leave is complex across the organisation.

MS LE COUTEUR: I have a follow-up about workforce and staffing. How much of ACT Health is permanent and how much is casual and, of the casual, short-term and long-term contracts? You might need to break that down between the different types of—

Ms Fitzharris: We might take that one on notice. I think that there was a question on notice about this recently. We will provide that. We will take it on notice.

MRS DUNNE: This may also be a question to take on notice. I hear reports from people—and it is only anecdotally—that there is a high proportion of people who are working double shifts. Do you have the information about the number of people who work double shifts or who are working substantially more than standard hours in a week across the health professions?

Ms Fitzharris: We can take that on notice.

THE CHAIR: I want to move on to the overnight occupancy rate for beds. Do we need to get others up or do I ask the question?

Ms McDonald: We can bring Mark up to help if there are details.

THE CHAIR: First I want to talk about patient flow strategies to improve bed lock.

Ms McDonald: I might give an overarching perspective on it. We have in place quite a lot of patient flow strategies in terms of trying to maximise patient flow across the organisation, in particular the communication of patient flow and the particular status of the hospital at any given time, especially first thing in the morning when patients are being moved around the organisation.

We have just formed a working group to establish a timely care strategy with a specific focus on patient flow. That is not just within the hospital. It is actually people coming in but people leaving the hospital as well and what we are doing in the community and our services to maximise the time people are in the community and spending less time within the actual hospital, but making sure that they get the right care in the right place at the right time.

Some of those strategies are things like regular bed management. We have regular patient flow meetings in the emergency department in the morning. That is texted to, I think, about 90 people in the organisation to say this is what is happening. We continually monitor our ED activity, in particular those complex areas of care—our intensive care unit and our coronary care unit—in terms of our bed occupancy and our capacity in those areas. We also monitor and drive flow through the organisation in terms of the wards and how quickly they are bringing people out of the ED but also how well they are discharging patients and getting that flow to happen through their wards.

This is not something that happens only a couple of times a day or during the week. This is an everyday, 24 hours a day, thing that are we doing. We always have somebody in the organisation, whether that is an after-hours nursing supervisor or our patient flow coordinators during the day, who have an oversight and understand what is happening across the organisation. And then there are particular procedures where they escalate if they feel we are getting to capacity or there is an issue here, an issue there.

Then we have Mark Dykgraaf's role which actually helps to drive flow across the organisation. But I might, with your willingness, hand over to Mark here. He can give you a lot more detail on that if you had specific questions.

THE CHAIR: The Canberra Hospital occupancy rate is currently sitting at about 94 per cent, in the annual report, with a target of 90 per cent. What information can you provide in relation to the rate of patient numbers through each bed in a day?

Mr Dykgraaf: I acknowledge the privilege statement. In terms of the movement of patients through the hospital, I note Ms McDonald's commentary regarding the daily activities that we undertake. On any particular day Monday to Friday we will discharge anywhere between 100 and 140 patients from those inpatient beds. Across most weekends now, Saturday and Sunday, we will discharge between 130 and 170 patients. If you think about the bed stock at Canberra Health Services, both at UCH and at the Canberra Hospital site, there is a significant rate of patients moving through those beds.

In terms of some of my commentary about the 94 per cent occupancy at a target of 90 per cent, I note commentary earlier where we have seen a rise in demand for services across the board; over four per cent for ED again in this reporting period. I note elective surgery rising at over two per cent through the reporting period and also emergency surgery rising by over six per cent. Dealing with occupancy remains a significant challenge.

In terms of dealing with it in a broader sense, I note the winter plan, which we are in the middle of or coming toward the end of, where we have inserted an additional 84 beds to deal with the winter peak. That strategy has worked well and we have been able to maintain occupancy levels that are more comfortable than they might have been last winter, noting the challenge of last winter.

We are also working with our colleagues in the digital solutions division on a very important strategic project around the digital patient journey. We already have journey boards on every ward. The idea of what we do in patient flow is that everybody has a role to play in the patient progression through the organisation, whether that is an administrative staff member at the front desk or a wardsman or somebody in pathology and so on.

The digital patient journey will build on the work of our journey boards with quite a sophisticated tool that will enable us to track individual patients as they move through the hospital and health service. We will also be able to see what is happening in a ward and we will be able to see our patients in ED that will need to come from the ED to our ward. It is quite an important tool.

THE CHAIR: Which will obviously help with staffing for the wards as well, from a nurse perspective?

Mr Dykgraaf: Indeed. The staffing ratios in the wards are, of course, something that we manage based on the number of beds that are open. As part of the winter strategy we were in quite a comprehensive campaign recruiting additional nurses to be able to staff those 84 beds; additional doctors, additional allied health professionals and so on.

The digital patient journey will give us a much better look at what is happening to the patient as they move through the organisation. We expect phase 1 of that particular project, a comprehensive project, to be ready and rolled out by 30 June, early July next year.

THE CHAIR: The winter bed strategy, is that what you suggested?

Mr Dykgraaf: Correct.

THE CHAIR: That is the 80-odd?

Mr Dykgraaf: Eighty-four beds.

THE CHAIR: What were the benefits of having that particular strategy? Was that to cope with the additional flu cases? I note Ms Le Couteur's earlier questions about homelessness. Obviously in winter there would be more need for people who are

homeless to present at the ED, I would imagine, just from the cold alone. Anything else?

Mr Dykgraaf: The winter bed strategy is about dealing with a known peak in demand for our services, and that known peak is driven by a number of things. One of them is flu. Dr Kelly will be able to talk to the flu season more comprehensively than I could. But we note that the flu season this year has had minimal impact.

What you also see is that people will get respiratory illnesses that are non-flu on top of chronic conditions. They come to the hospital in a more complex state, and you particularly see that with older people who are multi-morbid. They might have cardiac disease; they might have respiratory disease. Then they get an acute respiratory illness on top of that, it tips them over the edge and they appear at the hospital. If you look at our September and October demand figures through Canberra Health Services you will see figures that were similar to last year.

On that basis of ongoing rising demand, you see the winter peak has fallen. The benefit of it was that we were able to treat people in a more timely fashion. We were able to get them to inpatient beds more readily. In our paediatric area we have 12 additional beds for the winter, and we flex them up and down very rapidly because kids come in, they are acutely unwell, but often they improve very rapidly.

MRS DUNNE: I have a question about the winter bed strategy and the 84 beds. Where were those 84 beds? I presume they are not there now, because winter is over. Where were they physically located? How were they accommodated? You do not just get extra accommodation for 84 beds out of nowhere.

Mr Dykgraaf: No, you do not. Those 84 beds are still in operation, and they will be in operation until the end of November. While we talk about a winter strategy, it rolls clearly into the spring; it is a five-month period of the year.

MRS DUNNE: For the extra-long Canberra winter.

THE CHAIR: Well, it is still cold.

Mr Dykgraaf: Yes, indeed. We moved the acute surgical unit which is near the ED up into the tower block. We created 16 additional beds in the ED. That was very important in terms of being able to deal with the demand as it came through. We opened a 16-bed medical ward, also up in the tower block, to deal with that acute medicine demand. I have mentioned the 12 beds in paediatrics. The balance of the beds sat between our surgical division, our cancer division and our rehab division, and I have mentioned medicine as a discrete space. Those beds have been functionally open for most of the winter—I note that the paediatric beds open and close—so it is right across the organisation in our various divisions.

MRS DUNNE: You said you opened 16 beds in the tower block and you moved some other beds to the tower block. Where did you move them to in the tower block?

Mr Dykgraaf: We moved them to wards. It was quite a complex movement of wards to get ready for the winter. We moved them up onto level 7B. Level 7B is a 32-bed

unit. Half of that unit was taken for the acute surgical unit. The acute surgical unit is a 48-hour surgical turnover, so a rapid turnover. The other half of those beds were turned into our winter medicine ward, dealing with people who come in with medical conditions: respiratory illness, cardiac conditions, et cetera.

MRS DUNNE: You said you had 16 extra beds in ED.

Mr Dykgraaf: Correct.

MRS DUNNE: They will be closed down?

Mr Dykgraaf: Yes. We will expect to close them next week. We need to do that because we need to bring the acute surgical unit back onto its footplate in early December.

MRS DUNNE: Why is that?

Mr Dykgraaf: By preference, you have your acute surgical unit near the ED so that patients can move rapidly from the ED to the acute surgical unit. We are also continuing to do hydraulic works up in the tower block. This will be the last phase of those hydraulic works, which will commence in early to mid-December on level 7. So we need to decamp level 7.

MRS DUNNE: You need to decamp so that you can do that.

Mr Dykgraaf: There will be lighting and some bathroom upgrades at the same time on level 7. That work will run from December through to the end of May, again getting us ready for the winter.

MRS DUNNE: So you can ramp up for the next season.

Mr Dykgraaf: Yes.

MRS DUNNE: Can I just touch on targets. Correct me if I am wrong, but my recollection is that the targets used to be slightly lower than 90 per cent: in the mid-80s or something like that. Is that correct?

Mr Dykgraaf: I cannot comment; I would need to double-check.

MRS DUNNE: Could we check that, please?

Mr Dykgraaf: Yes.

MRS DUNNE: Also, Calvary is not up to target. What are the factors for Calvary not meeting that target in this period? That may be a question on notice. And what are the possibilities for shuffling demand across to Calvary, which is not up to target?

Ms Fitzharris: I might ask Karen Doran to come up, but if I could make a point on that, that is an important point around territory-wide health service delivery and planning right across the territory. These figures might in the broader sense show that

there is some capacity at Calvary and we simply must use that better. There has been a very significant piece of work at the strategic level coming down into the service delivery level, and I think that will progress really well. I note that Mark Dykgraaf will be leaving Canberra Public Hospital very soon; we will look forward to working with him in that capacity when he takes up his new position at Calvary.

I do note aspects of the work that we have been doing. For example, the investment in the maternity ward is a really good example of better using the capacity, not just the physical capacity but the staffing capacity across the territory. The upgrades to the emergency department which are underway and will be completed next year are another example of where we have to do that. We cannot have a situation where we have some capacity in the territory that is not properly balanced in the appropriate way for the appropriate delineation between what both hospitals can offer. That has been a challenge over many years, and one we are very keen to progress.

While we will miss Mark, we will welcome his contribution from Calvary. We expect to see that relationship—from the highest levels of both organisations, and the government and Calvary, right through to the clinicians—continue to improve. Perhaps Karen Doran can speak a little about Calvary.

Ms Doran: I acknowledge the privilege statement.

This is an issue that is just coming to light as one of the advantages of the splitting of the organisations: the ability within ACT Health to take a territory-wide focus on a whole range of issues, one of which is bed occupancy rates.

In 2017-18, the overall occupancy rate was at 86 per cent. As we have identified, it was over 90 in Canberra Hospital and below the target of 90 at Calvary. In our discussions with Calvary around their performance agreement, and the services that they can contribute to the overall system, this is one of the issues that we have been working through, looking at opportunities to leverage what is, at the moment, capacity within their hospital campus, and looking at what we call the role delineation, the split of services between the two hospitals, and how we can best balance that to relieve pressure on the Canberra Hospital and pick up some of that capacity at Calvary Hospital.

There have been a number of contributing factors to the below-level bed occupancy at Calvary. Part of that has been the opening of UCH, which meant some transfer of services off their campus. That also contributed to Canberra Hospital and supported the ability for the winter bed strategy and the bringing online of the additional beds there. It has probably been responded to more quickly at the Canberra Hospital, and we are still going through the process of responding to that at Calvary. As the minister mentioned, we are looking at some infrastructure works to support that so that they can bring in new services and pick up some of that demand pressure from Canberra Hospital on the Calvary campus.

Focusing on maternity in 2017-18, some infrastructure improvements were done there which allowed an increase in maternity services at Calvary and relieved pressure at the Canberra Hospital. Going forward, we have been having discussions around emergency and elective surgeries, and the capacity for Calvary to take on more of that

work, again supporting the pressures that the Canberra Hospital is experiencing, but also supporting the government's commitment to reducing elective surgery waiting lists and having higher targets of elective surgery throughput in that area. For Calvary to do that, we are looking at their infrastructure needs, their theatres and their procedure room needs. There were some commitments in the 2018-19 budget to some capital works there to support that.

These are issues that are part of ongoing discussions, part of our striking a performance agreement with Calvary. Given our current relationships with Calvary, it is something that we have been able to do much more productively in the past 12 months and really get some of these beneficial outcomes on a system-wide basis.

THE CHAIR: Ms Doran, you mentioned the upgrade to the Calvary maternity sections. What kind of impact will they have? How many extra beds will that give us? What is the outcome of that upgrade?

Ms Doran: In simple terms, yes, it is bringing online extra beds and birthing suites, with the outcome of allowing them to increase their provision of maternity services. I will just try to find the exact numbers for you. It was an area where there was demand pressure on the Canberra Hospital and less flowthrough in the Calvary Hospital. Part of that was the perceived better facilities at Canberra Hospital: newer, more modern. The upgrade at Calvary has been to balance that perception.

There are also initiatives in place to communicate better with our community about the two hospital facilities that are available, and to look at ways that we can give people the option or the information to allow them to be redirected to the Calvary Hospital if that suits their circumstances and preferences.

It is a sort of combined initiative across getting the infrastructure in place but then getting the policy in place as well, again on a system-wide basis to allow people to get their treatment in the best place, the most convenient place, and balancing the pressure across the system as best we can.

THE CHAIR: Both you and Mr Dykgraaf mentioned the elective surgery waiting times and the relief the winter beds have for that. Can you go into a bit more detail about how that has helped with the elective surgery wait times? Ms Doran, would you like to start from a Calvary perspective?

Ms Doran: From a Calvary perspective, we have had two initiatives in the elective surgery space. There was some initial funding provided in the 2017-18 budget review cycle which allowed an increased focus on elective surgery, a ramp-up of elective surgery, effectively in the last three months of that financial year. The 2018-19 budget then provided stability through additional funding to support elective emergency surgeries. There has been significant benefit to the system in having that certainty and stability of funding, which has allowed processes to be put in place to keep the momentum that we established in the latter part of 2017-18 and progress that through this financial year and going forward. It allows staffing to be put in place on a constant basis, and planning on a long-term basis to be established to address the waiting lists in elective surgery.

In 2017-18 the number that went through in terms of elective surgeries was 13,000—I have not got the exact number—which is the highest that we have had for quite a number of years. The target for 2018-19 is at 14,000. What that has done for waiting lists is to bring the waiting list down. It was running in the 500 to 600 range; we ended 2017-18 at 399. This is those on the waiting list for longer than the clinically recommended time. We are hoping that over 2018-19, we will be able to continue to improve that. The challenge we have in that space is that the demand for elective surgery is growing faster than we can provide it, so we always have numbers coming onto the waiting list that are higher than what we are able to take off in any period.

THE CHAIR: Did you have anything to add, Mr Dykgraaf?

Mr Dykgraaf: I think Ms Doran has covered it very well.

THE CHAIR: We might take a very short break.

Short suspension.

MRS DUNNE: Going back to yesterday's *Canberra Times* report about the AIHW cost of acute admitted patients in the public hospitals in 2012-13 and 2014-15, the figures are not great, as we have seen. The thing I want to drill down into is the statement reported in the *Canberra Times* that the future figures for 2015-16 and 2016-17 would show that we were heading in the right direction. There was a figure of 10 per cent improvement. What is the source of those figures and are they available?

Ms Doran: There are a number of bodies that collect costing information for the health system. The AIHW report fed off information that is collected by IHPA: undisclosed information that is with IHPA. I will also—

MRS DUNNE: For Hansard, could you expand the acronym?

Ms Doran: IHPA is the Independent Hospital Pricing Authority. It is the body that independently collects costing information and determines effectively the national efficient price for hospital health services. The AIHW report, while it feeds off data collected by IHPA, is a different measure and includes different information to the normal IHPA national efficient price framework. It was also a rather historical set of data: it was 2012-13 and 2013-14. Through the processes of our submitting data to IHPA, there will be a report issued in February which will reflect—

MRS DUNNE: By IHPA?

Ms Doran: Yes. It will reflect, on a national basis and hence for jurisdictions and states, their costing levels in respect of 2016-17. We have our estimate of how that number will come out based on the information we have submitted, but we always use caution until the actual report is finalised before we announce that number officially. Based on our estimates, that number will come in at about 10 per cent below the 6,000 number that was reported in the AIHW report.

MRS DUNNE: So that is about 5,400?

Ms Doran: Around the 5,500, 5,600 mark.

MRS DUNNE: Does the methodology used differ between the IHPA report and the AIHW report, and in what ways if it does?

Ms Doran: It is a complex area, I think it is fair to say. But—

MRS DUNNE: Damn straight it is.

Ms Doran: the methodologies are evolving over time. Even with IHPA between different years, the methodologies are improving as the national framework evolves and learns. What is being captured in the costing information is changing from year to year. So it is always difficult to compare even year to year within the IHPA reports. It is a further level of complexity to compare between the IHPA and AIHW reports. There are a number of items included in that AIHW costing from 2012-13 and 2013-14. One example, certainly not totally inclusive, is our immunisation programs. At that stage the data for that and the costs in respect of that were included in our cost data, and so—

MRS DUNNE: In the 2012-13—

Ms Doran: In the AIHW report, whereas now those costs are excluded from—

MRS DUNNE: Are you saying that we are not comparing like with like; that our immunisation data was included but in other states it was not?

Ms Doran: I was specifically comparing between reports: our data, AIHW to IHPA. Between states, I would not even begin to comment, because the way in which jurisdictions interpret the methodology and the circumstances in different jurisdictions can be very different. That is another dimension of complexity. In the territory we have largely a single hospital system but a system that extends into the community health space and the mental health space. It is always a complexity for us in working through our data just to separate what is counted and what is not counted.

MRS DUNNE: But it was reported yesterday that a hospital spokesman or an ACT Health spokesman said that there was a quantifiable decrease. Can that information be provided to the committee?

Ms Doran: That information will become public in February next year. We can disclose our estimates but they would have to be qualified on the basis that we cannot pre-empt this data—

MRS DUNNE: What is it that ACT Health provided to IPHA?

Ms Doran: We provide, essentially, inputs to their methodology. Their methodology then produces the output. We provide source data that they then run through their programs and methodology to convert it to a price calculation.

MRS DUNNE: So what you are saying is that we have to watch this space until

February?

Ms Doran: Yes.

MRS DUNNE: Are you constrained? Do you have an arrangement with IPHA that you provide it to them and it is confidential to them until they publish, or what?

Ms Doran: I think we could provide an estimate but it would have to be taken as an estimate—

MRS DUNNE: I would like to see the estimate, thank you.

Ms Doran: because we cannot confirm what the IPHA publication will produce.

MRS DUNNE: I understand that it would be your estimate, but it would be useful for the committee to see that. Thank you.

MS LE COUTEUR: On acute services and hospital in the home, page 11 says you are going to be expanding this. It seems like it will be an excellent service. Are the eligibility criteria going to change now that it is going to be bigger and territory wide?

Ms McDonald: It is a great program. We have a project being undertaken to encompass hospital in the home that is focused on care closer to home. That will see a different approach across the system.

Mr Bone: There are currently two hospital in the home programs. There is one run out of Calvary Public Hospital Bruce and there is one run out of Canberra Hospital, formerly Canberra Hospital and Health Services. We have a body of work occurring at present that we have called "care closer to home" that is looking to incorporate both hospital in the home programs into a single entry point where we can deliver a unified service across the territory. That work is currently being undertaken under a steering committee chaired by Sue Andrews, our consumer rep, and I am expecting that next week I will get the first report on how we are going to implement the new model as proposed for February 2019.

MS LE COUTEUR: You said care closer to the home. Does this imply that it is no longer going to be in the home, or is that just a name?

Mr Bone: We have deliberately done that because we have taken a phased approach to how we look at delivering our services. The first one we are focusing on is hospital in the home, but we have a broader approach where we are going to look at how we manage all of the services that could be delivered in the community. We deliberately chose care closer to home because it may be that you could deliver services in community health centres, in walk-in centres and in community halls if we were to go to regional areas with some of our partners. We did not want to restrict it to just being delivered in the home, but closer to where people live.

Ms Doran: Calvary is also a participant in this program. They have been piloting an element of care closer to home that is looking at care into retirement homes, which they call their GRACE program. That is on the back of the pilot. We are expecting

them to be expanding that service going into 2019-20. That is just a demonstration of how we have tried to broaden it to pick up different elements or different opportunities for this sort of service.

MS LE COUTEUR: Does "grace program" imply a free program? What is it?

Ms Doran: Sorry?

MS LE COUTEUR: You said Calvary's program was called a grace program. I have usually heard grace in that sort of context as being—

Ms Fitzharris: It is not like saying grace before dinner at some geriatric—

MS LE COUTEUR: No, as in free, as in grace-and-favour apartments and so on. Was that—

Ms Doran: It is another acronym. It is Geriatric Rapid—

MS LE COUTEUR: Okay, it does not matter.

Ms Fitzharris: It is proving to be a very successful program with nurse practitioners.

Mr Bone: GRACE has been very successful at Calvary but there is another program run out of the rehab and aged care division that provides a similar service. Again, we cannot roll them all up into a single first phase. So we will be looking at GRACE early in the new year and at having a single model that delivers to meet the needs of the community.

MS LE COUTEUR: I know the hospital in the home has been going for a while. Have you got any data on the outcomes for patients? Has it been better for them because they do not get cross-infections and they get better—I was going to say better food but maybe that is an impolite comment to make.

Mr Bone: I know that we do have some patient satisfaction data which would be about patient outcomes, but most of our other data will be rates: the number of patients we see and where we see them. But I will take your question on notice.

MS LE COUTEUR: While you are taking it on notice, have you got any data about the cost? Does it save ACT Health money because the patient is providing their own bed, or does it cost you because people are spending their time on the road going to visit?

Mr Bone: I will take the question on notice. In principle, providing care to patients closer to home or in their homes is preferable to their being in hospital, but on the cost effectiveness I would need to come back with a response.

MRS DUNNE: While you are taking things on notice in this space, I presume you have performance measures for the hospital in the home program rather than just patient satisfaction.

Mr Bone: Correct.

MRS DUNNE: Perhaps you could tell the committee what the performance measures are and how you are performing. I presume they relate to a certain number of non-readmissions and those sorts of things.

Mr Bone: Yes, I am happy to take the question on notice in relation to the information on the performance indicators.

MRS DUNNE: "Non-readmission" was not a very technical term but you know what I mean, Mr Bone?

Mr Bone: That is right. I understood, yes.

Ms Doran: I think it is worth nothing that it is a relatively new program. While these are very important issues, collecting data can take a little bit of time as well.

THE CHAIR: Which programs are new: both hospital in the home and GRACE?

MS LE COUTEUR: Hospital in the home has been going for years.

Ms McDonald: I think, yes, we—

MS LE COUTEUR: Maybe it has been expanded but it has been going for years.

MRS DUNNE: Yes.

Ms McDonald: I think we probably need to separate those out. We can certainly have a look at giving you the data on hospital in the home. The performance indicators that you could probably expect would mainly be about activity, patient experience and patient satisfaction. I think the question was specific about looking at outcomes and whether they are better. We could look at infection rates. But this is a piece of work that we just have to pull together for that particular service.

MRS DUNNE: Yes, I would be interested to see what the performance measures are. Also, are you thinking of ramping up the performance measures? You have not been here very long, Ms McDonald, but I tend to have a thing about activity not being a very good measure of performance.

Ms McDonald: I would not disagree with that. I wholeheartedly am in support. I think that my desire for performance measures might outstrip yours, to be honest—

MRS DUNNE: Good, we could have a competition.

Ms McDonald: with understanding our performance and the impact and the outcomes on our patients. Having said that, I would like to measure everything but measuring everything is not possible. Also, clinical outcomes are always particularly difficult to quantify and to measure. It does not mean that we should not try but I just recognise the complexity.

I have one comment on hospital in the home, its effectiveness and why we would expand. We need to look at it but I think people would understand that a hospital bed is for the sickest and most complex patient. Yes, there are associated risks with being a hospital patient. So, yes, if we can nurse someone at home or help provide their care closer to home, that is always our preference. It is actually a better experience for patients and fundamentally that is what we are about; it is the patient experience and the right care in the right place, at the right time, which is what this is about. Yes, we would absolutely wholeheartedly support it. We will look at some performance measures around that.

Mr De'Ath: I think from a policy and system-wide perspective, we will be continuing to work on the sort of economic modelling. I think those are very good questions. Yes, that will be a piece of ongoing work for us.

MS LE COUTEUR: Another part of hospital in the home is home birth. How are we going with the home birth program, particularly with the possible expansion to the north side of Canberra?

Ms McDonald: I invite Liz Chatham from maternity to join us.

Ms Chatham: I acknowledge the privilege statement. Sorry, can you repeat your question?

MS LE COUTEUR: I was asking about the home birth program and, in particular, a possible expansion to those people who live in northern Canberra or even the deep south of Canberra; that is, more than 20 minutes away from Canberra Hospital.

Ms Chatham: The home birth program is going pretty well. We have had 70 babies born as of 23 October this year. We are actually going through an internal process review and we are doing an external review after we hit 20 births, which we hope to do by the end of the year. I think the expansion to the northern side of Canberra will depend on the outcomes of the pilot that is underway. Like many people, I think that expanding it to the northern part of Canberra would be fantastic, but it certainly would depend on Calvary hospital being the referral point for those people having home births in that area. I guess that is a conversation with Calvary going forward following the evaluation.

MS LE COUTEUR: What about, though, the people in the deep south who are more than 20—

THE CHAIR: Deep south! It is not that far.

MS LE COUTEUR: Well, who are arguably more than 20 minutes away from—

MRS DUNNE: But I am sure she was not implying *Deliverance*—

MS LE COUTEUR: from Woden, who will being going to Woden for birth.

Ms Chatham: There are very strict clinical and geographical criteria put around the trial because it was a new pilot project. They wanted to ensure safety. The actual

distance from the hospital that women can be a part of the project is about 20 minutes, allowing for an ambulance to leave their site, wherever they might be, go to the home and then return to Canberra Hospital. That was set by ACT ambulance. We are hoping that the really very strong positive outcomes that will hopefully come from the evaluation will encourage the Ambulance Service and Calvary to look at the extension of those boundaries. But at this point, while it is in a pilot program, we are sort of bound by the criteria binding that project.

MS LE COUTEUR: Right, okay.

Ms Chatham: But it is very—

MS LE COUTEUR: I hope it—

Ms Chatham: It is very successful so far, and the women—

MS LE COUTEUR: Good.

Ms Chatham: love it, as you would know.

MS LE COUTEUR: I know, I know.

Ms Chatham: Yes.

MS LE COUTEUR: I suppose that I am particularly reflecting on my daughter, who lives in rural New South Wales, a lot more than 20 minutes away from a hospital.

Ms Chatham: Yes.

MS LE COUTEUR: She was actually very close to the local hospital but she could only give birth there if she was on time. Once she was after time, she had to make a considerably longer trip and has since—it sort of seems crazy. Anyway, we are not learning from the experiences of people in rural Australia.

Ms Chatham: We are learning applying it here. I think it is very early days. The territory has taken the step to move to home births. I think that—

MS LE COUTEUR: Which is great.

Ms Chatham: they are just needing the reassurance that we can respond well to any need that we may have in the clinical setting and make sure that the women and the babies are as safe as they possibly can be. I think in the future we can see it expanding somewhat. But I cannot know that until the evaluation comes up.

THE CHAIR: When is the evaluation due?

Ms Chatham: We have two evaluations. We have a halfway evaluation, which is at 20 births, and then a full evaluation at 40 births, but we are actually doing a process evaluation as we speak. We will have those results by the end of the year.

MS LE COUTEUR: Clearly, as you said, basically it has been very successful.

Ms Chatham: Yes, it has.

MS LE COUTEUR: Have any mothers and babies required to be ambulance transported.

Ms Chatham: Yes, we have had 17 babies born and three have required transfer.

MRS DUNNE: Seventeen, sorry; I thought you said 70 before.

Ms Chatham: No.

MS LE COUTEUR: Yes, I thought you said—

Ms Chatham: No, sorry, only 17. Sorry if I was unclear. It is 17. That reflects the very strict criteria. We have had three women transfer into hospital. All of them were in the post-birth period. Two were for suturing of perineal tears and one was for a PPH of 800mL, but all those women—

THE CHAIR: What does "PPH" mean?

Ms Chatham: It was a postpartum haemorrhage of 800mL. That woman transferred in just to make sure she was okay and then she went home again. So all the women and babies were well and healthy. It has been lovely. It is a lovely service to watch grow.

THE CHAIR: I want to talk about the improved emergency department timeliness. There was a 13 per cent increase in category 4 and 5 presentations at walk-in centres. Does that correlate?

Ms McDonald: We cannot correlate it directly at this point in time.

THE CHAIR: Does it provide evidence about what the walk-in centres are doing in relation to helping to take some of the pressure off the emergency department?

Ms McDonald: The information that we get on the walk-in centres is the type of presentation, what people are coming in with. On first glance, and it is early data—I can ask Cathie to join me if she would like to—the sorts of illnesses that people are presenting with are those sorts of category 4 and 5 type things that people would often present to an emergency department with; or go to their local GP with, to be honest.

Ms Fitzharris: Particularly with Gungahlin opening and doing very well in presentations. It is comparable to Belconnen and Tuggeranong, which have maintained the same levels of presentations. UC have expressed an interest to work with us to do some research on walk-in centres; we will look forward to having some further conversations with them about how they can conduct some of that research with us.

THE CHAIR: In the past, I have used the walk-in centre, but it has been a little

while; I usually wait until I am too acute.

Ms Fitzharris: Please do not do that.

THE CHAIR: I know. I am very bad at this. Mrs Dunne will also attest to this. She is nodding. Walk-in centres provide medical certificates for people presenting. That is correct, isn't it?

Ms O'Neill: I acknowledge the privilege statement.

They offer certificates of attendance. There are some slight differences in the legislation about what can be provided from a doctor versus what can be provided from another health professional. The ones that are provided through the walk-in centres are very similar to the ones that you could get from a pharmacy, for example.

THE CHAIR: But for the sake of attendance in a workplace, they could still be classified as saying that you were too ill to attend work.

Ms O'Neill: Yes.

THE CHAIR: Are there any numbers on patients who were going to Belconnen walk-in centre and are now going to the Gungahlin walk-in centre?

Ms O'Neill: Again, we cannot directly correlate that data, but the numbers in Belconnen have not dropped off with the opening of Gungahlin, so it would appear that the presentations at Gungahlin are new demand.

THE CHAIR: Do you share patient records with GPs for the sake of continuity of care and those sorts of things?

Ms O'Neill: If the patient consents, there is an event summary, as it is called, that the walk-in centre staff complete and distribute to the GPs.

THE CHAIR: How is that managed for privacy?

Ms O'Neill: It is done through secure distribution, electronically.

MS LE COUTEUR: Would that also go on your My Health record?

Ms O'Neill: Not at this stage, but the processes within the hospital are improving in terms of the documents that we are uploading. Peter will be able to give us some more information on that.

Mr O'Halloran: The short story at this point in time is that those documents are not uploaded to the My Health record. There are some very specific formats that are applied to document types—discharge summaries, for example—being uploaded. We are continuing to work with the Digital Health Agency around the formats of those documents to enable other document types such as discharge letters from emergency departments and documents from the walk-in centres to be uploaded, but the initial focus of the Digital Health Agency is on discharge summaries for admitted patients,

followed by pathology and medical imaging results, which we are also now uploading.

MS LE COUTEUR: So the ACT does now upload those if you have a My Health record?

Mr O'Halloran: That is correct. Canberra Hospital was the first public hospital in Australia to upload discharge summaries to what was then the personally controlled electronic health record, now the My Health record. We have also now connected for other document types that are being uploaded. We are now uploading diagnostic imaging reports for inpatient episodes, and it is the same for pathology. Those documents are being uploaded. In the past few months, we have uploaded nearly 39,000 pathology reports and over 3,500 diagnostic imaging reports. The take-up of that by citizens across the ACT seems to be quite high.

MRS DUNNE: The reports, the images or both?

Mr O'Halloran: At this stage it is just the reports. The national infrastructure cannot cope with the volume of the images should they be uploaded, given that a modern medical imaging modality for a scan could be 10, 20 or 30 gigabytes, based on some of the technology we are now using. That would crash a national system.

MS LE COUTEUR: Clearly, after the past couple of days. Are you working with the broader medical fraternity in the ACT around getting people's information onto My Health? Do you have a specific role in that? Someone within ACT Health presumably does.

Mr O'Halloran: Working with other health professionals across the ACT is broadly managed by the Australian Digital Health Agency. They then subcontract that work out to the various public health networks, PHNs, across Australia. In our case, the Capital Health Network is working with GPs, specialists, community pharmacies and the like to work on that take-up. They have an entire project team working with those users to ensure that they are connected and that they are providing information to the patients and consumers they are dealing with. We work very closely with that team. We have a monthly meeting with them where we exchange information. They identify those particular issues from what we are doing and vice versa. We have provided a number of information sessions in conjunction with them.

MRS DUNNE: I have some medical imaging questions. Specifically I understand that in the second half of last year ACT Health migrated from what I understand was a Siemens software system in medical imaging to an AGFA system. It has been reported to me that there were some problems with that. Before I go to the problems, is that the case: that we moved from Siemens to AGFA software?

Mr O'Halloran: At this point in time we have not actually introduced the new system. ACT Health undertook a procurement, commercial approach to the market about two, 2½ years ago to procure a new medical imaging RIS/PACS system. I am not even going to try to explain the acronym. It is a medical imaging diagnostic system that manages the images. AGFA was the successful respondent for that tender. The contract was awarded. There has been a project in place since then.

The system is scheduled to go live in mid-February next year. The project will be technically complete in about 14 days. However, obviously introducing a new system of that magnitude a few weeks before Christmas and all the various things is not ideal from a clinical perspective. That is being implemented in mid-February at the request of medical imaging.

MRS DUNNE: What is the preparation that is involved in switching from the Siemens system to the AGFA system?

Mr O'Halloran: It is extensive. We have actually set up an entire development and test environment. There is the various hardware. It will involve replacement of all the workstations for radiologists, new medical imaging screens. It sounds silly but it is about $10,000 a screen per radiologist to ensure that there are no blemishes that can be misinterpreted as something on a scan. But it is also completely new hardware. It is interfacing into all our core systems so that orders for imaging can come from our existing systems and the results can flow through.

There is also fairly extensive work with the staff in medical imaging in relation to workflows that will change. It will change how the radiologists work, it will change how the radiographers work and it will also change how the administration staff work. There have been a range of subject matter experts from across medical imaging who have been brought in to work with the project team to work through those issues, and there is a fair range of technical aspects of it.

In addition, we are migrating at the moment all the previous imaging and reports since the Siemens system was commissioned about 10 years ago so that when we go live with the new system the entire history of patient records and all the imaging that is there is migrated to the new system on day one.

MRS DUNNE: I have been told that in the migration process many images have become separated from the patient records. Is that the case?

Mr O'Halloran: I am certainly not aware of that. There have been a number of testing cycles to look at the migration and how it works. In essence, how it works is: there is the actual port that is produced, which is then linked to one or more images from the study. Those linkages are there. They have not been separated. There has been extensive testing to ensure that there is no separation and ensure that the coding of the diagnoses of the modality type of a particular body part image is not lost in any way. I am certainly not aware of any part of that. We have actually had a fairly significant team, including clinical oversight, looking at how that migration works.

MRS DUNNE: As far as you know, there has been no problem with the transfer of medical images from the old Siemens software to the new AGFA software?

Mr O'Halloran: There have been a number of issues that we have worked through over the months, everything from the speed at which we extract it from the Siemens system and how we map the codes. But I am certainly not aware of any outstanding issues on this matter.

MRS DUNNE: There is no possibility that patient records and images have become

detached from one another?

Mr O'Halloran: That is correct. They have not become detached.

MRS DUNNE: Are you auditing as you go along to ensure that that is the case?

Mr O'Halloran: There is a range of tests done on the data that is being migrated to ensure that that is the case. Secondly, prior to going live with the new system there will be a further audit to check that that has not occurred. But at this stage the testing that has been undertaken there has been highly successful. We have not identified any records becoming detached.

I would also note at this point in time there are no clinical staff accessing the system in a production sense. They may only be accessing it purely for training, for identifying how the system will work in the future. It is certainly not being used for any clinical treatment.

MRS DUNNE: Because it has not gone live yet?

Mr O'Halloran: It is not a live system yet.

MRS DUNNE: Are the two systems, the Siemens system that you are phasing out of and the new AGFA system, comparable in terms of capacity and functionality?

Mr O'Halloran: No they are not. The short summary is: the Siemens system was probably cutting edge when it went in over a decade ago. It has not progressed in a substantial way. I think we are now the only customer in Australia still on that platform. And there have been very few enhancements to that product.

The AGFA product that we are putting in is probably seen by many as the leading product in the country at the moment and is certainly being implemented in a couple of other hospitals, most notably recently in Queensland. It has a number of enhanced workflow requirements, much easier coding, the screens are much clearer.

As part of the procurement process we had a range of clinicians in the room actually looking at it who rated all various respondents. The unanimous view that came out of those sessions was that this was much clearer and easier to use. I understand the medical imaging department has predicted approximately 10 per cent improvement in efficiency of their operations base when the new software goes in.

It will also enable us to offer things such as external access, for the first time, to our reports and images, directly through a smartphone or tablet app as well for some of our clinical colleagues that we work with. It is actually fundamentally a stepped change in how we operate in terms of the IT systems for medical imaging.

MRS DUNNE: If I come back in estimates next June for an update, you will be able to tell me that everything is fantastic?

Mr O'Halloran: I certainly hope so, and that is our intention.

MRS DUNNE: I will hold you to that.

Mr O'Halloran: I look forward to it.

MS LE COUTEUR: On page 21, you have a heading about stroke services. This is an area of great interest to me. I would like to hear more than the couple of sentences here, say. In the second sentence, you refer to the development of the endovascular clot retrieval service in the ACT. Does this mean that people who have strokes and do not immediately get themselves to hospital have a chance of having something done with the clots?

Ms McDonald: We might invite Girish up to talk about endovascular clot retrieval from a clinical perspective; I would not like to give you those answers myself. We can get an overview of the stroke service and then endovascular clot retrieval in particular. From a clinical perspective, what does this mean for patients?

Dr Talaulikar: I acknowledge that I accept this statement on privilege.

In terms of the stroke services, there are various multiple elements. We have the major components of it functioning quite well within the ACT. There is a very small proportion of patients who are eligible for plaque retrieval, and we are in the process of developing the pathway for ensuring that we have a 24/7 plaque retrieval program. That involves a number of components, which includes making sure that we have skilled medical professionals and making sure that we have the infrastructure in place. There are a number of steps to be taken in relation to that. But in terms of triaging the patients presenting with stroke and in terms of ambulance retrieval, presentation to ED and thrombolysis of appropriate patients, we perform at par with other jurisdictions.

MS LE COUTEUR: Sorry, I did not hear the last part of your sentence.

Dr Talaulikar: Thrombolysis of appropriate patients. When a patient presents with stroke, there are one of three things you could do. Depending on whether it is a stroke caused by a haemorrhage or a ruptured blood vessel or a stroke caused by a clot, the treatment varies. If it is a stroke caused by a clot, there is a subset of patients who are suitable for thrombolysis, which is administering an IV medication to dissolve the clot. And there is a subgroup of patients who are eligible for clot extraction or clot retrieval.

We have well-developed streamlined pathways all the way from recognition of the stroke to transport of the stroke patient in a timely manner to the hospital emergency; imaging of the patient using appropriate modalities within the hospital emergencies, both at Canberra Hospital and at Calvary public; and then administration of thrombolytic therapy where deemed appropriate.

In relation to the next step in terms of eligible patients who are suitable for clot retrieval, we do offer clot retrieval services presently, but we do not offer them on a 24/7 basis. We are working towards enabling a 24/7 clot retrieval service, but that requires a couple of steps to be taken. One is having skilled personnel who are able to man a roster 24/7; the second is having adequate infrastructure to get it done.

MS LE COUTEUR: How long is it taking between when someone rings up and says, "I believe X is having a stroke." to being in a position to diagnose that they have a clot or a bleed and thus do something?

Dr Talaulikar: In terms of the exact numbers—

MS LE COUTEUR: Approximately. You cannot do it to the minute.

Ms Fitzharris: Do you mean from when they arrive at the hospital or from when they call the ambulance?

Dr Talaulikar: From the moment they call the ambulance to the time they reach emergency—

MS LE COUTEUR: Really from when they call the ambulance, because that is when, from your point of view, it starts.

Dr Talaulikar: I do not have the numbers off the top of my head for you, but I can provide them to you. You are basically looking for numbers from presentation to ED to imaging to thrombolysis?

MS LE COUTEUR: I guess so. I was really looking at from the ambulance stage. You ring the ambulance and you say, "I think he is having a stroke." How long is it—

Mr Bone: I think we would need to take that on notice. The clinical indicators that specialists use are from the time of the stroke event to when thrombolysis is appropriate. We know the time frame for that, because if we sit outside that time frame the benefits of thrombolysis are less effective.

MS LE COUTEUR: I am very aware of that, I am afraid.

Mr Bone: In terms of from when the call is made, which could be separate from the stroke event itself, to when the patient gets to hospital, we would have to take that on notice.

MS LE COUTEUR: Yes. It sounds as though you have done some work to make it quicker once they get to hospital to get to the diagnosis stage?

Dr Talaulikar: We benchmark well nationally in terms of the thrombolytic therapy, so I am pretty confident that the numbers match up.

MS LE COUTEUR: I am not attempting to criticise. This is something I am personally very interested in. I would be very happy to hear that you have done some work which has managed to take even 20 minutes off that time span. I know it could make a significant difference. And after that, have you still got the situation where patients go to Canberra Hospital as the stroke ward or do you now have stroke wards in Calvary as well?

Dr Talaulikar: We have two stroke programs for the territory. There is one which operates through Calvary public and there is one at the Canberra Hospital. That is

quite advantageous, because from the geographical distribution perspective we are able to direct the ambulances appropriately.

We do not have a clot retrieval program at Calvary public. That is for a whole range of very good reasons. It is a complex service and it has to be located in the one area. Patients who are suitable for thrombolytic therapy get thrombolytic therapy in both stroke units, Calvary and Canberra Hospital. Patients who are eligible for clot retrieval are transferred from Calvary to Canberra Hospital in a timely manner. Patients who are not eligible for either—and that will be eight out of 10 patients, or the majority—go to the stroke ward, and there is a stroke ward in each of the two hospitals, and onward from there they go on the rehab program.

Ms McDonald: If you would like us to talk about the rehab program, I am sure we could bring Linda up to cover that.

THE CHAIR: We have rehabilitation in the next session.

MS LE COUTEUR: I am aware it is very important to stroke patients.

MS CHEYNE: This is a question about sexual health testing at Canberra's walk-in centres. I know sexual health is for later today, but walk-in centres are now; so I was told to come now, if that is alright?

Ms McDonald: Yes.

MS CHEYNE: But I will come back at 3.30 if that is better for everyone else.

Ms McDonald: I am sure that Girish can talk about it from the clinical perspective and Cathie from the walk-in centre perspective.

MS CHEYNE: My question is simple. Earlier this year the government was trialling sexual health testing at Canberra's walk-in centres and universities. Will this trial be extended? How did it go? When will we see the initiative rolled out in a longer-term sense?

Ms O'Neill: Yes, the pilot was run out of Belconnen and Tuggeranong community health centres after-hours. It was run in conjunction with the AIDS Action Council. It involved not only testing but also some peer mentoring, as they call it. The numbers were low, but what was pleasing was that the rate of diagnosis and the rate of screening through that program was actually higher than we see in some of our other programs.

The results of that are currently being considered and we are currently working through the clinical protocol approach with the walk-in centres to see whether we cannot increase what we are calling opportunistic screening of people who are coming to the walk-in centres. That is a piece of work that is currently underway.

MS CHEYNE: What is "opportunistic screening"?

Ms O'Neill: When people present, we can actually ask some questions around

whether or not they wanted to have some—

MS CHEYNE: Right; so I could come in with my hand cut off and you could say, "Do you also want to be sexually tested?"

Ms O'Neill: Well, there has been—

THE CHAIR: You would not be in a walk-in centre if your hand was cut off.

MRS DUNNE: No, you would go to the hospital.

THE CHAIR: Maybe not your hand cut off.

Ms O'Neill: I am sure it would not be the first question asked.

MS CHEYNE: Maybe not that extreme.

Ms O'Neill: Some of the work we are doing around the walk-in centres at the moment is running a generic program for minor illnesses and injuries. But we are exploring whether or not we can run some supplementary specific programs such as sexual health through the walk-in centres. But there are some logistical things we need to work through around that, but it is certainly something that we are considering.

MS CHEYNE: What logistical things?

Ms O'Neill: Whether you have the right trained staff there at the right time.

MS CHEYNE: Of course, yes.

Ms O'Neill: How do you advertise that? We would not necessarily run that in all four centres, potentially five centres, on every day; so how do you actually market that so the patient requiring those services is turning up to the right centres? There are a whole lot of things that we are working through with that at the moment.

MS CHEYNE: Were numbers low for that trial because it was not advertised very widely—I mean "widely" as in I did not know? I did not know. If I did not know, I do not think it is likely—

Ms O'Neill: I have not actually seen the formal written evaluation report; so I would not want to comment on some of those factors, but I am happy to take that on notice and get report back.

MS CHEYNE: Yes, I would be interested to know how it was advertised. While we are on walk-in centres—are you walk-in centres generally or are you sexual health?

Ms O'Neill: Walk-in centres, yes; not sexual health.

MS CHEYNE: What are the reasons that women cannot get the pill at walk-in centres?

Ms O'Neill: They can. Well, they can get emergency contraception.

MS CHEYNE: Right.

Ms O'Neill: The basic principle behind the walk-in centres is for one-off treatments.

MS CHEYNE: Okay.

Ms O'Neill: Where possible, we prefer women in that sort of situation to develop a relationship with their GP so that they can do the ongoing monitoring. Emergency contraception is certainly available through the walk-in centres. Again, that is another area that we are exploring through the extension of the model for the walk-in centres because we know that there is a cohort, particularly of younger women, who do not necessarily have a GP. Certainly, we want to see what we can do to help meet the needs of those people.

MS CHEYNE: I think it is more credit to the feedback that we get about walk-in centres that I get asked about it. I am speaking anecdotally. I appreciate that for a lot of women the pill can be complicated, but for some women it is very straightforward. However, having to wait an hour at your GP for a 2½ minute consult, whereas at walk-in centres you can be seen very quickly, I am asked, "Why can't I just get the pill there?" Given that your basic principle is: "No, we just want to have people for one-off treatment," that makes sense.

Going back to sexual health, there was a recommendation in an estimates committee report about having condoms available at walk-in centres. I think the government agreed to it. Has there been any progress on that?

Ms O'Neill: I cannot comment on that. I do not know. We will take that on notice.

MS CHEYNE: Thank you.

THE CHAIR: I have, hopefully, a very quick question on cardiac ablation.

MRS DUNNE: It was just described to me; I am recovering.

THE CHAIR: This year my father had to have cardiac ablation done and they had to bring a machine in from Sydney. I note in the annual report that we are going from the cardiac-electrophysiology services. I think we are starting implementation of the service. The second phase will see the introduction of the ablation service. What are the time frames around that? It is obviously very close to my heart.

Ms McDonald: I can give the introductory remarks because I have asked this question in terms of what is happening and can we make it faster. We certainly have the clinicians that can do cardiac ablation in place. We are working through it quite quickly and that time line has sped up in terms of equipment and those sorts of things.

THE CHAIR: My cardiologist can do it. I see him on a regular basis.

Ms McDonald: I might get Girish to talk through this. There are a couple of key

issues with equipment and location and those sorts of things that we are working on now, and we are really hopeful to get the service in place and happening very soon.

Dr Talaulikar: The question is on the time line for starting or commencing the ablation service; is that correct?

THE CHAIR: Yes.

Dr Talaulikar: There are three elements to getting there. The first is making sure that we have got the right space so that the equipment can be installed safely, and we are working with a biomedical team to achieve that in a timely manner. We are looking at the cath lab where the additional equipment is going to go, and working with the vendors who are going to supply the equipment, to look at what infrastructure changes we need to make so that the equipment can be installed safely. We are hoping, and it is highly likely, that in the next fortnight we will know what infrastructure changes we need to put in place, and then it is a matter of putting them in place and installing the equipment.

We are working through the governance processes so that we have very clear documents outlining who is available to be referred for this service, how the triaging and wait lists will be managed, how the decisions in relation to selection procedures will be done, and getting a robust, secure program so that we ensure patient safety through the whole journey. Those documents are being developed as we speak, and I am confident that before the end of this year those will be completed and finalised.

The third step to it is contract negotiation, which should not take more than three or four months. All things working, I am optimistic that in the second quarter of next year we should be ready to go live.

THE CHAIR: I must say it is an amazing technology. My father is relatively healthy since he had his ablation done earlier this year. It was quite extraordinary to see the results. I am glad to see it is coming on line.

MRS DUNNE: In relation to the training accreditation for radiology, when we were here during estimates there were commitments made about the time frames and the work that needed to be done to get things up to speed. I note that Dr Fletcher, who has now resigned, was a pivotal part of that. Where are we and has Dr Fletcher's departure made a difference to that time frame?

Ms McDonald: I can talk to that. Dr Fletcher did a lot of work. He has not departed yet. I think he is still the chief medical officer. There was a time line that we needed to submit all our responses to on the recommendations for the training. That time line has been met, and it is with the college now for consideration.

We did a teleconference with the college before we submitted the final documentation, and there was a very positive feedback that we had met all the recommendations. We have had really great feedback from the registrars themselves about seeing a difference in the environment and the support for their training.

We are waiting on the final outcome from the college to come back to us about the

recommendations and us having met those, and then the grading for our training program, which we are quite optimistic about. There has been a lot of work done in a very short space of time to meet those recommendations for the training.

MRS DUNNE: I have two very quick questions to follow up on that. One of the issues—and Dr Fletcher concentrated on this during the estimates hearings—was our failure, for want of a better word, to establish networks for training and for diversity of training. There was some discussion that we needed a country network but also that there were failings in that we did not have a breast screening network. Where are we at with those issues?

Ms McDonald: I can get Chris to talk in more detail about that. He is probably more across that than I am.

MRS DUNNE: While Mr Bone is coming, the other question is: in answer to a question on notice to Minister Fitzharris, I was told that there had been three clinical directors of medical imaging in the period from February 2017. Is there a current occupant and is that person a permanent occupant of that position?

Ms McDonald: There is a current occupant, and his contract is for six months, while we go through a formal recruitment process.

MRS DUNNE: We are likely to have a fourth person?

Ms McDonald: Not necessarily; it might be the same person.

MRS DUNNE: But the potential is that somebody else might get that job?

Ms McDonald: He is acting in the role at the moment. There is always the potential, but he is acting in the role.

MRS DUNNE: My question, Mr Bone, is: where are we with establishing the networks, the enhanced training?

Mr Bone: We have established a network with Orange and we will have from the start of next year a registrar rotating through Orange. Orange has been accredited and has funding to support that. That is established. We have recruited to the position to do that rotation.

MRS DUNNE: Does that mean you will actually have an extra trainee?

Mr Bone: Yes. We have carried the trainee for the last 12 months for the Orange rotation. We were unable to establish it as Orange were going through the accreditation process themselves.

MRS DUNNE: And what about breast screening?

Mr Bone: I understand that the work we are doing with breast screening is that we have the resources to do that and that any gaps that we have got in breast screening will be addressed in 2019.

MRS DUNNE: Will medical imaging at the hospital have a formal relationship with BreastScreen ACT?

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

THE CHAIR: We will now break for lunch and resume with Minister Fitzharris, as Minister for Health and Wellbeing, at 2.30 pm.

Hearing suspended from 1.05 to 2.32 pm.

THE CHAIR: We will continue with health and wellbeing, and we will be focusing on the areas of rehabilitation, aged and community care, and cancer services, including palliative care. I would like to start off by talking about breast screening rates in the ACT. I was wondering what was being done to help improve those.

Ms O'Neill: Whilst our breast screening rate is lower than the target, it is actually higher than the national average. The target rates have been quite difficult to achieve nationally. Part of that is that the denominator, which is the number of women between 50 and 74, is increasing as the population ages. That is part of the problem. We actually performed more breast screens last year, year on year, so we are doing more screening, but in light of that large population base we are not hitting the screening targets.

We have a very active promotions program. The breast screening team work very closely with general practitioners and practice nurses to make sure that appropriate women are attending their breast screens. You might have noticed that during breast screen awareness month there was a very large social media campaign, which has been quite successful. And the team attends all relevant field days and Country Women's Association type meetings, all those sorts of things where the potential target group will be there.

THE CHAIR: I know myself that I am not very good at taking care of myself. For mums in particular, and women who work and get busy, are there ways that the community can help raise awareness of how important breast screening is? I did a social media post for breast screening. I have to go every year. I decided to put that out on my social media to try to encourage other women. Apparently six of my friends went and got their first ever breast screen done. We are in that target category. Are there things we can be doing?

Ms O'Neill: Certainly. I think we can all get out any of those messages. I recently did a group booking with friends of mine, for the same reason. One of the things that we struggle with is the two-year screenings. Women are encouraged to have their screen every two years. The data capture on that is so tight that if you have it at 27 months you are counted as not having your screening in the appropriate time frame. That again affects our screening rates. The more we assist our friends to go and have their appointments the better.

THE CHAIR: What about on the upper end of the breast screens? Again, there would be a lot of women on the higher side of the breast screen target age range that

probably do not necessarily think about it. What sorts of initiatives are we looking at for those women?

Ms O'Neill: The 70 to 74-year-old age group is relatively new. The commonwealth started funding that a year ago. We have exceeded the target screening rate for that age group in the ACT. We have not had any difficulty in getting those women to come and have their screens.

THE CHAIR: That is excellent; that is really good to hear. What sort of follow-up services are available for older Canberrans who may have had surgery after a breast screen and then are discharged from hospital?

Ms O'Neill: The BreastScreen Australia program is a screening program. If women are symptomatic or have been diagnosed with breast cancer, it goes through a different pathway. Then they are referred for screening and diagnostic services through what tends to be private radiologists. The program that we run is the commonwealth-funded program, which is just for screening.

THE CHAIR: What are your detection rates? Are they pretty high?

Ms O'Neill: I cannot answer that off the top of my head, but they are in line with the national benchmarks. BreastScreen is probably one of the most regulated services in health. There are a range of KPIs that we have to report against regularly, and the detection rates are in line with those. I can provide you with specific numbers if you want me to.

THE CHAIR: Only if it is not too much hassle.

MRS DUNNE: Could I go back to something that I wanted to raise this morning. It may be that there is nobody here to answer it. It has been reported to me that at least one operating theatre was out of operation for a long time, with a problem with the air-handling unit. I just wanted to touch on that and ask what the problem was and whether it has been alleviated, and also ask whether that or other theatres have been out of operation for other reasons.

Mr Mooney: Could you repeat the question, please?

MRS DUNNE: I understand that an operating theatre was out of action for a while because of a problem with the air-handling unit in the operating theatre. Is that the case? How long was it out for? And have there been other outages of that or other operating theatres for other reasons?

Mr Mooney: Theatre 14 was identified as part of routine maintenance in June of this year; it was taken out of service while we did an investigation as to the actual cause of the issue. We found some mould in an element of one of the HEPA filters, high-efficiency particle air filters. Once that was found, we went through a process to work with infection prevention and control to first of all contain it and understand the cause of the problem and then, with infection prevention and control, to work out a plan to return it back into service. It has been returned back into service.

MRS DUNNE: That was the only theatre that was found to have a problem with mould and HEPA filters?

Mr Mooney: That I am aware of, yes.

MRS DUNNE: Did you check the others?

Mr Mooney: We have a regular program of HEPA filter checking as part of our maintenance program. We have not come up with any other issues that have been reported to me in the theatre space.

MRS DUNNE: So that was the only theatre? Have any other theatres been out for any other reason?

Mr Wood: I acknowledge the privilege statement. Theatre 14, which is the iMRI theatre, was out for a period of time.

THE CHAIR: iMRI?

Mr Wood: Magnetic resonance imaging. That was out for a period of time in June. We worked with facilities management and infection prevention and control to ensure that it was down for the minimum time possible, and it is now back up and running and providing full service.

MRS DUNNE: How long was it down for?

Mr Wood: Colm, can you clarify how long it was?

Mr Mooney: I am just checking my notes here. I cannot confirm exactly, but I believe a couple of weeks at most.

Mr Wood: I will take that on notice. It was down initially, and then we took it down for another period of time while we had it investigated as well. I will provide those dates on notice for you. To my recollection, the only other time we have had theatres out of service for a period of time is when we did the hydraulic works within the theatre, and that was between March and June—it was staggered—in 2017.

MRS DUNNE: What were the hydraulic works?

Mr Mooney: That is part of the UMAHA program, upgrading and maintaining ACT health assets. That was a program of just upgrading the pipework. Over the years we had a lot of deterioration of the copper pipes, and thinning of the pipes, which was leading to an increasing number of failures within the pipework. That was one of the high-risk items that had been identified as part of the original AECOM report from 2015. That formed part of the UMAHA program of work. It is a rolling program in building 12.

MRS DUNNE: You systematically went through and upgraded the pipework across all of the theatres?

Mr Mooney: In building 12, yes. We had to work with Daniel's area to shut down theatres and work outside normal hours to minimise the amount of impact on the theatre area. It was a team of people working through at nights and, when we were shutting things down, trying to use as much of the time as possible. It is pretty valuable, available time in that space. We were also doing LED lights and suchlike in that space when we were shutting down areas of the operating suites.

MRS DUNNE: How long did that UMAHA program go on?

Mr Mooney: That is an ongoing program—not in building 12; it has moved now.

MRS DUNNE: In relation to the operating theatres, how long did that take?

Mr Wood: I had a look at that this morning. We did it over periods of time from March until the last one finished in June. There were some postponements and some negotiation around elective theatre lists, so there was some downtime there. Routinely when we do maintenance in the operating rooms we try to do it out of hours and try to limit the impact because, as we have heard this morning, there is increased demand for both emergency and elective. We try to do it on weekends and after hours and therefore limit the impact on patients and service.

MRS DUNNE: Minister, building 12 was built about the turn of the century; is that right?

Mr Mooney: Mid 90s. I believe that the opening date was in 1994. I can get somebody to confirm it, but in one of the offices I have a picture on the wall.

MRS DUNNE: So it is a 25-year-old building. Are thinning of the copper pipes and the other sorts of things that we have discussed, the switchboard issues et cetera, things you would expect to see in a 25-year-old building? I know it gets a fair flogging but—

Mr Mooney: Taking the point about the switchboard, we have a switchboard in building 12 and a switchboard in building 2. Building 2, as you know, services a lot of the buildings around the campus. The key issue about both building switchboards was that we have a single point of failure. No matter how many generators we have, if we lose power we lose a section of that board. While building 12 is younger than building 2, the electrical mains switchboard still has the same issue, which is a single point of failure.

Over time things have evolved in building design and things like that from a maintenance point of view, particularly in a hospital space and in data-centric spaces where the whole redundancy and backup supply for the electrical backbone of the building is critical. When they built the building it was best practice at that time, but things move on, and in particular the single point of failure had to be addressed. Also the ability to service the board without impacting on many places downstream was a big issue. That is probably one of our biggest issues in building 2, and that is why—

MRS DUNNE: I am really interested in building 12, which is a much newer building.

Mr Mooney: Yes, but—

MRS DUNNE: Is what we see there expected fair wear and tear on a 25-year-old building, or is there something unusual about it?

Mr Mooney: You mentioned the switchboard and the copper pipes. The switchboard is not so much fair wear and tear as just an issue with the make of the board in relation to the single point of failure. Going back to the pipes, the failure mode that we have seen is just a thinning of the pipes. As to what exactly has caused that over time, there are many factors. The reality is that those pipes have thinned and we have got to put in place a solution, which we have been doing.

We have also put in place an ability to better maintain the areas. As part of the work that we have done in the theatres, we have put in isolation valves so that we do not have to shut down the whole space; we can just do it locally, which makes for much easier maintenance in the future. Also, from the point of view of TMVs, thermostatic mixing valves, as a result of installing new ones that are better able to be maintained, we can turn them off without impacting elsewhere.

In the past the design for maintenance has not always been factored in; it has been more just a design to get the building finished, so consideration of the person who has to maintain it was not always foremost in the mind of the contractor or indeed the architect designing it or the mechanical engineer, whichever skill was involved. We have come a long way since then. We have factored that in in our hospital out at UCH with the design, construct and maintain delivery model, where maintenance were involved very much at the beginning of that design.

That is something we have replicated also within our own facilities management area, where we have introduced standard facility specifications that go beyond just your standard Australasian health facility guidelines to make sure that the guys and girls who are maintaining the facilities after they have been handed over have a good chance of maintaining them, rather than having difficult access points and things like that. So it has just been an evolution of design.

MRS DUNNE: In relation to the work that was done in the theatre, you said that there had been failures. Does that mean that pipes had broken and, if they had—

Mr Mooney: No. As part of the inspection we identified the presence of mould. As a result of that, through our inspections we had to follow a process of trying to understand the cause of it, which we have got to the bottom of. We are looking at the design enhancements in that space. For that particular theatre the HEPA filter is remote from the room, as opposed to in the room. It does not terminate in the room. That is an unusual design. Most best practice design now would have your HEPA filter terminating in the room. That is something we are working on with the clinical space at present, as part of the design and development of what will be a permanent solution in there.

We are also looking at the potential future use of that particular theatre space, which is more to do with the types of operations that would go on in that area. We are considering that in conjunction with the clinical spaces to make sure that, whatever

design we put in as a permanent solution, we will have something that lends itself to the future use of that room.

MRS DUNNE: I understand from the contracts and answers to questions on notice that there has been a lot of work done in the bathrooms in the delivery suites. What was the cause of that?

Mr Mooney: We have an issue in the birthing suites, and it also manifests itself in the postnatal ward, as was noted in a question on notice, with a spindle fitting, This spindle fitting is basically a device that sits behind your shower. When you turn the shower on, every time you turn it, you turn the spindle. This spindle was put into our bathrooms in the women's and children's as a connection point from the piping system behind. There was a double-skin wall, and with the double-skin wall you could not quite get into the actuation of the piping system, so you had to extend it out. That was the spindle extension. It is an acceptable fitting. However, over time they work themselves loose. That is what has been the cause of the problem that has contributed to a progressive leaking in the birthing ensuites.

MRS DUNNE: Into the wall cavity?

Mr Mooney: Into the wall cavity.

MRS DUNNE: So you get mould.

Mr Mooney: First of all you get water. You get build-up and then you get the vinyl floor bubbling. That is what it manifests itself as first of all. Obviously we had to get to the bottom of what was causing that. We got to that point and then we had to work out a solution. Similar to the doors discussion this morning, we are talking about doing something in a live operating environment—very busy.

We worked with Daniel's team sometimes and we worked with Liz Chatham's team to work out a solution where we could work around the operational demands of the area. We did that. We engaged a contractor to do rooms. It would take two rooms, because these rooms are nested ensuites, so if you want to do one, you have to do the other. It took three months to do two rooms because we had to seal it all off, do all the work, then retest it and get it certified that everything was reinstalled correctly. We removed the spindle and got it back to a point where, essentially, we do not want to have to go back into those walls again for many years to come.

MRS DUNNE: So you had to actually—

Mr Mooney: Rebuild the room.

MRS DUNNE: So double-skin walls—

Mr Mooney: The double-skin wall was a feature of the actual room. But everything had to be stripped out, bagged and then taken out.

MRS DUNNE: Because of the water ingress?

Mr Mooney: Because of the water. We had stopped the leak, but basically you have soggy plasterboard and soggy vinyl floors. It has just been sitting there. I have to say, we did testing with independent consultants, and the rooms were sealed. Everything was contained within the cavities. We were able to compare test samples with what we had. From that point of view it was contained within the wall cavity; it was not in the room that was being used. We had also increased the regime around cleaning of those rooms. Those rooms get very well cleaned anyway because of the turnover of people going in and out.

We started the program of work there. As I said, it takes three months for every room. I think in the birthing ensuites there are 15 rooms. So you can do the maths as to how long it takes. You have to maintain continuity of operations. We had another issue, a similar set-up, in the postnatal ward. Thankfully it was only in two rooms, which we have fixed.

Coincidentally we have had one in the paediatric medical ward. That one was not the same failure mode. It was a pinhole in the pipe that just leaked. Things like that happen. It was a pinhole in the pipe. Being a pinhole, it manifested itself much more quickly, because more water came out. So we identified that, we closed off the rooms, as has been well documented, and we have a program of work at the moment underway that should be finished before Christmas to finish that.

That is the extent of the work that we have going on there. We have in total 113 rooms in the women's and children's. We have instigated a three-monthly program check on all of the spindles to make sure that they are tight. And we are in the process of setting up a plan to understand, through some minimally invasive investigation, what the extent of the problem is in the rest of the rooms and, depending on the outcome of that, what we need to do. That is the most up-to-date position.

MRS DUNNE: On notice, can somebody provide the committee with a drawing? I am having trouble getting my head around the spindle stuff. And are these issues subject to building warranty?

Mr Mooney: On the issue of warranty and builders issues and all that, we are taking advice from the GSO on that at the moment. It is not finished yet.

MRS DUNNE: If you could keep the committee posted, that would be fantastic.

Mr Mooney: Yes.

MS LE COUTEUR: I have a question. I was written to—as I understand it, you were the minister—by Rebecca Davey of Arthritis ACT.

Ms Fitzharris: Yes.

MS LE COUTEUR: We have discussed the hydrotherapy situation for south Canberra in the past in this venue. She said that she was of the positive belief that the Mt Stromlo facility would provide hydrotherapy. But she is now of the belief that it is not going to be heated quite enough; so that is not going to work. What are you

looking at in terms of the provision of hydrotherapy, specifically for people in the south, on the basis of Ms Davey's letter? She also suggested that if everyone from the south went north, you might have an accommodation problem there.

Ms Fitzharris: We can talk to it. There are a range of issues around this. One, of course, to a certain extent is around hydrotherapy services for all of Canberra.

MS LE COUTEUR: Yes, absolutely.

Ms Fitzharris: Clearly, if you were within a 10-minute drive from Canberra Hospital or a 10-minute drive from UC hospital, it would depend on your perspective. We have the wonderful new facility at UC hospital. There have been a number of different pieces of correspondence. I think the one that you are referring to is perhaps one from August that Minister Berry responded to, because that was specifically about Stromlo.

MRS DUNNE: No, it was more recent than that.

Ms Fitzharris: Then there has been subsequent correspondence from Minister Berry about Stromlo. But from ACT Health's point of view and Canberra Health Services point of view, there is work going on across both to work with both the current users of the hydrotherapy pool at Canberra Hospital as well as with Arthritis ACT to look at future needs and other service provision across the territory. There may be a number of people who are participating in this discussion.

Ms Doran: I acknowledge the privilege statement, thank you. Yes, as the minister has mentioned, we do have a new pool at UCH, which was intended to be the main pool for rehabilitation services. It was intended that the pool at the Canberra Hospital would be closed down as a consequence. The pool at Canberra Hospital is nearing end of life. The cost of maintaining it is becoming sort of unsustainable, relative to other options.

In working with Arthritis ACT, we recognise their requirements for some services on the south, so we are working with them and continuing to work with them to find both short-term and longer term solutions. In the short term, we have maintained their access to the pool at the Canberra Hospital. We have an agreement with them that runs through to 30 June 2019. In the period up until then, we will continue to work with them to find other options that may meet the needs of their members on the south side.

There are a number of pools on the south side that we are exploring, both private and public. I think, though, that the challenge, the particular needs of Arthritis ACT for a pool that is heated to a particular temperature, is not a condition that is met in a lot of those pools. That was, in fact, the issue with the potential Stromlo solution. As we look in more detail into the plans for the pool there, it is not believed that it will be heated to the temperature that they require.

MRS DUNNE: I think this is the point where Ms Le Couteur came in. In the budget estimates hearings the minister said that Stromlo would have a hydrotherapy pool. I thought to myself at the time, "Gee, I did not know that." I went back through the documentation. I wrote to Minister Berry. The answer came back that said, "No, it is

not a hydrotherapy pool." Then the minister's claim here that there was going to be a hydrotherapy pool at Stromlo was repeated on Chief Minister's talkback, which is when Ms Davey wrote to various people. I want to clarify this: the minister's statement in budget estimates was that there was—

Ms Fitzharris: Which minister—me or Minister Berry?

MRS DUNNE: You. In the middle of a discussion about hydrotherapy, you said that there would be a hydrotherapy pool at Stromlo.

Ms Fitzharris: Certainly, my understanding is that there have been a variety of discussions about a 31, 32 and 33-degree heated pool. At the time I think there was possibly not as precise an understanding of the terminology and definition. There is certainly a warm water pool that can be heated to 31 or 32 degrees. That is the plan for Stromlo. That is what I was referring to.

The subsequent discussions have been also around the use of the hydrotherapy pool, in effect, I guess—perhaps others can comment on this more precisely—around hydrotherapy services that are part of a structured rehabilitation program, as opposed to: "I would like to go a 33-degree heated pool today just to relieve some pain." There are a range of issues that we are working through here. They include those and also include, as Karen said, working with Arthritis ACT to maintain access to Canberra Hospital pool. I would say, as I said previously, that the decision to close the pool at Canberra Hospital was taken some time ago and fairly comprehensively communicated and understood a number of years ago, before UCH opened.

I think we will continue to monitor both the usage at UCH and the usage at Canberra Hospital and continue to look at access to hydrotherapy services, whether you are on a prescribed or special rehabilitation program, as opposed to your just liking to have access to a pool heated to 33 degrees. I certainly recognise that this is beneficial for the people using them. But there are a range of different matters that we are working through. They are not fully resolved yet, but we are collectively working through how we do resolve them.

MRS DUNNE: Perhaps, on notice, you might be able to provide the committee with the number of potential pools there are.

Ms Fitzharris: Yes.

MRS DUNNE: The ones that actually operate at a hydrotherapy level in terms of temperature.

Ms Fitzharris: Sure, yes.

Ms Doran: I could, in fact, get you a list.

THE CHAIR: Ms Doran was trying to give you that information before.

MRS DUNNE: Okay.

Ms Doran: These are pools that we have identified that are heated to 33 degrees, which is the critical point here.

MRS DUNNE: That is the critical number.

Ms Doran: I will say that these have just been identified. It does not necessarily mean that they have capacity. We have not explored that far as yet. The majority of them are private pools. On the south side we have Hughes Hydro, Kings Calwell, Kingswim Deakin and Calvary John James pool at Deakin. That last one is one where we are in the process of some discussions and looking at options there. It is largely utilised at the moment, but we are just exploring what flexibilities there may be. Then, in terms of other public facilities on the south side, the Malkara special school at Garran is a possibility. We are genuinely exploring options as we can and working with the association.

MRS DUNNE: And on the north side, apart from the—

Ms Doran: On the north side, you have—

MRS DUNNE: There is the Club Lime one.

Ms Doran: Club MMM, I have written down here, at CISAC; a private hydrotherapy pool at Dickson; Kingswim at Majura Park; Black Mountain special school at O'Connor; and Turner School.

MS LE COUTEUR: What are the financial implications for people who are currently using the public facilities in the hospital and who may potentially, from what you are saying, have to move to a private facility?

Ms Doran: These are issues we would have to work through when we have found an option that is even viable in terms of hours. We do have an SLA with Arthritis ACT around access to hydrotherapy pools and other services. It would be in the negotiating of that arrangement with them.

MRS DUNNE: A service-level agreement?

Ms Doran: A service-level agreement.

THE CHAIR: I want to talk a little about the chemo co-payment scheme. Has any other jurisdiction embarked on such a reform?

Ms Fitzharris: There are a very wide variety of arrangements around the country, yes.

MRS DUNNE: How many patients on average would be subject to the chemo co-payment?

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

MRS DUNNE: Is it tens, hundreds, thousands?

Ms McDonald: We are still looking at the actual numbers. From a Canberra Health Services perspective, we can count the numbers of patients that we have that we dispense chemo drugs to but we cannot count all the patients that go to private pharmacies to get their drugs dispensed.

Ms Fitzharris: We are talking about public patients in public hospitals in terms of a chemo co-payment charging here. That had previously been the case. It is the case that some jurisdictions have an agreement with the commonwealth that is historic, for a variety of different reasons; others do not. I think in the paper today there was comment on public patients in both the Canberra Hospital and Calvary and the different types of chemotherapy they would be prescribed. The more difficult ceasing of the co-payment was for oral chemotherapy, and that took a little longer. Some people did have to pay after early August, but they are in the process of being reimbursed. A patient today would not have to pay.

MRS DUNNE: Could somebody explain why it was difficult to cease the co-payment?

THE CHAIR: I was actually going to ask how we manage the co-payment system. Is that something that we got from another jurisdiction? Are there lessons that we have learnt from other jurisdictions, or is this just something that we have been doing?

Ms Fitzharris: No, it is a quite complicated and wide variety of different schemes around the country. Some have schemes that have an agreement with the commonwealth—Victoria or South Australia have, I think—that others do not have. Two or three do. Certainly Victoria does. A patient's experience in Victoria will be different to what it would be in the ACT and New South Wales and other jurisdictions as well. There is no one common arrangement, as we understand it, around the country.

THE CHAIR: What are we trying to do with our co-payment system here in the ACT?

Ms Fitzharris: Certainly in terms of public patients in public hospitals, it is also the case that the variety of prescriptions dispensed at the hospital is extremely wide and extremely varied across a whole range of different patients as well. There may be, for example, non-cancer patients receiving chemotherapy. We are looking at that for cancer patients with chemotherapy co-payments at the hospital. That has been implemented, apart from some slight challenges around oral chemotherapy in the early stages of that earlier this year, from August.

THE CHAIR: Is it the policy of government to eventually cover all chemo co-payments?

Ms Fitzharris: Not at this stage, no.

THE CHAIR: What are the challenges in trying to manage it through the community pharmacies as well?

Ms Fitzharris: At this stage we doubt that that is achievable. I am not aware of any

other jurisdiction that currently does that as well. There is the PBS scheme; there is the PBS threshold.

Ms McDonald: Would you like me to talk a bit about the complications?

Ms Fitzharris: Yes. It is fair to say it is very complicated, and certainly at the community pharmacy level as well it is varied. We obviously have a lot of patients in the ACT from New South Wales as well, and patients receiving a very wide variety of medications. You will find some patients that have a particular disease and that get the script on the PBS queuing up at a community pharmacy and others that are next in the queue do not and pay a thousand times more. It is a very complex scheme.

THE CHAIR: Would that be the same along the palliative care lines as well, not necessarily from a co-payment perspective? There are some patients that receive palliative care options in hospital but there are others that receive it in the public domain, like at home?

Ms Fitzharris: Yes.

MRS DUNNE: But all palliative care through Calvary and TCH is public.

THE CHAIR: I did not mean public. When I said "public" I meant at home or in hospital.

Ms Fitzharris: You mean in terms of the treatment or the care and the medications?

THE CHAIR: Both.

Ms McDonald: I think we probably need to unpack the question about palliative care and separate it from the question of the chemo co-payments and the chemo drugs that we are covering the co-payment for for the public cancer patients. There is palliative care which is publicly funded, and you can have palliative care in the hospital. We do have at-home services. But in terms of medications, not all palliative care patients are on cancer or chemo drugs.

THE CHAIR: No, absolutely not.

Ms McDonald: Clarifying that, yes.

THE CHAIR: There are some palliative care medications that patients would get from a community pharmacy, as opposed to those that they would have at hospital?

Ms Fitzharris: Yes, which is similar to just about every medication.

MRS DUNNE: Can I just go back to the issue of the co-payment for chemotherapy. Earlier this year, in July-August, the government made an announcement that it was going to cease the requirement for co-payments for public patients.

Ms Fitzharris: In a public hospital, yes.

MRS DUNNE: But some of those people are still paying a co-payment, it would seem.

Ms Fitzharris: No. That is what I just said. They had been charged for the oral chemotherapy.

MRS DUNNE: Why were they charged for oral chemotherapy? It is still chemotherapy.

Ms Fitzharris: That is right. You might explain the difference.

Ms McDonald: The first stage was to actually cover the injectable and infusible drugs, and we stopped the co-payment on that. Then we had to put in a process to stop the co-payment on oral drugs.

MRS DUNNE: Why is there a difference in the treatment of co-payments between injectables, infusibles, and oral drugs?

Ms Fitzharris: There is not. There was an administrative issue.

Ms McDonald: It was just administrative in terms of how we do that. It was just a phasing of how we actually do that. Now what we have got in place is that those people who were charged a co-payment, we have written to. We have asked them to call us and tell us how they would like to get reimbursed. They will all be covered. Those letters, I think, were going out this week. But we have stopped it prior to those letters going out. Nobody who gets their chemo orals or injectables or infusibles from the hospital gets charged a co-payment.

MRS DUNNE: Just to cover off on the other point that you, minister, made that some patients who are not cancer patients get chemotherapy—and I understand that is the case for some people with MS—do non-cancer patients pay a co-payment for chemo, and will they continue to?

Ms Fitzharris: As would a range of other public patients also pay co-payments for particular medications.

MRS DUNNE: Even if they are in the hospital? If they are receiving outpatient services in the hospital and they are getting their drugs through the hospital pharmacy, they will pay a co-payment? Is that the dispensing fee?

Ms McDonald: We can get Chris to clarify for you in terms of co-payments.

MRS DUNNE: Clarification would be lovely.

Mr Bone: The hospital pharmacy does not provide outpatient drugs. They are provided by community pharmacies. The exception to that is the patients who receive chemotherapy through the cancer services. Patients who have their scripts filled in the community will all pay a co-payment under the PBS model.

MRS DUNNE: It is not strictly true that the hospital pharmacy does not provide

pharmaceuticals to outpatients?

Mr Bone: I will take that on notice. My understanding, and my personal experience, is that outpatient drugs are not provided from their pharmacy.

MRS DUNNE: Kalydeco is, and it is always provided through the hospitals.

Mr Bone: There may be some S100s, but as a routine, yes.

MRS DUNNE: I know they are probably exceptional drugs, but there are some.

Mr Bone: I will take that on notice, but, yes.

MRS DUNNE: It would be interesting to know what sorts of drugs are routinely provided to outpatients through the hospital pharmacy. I know of one that is.

Mr Bone: I will take that on notice.

THE CHAIR: I note the time. We will take our afternoon tea break now, and we will be back with Minister Fitzharris for the alcohol and drug services and population health.

Hearing suspended from 3.16 to 3.29 pm.

THE CHAIR: Welcome back to our final session for the 2017-18 annual reports hearing of the health, ageing and community services committee. This afternoon we will be finishing with the Minister for Health and Wellbeing and we will be focusing on alcohol and drug services and population health. I want to go to pill testing. That happened in the reporting period of this annual report?

Ms Fitzharris: It did.

THE CHAIR: Can you give me a bit of a breakdown on how that all went and what it looked like?

Ms Fitzharris: I will invite Dr Kelly to talk about pill testing.

Dr Kelly: You do not want to start, minister?

Ms Fitzharris: I will, thank you. We were clearly an Australian first. It was quite a significant decision to take, but, as I have said, it was taken after a very detailed consideration of the proposal. The first one we received was for the previous year, but the working group that was established, led by Dr Kelly and involving agencies across government, asked many questions about the operation of the pill testing facility at Groovin the Moo earlier this year. The proponents, now called Pill Testing Australia but then called STA-SAFE, answered every requirement the working group asked of them. We were really pleased. We have received a second proposal from them for Groovin the Moo in the ACT next year. That is currently under consideration by the working group and by government. Dr Kelly will talk you through the results and some of the figures.

Dr Kelly: I acknowledge the privilege statement. The minister has outlined the process that we went through to get to Australia's first ever pill testing trial at Groovin the Moo earlier this year. It went ahead. We were overwhelmed by the response in terms of the people that came. We tested a large number of samples. Two of the 85 samples that were submitted for testing were quite dangerous drugs. Our understanding is that those were not consumed because of the results. I remember answering questions on this matter at previous hearings and saying that my view was that if we saved one life that was worth doing.

THE CHAIR: Absolutely.

Dr Kelly: I cannot say for sure that we saved two lives, but I know that the things that were found were similar to medications that had been taken in similar settings around Australia and internationally which had led to severe morbidity and sometimes death. So from that point of view it was worth doing.

We went through the whole process, and there was an evaluation afterwards to see how the process went. There were a few learnings from that. There was a proposal the minister has not mentioned yet for tomorrow at Spilt Milk. For reasons outside our control, that will not go ahead, which is a pity. However, that is how it is. We would have instituted the things that we learnt from the first trial if that second trial had gone ahead as planned tomorrow.

The minister has mentioned that we have now before us, as of this week, or it might have been last weekend, a proposal for Groovin the Moo for next year. As has been announced, that will be on ACT government land, so that will make things much easier.

THE CHAIR: I will come back to some of my other questions, but is there going to be consideration of that proposal?

Dr Kelly: My role is as chair of the cross-government working group. That includes people from ambulance, police and the justice area of Justice and Community Safety. On a case-by-case basis we will look at these things.

Now we are quite used to this sort of proposal and the sorts of issues that we need to look at. We have worked through the legal components. We have worked through the health issues. And very specifically and importantly, it is seeing pill testing as part of a harm minimisation approach for not only drugs but also other risk-taking behaviours of a hard to reach group in terms of health promotion.

There is another proposal that is being considered at the moment around sexual health testing at Groovin the Moo. I am sure that will be good news to another member of the committee.

MS CHEYNE: Tell us more.

Dr Kelly: It is for chlamydia testing at that as well. The organisers of the Groovin the Moo festival, which happens in different places around Australia, not only here in the

ACT, instituted a similar trial in Maitland last year.

THE CHAIR: For sexual health testing?

Dr Kelly: Sexual health, yes. Again, it is about just offering that as a service for people who come. If they want to take that up, it is used in that way.

THE CHAIR: I am sure there will be supplementary questions on that in a moment.

Dr Kelly: I am sure there will be.

THE CHAIR: Can I just go back to the pill testing for a minute? What were the numbers of people that came to get their pills tested?

Dr Kelly: I do not have the numbers that actually came into the tent, because there were some groups of people with only one sample being given.

THE CHAIR: How many pills were tested?

Dr Kelly: There were 85 pills tested. There were a range of substances found, from things that had no psychoactive substance in them—some very strange things like polish, toothpaste, paint and Panadol tablets. People were asked what they thought they had bought, and most people thought they had bought ecstasy or MDMA. For the majority of pills, that was true, according to our testing; that is what we found also. But then there was this range of other stuff which was either inactive or vaguely different from MDMA, and there were these two quite dangerous compounds that we found.

THE CHAIR: Speaking as a mum, my son attended Groovin in the Moo this year and he took some of his friends to the tent, so he tells me. For me, it was quite refreshing that they did want to get their pills tested. What actually happens? What do you do? Do you scrape off a bit of the pill? How does it actually work?

Dr Kelly: I have not been to the tent myself. It would be interesting to hear from your son. We work through this very carefully with the group that was organising it, STA-SAFE as it was, now called Pill Testing Australia. There is a machine there. People come in. There is a discussion with each person explaining what is going to happen. There are very strong messages around any pill not being safe. We are not saying anything is safe. Taking drugs when you do not know where they have come from is not a good idea.

THE CHAIR: Yes.

Dr Kelly: Importantly, these are people, usually young people, that have made that decision to purchase that substance already. They bring it in. They deposit it in the machine. When we say "pills," it can be powder; it can be liquid; it can be all sorts of different things that can be tested. So a portion of that is placed in the machine and destroyed by the machine process.

THE CHAIR: Right.

Dr Kelly: There is no handing back anything. At the end of that time, it is removed and it is discarded. At no time was anyone in there other than the person who had already purchased that substance and who was in possession of that substance. That was an important legal component to go through. The machine does its thing. It takes a while. It gives a chance for the patrons to sit down, to think about what is going on, to read some stuff, to talk to some professionals about it.

We have found, as is being found wherever this is being done, particularly in Europe—in certain parts of Europe it is pretty much routine—that people change their mind, sometimes on the basis of the result but sometimes just on the basis on having been in the tent. That is a chance to talk about those things, to talk about risk-taking behaviour more broadly. That is why it would actually be really interesting to do both—that and the sexual health testing. Yes, we know that there is a link there with unsafe sexual practices. So we will work through that as well.

THE CHAIR: I know my son commented to me that he was a designated driver for the night. He was sober, and he tells me he does not take anything else, except alcohol. He is 19, anyway. But he said that the big thing for him was that he found it interesting that his friends were able to ask lots of questions and to have them honestly answered. There was no hiding anything. He felt that was a really positive matter that came out of it. There was no question that was unable to be answered. He felt that everything was very honest. I do not know if you can comment on that.

Dr Kelly: That is very good feedback, thank you. I will pass that on to the team that were there. The people that were there were really highly trained professionals. They are in a voluntary capacity. This was at absolutely no cost to the ACT. But there were chemists—PhD chemists; there was an emergency room physician who we know is quite actively engaged in talking about this matter; there were nurses and so on. So there were people there that really knew their stuff. That was an important part of this. We wanted the A team there, not the B team.

THE CHAIR: A 19-year-old boy thought it was amazing, so there you go.

Dr Kelly: Thanks.

Ms Fitzharris: In addition to that, I think STA-SAFE were the first people to say that the safest decision you can make right now is not to take this illicit substance. They have very comprehensive material that people have to read in order to participate in the service. I did take the opportunity to send that to Minister Hunt to explain to him some misperceptions I think he had in the decision-making on the Spilt Milk Festival. They will be the first group of people to say to you that this is not safe, but if you make the choice to do this you may as well be as safe as you can be.

That message could not have been more consistent, including both in what they said and in what they provided to anybody who interacted with them on the day. I think that is a commonly held misperception that goes to the issue of what responsibility governments have to look at policies and to make sure that they are working. I think it is fair to say that for many years quite a number of our drug policies have been working but that quite a few of them are not.

We hope that we are able to continue this next year at Groovin the Moo, in its new location. We will continue to look at what is working and what is not and find new ways to do things that stop people from causing significant harm to themselves and the flow-on effects we know that has to families, communities and individual's lives.

It is a significant step. I am taking a paper to the next COAG Health Council on the process that we went through to share that learning. I have done that informally with health ministers at a number of meetings now. I hope that by leading this here in the ACT we can show other jurisdictions and have a second opportunity to look at this next year and take on board some of those learnings. I think the former AMA president nationally did not support pill testing on the basis that there was no evidence to support it. You can only get evidence by undertaking it.

THE CHAIR: By trialling it.

Ms Fitzharris: But I do note that the current national president of the AMA is supportive of pill testing, as was the AMA here locally as well. I think there is momentum behind this now. We hope many other jurisdictions can also learn from what we have done here.

MS LE COUTEUR: My question is a quick one. Where the festival is not being held on ACT land, such as tomorrow, is the ACT government considering another location that could be convenient to people attending a festival—conversely, somewhere that will be convenient to teenagers, young people in Canberra, who may be consuming pills but not attending festivals?

Ms Fitzharris: The proposal that STA-SAFE had already provided to Spilt Milk for tomorrow's festival was after the commonwealth indicated they would not support—very strongly would not support—it happening on commonwealth land. We did receive a second proposal to hold an off-site festival. That was again assessed by the working group, but for a variety of reasons we were not able to have the time to thoroughly consider all the issues, as we had done for the music festival proposal earlier in the year.

MS LE COUTEUR: But are you looking at all at proposals not linked to festivals?

Ms Fitzharris: We received a proposal from STA-SAFE. We looked at that proposal, which was to conduct pill testing tomorrow at an off-site location. But, no; the short answer is no.

MS LE COUTEUR: My question was getting a bit broader than that, apart from just at festival time. Pills are consumed in Canberra, not just at festivals. I guess what are the issues—

Ms Fitzharris: Yes, perhaps Dr Kelly can add to this, but we also have under development, and to be released later this year, a national drug strategy looking at alcohol, tobacco and drugs. That was agreed last year. We have been developing the ACT's response to that. That has been through extensive stakeholder and community consultation over the course of this year. That will be released later in the year.

I think what we can have a discussion about at that point is how we best minimise harm in relation to drug use, the illicit use of drugs, and how we best minimise harm. I think it is worth while looking at these issues through that lens of what we can do that will most significantly minimise harm in the drug policy space. That may include pill testing outside music festivals. It may include a range of other factors where we think that maybe we can have a better effect on minimising harm from drug use.

Dr Kelly: A couple of weeks ago I was in Europe and I visited the European drug monitoring centre. This is one of those whole-of-European Union centres, including, for the moment the UK. Specifically with Brexit I think it has problems. I had specific discussions not only with those that are involved with pill testing at festivals but also with those that are looking at surveillance of drug taking more broadly.

There are places in Europe where a more comprehensive approach as a kind of a standing thing—not just for pill testing—is there. There are a range of ways that that could be done. We already have the ACTINOS network that is run out of Calvary emergency department, where there is an arrangement between Calvary and the ACT Government Analytical Laboratory to look at unusual overdoses and to test the pills and/or the human samples from that.

Pill testing at festivals is another way of getting information. Drug seizures are another way of getting information. Then the fourth component would be the one that you are suggesting—some sort of standing capacity to look at that on a Saturday night in Civic, for example.

MS LE COUTEUR: Yes.

Dr Kelly: Those are things that would need really careful consideration from a legal and health perspective. As the minister said, that was kind of what was suggested but only for this weekend. It was a proposal that we actually advised government not to take up on this occasion for Spilt Milk because of the complexity of working through those matters. But it is a thing internationally. The ACT is already leading on this. I think, as the minister mentioned, that as part of the drug strategy action plan there is a component there around early warning systems. That is a discussion that will happen.

MS CHEYNE: Is the sexual health testing definitely going to go ahead at Groovin the Moo?

Dr Kelly: NSW Health worked with Cattleyard, the promoters of Groovin the Moo, and did this as part of a range of different ways of looking at sexual health testing in that particular age group in Maitland last year. I think Maitland is the one that happens about three or four days before the one in the ACT. Anyway, it is in the series. New South Wales have offered to share with us what they did in some detail, and various collateral that they worked out in terms of pamphlets and so on, and the method. We are just at the moment working through that internally. Then we will approach Groovin the Moo, but they seemed to be fine with that in Maitland at least. Then it is just a question of space.

MS CHEYNE: Is it also a question of resourcing, who is going to do it?

Dr Kelly: There is a bit of that too, but that is fine. We can work through that with sexual health.

MS CHEYNE: It would be ACT Health staff from the Sexual Health Centre?

Dr Kelly: Yes, with the sexual health service; that is the proposal. But it is early days. We had a meeting about it a couple of weeks ago. We have got time. It is in May.

MS CHEYNE: Is it pretty likely, though? I know you do not want to let me down.

Dr Kelly: Yes, if Cattleyard agrees and there is space. We would have to work that out. The key component of the medical precinct is exactly what is at Spilt Milk this weekend, which is dealing with acute issues and triaging to see whether people need to go to hospital. Last year that precinct at Spilt Milk treated 500 people in the 12 hours of the festival, and three were sent to hospital. That is the key component. Pill testing may be another part, depending on how that goes forward and on agreements, and then this could be another part of a wider health precinct.

MS CHEYNE: I know it is early days, but would rapid HIV testing potentially be part of that as well?

Dr Kelly: Not at the moment.

MS CHEYNE: Why not?

Dr Kelly: As I recall the proposal—and I might have to take that on notice—it was mainly focusing on chlamydia and gonorrhoea. There would not be blood testing. You would need blood testing for the rapid HIV test, even though it is a finger prick.

MS CHEYNE: Do we do rapid HIV testing? Does ACT Health do that or is it mostly done through a community organisation?

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

MRS DUNNE: On public health, I would like to go back to some of the issues that were touched on in the chamber a while ago in relation to DAPIS and DORA. Will the real-time prescription monitoring system be delivered by the expected March date?

Dr Kelly: That is the plan.

MRS DUNNE: That is the plan?

Dr Kelly: Yes.

MRS DUNNE: Are there any impediments on the horizon?

Dr Kelly: No. I am looking for my notes here, but the project is going very well and

we are continuing to be in discussions with our colleagues interstate and in the federal government in relation to the national scheme as well, which is very similar.

MRS DUNNE: Can you talk briefly about where we are at with the national scheme?

Dr Kelly: Yes.

MRS DUNNE: Minister, you were quite keen on it when you were the chair of the health ministers council. Where are we with that?

Dr Kelly: Again, it is proceeding and we are part of the discussions in relation to that going forward. As we have talked about many times before—and the minister, in the chamber, has talked about the ACT scheme—Tasmania has been leading the country for some years but the new scheme will leapfrog that, and we certainly will be ready to join that when that comes to pass.

MRS DUNNE: You are saying it is proceeding, but what does that mean?

Dr Kelly: It has been very slow. I will be blunt about that.

MRS DUNNE: Brutally honest?

Dr Kelly: Yes. If we had waited and not done anything back in 2012, when it was "this is almost here", then we would still be sitting here without anything. We have got what we have got. It is not a perfect scheme but it certainly does supply information that is already able to be shared with practitioners at the bed or desk side. The DORA scheme, which will come online early next year, will allow even more access of practitioners to that information. I am hopeful that the national scheme will go ahead as planned and it will be a really good thing. Certainly that cross-border issue that we are always facing will be resolved by that. But our experiences of these large IT projects at the commonwealth level are not always as first advertised.

Ms Fitzharris: We did make some changes—and I think they are underway—around the reporting from pharmacies, which had previously been on a weekly basis and now, with their agreement and good work with the community pharmacies, is on a daily basis instead. That was significant. We were really pleased that the community pharmacies were able to come on board with that, and that has been implemented. In between having DAPIS and going to DORA next year, there have been ways that we can improve things in the intervening period as well.

MS LE COUTEUR: This is probably a very straightforward question, but which hospital is the acute care of the elderly ward in?

Ms Fitzharris: Canberra Hospital.

MS LE COUTEUR: We have more people going in. Page 98 says we have just refurbished it.

Ms Fitzharris: Yes.

MS LE COUTEUR: Which suggests it is in Canberra Hospital.

Ms Fitzharris: Yes. It was opened in February, I think.

MS LE COUTEUR: Is that where the new geriatric special care unit is? It is a segregated area. Does that mean it is in the same place?

Mr Bone: The special care geriatric unit is in the ward opposite the ward that was refurbished earlier in the year.

MS LE COUTEUR: They are both in Canberra Hospital?

Mr Bone: They are both in Canberra Hospital.

MS LE COUTEUR: Have they been built big enough for the expected increase in patients with dementia?

Mr Bone: They are both existing wards within the infrastructure. The ward that was opened earlier in the year was within the infrastructure that we had; it is a fully refurbished ward for the purpose of looking after elderly patients and those with cognitive impairment. The acute care of the elderly unit is incorporated into a larger ward; it is a smaller bed component of a 28-bed ward.

MS LE COUTEUR: How does it differ from the rest of the ward?

Mr Bone: It is just a service within the ward. Physically there is no difference from the rest of the ward.

MS LE COUTEUR: How does the geriatric special care unit work with the older persons mental health unit? Presumably there is a fair degree of crossover with the other patients.

Mr Bone: They work collaboratively, but there is no shared bed-card unit. Either the geriatric unit is the lead commission for the patient or aged care mental health is. I will let Tina talk to aged care mental health.

Ms Bracher: Both the geriatric team and the older persons mental health team do a consult liaison role in reverse for each other. If a geriatrician wants a mental health assessment, our older persons psychiatrists will do that assessment and vice versa. If the older persons psychiatrist is worried about the physical or cognitive function of an older person, they will do a secondary consult to a geriatrician.

MS LE COUTEUR: When patients are ready for discharge, for those people who have to move out of a home—who were in a home environment and, after whatever took them to hospital, are not able to go back home—are you finding delays in finding suitable accommodation for the elderly?

Ms Bracher: I think that is variable. Speaking from the older persons mental health perspective, that is variable. Some people we can move into that form of care relatively smoothly, but for some people and some families it can be quite a slow and

protracted process.

MS LE COUTEUR: From looking at the page before, checking about timeliness for ACAT assessments, it seems as though there are a variety of different times. It is not clear to me whether it is in your best interests to be or not be in hospital to get an ACAT assessment. How are those going?

Ms Bracher: What page are you on, Ms Le Couteur?

MS LE COUTEUR: Pages 97 and 98. Page 97 mentions ACAT, as does page 99. At the top of 99, it says:

> … ACAT has met the Key Performance Indicators (KPIs) for hospital and community assessments …

For a hospital that is three to 14 and in a community setting it is 36. That is the longer reference. The thing that gets confusing is that most of these things are referred to in a couple of places. On page 97 it says:

> … hospitalised older persons wait an appropriate time for access for comprehensive assessment by the … ACAT …

That would be, I assume, for them to get better from whatever it was that got them into hospital.

Mr Bone: Correct. I am no expert in the ACAT process, but the acute episode needs to have been remedied before they can be assessed for ACAT, and the ACAT team, as you indicated, does assessments both in the hospital and in the community. That assessment is undertaken by a credentialed team; then the referral through the ACAT process for whatever outcome is appropriate for the patient takes place. It is a protracted process. Once the acute episode is over, it is about five to 10 days for us to get our part of the process completed. Then it is up to the ACAT process for placement.

MS LE COUTEUR: ACAT process for placement?

Mr Bone: For whatever is required for the person.

MS LE COUTEUR: So they are the people who are going to find suitable accommodation?

Mr Bone: It is part of our team, but there has to be approval through the ACAT process, which is a commonwealth process.

MS LE COUTEUR: Yes. So people could be waiting five to 10 days to get assessed and then an indefinite amount of time to find somewhere to go to.

Mr Bone: There has to be agreement with individual patients. It is an agreed outcome for the patient between the staff, the patient and the family.

MS LE COUTEUR: What is the usual amount of time after you have got your ACAT assessment?

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

THE CHAIR: That is a commonwealth matter.

MS LE COUTEUR: It is managed by the commonwealth, but they are lying in your hospital while they are waiting, so you must have some idea of how long it is.

Mr Bone: I will take the question on notice.

MS LE COUTEUR: Thank you.

MS CHEYNE: Going back to sexual health, first of all—very similar to my opening question in estimates—where in the report can I find detail about sexual health?

Dr Kelly: I would have to look at that. There is not a lot—

MS CHEYNE: I have looked a lot.

Dr Kelly: I am sure you have looked.

MS CHEYNE: I have looked.

Dr Kelly: And you cannot find anything.

Ms Fitzharris: Are you talking about sexual health services or—

MS CHEYNE: Anything.

Ms Fitzharris: The Chief Health Officer's report probably—

MS CHEYNE: Separately, yes.

Ms Fitzharris: It would be separate.

MS CHEYNE: It is better.

Ms Fitzharris: On sexual health services, though, we will look forward to any recommendations you might make, but in terms of explaining the variety of services that are provided through the annual report, you probably—

MS CHEYNE: I do not want to add pages. I want to protect the environment, but—

Ms Fitzharris: It is a reasonable question. Each time we come, someone will come up here and explain an extraordinary service that is provided. It can be hard to capture that. I would be reluctant to add to the burden of actually providing that really good service but maybe there are better ways for us to reflect on how we can highlight the range of services, because it is extraordinary.

MS CHEYNE: Yes. Given our very robust conversation in estimates about how important health and wellbeing is across the whole body, seeing a little more about sexual health in here would send a good message.

Dr Kelly: There are four pages in the CHO report.

MS CHEYNE: In your report, yes.

Dr Kelly: I guess it is—

MS CHEYNE: You can copy and paste them into here.

Dr Kelly: We could, yes.

Ms Fitzharris: I think we refer to the Chief Health Officer's report in there.

MS CHEYNE: You do; you do. I have read that, at least.

Dr Kelly: Our quarterly population health bulletins also always give the surveillance details in terms of people who have been diagnosed and been notified. Most sexually transmitted infections are notifiable diseases in the ACT. So that is available.

MS CHEYNE: Even if there was just a heading and it said, "See CHO report," I think that would be—

Dr Kelly: I will take that as an instruction so that we can get this right next time.

MS CHEYNE: Outstanding. We talked at estimates about the pretty interesting and slightly disturbing trend that some STIs are not just increasing because people are turning up to be tested more but actually increasing. Have we done any awareness campaigns? Have we thought about doing some? The AIDS Action Council have said to me that they think we should really be targeting international students in particular.

Dr Kelly: A range of people work with us in this sector. The AIDS Action Council is a very key partner, funded quite substantially by the ACT government. It is probably in the annual report, but I would have to find it. They have a range of not only counselling services related to people who have already been diagnosed but also preventative services. That is a component. We do work closely with the universities, for example. During orientation week we have a range of things that we discuss about moving to Canberra or, indeed, for international students, moving to Australia. We do talk about harm minimisation elements, including sexual health, during that period. We also talk about death cap mushrooms and all sorts of weird things that they may not have heard of. That is all there.

On the rates, we are already seeing a decrease in the HIV rate. Last time we spoke, that had for a couple of years beforehand been going up, as it had been in the rest of Australia. But the effect of pre-exposure prophylaxis is already biting it very quickly.

MS CHEYNE: Yes; I am hearing good things.

Dr Kelly: That is a positive thing for HIV. But, as discussed last time—

MS CHEYNE: There is a very negative correlation for STIs otherwise.

Dr Kelly: there are issues with sexually transmitted infections of other types, and because of the dilution of the safe sex message. It is reported on in the CHO report around drug resistance of gonorrhoea, for example. It is something that is really emerging internationally and in Australia, up to and including completely incurable, basically: not being able to use any of the current medicine. That is a very disturbing trend internationally. In the ACT we have not found that yet, but we are not an island, so—well, we sort of are. Sexually transmitted infections, like all infectious disease, know no borders, so we will import that either from other parts of Australia or internationally. It is just a matter of time. Syphilis has continued to increase. Chlamydia has stabilised. So it is mixed look really.

THE CHAIR: What about gonorrhoea?

Dr Kelly: Gonorrhoea has increased, particularly among men who have sex with men, but not only in that group.

MS CHEYNE: Has there been any work done to identify why?

Dr Kelly: Yes. The Kirby Institute in Sydney is the leader in research on not only HIV but also other sexually transmitted infections. They undertake a gay men's survey every year, I think in the capital cities but maybe more broadly than that; certainly Canberra is one of the sites. They explore changes in sexual practices, particularly around safe sexual practices. It was pretty clear almost immediately when PrEP came in that that had changed a lot. So it is definitely an issue in that group.

MS CHEYNE: It is interesting that it is with gonorrhoea but not with chlamydia.

Dr Kelly: I think it is to do with what is circulating in that group. It tends to be gonorrhoea.

MS CHEYNE: Interesting. Going to the Sexual Health Centre, we were talking about how the demand is increasing because people are turning up. Fantastic. Good work, Canberra. Is the facility satisfactory for the demand? It is a pretty old building.

THE CHAIR: This is the one at the back of the Canberra Hospital?

MS CHEYNE: That is right.

Dr Talaulikar: That is correct, yes. You are quite right; the demand is increasing, particularly from walk-in clients. We are looking at whether we have sufficient staffing going into the future to meet the demand, and also looking carefully at the infrastructure.

MS CHEYNE: What does "looking at" mean? You can look and not do anything.

Dr Talaulikar: As we speak, I have asked the director of the Sexual Health Centre to provide me with a brief looking at the models of care going forward and what we are going to need to meet the demand. It is being prepared as we speak.

MS CHEYNE: And you are preparing that because you are aware that things are trending up but facilities are trending down?

Dr Talaulikar: Yes. The major growth is in the walk-in clients.

MS CHEYNE: Are you aware that there is a petition out at the moment about the Canberra Sexual Health Centre, calling on ACT Health to have a new one and have a satellite facility in Belconnen or Gungahlin?

Dr Talaulikar: I am not aware of that, no.

MS CHEYNE: I can send it through to you. You could sign it.

Dr Talaulikar: Well, we will receive it.

MS CHEYNE: Is a satellite facility an option?

Dr Talaulikar: We can certainly consider it as part of the brief. We have discussed using the walk-in centres as an alternative option, so we would certainly look at that as a part of the brief, yes.

MS CHEYNE: Excellent. I just put on the record again my thanks to the Sexual Health Centre for all the fantastic work that they do. They were at the Canberra Fair Day, as were a range of organisations, a few weeks ago. They were giving out free condoms. Fantastic service. We have talked about the supply of free condoms elsewhere, and I know that they also provide them at the Sexual Health Centre. How much is spent on acquiring the condoms to give out for free?

Dr Talaulikar: I need to take that on notice.

MS CHEYNE: Thank you. And does ACT Health have any relationship with condom manufacturers, like a deal where, if you buy in bulk, you get a discount in exchange for the promotion of safe sex through Ansell or something or we get them for free? Or are we buying them at market price?

Dr Talaulikar: I will take that on notice. I do not know. I doubt that we would be buying them at market price, but I do not know.

MS CHEYNE: You doubt that we are buying them at market price?

Dr Talaulikar: I do not know. I will have to take it on notice.

Dr Kelly: We have an answer to the condom question, in answer to your previous question. Free condoms are available at the Sexual Health Clinic, as you mentioned, but also at all of the ACT-run community health centres, including the WICs, the walk-in centres, and through some other services. Alcohol and drug services have

condoms for their clients. And there are some services that are funded by ACT Health but are run by non-government organisations. The AIDS Action Council have ACT-government funded condoms and directions as well.

Ms Fitzharris: Brought to you by the ACT government.

Dr Kelly: Brought to you by the ACT government.

MS CHEYNE: I have to say that is a great variety you have provided.

Dr Kelly: Yes. It is widespread, and they are free. One of my colleagues was at the sexual health conference in Auckland last week. It was interesting that, in talking to colleagues right throughout the western Pacific and up into Asia, she found that the issues we are facing are very similar, and no-one has the full answer yet. But the combination of promotion, prevention and provision of free condoms wherever possible, as well as good clinical services that can treat people quickly and do contact tracing to potential people that may have been infected—all of those basic things are what is being driven.

MS CHEYNE: That is fantastic. I am very pleased to hear you are doing that. In terms of the walk-in centres and having them available for free, I assume that, unlike at the Sexual Health Centre, they are not sitting in the waiting area. I am sure little kids might be saying, "What is this?" But you can never start too early in education.

Dr Kelly: I am not sure.

MS CHEYNE: You probably could. How do people know that they are available?

Dr Kelly: I would have to take that on notice, but that is something we are looking at in terms of making that easier for people to find. There was, some years ago now, a pilot program looking at sexual health screening in the walk-in centres.

MS CHEYNE: Yes; we were talking about that this morning.

Dr Kelly: That ties into the discussion the committee has already heard about what prevention activities could happen more broadly in the walk-in centres. They are a wonderful resource for that.

MS CHEYNE: What was the term used this morning: "opportunistic screening"?

Dr Kelly: Yes.

MS CHEYNE: It could be opportunistic: "Do you want a free condom?"

Dr Kelly: Yes. It is not only for sexual health but for chronic disease and other things.

MS CHEYNE: I am only half joking.

Dr Kelly: It is a conversation we are having.

MS CHEYNE: If you could take that on notice, that would be great.

THE CHAIR: I note that Sexual Health and Family Planning ACT do National Condom Day every year, on Valentine's Day, because buying a condom should be as easy as buying a rose to help protect.

Dr Kelly: Yes.

THE CHAIR: There are things out there, but we can always be doing more. Minister and Dr Kelly, you are going to love my next question. I would like to know what is being done to get people to eat enough fruit and vegetables.

Ms Fitzharris: We are eating enough fruit, just not enough vegetables.

Dr Kelly: Fruit is fine.

Ms Fitzharris: Fruit is okay. It is veggies.

THE CHAIR: As someone who is highly allergic to all fruit and vegetables, it is an interesting question coming from me.

Ms Fitzharris: There is a lot of work underway in schools, with an expanded program with the Canberra Business Chamber called healthier choices, which was initially trialled with four local businesses at five locations. It has just been rolled out more significantly and I think has been a successful partnership with the Business Chamber. There has been work on kilojoule labelling. We are always looking for new ways to do more in this area, but I think we have had real successes in the school canteen area in particular.

Dr Kelly: Yes, vegetables are the key. There was mention earlier this week of the research summit, and there was a specific slide that I remember the minister asking about afterwards on some really good research that had been done in the Hunter and New England looking at increasing school canteen adherence to the policy of healthy food in primary schools in the Hunter and New England. I think they started with 17 per cent compliance. They have published this paper and they are crowing around the world that they have got to 35 per cent compliance. We are at 95 per cent compliance, and I think that is something we should be really proud of—what we have done in primary schools in relation to the canteens.

The fresh taste program is much broader than that. It involves parents; it involves teachers; it involves curriculum development; it involves the canteens themselves but also school gardens and a whole range of things—a system-wide approach in primary schools specifically looking at healthy eating to make it the norm as early as possible. We have got similar things happening, not as intensively, with preschools. The it's your move program, which has moved into high schools and is really being snapped up and is mentioned specifically in the annual report, is trying to keep up with demand for that. Demand exceeds supply in a way, but we are working with many high schools around the ACT in relation to it's your move.

Some of that is related to good nutrition. The minister has mentioned the healthier

Canberra campaign with the Business Chamber. Again, businesses are knocking at the door. We are not having to go out and sell this campaign. It is about making the healthy choice, the easy choice, making things obvious—similar to the question earlier about choices about condoms. How do people know what is healthy food? We are working with businesses to actually show what healthy food is and working with nutritionists and so forth to really hammer home that message, in IGAs and other places.

They are the main things. It is a difficult nut to crack, if that is not a bad metaphor, but we still have very low uptake in terms of the national standards in relation to vegetable consumption, both for children and for adults. But we are showing some signs of improvement in childhood obesity. We are making some strides there. Physical activity is the other component of that, and that is also improving and there is increasing physical activity in our primary schools in particular.

THE CHAIR: Just very briefly, what is the age group where the vegetable intake is at its lowest? Do we know that?

Dr Kelly: Yes, I do know it. It is not in my mind just at the moment. Teenage boys are particularly bad. I think you are either living or have recently lived through those interesting times. It is on a long list of things that are not that great for that age group.

THE CHAIR: Teenage boys are interesting at the best of times.

Dr Kelly: That is a key time. The work we are doing around gestational diabetes points to an issue of poor nutrition and overweight and obesity in that 20-year-old female group as well. That is something that we are really looking at. There is a gap there between leaving school and thinking about getting pregnant. There are a lot of issues we do not have time to go into, really, around gestational diabetes. But that is a key area. Older people tend to do a bit better. Whether they have always been better or whether it is something to do with wisdom, I am not sure.

MRS DUNNE: How is vegetable uptake translated into the provision of hospital food?

Dr Kelly: I will need to pass that on to one of my colleagues.

MRS DUNNE: What is the system for devising diets in hospital, for hospital food?

Ms McDonald: I can give you some broad overview comments on that in terms of food services. Lisa is not here. We would have to take specific questions on notice, but the overview is that we have a menu that is designed in consultation with our dietitians across the hospital. They have, obviously, education and background in nutritional food and the nutritional guidelines that are available to guide food choices. They have input with our new chef for our food services in terms of designing the menu so that patients can then make choices from it.

MRS DUNNE: We have had a couple of instances lately where people with specialised diets have had pretty bad service at the hospital. I have experience—not my own personal experience but the experience of members of my family—with the

need for a specialised diet. What do we do for people who make dietary choices like vegetarianism or being a vegan? There are people who have dietary needs which are a bit out of the ordinary.

MS CODY: Mine.

MRS DUNNE: Ms Cody is a stand-out. Kids and adults with cystic fibrosis are in a constant battle to get high fat, high salt diets because everyone's immediate response is, "You shouldn't have that." How responsive is the food service to the patients on the ground when they arrive?

Ms McDonald: You would understand that there are increasing varieties of diets.

MRS DUNNE: It is probably increasingly challenging, yes.

Ms McDonald: Yes. It becomes increasingly challenging to have the options available. My understanding is that we make as many options available as possible so that people can choose. We have the dietetics team for people with specific needs, as long as we are aware of those when people are admitted. We can get specialised dietitians to come and help design the menu for particular patients across the organisation.

I do not think our menu will ever have every option on there that you could tick in order to get exactly what you would want. It would be prohibitive trying to have such variety on the menu. We are producing thousands of meals every day. Certainly, we can provide dietetics advice on and input into trying to put meals together that are suitable for people.

MRS DUNNE: How responsive is that? My experience, admittedly a couple of years old, was that you often waited two or three days to see a specialist dietitian.

Ms McDonald: Yes. I do not have referral times and those sorts of things—turnaround times—in front of me. We can certainly take that on notice, if you would like those sorts of times. We can look into that. I would suggest that it is probably something we can look at and improve on, turnaround times. It is also about translating that into what foods are available and making sure we have different options available. We have appointed a new chef for our food services. I have had discussions with him about improving the choices that we have and the flexibility in our food system, to be able to provide those options to patients with specific dietary needs.

MRS DUNNE: There was an instance reported in the paper over the weekend, or maybe late last week, of unthawed food being served up to patients in the paediatric ward. What is the overall process that results in food that has turned up on somebody's plate, on a tray, on a trolley, which is not thawed out?

Ms McDonald: I am not sure. I would need to look at the particular incident. I heard it reported, but I am not sure exactly what that looked like in that particular incident.

MRS DUNNE: Pretty unappetising.

Ms McDonald: Yes. In terms of what it was, we can take it on notice and provide you with information about the whole food production process, which is our cook-chill process. You can even visit our cook-chill facilities, if you would like to. We can take you through that process. Certainly, it would never be our intention that a meal would be served in that way.

MRS DUNNE: You heard it reported but you have not followed it up?

Ms McDonald: Yes, I followed it up. I do not have the right person here to give all the details. I cannot remember every specific incident. But we can provide you with more information about that, if you would like.

MRS DUNNE: Yes. I would like to take up the opportunity to delve further into the hospital food issue. One of the things that I get a lot of feedback about is hospital food.

Ms McDonald: So do I.

MRS DUNNE: It is interesting because when the first of those incidents was reported in the paper, the response from the hospital was, "We get almost no complaints about the food."

Ms McDonald: That is actually a fact. We do not get a huge number of complaints. With the thousands and thousands of meals that we provide every week to our patients, the number of complaints that we get about our food is quite minimal. So that is true; that is a fact. When we do get complaints, we do follow those up and try to rectify that. We do not respond just to complaints. We are continually trying to improve our food services and the food options that we are providing to people. The appointment of our head chef, who is very talented and has lots of great ideas on how to improve, is a signal that we are taking that seriously.

MRS DUNNE: When was the head chef appointed?

Ms McDonald: He was appointed, I think, four months ago—maybe six. I would have to check the exact date.

THE CHAIR: Recently?

Ms McDonald: Recently, yes. He is very dedicated and has lots of great ideas on how we can improve.

Ms Fitzharris: One of the earlier reports was about the National Capital Private Hospital. Even though the Canberra Hospital food services does supply that—

MRS DUNNE: Food services supplies nat cap, yes.

Ms Fitzharris: Yes, on request from another institution.

Mr De'Ath: During the accreditation process, I went down into our kitchen at Canberra Hospital, and our laundry services, and spent some time down there. I want to put in a plug for them. They are amazing people. I describe it as the largest

restaurant in Canberra. I would absolutely support our chief executive officer's comments that, considering what they achieve in that environment and for that service, which is quite phenomenal, I believe the complaints are incredibly minimal in comparison. I want to put in a plug for them. I thought they were amazing people.

MRS DUNNE: This is probably a question that could be taken on notice, in relation to population health: can someone tell me what the staff FTE was at the end of June 2017 and what it was at the end of June 2018? And has it changed under the restructure?

Dr Kelly: We will take that on notice.

MRS DUNNE: Thank you.

MS LE COUTEUR: Given that the Ngunnawal Bush Healing Farm is not being used as a drug and alcohol withdrawal facility, what plans are there for a dedicated Aboriginal and Torres Strait Islander withdrawal and rehabilitation facility?

Ms Fitzharris: They are two separate things. Quite a lot of work is underway. There is, as foreshadowed, a review underway of the Ngunnawal Bush Healing Farm. That has commenced. In addition, with the drug strategy action plan that I referenced earlier, there is quite a lot of work underway, particularly looking at how we provide more, and more culturally appropriate, services to the Aboriginal and Torres Strait Islander community, which will include both withdrawal and rehabilitation services.

MS LE COUTEUR: That will be publicly available in what sort of time frame?

Ms Fitzharris: In terms of the drug strategy action plan?

MS LE COUTEUR: Yes.

Ms Fitzharris: That will certainly be released before the end of the year.

MRS DUNNE: This calendar year?

Ms Fitzharris: Yes, in December.

THE CHAIR: Thank you, minister and officials, for everything today. The committee asks that answers taken to questions on notice at today's hearing be provided to the committee secretary five businesses days after receipt of the proof transcript. I remind members that written supplementary questions relating to annual reports will need to be provided to the committee secretary within five business days of the transcript becoming available. Day one for both of those is the day after receiving the transcript. Answers to supplementary questions will need to be provided to the committee secretary 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, which can be sent to the LAC committees' HACS email address.

When a proof *Hansard* is issued, it will be forwarded to witnesses, to provide the

opportunity to check the transcript and suggest any corrections. Please note that the transcript provided is intended to be a verbatim record of the evidence to the committee. Witnesses may correct obvious errors of transcription and spelling. However, if witnesses wish to alter the substance of or elaborate on their evidence, they must do so in writing to the committee via a letter addressed to the chair. I now formally declare today's public hearing closed.

The committee adjourned at 4.30 pm.