LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING AND COMMUNITY SERVICES

(Reference: Annual and financial reports 2018-2019)

Members:

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

TRANSCRIPT OF EVIDENCE

CANBERRA

MONDAY, 11 NOVEMBER 2019

Secretary to the committee:
Dr A Cullen (Ph: 620 50136)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

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Amended 20 May 2013

The committee met at 9.05 am.

Appearances:

Stephen-Smith, Ms Rachel, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Children, Youth and Families, Minister for Health and Minister for Urban Renewal

Health Directorate
De'Ath, Mr Michael, Director-General
Jonasson, Ms Kylie, Deputy Director-General, Health Systems, Policy and Research
George, Ms Jacinta, Executive Group Manager, Health System Planning and Evaluation
Culhane, Mr Michael, Executive Group Manager, Policy, Partnerships and Programs
Coleman, Dr Kerryn, Acting Chief Health Officer
Shadbolt, Associate Professor Bruce, Executive Branch Manager, Director of Research, Centre for Health and Medical Research
O'Halloran, Mr Peter, Chief Information Officer
Lopa, Ms Liz, Executive Group Manager, Strategic Infrastructure
Fletcher, Mr John, Executive Group Manager, Corporate and Governance
Stewart, Ms Margaret, Executive Branch Manager, Commissioning Branch
Philp, Mr Alan, Executive Group Manager, Health Systems, Policy and Research, Preventive and Population Health

Canberra Health Services
McDonald, Ms Bernadette, Chief Executive Officer
Mooney, Mr Colm, Executive Group Manger, Infrastructure and Health Support Services
Lamb, Ms Denise, Executive Group Manager, Quality, Safety Innovation and Improvement
O'Neill, Ms Cathie, Executive Director, Cancer and Ambulatory Support
Gilmore, Ms Lisa, Executive Director, Critical Care
Grace, Ms Karen, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
Bracher, Ms Katrina, Executive Director, Women, Youth and Children
Taylor, Ms Jacqui, Executive Director, Medicine

Major Projects Canberra
Edghill, Mr Duncan, Chief Projects Officer

THE CHAIR: I declare open this morning's session of the second day of public hearings of the Standing Committee on Health, Ageing and Community Services inquiry into annual and financial reports 2018-19.

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

I thank Minister Stephen-Smith and accompanying officials from Canberra Health Services and the Health Directorate for appearing today. I advise committee members and officials that Remembrance Day will be observed at 11 o'clock when we will break for a minute's silence to remember those who fought and lost their lives.

The proceedings are being recorded by Hansard for transcription purposes and are being webstreamed and broadcast live.

I remind witnesses of the protections and obligations entailed by parliamentary privilege and draw your attention to the privilege statement on the table. I ask you all to confirm for the record that you understand the implications of the statement?

Ms Stephen-Smith: Yes, we do.

THE CHAIR: Minister, do you have a brief opening statement?

Ms Stephen-Smith: No.

MRS DUNNE: I have some questions about Calvary; are there people from Calvary here?

Mr De'Ath: Calvary are not appearing, but our people covering Calvary agreements are here.

MRS DUNNE: So no-one from Calvary is here?

Mr De'Ath: There is no-one from Calvary here.

Ms Stephen-Smith: Is it usual practice that Calvary would appear at annual reports hearings?

MRS DUNNE: Sometimes it is. It used to be standard; then it became less frequent. I thought we had something to say about this last year in annual reports.

THE CHAIR: We did.

MRS DUNNE: Last year now Senator Gallagher but not then Senator Gallagher had a contract with Calvary hospital and I want to know what work she performed. Did she represent Calvary hospital on any ACT Health Directorate committees; if so, which ones?

Mr De'Ath: I acknowledge the privilege statement. Thank you for your question, Mrs Dunne. I will not be able to answer your question in full; we will have to take some of that on notice by contacting Calvary directly. The main committee I recall that was participated in was a series of 10 meetings which took place in preparation for planning our network system arrangements. As far as I am aware that was the main involvement we had.

MRS DUNNE: What do you mean by network systems arrangements?

Mr De'Ath: This was looking at the data and information for health services planning, some of which informed the SPIRE work, thinking about north side and just generally all relevant parties around the table looking at the data and information that would inform that work.

MRS DUNNE: Can you elaborate in general terms on what sort of data? Are we talking about demographics and the things that might inform whether we build new hospitals or expand hospitals?

Mr De'Ath: Correct.

MRS DUNNE: That actually moves me on to the next part of my question, which relates to the paper prepared by Dr Merchant and Ms Gallagher regarding the state of assets at the Calvary Public Hospital Bruce. It had things to say about the fact that 61 per cent of the Calvary asset was nearing the end of its life. Minister, I want to know, in light of that, what is the thinking about the north side hospital project and what is the likely time frame for a north side hospital project?

Ms Stephen-Smith: As you are aware, Mrs Dunne, the government did make investments into Calvary infrastructure in the last budget—

MRS DUNNE: Yes, I know that. I am not asking about that.

Ms Stephen-Smith: and Ms Lopa is able to talk about the progress on the north side hospital scoping study—

MRS DUNNE: Thank you.

Ms Stephen-Smith: scoping study; is that the right term?—which also has been funded.

Ms Lopa: I acknowledge the privilege statement. We have been working with Calvary hospital looking forward to a north side hospital. We are currently engaging a consultant to do a full condition assessment of all the buildings at Calvary so that we can understand what condition all the buildings are in, what they might possibly be used for in the future. We are going out for a consultant to do that now in partnership with Calvary. That will lead to a strategic asset management plan for Calvary as well so that they have information as to how they invest or where you invest in buildings going forward.

In the context of north side, that will give us some information about whether the new north side hospital is a new build with a refurbishment of some of Calvary, depending on what condition their buildings are in, or whether you might look at redeveloping everything over a period of time. But it is essential information for us to understand what could be kept, what is at the end of its useful life, what it could be repurposed into, and what it would cost to bring all those buildings up to standard.

MRS DUNNE: So the work that was done by Dr Merchant and Ms Gallagher did have some scenarios and some dollar figures. They also referred back to previous work that was done in 2012, from memory.

Ms Lopa: Yes.

MRS DUNNE: Is that work not enough? Is the current assessment building on that? What is the idea?

Ms Lopa: Yes, it will not ignore that information. It will all be gathered into what the consultant looks at. But I think when we spoke to Calvary about it, we all agreed that it would be good to get a state of play, what everything looks like, get an independent consultant's report that then can lead into a strategic asset management plan and a risk profile.

MS LE COUTEUR: Given that you are looking at such major work, are you going to be looking at traffic issues? In particular, one of the biggest problems with Calvary is that it not actually on the rapid bus route. It is conveniently located 500 metres away. Is that a consideration for you?

Ms Lopa: I think that in looking at all the options for north side hospital you would have to look at all those traffic considerations and access and those things as well. If one of the options was redeveloping the campus on the Calvary site, you would have to look at how access is gained by members of the public. You would have to look at road access, public transport access and how you would design the buildings so that they were most accessible, and then also how those linkages work across the campus for patient flows and those things. I think that in any analysis of any decision that you would make going forward, you would have to look at those things as well.

MS LE COUTEUR: It does not seem to have happened in some of our other hospital investments. There is quite a lot of space on that site, obviously. Assuming that the government has actually decided the light rail route in that neck of the woods, are you saying that the two will go together? Am I being optimistic in saying that that is what you are saying?

Ms Lopa: I am saying that I think, in looking at any options going forward, where the hospital is placed and what accessibility would be for the public would have to be looked at as well. Whether or not you would plan the hospital and plan the whole light rail and a bus network around it, I am not sure going forward whether that is what you would do. But I think that in making a decision about where you would put the north side hospital, you would look at all those issues.

MRS DUNNE: Can I clarify this? In respect of the work about the north side hospital, is there any thought that it can be anywhere other than the Calvary site?

Ms Lopa: I think we need to look at a redevelopment option. Then I think we need to look at a greenfield option too, if only for a comparison on cost. The options that we will look at will include redevelopment of Calvary, but I think we will also look at a completely greenfield option, just so that we can inform government, to be able to say, "Here is a completely greenfield option that will cost you X; or you can redevelop the Calvary site completely and it will cost X; and there are the costs and benefits of it. Or you could bring some of Calvary's buildings up to standard and build one or two new buildings and this is what that would cost and that is the cost and benefit of it."

MRS DUNNE: If you go to a greenfield site, minister, what implications does that have for our contractual arrangement with Calvary? Are you going to have a third hospital if you go to a greenfield site or would Calvary become unnecessary? I am not counting the rehabilitation hospital as an acute hospital. If we go to a greenfield site, are we talking about a third hospital or would Calvary be left to wither on the vine?

Ms Stephen-Smith: I certainly would not use that language, Mrs Dunne. You would be well aware that we have a network agreement with Calvary that ties us into their provision of services. At the moment, we are having a constructive discussion with Calvary about their continued provision of those services. They are a very valued partner in our public health system. So that is certainly not the kind of language or the kind of approach that we would consider. But in order to understand all of the implications and to ensure that taxpayers' money is being used most appropriately, we need to understand all of the options that are available to us. That work is being done entirely in partnership with Calvary and in an open conversation with them about all of the options that are being explored as part of this process.

MRS DUNNE: If you are going to explore a greenfield site, is it a theoretical site or do you have a site in mind?

Ms Lopa: At this point there is no site in mind. We are currently out with a statement of requirements to get a consultant. We have not identified a site and said, "Give us a greenfield option sitting here" at this point in time. I think if you were going to give a proper comparison, you would have to choose a site. You cannot just say theoretically that you could build a greenfield hospital anywhere because you would have to get the infrastructure costs. But we are looking at the infrastructure. The options we are looking at are not going into who runs the hospital. It is really just how much it would cost you to build a hospital of a certain scope in a certain location.

MRS DUNNE: Could you indicate for the committee, Ms Lopa, what the certain scope is? How many beds, how many accident and emergency bays et cetera.

Ms Lopa: Yes, that will be informed by the territory-wide planning work that is happening out of our service planning area. My understanding is that that scope has not quite been finalised as yet.

MRS DUNNE: When will that be finalised?

Ms Lopa: Sorry, I am just looking at our service planning executive. I would not like to speculate on her behalf.

MRS DUNNE: That is fine.

Ms George: I acknowledge the privilege statement. We have commenced the background work on the territory-wide health services plan and envisage it being completed by the end of June next year, 2020.

MRS DUNNE: You are doing that work now and expect to be finished by June. What is the timetable for the consultant? You said you are going out for a consultant now.

Ms George: Yes.

MRS DUNNE: If you have not got the parameters of what our needs will be, when could we expect to see the consultancy on the north side hospital?

Ms George: We will finish the plan by the end of June, Mrs Dunne. But we have started the demand modelling. We will be working with Liz's team and feeding information in about the numbers of beds, the number of theatres, the number of delivery suites, the number of emergency department treatment spaces that we are coming up with in our modelling.

MRS DUNNE: Is that an iterative process?

Ms George: Yes, it is.

MRS DUNNE: Overall, Ms Lopa, what is the timing on the consultancy on the north side hospital?

Ms Lopa: At the moment, the timing on the consultancy is that we would have something for government in around the same time frames: end of June, maybe July—mid-year, next year, depending on how that work goes with working with territory-wide planning and the options that we are looking at. We have not bedded down all the options yet. That is part of what the consultant will be looking at. We are aiming for about mid-year next year as well.

MRS DUNNE: Will this result in a master plan for the Calvary site, essentially?

Ms Stephen-Smith: I suspect that that would be the next stage of the process. This will be around what do we need on the north side; what do our options look like to inform a decision of government around which option is then chosen? If the option is to re-develop at Calvary, the next stage of work, I would expect, would be the development of an entire master plan for that campus that takes into account this work.

MRS DUNNE: I would like to ask more about the strategic planning, but maybe I will put a pin in it because technically we are supposed to be on Calvary.

THE CHAIR: Technically, yes.

MRS DUNNE: Okay, but do not go too far, Ms George.

MS LE COUTEUR: I would like to ask about the human research ethics committee. My first question is: basically what are we doing? I assume that it is all ANU research or am I missing something here?

Mr De'Ath: Associate Professor Shadbolt will join us.

Ms Stephen-Smith: I think it is important to emphasise, though, that ANU is not the only university that undertakes research in this city. University of Canberra has rocketed up the global rankings on the basis of its health research.

MS LE COUTEUR: This is part of the question I am asking. I thought of health research in Canberra as equalling ANU. Maybe I am incorrect in this.

Ms Stephen-Smith: I think this is the difference: medical research, probably yes; health research, maybe not.

MS LE COUTEUR: Would you like to enlighten us because it is a bit of a fine distinction here?

Prof Shadbolt: I acknowledge the privilege statement. In terms of human research ethics committees, there are a number of those in the ACT. There are at least four. There is one that is run by the Australian National University. It is focused on research that is coming out of that university and it also includes animal ethics as well as human research ethics. You will see research that is being done within the population, research that is being done outside the ACT because it is a national university. That all goes through that ethics committee.

The human research ethics committee that is mentioned in the annual report is the one that is run by the ACT Health Directorate. It covers research that is done within ACT Health facilities. It will typically include the research that is done—it could be collaborative research—with Canberra Hospital, Canberra Health Services patients et cetera. There is also a human research ethics committee with Calvary and there is also a human research ethics committee with the University of Canberra. There are a number of them. We are looking at trying to harmonise those.

Our ethics committee is part of the national mutual acceptance program which allows us to be able to work with ethics committees around Australia and take on board the findings that have come from their approval processes, and we have a relationship with the ANU where we can have similar types of approval processes where we accept and acknowledge what is being done. We have done that within their ethics committees.

We are trying to look at it becoming as efficient as possible, and these processes that I just described have allowed us to do that.

MS LE COUTEUR: You mentioned earlier an animal ethics committee. I assume that we do not do any animal medical or health—I am not quite sure which word I should use—research as part of the ACT government Health Directorate or Health Services. I assume that you mentioned that purely for completeness, not because it is actually relevant to what we are talking about because the ACT government's efforts are here.

Prof Shadbolt: Our human research ethics committee does not consider animal research as part of its process. That would typically go to the ANU or University of Canberra for its approval process.

MS LE COUTEUR: Not only that, I am assuming that we actually do not do any animal research. Not only do we not have the ethics committee but we do not do it. Am I correct in that?

Prof Shadbolt: We have labs and an animal facility at the Canberra Hospital site. It has been there for at least, I think—I cannot give you the exact date—a decade.

MS LE COUTEUR: What do we do there?

Prof Shadbolt: We have labs where we look at various experiments. We have some clinical scientists who were employed by ACT Health who typically may have a university appointment with the ANU, as an example. They will be doing experiments maybe in irritable bowel syndrome or looking at liver disease. That certainly has clinician scientists. They are very interested in being able to look at discoveries and be part of an international network of research and discovery.

It is very important for us, as the ACT, to be part of that international network and be part of that discovery process by clinicians. That is part of their job. It is part of what they are employed to do, to have part of their career dedicated to discovering and understanding the disease mechanisms, precision medicine, all these types of research that quite often rely on being involved with the animal model.

We have not been able to move away from that as of yet. Maybe in 10, 15 years we can look at replacing the animal model. But at this stage it is the state-of-the-art approach to being able to understand disease and disease mechanisms.

MS LE COUTEUR: This is a question for the minister. Where do we talk about the animal research ethics committee, given that we must have one and given that we are doing animal research at the hospital?

Ms Stephen-Smith: I think, as Associate Professor Shadbolt just said, animal research ethics would be covered by the ANU.

Prof Shadbolt: That is correct, yes.

MS LE COUTEUR: The ACT government has nothing to do with the ethics of the animal research happening on its premises, is that what you are saying?

Ms Stephen-Smith: We were just talking about trying to streamline ethics committees in relation to research and mutual recognition. Therefore, if that is our aim and the ANU has an ethics committee covering animal research—and I suggest that the individuals who are undertaking this research on the Canberra Hospital campus would be joint appointments with ANU and/or UC but probably, most likely in this case, ANU—they would be covered by that ethics committee.

MS LE COUTEUR: The ACT government does not have any involvement in the ethics committee?

Prof Shadbolt: Yes, we do.

MS LE COUTEUR: You do with humans but not animals?

Prof Shadbolt: We have a licence with the ANU as part of the lab. You have to have

them accredited and meeting a certain standard. We have a licence with the ANU to be able to run our ethics and so forth with them. We have members on that ethics committee that are there—

MS LE COUTEUR: When you say "we", who is—

Prof Shadbolt: ACT government.

MS LE COUTEUR: ACT Health?

Prof Shadbolt: ACT Health.

MS LE COUTEUR: As members on the animal ethics research committee that is part of the ANU?

Prof Shadbolt: Yes.

MS LE COUTEUR: That sounds a bit more positive. It sounded like we had absolutely nothing to do with it. If it is happening on the premises we—

Prof Shadbolt: Definitely there would be no research undertaken on animals within those laboratories without it first going through the ANU ethics committee for animal research. It is a must.

MS LE COUTEUR: Is there any published list of the animal and/or human—I am surprised about the animals—criteria for deciding whether something is or is not ethical?

Prof Shadbolt: I can provide that to the committee if it is requested.

MS LE COUTEUR: Thank you. I am actually gobsmacked here. I really did not realise we did animal research.

Prof Shadbolt: A lot of our precision medicine around rare diseases and neurological diseases requires us to be able to put the cells into animals to be able to understand which drug will work and what will work. We are one of the leading sites in Australia for that.

THE CHAIR: Can you expand on research with the Aboriginal and Torres Strait Islander peoples and communities and what we are doing around that side of the ethics committee stuff?

Prof Shadbolt: I cannot tell you about projects of that nature, but I can get back to you with that. I can give you overall numbers of projects that have been reviewed.

THE CHAIR: They have a higher rate of heart disease, diabetes and those sorts of things. I am assuming it is how we can look at that and help out.

Prof Shadbolt: Definitely. Whatever is done in that space with Aboriginal and Torres Strait Islander people is a co-designed type of model. I am not sure of the projects that

have gone through the actual ethics committee. I would guess that it would be cardiac and heart failure. Those types of projects are very much active in the ACT.

MRS DUNNE: Can I ask for some elaboration about what the ethics committee does. It oversees research? It approves research? I am just trying to get a feel for its remit. The report basically has a small amount of narrative, lists the members and talks about the meetings, but it does not elaborate on the projects that they have approved or the projects that they are overseeing. I would like to get a feel in more detail as to what the committee does.

Prof Shadbolt: The committee follows the 2007 national statement on the conduct of ethical research.

MRS DUNNE: Do you have to get a tick-off from the committee before you undertake research?

Prof Shadbolt: This is correct.

MRS DUNNE: Is there any monitoring of research after the tick off?

Prof Shadbolt: This is correct. Yes, there is.

MRS DUNNE: But it is not reported here. This is very bare-bones reporting.

Prof Shadbolt: We could probably look at elaborating that further in future.

MRS DUNNE: For instance, and this may be something that you have to take on notice, what research was approved in the reporting year?

Prof Shadbolt: I can tell you the numbers if that helps.

MRS DUNNE: That would be a start.

Prof Shadbolt: We had 152 new research proposals over that period. Of those, 121 were considered to be low risk. That is where there is no impact directly on a patient or there is some sort of influence on that patient. It might be reviewing records or some sort of audit approach to research. We had 31 that were considered greater than low risk. That is the more standard project where you see that there is some sort of experimentation, clinical trial or something like this. There were 140 new research proposals approved; 114 were approved as low risk and 26 were approved as greater than low risk. We had 46 research projects completed during the period. That is the monitoring: we monitor them and record that they are completed. Eight were low risk and 38 greater than low risk. We had no complaints to the ethics committee.

MRS DUNNE: Who actually does the monitoring? Is it the committee or are there staff as well?

Prof Shadbolt: There are staff who do that, yes.

MRS DUNNE: What is the establishment for this?

Prof Shadbolt: We have four staff. We have a director of human research ethics, a senior officer, an ethics officer and an admin support.

THE CHAIR: The membership of the board does not look like a board. How often does that rotate or change? What are the time frames for appointees?

Prof Shadbolt: I am not sure of the exact dates. From memory, it is every two years, but I would have to check that.

THE CHAIR: You have haematology, rheumatology and gastroenterology type experts, by the look of things. Would you bring in other experts if a project required additional input or expertise?

Prof Shadbolt: We have subcommittees for that. There is a clinical trials subcommittee and a social research subcommittee. I have sat on the clinical trials subcommittee, so I know how that works. It is very much providing that extra expertise on particular types of research that then feeds back into the main research committee, the ethics committee.

MRS DUNNE: In the year under report, has there been any research approved or concluded in relation to foetal tissue research?

Prof Shadbolt: I would have to check that out.

MRS DUNNE: Has there been any end of life research done in that period?

Prof Shadbolt: I would think that there has been, but I cannot tell you that or identify the exact projects.

MRS DUNNE: For those things, could you give the committee some sort of breakdown about what the research was about, when it was approved, whether it has concluded, et cetera?

Prof Shadbolt: Yes.

MRS DUNNE: We might have some recommendations about some more thorough reporting in this space.

MS LE COUTEUR: We might, possibly. The report says that the directorate is developing a research strategy to provide a high-level strategic vision of what research might be done. What direction are we trying to go in with research? Are we trying to do research purely to help our current population or is it research for bigger aims? Where is our thinking on this?

Ms Stephen-Smith: The first thing to say is that over the past year and a bit, there has been quite a lot of focus on improving the partnership between the ACT Health Directorate, Canberra Health Services, the ANU and University of Canberra. It is partly around recognising the opportunities we have here to undertake research, then applying that research for the benefit of patients in the ACT, whether they are

Canberrans or from southern New South Wales.

It is also about building research partnerships with partners in New South Wales: the University of Wollongong and others in our region. There are two reasons for that. One is to ensure that patients in the ACT get the benefits of early access to new drugs and new treatments. The other is that you need to be doing research in order to be able to access the research that others are doing.

It is important for us to be active in that research space, whether that is about new medicines and treatments or whether that is about clinical pathways and the kind of research that is done around how hospitals and teams work, how patients are treated and things like wound care. There is a lot of research in those spaces. Having people active in those spaces and understanding the latest research helps them to be able to apply that research for the benefit of patients in the ACT.

Mr De'Ath can talk about the partnership board and the work that is being done to build those partnerships; maybe with New South Wales as well. Someone else might want to talk about the priorities we are putting around that.

Mr De'Ath: You may recall that some time ago we held a health systems research teaching education summit. One of the key outcomes of that summit was the forming of a partnership board which has representation of the CEO of Canberra Health Services, the CEO of Calvary public health service, Health Care Consumers, the Dean of Health and Medicine from both ANU and University of Canberra and I. I chair that board.

That board has established two working groups, one on research and one on teaching and education. That is quite a powerful mechanism for strengthening the partnership to take this forward. Part of that partnership board has been considering the structure of research in terms of personnel, resources and so on. That work is in its early stages, but we are considering how to go forward in a much more collaborative way as opposed to ACT Health Directorate acting fairly independently in the space. We are very excited about that work.

The other reference that the minister made was to our partnership with New South Wales. We have had excellent engagement. I have been working very closely with Elizabeth Koff, the Secretary to NSW Health. Ministers have been engaging together and effectively championing a new approach to looking at the health service system across our borders. We are focusing on what that will mean for citizens in both parts, in southern New South Wales and in the ACT, to strengthen our health system, to help to manage the demand that comes on to the territory, while at the same time ensuring that all of our specialties remain strong and viable. Primarily, it is about citizens getting the best health care, both within and across our borders. That work is being progressed at the moment. There are fortnightly meetings. Ms Jonasson leads those meetings with a New South Wales counterpart, and we are looking forward to what that work will deliver over time.

Associate Professor Shadbolt might be able to add a bit more on your specific questions around the research areas.

Prof Shadbolt: Certainly, we are very interested in research related to translation impact. That is critical for where we are going. In terms of the territory, in terms of our community and in terms of what is happening nationally, being able to take research that is created either in the primary state or in the fundamental state and move it through into services is critical for us to be able to leverage its benefits.

That has been the big gap that has been seen internationally in terms of how we can get research as quickly as we possibly can and so that our patients can access it and benefit from it.

That is part of the direction in which we are trying to put a lot of energy and emphasis. NHMRC are structuring their research grants in that direction. We have recently established a research innovation fund and we are looking at being able to make it part of the requirements in terms of the guidelines for those who apply for it that they will demonstrate potentially how it will have an impact and be able to be translated into our services here.

That is what we are planning to do in the next year or two, to be able to build capacity in this area and to be able to grow our workforce of clinicians, scientists and researchers that will enable that as best we can.

Ms Stephen-Smith: In terms of reporting, obviously, there is a limit to how much information from every bit of Canberra Health Services and the Health Directorate can be included in the annual report. There is quite a lot of information on the website about the various research priorities and activities that are going on. You might want to have a look at that in terms of scaling a recommendation around reporting.

MRS DUNNE: I will move back to my current favourite topic. I want to ask some further questions about Calvary hospital. The first one relates to the national efficient price. I know that the current published information in relation to the national efficient price is for 2014-15. First and foremost, when will we get updated information about the national efficient price?

Ms Stewart: I acknowledge the privilege statement. Could you repeat your question?

MRS DUNNE: I am going to ask some questions about the national efficient price, but before I do, I notice that the stuff on the MyHospitals website is dated 2014-15. I am wondering when we will see more up-to-date information in relation to the national efficient price, seeing that it is set every year. Do you know, or is that a question for the—

Ms Stewart: The national efficient price is published by the Independent Hospital Pricing Authority, I believe,

MRS DUNNE: The MyHospitals website refers to data which is from 2014-15.

Ms Stewart: That is not updated by us.

MRS DUNNE: I know; I am wondering whether you—

Ms Stewart: But we can get you the national efficient price—

MRS DUNNE: I can do that; I know what it is. I am going to ask some questions, but they are prefaced by the most available information being for 2014-15. In 2014-15 the national weighted activity units in relation to the national efficient price for Calvary was $6,000, whereas the metropolitan hospital group peer group average was $4,600. What causes the discrepancy of close to $1,400 between Calvary hospital and its peer group hospitals? Have we made any progress in closing that gap since 2014-15?

Ms Stewart: We have some more up-to-date figures than that. It might be at the jurisdiction level.

MRS DUNNE: How up to date is your information?

Ms Stewart: For comparative purposes, the most recent we have is for 2016-17. That would be constrained, for comparative purposes, by what is available nationally, and the latest report from IHPA is for the 2016-17 year. I understand that the information for the 2017-18 year will be available in March, but I will check that for you because we have that—

MRS DUNNE: What is the 2016-17 information in relation to the NWAUs at Calvary and how do they compare with the peer group?

Ms Stewart: I have it as cost per separation, weighted separation. I am sorry; I have lots of information here.

MRS DUNNE: Perhaps we can take it on notice rather than—

Ms Stewart: I can get it to you today.

MRS DUNNE: Sure. What I would like to know is: for the most up-to-date period that you have, what is—I thought they had stopped calling them cost-weighted separations but call them what you like—the Calvary figure and how does it compare to its peer group?

Ms Stewart: I have ACT figures here; I am not sure that I have Calvary specifically. I will have to ask—

MRS DUNNE: We cannot compare. ACT figures are hard to compare because Canberra is in one peer group and Calvary is in another peer group, so I would like it for both. If you are the right person, Ms Stewart, can you provide that for Canberra as well, or can somebody provide that for Canberra as well?

Mr De'Ath: Mrs Dunne, from what I am hearing, that is possible; we can do that in the hearings today.

MRS DUNNE: Yes, sure. Either on notice or in the course of the day; that would be—

Mr De'Ath: We will prepare that and come back to the table.

Ms Stephen-Smith: Mrs Dunne, I think you were asking about the timing of updates for IHPA data; is that—

MRS DUNNE: No.

Ms Stephen-Smith: Were you just asking if that was the most up to date that is currently available?

MRS DUNNE: I am just asking which is the most up to date. The stuff on MyHospitals is fairly radically out of date. And IHPA set the national efficient price every year but their reporting lags a couple of years behind. Is that right?

Ms Stephen-Smith: Yes, that is right. The 2017-18 annual cost report is expected to be published in about March 2020.

MRS DUNNE: I have a couple of other quick questions on Calvary. Has the network agreement been finalised yet?

Ms Stephen-Smith: The network agreement is ongoing.

MRS DUNNE: I thought there was a revision.

Ms Stewart: There has been a review of the network agreement. That is still in progress with Calvary. We do not have revisions as such.

MRS DUNNE: When is that likely to be finalised?

Ms Stewart: We are working with Calvary at the moment. I do not have a specific end date for it.

MRS DUNNE: We do have a current agreement and you are looking at revisions.

Ms Stewart: It is a current agreement. The agreement operates as is. If there are to be revisions, we are in negotiation with Calvary at the moment over that.

MRS DUNNE: Does Clare Holland House come under the Calvary agreement or is there a separate agreement for Clare Holland House?

Ms Stewart: It does not come under the Calvary network agreement. The funding for Clare Holland House operations, the services undertaken at Clare Holland House, is included in our annual performance plan with Calvary.

MRS DUNNE: What is the difference?

Ms Stewart: The annual performance plans are provisioned under the Calvary network agreement. The Calvary network agreement sits at the top and that is a perpetual agreement. It is the—

MRS DUNNE: It is also perpetually being updated.

Ms Stewart: It is the ongoing agreement, the contractual arrangement. And each year we sign a performance plan with Calvary to govern the actual funding for the financial year and the activity that they will deliver for that year.

MRS DUNNE: Are those performance plans available? Can the committee see them?

Ms Stewart: We do not publish them, but I believe we can provide them, as long as I get clearance.

Mr De'Ath: We will check that; there may be commercially sensitive components.

MRS DUNNE: That would be good. Could we see the one for the reporting period, and if there is one for this financial year as well, that would be handy.

Mr De'Ath: We will take it on notice as to whether that is possible.

MRS DUNNE: Should I ask about Clare Holland House here or wait until we get to palliative care?

Ms Stephen-Smith: If you want to ask here, I think that is—

Ms Stewart: It would depend on what your question is, Mrs Dunne.

MRS DUNNE: There was to be a new agreement with Clare Holland House which I understand was due to be finalised in August. Has it been finalised?

Ms Stewart: No, it has not. That is another ongoing piece that we have with Calvary.

MRS DUNNE: What are the issues that are being negotiated in the agreement?

Ms Stewart: Because the Calvary network agreement does not cover the operations at Clare Holland House in a contractual sense, we do not have an operating agreement with Calvary for the operations at Clare Holland House. That is where we are currently negotiating.

MRS DUNNE: How does Clare Holland House currently operate? In what sort of legal space does it operate? The funding comes from ACT Health. What is the legal or administrative underpinning of that at the moment?

Ms Stewart: I would have to check exactly what that is in law.

MRS DUNNE: What is the administrative underpinning?

Ms Stewart: As I mentioned, the administrative underpinning is the performance plan that we have with Calvary each year that governs the funding and the activity that they will deliver through Clare Holland House. That is all monitored and managed through that.

MRS DUNNE: And that is in the document that Mr De'Ath was going to see whether we could get a copy of?

Ms Stewart: Yes.

MRS DUNNE: There was a commonwealth and Snow Foundation grant for the extension of Clare Holland House. Who is responsible for executing that?

Ms Lopa: The Clare Holland House expansion is underway. There is a tender out at the moment for a design consultant to do the designing of the buildings. The steering committee for that project is made up of ACT Health, Calvary, the Snow Foundation and a representative from major projects Canberra, the old infrastructure and capital works.

MRS DUNNE: No-one from the commonwealth?

Ms Lopa: No-one from the commonwealth. We have a project agreement with the commonwealth; the money has been transferred into ACT treasury, to the ACT government. We have a project agreement with the commonwealth where we report back to the commonwealth on milestones.

MRS DUNNE: I think that was announced partway through last calendar year. What has been happening since that funding was announced?

Ms Lopa: The project with the commonwealth was agreed to and signed.

MRS DUNNE: When was that, just to refresh my memory?

Ms Lopa: I will take that on notice. I am not sure off the top of my head. It may have been before my time or just before I started; I will check that. There has been a lot of governance work done around how the project will work, with money coming from the Snow Foundation and money coming from the ACT government but Calvary running the facility, and how that governance will work, to make sure that we are all on the same page in making sure that the project runs smoothly, especially with the clinicians who are in there every day doing the work, making sure that they are being consulted. The work to set all of that up has now been done. We have a steering committee, we have a project control group, and we have a design consultant just starting to do the design work now.

MRS DUNNE: What is the timetable for it being shovel ready, completed and patients in?

Ms Lopa: Yes, the timetable at the moment is that construction will start mid-next year. That will depend a little bit on the design. One of the things that the design will be looking at is that we have this bucket of money that came from the commonwealth and that came from the Snow Foundation. It will look at what is the most we can get out of that money, what is the most number of beds, what is the best design we can get? At the moment it is due for construction start about mid-next year. I will have to check; I am not sure that we have an end date as yet because it depends on what the design comes out at. I will take on notice how long that build will be.

MRS DUNNE: The ACT's commitment is to staff the building.

Ms Lopa: Yes.

MRS DUNNE: It makes it very hard to do workforce planning if you do not know what the end date is.

Ms Lopa: Yes, we will know what the end date is. I will take it on notice. The build will be 12 to 18 months, I think. It will not change.

MRS DUNNE: Roughly, how many beds are we talking about?

Ms Lopa: We are talking about a minimum of eight. I think the commitment was a minimum of eight but anywhere up to 12, depending on how we can design it and what we can get for the money that is available.

THE CHAIR: Has there been an opportunity to—

MRS DUNNE: It is a long build.

THE CHAIR: Yes. Have you looked at what is best practice, what is going to suit clients or patients? I am not sure what you would refer to them as?

Ms Lopa: Yes, that will all be done through the design as we now go through design. There will be a lot of consultation with the people who work there—the clinicians who work there and the nurses—but also with families as we go through the design process to make sure that we are designing to best practice, to make sure we stay in the character of Clare Holland House and to make sure that it is continuing to deliver the fantastic service that it delivers now.

THE CHAIR: I am under the impression that we have a lot of volunteers who work at Clare Holland House. Will they also have an opportunity to be involved in that? We often hear lots of interesting stuff from volunteers that might help.

Ms Lopa: Yes, absolutely. I think we definitely should be speaking to them and I will make sure that, as we go through the design process, the user groups include making sure that we engage with the volunteers. You are right; quite often they come across things in the buildings and the way they do things that maybe a clinician does not see or they get to spend time in different areas. We will make sure that that happens.

THE CHAIR: Have you looked at other jurisdictions to see any new fabulous things that are happening?

Ms Lopa: As part of the design work, the consultancy will look at best practice. It will obviously look at things like the Australasian health facility guidelines, which are updated fairly regularly to make sure that we are adhering to all those guidelines. But also I think that that is part of the conversations with the clinicians et cetera. This is their area of expertise. This is what they do every day in their workplace.

Best practice always comes into making sure that when you are designing something new you also have to make sure it fits in with the rest of Clare Holland House, because it is not a revamp of the whole. For example, you would not have a different model of care for the new build. We have to make sure that the model of care is consistent across the whole site.

Ms De'Ath: Mrs Dunne, just for the record, I understand that Senator Seselja announced commonwealth funding on 25 September last year.

MRS DUNNE: It was last year. I thought it was but I could not remember. Thanks.

THE CHAIR: The years just get away, don't they?

MRS DUNNE: They do blur.

MS LE COUTEUR: I am interested in 5G. We have a Radiation Council. I have received a number of emails from a number of very concerned people suggesting to me that 5G will be anything from mildly deleterious to frying our brains. I was wondering what role you have, what advice you have and what we can do for the people in Canberra who are really concerned that 5G may be about to fry our brains?

Dr Coleman: I acknowledge the privilege statement. We refer to the advice from the experts at both international and national levels on this. The advice is that there are no demonstrated clinical health effects from 5G.

MS LE COUTEUR: I was told that Belgium has made the decision not to implement 5G because it believed the risks were not adequately researched.

Dr Coleman: I was not aware of that. We will have to look into that. I think all of the jurisdictions in Australia have agreed to refer to the World Health Organisation as well as the national expert body on this.

MS LE COUTEUR: So we just basically refer elsewhere on this ourselves.

Dr Coleman: Absolutely. They are in the best possible position to evaluate the current evidence in this space.

MS LE COUTEUR: We talked about research earlier. I am not really suggesting that this is an area where the ACT should be doing research apart from looking at other people's information. That is not where I am going but—

Dr Coleman: Minister Stephen-Smith has certainly had several letters from some concerned members of the population. We have written back with as much of the information and as many of the links to the validated information that we can find. Minister, I think you referred to a community meeting and that had some conversations as well.

Ms Stephen-Smith: Yes, I also had some questions at Tuggeranong Community Council when I was there in October and I received some information. We will obviously continue to monitor the evidence base as it emerges. But at the moment all

we can do is go on the evidence that is available. As Dr Coleman has said, that is indicating no evidence of adverse impact at this time.

MS LE COUTEUR: Do you also monitor X-rays in dentists? The reason I am asking this is that when I was younger, these were things that people got quite concerned about. Now it seems like every time you go to the dentist you have a couple of X-rays. Is there reason for anyone to be concerned about this?

Dr Coleman: As I think you mentioned, we have a Radiation Council. It has expertise and membership of people who work both in the private and the public industry. Under legislation, their job is to provide advice to the minister on the use of radiation as well as the storage, transport and disposal of radiation. One of their jobs is to identify any particular issues that are becoming a problem. This is not one that they have identified and raised to us.

MS LE COUTEUR: How do we dispose of—what do we call it?—our radiation-causing things that we are no longer using? You will have a better term than that.

Dr Coleman: I will have to take that on notice, sorry.

MS LE COUTEUR: Radioactive waste, I guess you would call it.

Dr Coleman: I am not sure. We all have regulations around how that is to be safely disposed of, but the exact detail I would not be able to tell you at the moment.

MS LE COUTEUR: I assume it is not in the ACT that we dispose of it?

Dr Coleman: I would not be able to confirm that for you. I will have to; there will be a safety regulation around that which the council oversees. We can provide those details to you but just not at the moment.

MS LE COUTEUR: Thank you.

THE CHAIR: I have some more questions on that line. I noticed in the Health Directorate annual report that there were a relatively low number of radiation incidents. How do you manage those when they occur? It talks about some management guidelines and the incidents were deemed insignificant. But what sorts of things do you put in place after these things happen? Are there things that you have learnt from these incidents?

Dr Coleman: As you have indicated, none of these has been particularly serious. I do not think that there are any wide-reaching, wide-impacting recommendations that we can take from these. Every incident or complaint that we receive is investigated and looked into. And then the level at which they are assessed is dependent on what the identified risk is and what needs to be done about that.

THE CHAIR: Are these the sorts of things that you report on every 12 months or do they get reported to the council? I note the council meets approximately every six weeks.

Dr Coleman: Six to eight weeks, yes.

THE CHAIR: If an incident happens between meeting times does that get reported to the council automatically, or how does that work?

Dr Coleman: I think the Radiation Council actively reviews all those as they come up, a little like the medicines place in TDA. All those adverse events are reported to them and then they review them from the expert opinion. If there is anything we need to do about it then that is advised and implemented.

THE CHAIR: But the council are the ones that do the overall—

Dr Coleman: If anything is seen as serious enough or systemic enough then it is referred to them for advice.

THE CHAIR: But the day-to-day, minor incidents are managed from a—

Dr Coleman: Internally, yes. We have two staff members who have some expertise in this place and offer secretariat support to the Radiation Council so that they have the technical expertise to do that first-level review.

THE CHAIR: I note that there was one accidental exposure of a staff member. Did you find that there were issues where staff maybe were not as well informed as they could have been or it was just an accident, that sometimes these things—

Dr Coleman: On the specific issue, I will have to get some specific advice on a particular incident.

THE CHAIR: Minister, I hope I am asking this in the right place. Please inform me if I am not. The Weston Creek walk-in centre—can I ask this now?

Mr De'Ath: That might be CHS.

Ms Stephen-Smith: Probably. It is CHS but you—

THE CHAIR: It is CHS, is it?

Ms Stephen-Smith: It depends what you want to ask. Will it be open by the end of this year? Yes, it will.

THE CHAIR: That was really where I was going with that. I really want to know when it is opening. Before the end of the year?

Ms Stephen-Smith: Yes.

MS LE COUTEUR: Before Christmas?

Ms Stephen-Smith: Yes.

MRS DUNNE: First of all, before I ask specific questions I am utterly confused by this report and the things that are in it. For instance, why is the local hospital network in the Health Directorate? Quite frankly, I went looking for some data the day that the annual reports came out and it did take me a little while to find it because it was not where I thought it would be. It was hidden at the back of the Health Directorate report and not in the Canberra Health Services report.

Ms Stephen-Smith: I guess the short answer is because the Health Directorate is the body that looks after the local hospital network—

Mr De'Ath: From a system perspective.

Ms Stephen-Smith: from a system perspective. Essentially the directorate is the steward of the system. The local hospital network includes Calvary as well as Canberra Health Services for Canberra Hospital. In terms of having the responsibility for making the agreements with the various arms of the hospital network and delivering a network across the whole of the ACT, that is the responsibility of the directorate. I am sure that Mr De'Ath can explain that more articulately than I just did.

Mr De'Ath: I think you did very well. Margaret may be able to provide further detail. But we will see what further questions you might have specifically, Mrs Dunne.

MRS DUNNE: That sort of makes sense. The thing that I was looking for, of course—you would not be surprised—was the percentage of elective surgery admitted on time et cetera and also the timeliness of the emergency department. I went through the indicators in the Canberra Health Service report. When I got to that, basically by comparison with previous annual reports, indicators 1, 2, 3 and 4 were there but indicator 5 was not there; it was somewhere else. It did take me a while to find it. I thought that you might have been hiding it from me but you failed!

Ms Stephen-Smith: No, not at all.

MRS DUNNE: It is not clear from the ACT hospital network strategic indicators that you are reporting on both Canberra and Calvary.

Ms Stephen-Smith: The LHN report would cover the whole—

MRS DUNNE: Yes, but when you get to the strategic objectives once upon a time you reported separately on Canberra and Calvary and collectively; now you do not.

Ms Stephen-Smith: Sorry, can you point me to which page numbers you are looking at?

MRS DUNNE: It is 338 in the orange one, ACT Health Directorate

Ms Stephen-Smith: Just so I can follow the conversation.

MRS DUNNE: That is the first of the strategic objectives. My recollection is that previously these were reported on by both Calvary and Canberra hospitals, and collectively. Now they are reported collectively. I am wondering: is that the case? If it

is the case, why is it the case? And why is this better?

Ms Stewart: I am sorry, I cannot answer about the history of why it was previously reported split out but you are correct that this is a territory-wide result that sits here at the moment.

MRS DUNNE: We have seen, for instance, some improvements in elective surgery waiting times but there are still long waits and a large number of people on the long-wait list. What are we doing to address that?

Mr De'Ath: Let us take it one part at a time. I will ask John Fletcher to respond in the first instance.

Mr Fletcher: I have some background to the way that the Health Directorate annual report is structured. It results from some new administrative orders that came into effect in October. There was a process whereby, under the administrative orders, the strategic indicators and objectives were between the Health Directorate and Canberra Health Services. So the report is a bit disjointed. It is disjointed also in that it has some complexity about it in relation to the financial statements, in that the Health Directorate did not have a budget at budget 2018-19. So there were some administrative arrangements under the FMA that we needed to restructure.

MRS DUNNE: You had to restructure it retrospectively.

Mr Fletcher: In terms of the LHN, the performance indicators that are at the statement of performance in the LHN, on page 335, are really unchanged; it is just that you need to look in different components of the reports to find some of those performance indicators. On page 335, you will see a range of indicators that relate to the ACT local hospital network, with an explanation of what they are and what they measure and an explanation of the variances.

Ms Stephen-Smith: Mrs Dunne, I think your specific question was about what we are doing about this.

MRS DUNNE: Yes, but before that, I acknowledge that there is activity shown on page 335, but my question was actually about elective surgery. And in future are we going to see more granular reporting to cover Calvary and Canberra hospitals?

Ms Stephen-Smith: We can certainly take that on board, and if the committee makes a recommendation that that is what should be included in the annual report, we will act on that recommendation. It is a very good point, Mrs Dunne, because there is both the territory-wide view and then the Canberra Health Services and Calvary view. Elective surgery is a good example of where there has been a territory-wide approach taken to reducing elective surgery wait times. As you have noted, the hospitals jointly achieved the recommended 30-day treatment time for 96 per cent of category 1 patients, which was an improvement. Timeliness also improved for categories 2 and 3. But we have also seen the numbers continue to increase.

MRS DUNNE: But also the number of long waits has roughly doubled.

Ms Stephen-Smith: Yes. Despite delivering the highest record number of elective surgeries last year, and 600 more than in 2017-18, there continue to be people on those long-wait lists.

Things have been done to address that. They include two new theatres at Calvary Public Hospital Bruce as well as the staff to support those theatres, one this year and one opening in 2021. One of the important things that points to the territory-wide approach is the expanded urology services and staffing at Calvary. That is a real recognition that Calvary had the expertise in that particular space and an opportunity to take the load in that space, taking some of that load off Canberra Hospital and using our resources across the territory to the best of our ability. And you have spoken with Canberra Health Services about their timely care strategies, which cover both emergency and elective surgery in terms of improving patient flow through the hospital so that we can meet those demands.

It is a challenge—it is a challenge for us; it is a challenge for health systems across the country—that despite increasing numbers of elective surgeries being performed, wait lists continue to grow. In some senses, it is a self-fulfilling prophecy: as people see that elective surgery is increasing, they are more likely to add themselves to the wait list if they have a choice about it.

They are just a couple of examples of how the territory-wide approach is working.

MRS DUNNE: On the territory-wide approach, minister, you say that there are two extra theatres at Calvary, one staffed this year. When you say this year, do you mean this reporting period?

Ms Stephen-Smith: 2019-20.

MRS DUNNE: And the one next year is 2020-21?

Ms Stephen-Smith: Yes.

MRS DUNNE: What establishment do you need to staff a theatre? And is it being staffed for a particular purpose? You said, for instance, that you are expanding urology. Are they urology theatres? And for them to operate roughly from 8 am to 5 pm, in addition to the surgeon performing the surgery, what other staff do you need and how variable is that?

Ms Stephen-Smith: I will have to take that on notice.

Ms Stewart: I do not have an exact ratio, Mrs Dunne, but we can talk about the number of procedures. We have had an uplift in 2019-20—

MRS DUNNE: No. I know that we have had an uplift in the number of procedures, but you are saying that you are staffing a theatre; I am asking how many staff that is, a ballpark figure.

Ms Stephen-Smith: I believe that I have those numbers in my office, but I do not have them with me at the moment. Can we take that on notice and come back after the

break?

MRS DUNNE: Okay. In relation to the long wait list, there was a supplementary appropriation with more budget allocation—I think $6 million—within this reporting period. I think it was in this reporting period. What happened to that money and how many actual occasions of service resulted from the supplementary appropriation?

Ms Stephen-Smith: The supplementary appropriation at midyear in 2018-19?

Ms Stewart: It was 2017-18.

MRS DUNNE: There was an appropriation, I think, in December-January 2018. There was a supplementary appropriation—I cannot swear to the figure now but I think it was $4.6 or $6.4 million—for extra surgeries. What happened?

Ms Stewart: It was around the $6 million mark; we can get that figure exactly. And we do have the number of surgeries, but I just do not have it at my fingertips. We can get it for you.

MRS DUNNE: Could you take that on notice.

Ms Stewart: Yes. We will get it to you today.

MRS DUNNE: There were big promises made about how that would cut the long wait, but we have a bigger long wait even though we had that supplementary appropriation.

Ms Stewart: It reduced the long waits in that year quite substantially. I think it was down to around a hundred and something.

MRS DUNNE: But now it is up to four hundred and something.

Ms Stewart: And in the reporting year there has been an increase in the number of people waiting longer.

MRS DUNNE: It would be useful if there were some way to describe diagrammatically the input of that money, the impact it had on the long waits and what has happened to the long waits since, and then perhaps give some sort of analysis about why we have a bigger number of long waits than we did back then.

Ms Stephen-Smith: If memory serves correctly, the quarterly report for the January to March quarter of last financial year had a long wait figure of 699 people exceeding the wait time. That came down to 635 by the end of June, in the last quarterly report. That gives you some measure of it. I cannot remember what the previous quarterly figure was, but there was some impact in terms of reduction in the number of people waiting between the third quarter of 2018-19 and the fourth quarter of 2018-19. But we will take that on notice and provide some further information.

MRS DUNNE: For some reason, I just cannot see it now, but I did see in here that the figure for long waits had gone up from 133 to four hundred.

Ms Stewart: It is actually reported in Canberra Health Services. That is where you have seen it.

MRS DUNNE: Okay. I knew I had seen it. I thought it was in the local hospital network, but it is in Canberra Health Services.

Ms Stephen-Smith: Mrs Dunne, Mr De'Ath has provided some information. The numbers went from 410 in quarter 1 to 516 in quarter 2, 699 in quarter 3, and 635 in quarter 4. So they definitely did increase over the first three quarters; then they reduced again, which potentially reflects the impact of that investment. One of the things I have been told in relation to this was that there was a focus on ensuring that category 1 patients were being seen on time. Those tend to be the more complex patients, so increasing the number of category 1 patients who are seen within the 30 days has had a flow-on impact on some of the other categories.

MRS DUNNE: My recollection—and this is wearing my PAC hat, because the supplementary appropriation went to PAC—is that the supplementary appropriation was for the long waits, not for the category 1s. Is that correct?

Ms Stewart: I believe so. Minister, I think you were talking about last year but the supplementary appropriation that I think Mrs Dunne is referring to is 17-18. Is that correct?

MRS DUNNE: Yes, I think so. It was appropriated late—

Ms Stewart: Was it the supplementary?

MRS DUNNE: December 17-18 or February 18.

Ms Stephen-Smith: Okay, sorry. I was thinking, "Is she talking about the blitz?" Is that what it was referred to?

Ms Stewart: Not "the Blitz" but the lowercase version, yes.

Ms Stephen-Smith: A mini blitz, perhaps, in 17-18 to—I would have to go back to read the exact words but I think one of the intents was to reduce the number of people waiting longer than clinically recommended time frames.

MRS DUNNE: And we have got that down to 130 or something like that.

Ms Stewart: I have got 144 in my head but I would have to check that.

MRS DUNNE: It was one and a double number as I recollect, yes.

THE CHAIR: My understanding is that the then minister for health made a statement that a $6.4 million funding boost to elective surgery would see 600 additional patients receive treatment within recommended time frames that year and help ACT Health achieve more than 13,000 elective surgeries in the financial year and that:

> This will be accomplished by delivering more surgeries … in the public and private system by increasing the allocation of operating sessions to … specialties with high demand, such as paediatric and adult general surgery, orthopaedic surgery, urology and gynaecological surgery.

Ms Stephen-Smith: But this is the previous financial year we are referring to, right?

MRS DUNNE: Yes, it is.

Ms Stephen-Smith: I thought you were talking about this financial year, so I was getting quite confused.

MRS DUNNE: No, sorry.

THE CHAIR: It was the 2017-18 supplementary appropriation.

Mr De'Ath: Thank you, Mrs Dunne. We will endeavour to come back with as much information as we can after the break.

MRS DUNNE: Great.

Ms Stewart: I can give one response, Mrs Dunne. You were asking about greater granularity in the reporting of "seen on time" and "surgeries performed on time". The quarterly performance report that the directorate publishes will, from quarter 1 this financial year, report at hospital level.

MRS DUNNE: Excellent. I have a couple of questions about surgery. You talked, minister, about specialising in urology. Is all of urology going to Calvary, or is it principally going to Calvary?

Ms Stephen-Smith: That is not my understanding.

Ms Stewart: No, it is not all of urology.

MRS DUNNE: But a lot of it is?

Ms Stewart: There is a new model of care being created at Calvary, which is a much more efficient model, as I understand it. I am not the expert in this but, as I understand it, the notion was to incorporate a more efficient consultation and diagnostic procedure process. There is some infrastructural spending that goes around setting that up as well, so it is still in train. Money was approved for the current financial year to establish that.

MRS DUNNE: Is that for diagnostic clinics as well as surgery and follow-up?

Ms Stewart: It is outpatients diagnostic procedure as well as surgery.

MRS DUNNE: Also in relation to specialising, there has been a lot of orthopaedic work done in the private system, mainly at Calvary John James. Is that still the case?

Ms Stewart: Yes.

MRS DUNNE: How much orthopaedic work would be done in the private system at Calvary John James?

Ms Stewart: I would have to take that one on notice, if we can get it.

Ms Stephen-Smith: I think we will be able to answer that when Canberra Health Services is here.

MRS DUNNE: The thing is, the performance indicators are here in the Health Directorate's report but the subject matter is somewhere else, so it is clunky.

Ms Stephen-Smith: Yes, it is.

THE CHAIR: We are going to look at this for the next reports.

MRS DUNNE: I will put a pin in that question and we will come back to it.

Hearing suspended from 10.30 am to 10.43 am.

THE CHAIR: Ms McDonald, you are the only new person at the table; would you confirm that you have read and understood the privilege implications?

Ms McDonald: Yes, I have.

Ms Stephen-Smith: If I can respond to a question Mrs Dunne asked earlier about the staffing associated with the additional theatres at Calvary Public Hospital Bruce. I am advised that the likely employment by Calvary for the two theatres is 15.5 FTE. That is the Health Directorate's estimate of likely numbers. If you want us to go to Calvary and ask specifically we can do that, Mrs Dunne.

MRS DUNNE: No, I was looking for a ballpark because it depends on the acuity of services you are offering on a day-by-day basis.

Ms Stephen-Smith: Yes.

THE CHAIR: I want to ask about the Chief Nursing and Midwifery Officer. I believe this role is still vacant, is that correct?

Mr De'Ath: The role is in recruitment and we are finalising that process at the moment.

THE CHAIR: So we hope to have someone in the role—

Mr De'Ath: Very shortly.

THE CHAIR: Will that then give you a chance to look at some of the prescribing roles for nurse practitioners and those sorts of things?

Ms Jonasson: I acknowledge the privilege statement. Thank you for the question. Yes,

it will; all those issues will be something the new chief nurse will be able to look into.

THE CHAIR: I guess the chief nurse will come up with policies around training nurses and those sorts of things. So that is probably for another reporting period where we will be able to ask lots of questions.

Ms Jonasson: Yes, it will be.

Mr De'Ath: Like our other chief roles, the professional-led roles, the chief nurse will have system oversight for a broad range of issues. We are looking forward to that person joining us and that will largely finalise our recruitment into the office for professional education and leadership.

THE CHAIR: I want to talk about recruitment policy for Canberra Health Services. Has there been a change in policy for recruitment around temporary and permanent employees?

Ms McDonald: Yes, our people and culture team are looking at all our policies regarding recruitment and the difference between permanent and temporary contracts in particular. We are endeavouring to meet the government's approach to secure work. We value providing as many of our employees as possible with a secure, permanent, appointment.

We are looking at all groups of staff across the organisation. Where we have worked first and responded is our work with the ANMF in regards to our graduate nurse program. Our next intake of graduate nurses next year will be offered permanent contracts with the usual probationary periods that apply to all of our positions across the organisation.

We are also working through each of our key groups where there are large numbers of temporary employees to see if we can shift that to permanent contracts. The nature of our business means that we have some people on training programs who work with us for 12 months or shorter periods based on training requirements. A lot of our junior medical officers fit into that category, but we are looking at increasing where we can our numbers of permanent contracted staff.

THE CHAIR: Is there a bit of an issue with some of the recruitment policies currently in place?

Ms McDonald: Not that I am aware of specifically. We have been looking at recruitment across the organisation and ensuring all our policies are up to date. We are also following all our recruitment policies across the organisation. We have had a couple of questions from a couple of our unions regarding some particular processes which we have addressed and followed up with preliminary assessments to make sure that we are in line with all of our policies. As far as I know, our policies are current.

The culture review mentioned some of our recruitment practices and that they could be improved. We have investigated each one of those areas to see if we need to improve and to address those issues where possible.

THE CHAIR: I assume you have been doing ongoing recruitment rounds; they are probably ongoing forever in Canberra Health Services.

Ms McDonald: Yes, they are. It is the nature of the business. We have more than 7,000 staff across the organisation. People leave the organisation for various reasons and we obviously need to recruit into those positions. It is a continual process. We have employed a director of workforce who is looking at where we need to prioritise our recruitment processes in particular areas of need across the organisation.

THE CHAIR: Can you provide your temporary contract staff for the last reporting period versus this reporting period.

Ms McDonald: I can take that on notice and provide the numbers to you today.

MRS DUNNE: I have a follow-up question. How have we got into the situation where we have such a large body of casualised staff, especially nursing staff, when the hospital is growing and the demand is growing? How is it that we have such a large proportion of staff that is casualised? What is the cost to the system of that?

Ms McDonald: Just to clarify, one question was about permanent versus temporary contracting. I think I have addressed that. In terms of casual staff, we always work to try to give people even a temporary longer-term contract rather than to have casual staff.

MRS DUNNE: Sorry, I was probably using "casualised" in a more casual sense than a—

Ms McDonald: In the more casual sense. So I will address that one if it is more in the casual sense. We run a 24-hour a day business. The nature of it is that we do have people who are off sick at short notice. We need to keep a number of staff who are casual, especially nursing staff who work in our pool where they have a set number of shifts for which we need to roster them, but they may be anywhere in the organisation. We have quite a few staff for whom that is their preference to work like that, but we try to keep those numbers as low as possible. However, we do need, at short notice, to fill in gaps across the organisation with the nature of our business—

MRS DUNNE: But why would you do that with casual staff rather than pool staff?

Ms McDonald: Sometimes you cannot get enough pool staff in the pool; so you would back that up with a smaller number of casual staff. Then sometimes you cannot even get enough of those staff. This is not unusual to the ACT. This is the nature of a health service and hospitals; it is the way they work. You try to minimise the use of casual staff because they are more expensive. But at some points in time you need to have the back up. We have to guarantee that we can cover our shifts. So we will have a group of casual staff, a group of pool staff and a group of rostered staff who are permanent employees of the organisation.

MS CHEYNE: On staffing, last year I asked about annual leave balances, in particular for nurses. On notice, I was provided with the average number of hours. It was 209 hours and the most that someone had was 1,500 hours. Is there an updated

figure for last year?

Ms McDonald: I do not have the updated figure with me right now. We could take that on notice and provide that today.

MS CHEYNE: Thank you.

MRS DUNNE: I go back to the local hospital network. I have a couple of questions. I think I covered most of the stuff relating to elective surgery. I would like the minister or the officials to reflect on this: I was told by a constituent who has had quite a lengthy wait that one of the surgeons said to her that if they did have lengthy waits, the surgeons got into big trouble. What sort of trouble do surgeons get into if they exceed their wait times?

Ms McDonald: I can talk to that. I am not sure of the details of what that is referring to but obviously what we do have are targets across the organisation and actually in our budget papers in regards to our performance. We discuss across the organisation what that looks like for patients. Obviously, we always ask all of our clinical staff to treat people based on their clinical priority. Unless I have details, I do not have an awareness of any surgeons being berated or any negative feedback for our surgeons in regards to not treating people in time.

MRS DUNNE: Great; thank you. In relation to interstate patients, I notice on page 330 that there was an 11 per cent increase in takings, shall we say, from user charges—the ACT government. I would presume that that is interstate residents using the hospital system.

Ms McDonald: Yes.

MRS DUNNE: Can someone give me some sort of analysis of whether that is an 11 per cent increase in interstate patients, is it that we are actually getting more money out of the states, or is it a combination of both of those things?

Ms Stewart: Sorry, Mrs Dunne; could you say which page you are referring to, please?

MRS DUNNE: Page 330; it is about the Health Directorate. It is under reporting note 16. It is under the Local Hospital Network.

Mr Fletcher: Yes, that figure of 11½ per cent is an increase in user charges above the 2018-19 year. The budget target was 107. The outcome is 120; so it represents an increase in the revenue.

MRS DUNNE: Yes, I can read that, Mr Fletcher. I am actually looking for some analysis about what contributed to that 11 per cent increase. Is it that we are seeing more interstate people?

Mr Fletcher: Yes.

MRS DUNNE: It is simply that we are seeing more interstate people?

Mr Fletcher: It is a result of our cross-border arrangements.

MRS DUNNE: Does that translate to an 11 per cent increase in interstate patients?

Mr Fletcher: I can only comment on the number that is there in terms of the revenue. We have more revenue from user charges from cross-border arrangements. I assume that that is because we have more cross-border patients but perhaps there is someone else who might like to make a comment about our arrangements cross-border.

MRS DUNNE: Yes, because from time to time ministers and officials have complained that they would like to get more money out of the states as well for the—

Ms McDonald: I will respond to that as well.

MRS DUNNE: So is this a reflection principally of an increase in patients from interstate or are we pouring back more money as well? Is there an analysis?

Ms Stewart: It can be a combination of increased patients but also increased—

MRS DUNNE: acuity—

Ms Stewart: Acuity, that is right.

MRS DUNNE: That is the third possibly, isn't it?

Ms Stewart: I am not sure whether we have any further details on the lag time involved in this. I am not sure that it necessarily relates to 2018-19 when it is cross-border flows. It could be a reconciliation issue where it is for previous years. Yes, it is previous year throughput as well. These things are reconciled at national level and then the flows come after the actuals have been reconciled. So it does not necessarily relate to—

MRS DUNNE: But you would take that into account—sorry, it is 11 o'clock.

THE CHAIR: I would like to interrupt proceedings, it being 11 o'clock. I ask everyone to stand in silence for a minute.

The committee having recognised a minute's silence—

MRS DUNNE: There would be a lag every year. I presume that the budgeted outcome would take into account the lag. And it might be easier to perhaps give the committee a written explanation. I am thinking about time here today. I am in your hands.

Ms Jonasson: We are happy to come back to you. Essentially the difference in the funding that we receive will be two things. As Ms Stewart alluded to, it is both the number of people and the acuity of the person that would be presenting. We do not have the breakdown of that for you here today. We would have to come back to you on that.

In terms of the lag, there is a reconciliation process that happens each year with New South Wales and we look back at what has been provided and—

MRS DUNNE: That reconciliation is essentially based on the cost-weighted separation. If somebody comes from Bega and has a triple bypass here you do not actually recover the cost incurred by the ACT health system; you get back what the cost-weighted separation is for a triple bypass?

Ms Jonasson: That is correct. It is not the cost that the ACT Health Service incurred.

MRS DUNNE: It is not the cost incurred, it is what the system says the cost should be.

Ms Jonasson: It is what the system says the cost should be.

Mr De'Ath: There are also the reconciliations with other jurisdictions as well, which—

MRS DUNNE: I understand. It is mainly New South Wales but it can be elsewhere as well, yes.

Mr De'Ath: That is the main activity.

MS LE COUTEUR: I think that this is the right place to ask this: how has the split of the directorate into the ACT Health Directorate and Canberra Health Services improved particularly the functionality of health policy and, secondly, health services delivery?

THE CHAIR: Maybe not in the annual reports hearings.

MS LE COUTEUR: Would anyone like to take that on? It was a bit of a big event that was meant to happen.

Ms Stephen-Smith: I ask Ms McDonald to comment on the delivery of services in particular.

Ms McDonald: From a delivery of services perspective, the focus within Canberra Health Services is just that. It is much more focused. We have set up very clearly focused people and culture services: our finance services and our quality and safety teams as corporate services and our infrastructure services. Our executive is very comprehensive now and focused just on the delivery of services across Canberra for CHS.

Specific examples include that our clinical executive directors now have a lot more support. For example, our clinical exec director for surgery has a lot more support around him in providing services so that he can focus on improvements and strategy for surgery across the organisation and we have got business partners from people and culture helping with staff recruitment and all those business processes. We have a very focused quality and safety business partner as well and a finance business partner. Each of these roles surrounds our executive directors, which allows them to focus on

the strategy and improvements within each of their clinical divisions. That is it broadly.

The structure is the way that most hospitals are structured, with executives and then senior managers, cascading down through the organisation. Whilst we have input into policy and system design, and work collaboratively with the Health Directorate, it is not our core focus. Our core focus is on delivering services and improving the delivery of those services every day.

MS LE COUTEUR: Were there some specific goals that you expected after the split, that X, Y and Z would happen? If so, what were they and were they achieved?

Ms Stephen-Smith: Ms McDonald has talked about the capacity for Canberra Health Services to focus on service delivery being one of the expectations in the split.

MS LE COUTEUR: Has that made a difference in terms of actual service delivery, as distinct from capacity? This is what I am trying to say.

Ms Stephen-Smith: I think that was what Ms McDonald was saying, that enabling those leaders to focus solely on the service delivery without that overlay of being part of a larger directorate has made a difference. There are a number of things that, I am sure, will be asked about during the day that Ms McDonald can go to in relation to both quality and efficiency of Canberra Health Services that are a direct result of that very specific focus.

As to enabling the directorate to focus on its territory-wide stewardship role, the significant issues around commonwealth-state relations and interstate relations, the health protection service aspect and the ICT digital health aspect—the other aspects of the service which often do not necessarily get as much focus as the Canberra Hospital might get—there is now an entire directorate that has that specific focus. Mr De'Ath might want to talk a bit about it.

Mr De'Ath: I think you have done that extremely well actually. That is much of what I would have said, just acknowledging the fact that we have effectively taken the components that we have of being one entity and created, if you like, a health department as you would regularly see in other jurisdictions. A largely new executive line-up has been recruited to deliver on the specifics of the new roles to exist in such an entity. That work has gone very well. It takes time to get through that but that is settling very well.

I look for critical indicators when you are running, effectively, a government bureaucracy, health, such as the quality of our system oversight, the strategic and service planning that we are doing, the regulatory functions that we have and how effectively those are operating. One of the lead indicators for me is: what am I seeing in terms of the quality of the advice and briefing to ministers and to government? I think that that, without a doubt, has shifted significantly.

We are now able to focus very much on our commonwealth relations work and our cross-border, interstate work, which is work that we have really needed to turn our attention to, to really start to guide and look for efficiency in the health system

funding space as it relates to all of that enormous amount of activity. About 25 or 30 per cent of our activity is cross-border New South Wales. It is really important that we work closely with them on that. We have been able to pay attention to that. That work is progressing across the board very well.

In regard to the research work we were talking about earlier, to be able to really concentrate now on what that looks like across the system with our partners—I am very pleased to leave Ms McDonald to deal with the very complex operations of delivering health services.

Ms Stephen-Smith: I think the other thing to mention—and it probably cuts across both—is the clarity of our relationship with our community and NGO partners and consumers. The establishment of new forums partly comes out of the culture review but partly is also about re-focusing on the things that each element of the directorate and Canberra Health Services does well. For example, we just recently established an NGO leadership forum with the directorate because we recognise that a lot of the community health service is delivered by our NGO partners, and that relationship had not been as strong as it should have been over recent years.

MS LE COUTEUR: That relationship is now with Canberra—

Ms Stephen-Smith: Primarily with the directorate.

MS LE COUTEUR: Even though they are delivering actual services, many of the NGOs—

Ms Stephen-Smith: For example, they might be delivering alcohol and other drug services that are contracted through the directorate but they work very closely with Canberra Health Services. There is coordination across that.

Mr De'Ath: I think, just to take that a little further, that is where we have established a pretty robust health services planning area that looks right across and thinks about what is being delivered in our different health services; how that relates to what happens with the NGO sector; as the minister has alluded to, getting much better engagement and co-design and planning with the NGO sector, which we are stepping off into that space; and also strengthening our work with the primary care sector.

We had a GP forum the other night. It was fantastic. There was great representation from I cannot remember how many GPs. Someone could tell us. But we had a room full at the ANU. It was a really great briefing, with solid engagement from them and also with the Capital Health Network.

MS CHEYNE: I have a range of questions about sexual health. My first question relates to the *Population Health Bulletin*, which I understand is available quarterly. I cannot see an update online since August 2018. Am I looking in the wrong place?

Mr De'Ath: We might ask you to repeat the question, if you would not mind, Ms Cheyne.

MS CHEYNE: Sure. I will give a preamble. STIs, BBVs et cetera obviously are

notifiable diseases. I understand that they are reported quarterly in the *ACT Population Health Bulletin*. I looked it up online, and I cannot see a *Population Health Bulletin* since August 2018. I am wondering whether that bulletin has ceased. Where can I find some up-to-date figures?

Dr Coleman: That is a great question because one of the things we have been doing over the last 12 months is looking at how we report our STI and BBV statistics. One of the things that the committee of stakeholders brought to us is that they are not readily available and in a format that actually works for them. Our notifiable disease team has been working hard on a new presentation, and that will be coming through very shortly and will be able to be put up. The other thing we have had done is a report by the Kirby Institute, which is the national centre for reporting on these particular statistics, which enables us to assess how well we are moving against some of the national targets. That should be available more publicly soon.

MS CHEYNE: We have previously asked about how we are trending, and the feedback I continue to get is that the numbers of notifications continue to increase but we have not been able to get a better understanding of why that is happening. Are notifications increasing because testing is increasing or is it because messages are not getting through to people and the same people are presenting with a notifiable disease? Do we have any breakdown on that?

Dr Coleman: If we are talking about STIs in particular, I will focus on chlamydia first of all because that is the condition that has the most frequent number of notifications. We have had around 1,500 in the last year, which is a lot, and this is increasing. It is something that is seen nationally and it is something that we are all struggling with. This is occurring in two main population groups. One is in the youth group, in ages between about 15 and 29, both male and female. We still have quite a few STIs appearing in the men who have sex with men group, as a high-risk population group.

In the last six months we have done some interesting work with youth in trying to do some market research around what they understand about STIs and what they think about prevention. At the moment we are looking at what information we might need to get out there and how we might target that. We are moving ahead with that one.

MS CHEYNE: What have you found?

Dr Coleman: We have found that a lot of youth think that it is not an issue anymore, that we have solved the STI problem. I know; it is very surprising. They also do not think that it is for them. They think they are protected, even if there is an issue. They are also very keen that when they get this information, they want to be able to link directly to a service and have a very easy method of making an appointment and getting a service to get tested and treated. We are looking at how we implement those as part of a program and a market communications campaign.

MS CHEYNE: With the data being identified, presumably, when it comes to you and when it is reported nationally, you would be able to do a breakdown of how many people are being tested for the first time and also have a notifiable disease. Are you looking into doing some work there to really drill down into some of that data and

publishing it in a de-identified way, to work out where we are as a community?

Dr Coleman: The data we get does not allow us to track an individual person and see how many times they have been notified and whether they are frequent flyers or have that kind of history. We are not able to do that.

MS CHEYNE: Why not?

Dr Coleman: Because we do not do data linkage between those individual presentations. The data we get is used for population purposes, so we can talk about absolute numbers. We can have a look at how many tests have been done as opposed to how many notifications and those kinds of things. But we cannot look at individual people because we do not get that degree of identification to allow us to do that.

MS CHEYNE: Don't we have to report to Medicare about the people who are appearing?

Dr Coleman: No, Medicare is a separate system. We get notified data under the notifiable disease system, which is a requirement of doctors and pathology labs, under legislation, to give us the notification. We do get identifiable data in that way, but our remit around that is to be able to follow that up with the individual to see whether there are any public health risks, and to make sure that they get treatment appropriately and that we do appropriate contact tracing. We are not able to, at this stage, link those kinds of individuals up to see how frequently or whether they are getting testing.

MS CHEYNE: What would need to be done to be able to do that linking?

Dr Coleman: There would need to be a specific research study, with specific ethics and an actual bid proposal.

MS CHEYNE: Would that be useful in terms of being able to see where we are at, as a community?

Dr Coleman: It could add some value, but there are some really big ticket items that we can address first, such as trying to get the communications out there, trying to make information readily available on where people can get STI screens done. One of the challenges we have with 1,500 notifications a year is that we cannot get our NGOs and our specialist services to carry that load. We have to increase our general practice role in this and get young people comfortable with going to their general practice and asking for that test, to have that screen done and get that treatment.

MS CHEYNE: Are we looking to increase staffing at the Canberra Sexual Health Centre?

Ms McDonald: Yes; we have increased some staffing. Every year we look at the staffing across the whole organisation. We have approved in the 2019-20 budget some increases in staffing at the Canberra Sexual Health Centre.

MS CHEYNE: Are we able to do a breakdown of the number of staff against how

many people are coming through the doors?

Ms McDonald: We can look at our patient population, our presentations and appointments and look at the staffing. I will take that on notice and provide it to you.

MS CHEYNE: Thank you. I have some more questions on this, but I appreciate that I have just taken a big chunk of time, so we can come back.

THE CHAIR: I want to talk about the library staff. How many reference librarians do you currently have at the Canberra Hospital library—librarians that specifically work on assisting staff at the Canberra Hospital to retrieve research articles?

Ms McDonald: I would have to take that on notice in terms of the specific type of librarians. It is only a small library. It is only a very small team. In total we have six to eight. My exec director who has responsibility for the library is not here today, so I will take the question on notice.

THE CHAIR: Okay. You may have to take the rest on notice. Is it easier for me to pop them on notice for you?

Ms McDonald: It depends.

THE CHAIR: I had heard that staff are being asked to limit their inquiries to only five articles per inquiry.

Ms McDonald: We are looking at the numbers of inquiries per person who makes an inquiry, not just staff. We have a lot of medical students who make inquiries in our library who ask for references to be pulled. Given the number of staff we have in the team—it is a small team, and it is a small library and a small service—we are trying to prioritise how many references people are allowed to request from the library. On notice, I can give you the numbers on that.

THE CHAIR: That would be good.

MRS DUNNE: In relation to that, Ms McDonald, you said that part of the workload was students. Do they not have access to library services at the university?

Ms McDonald: They do, yes.

MRS DUNNE: I also have had people complain to me that they have been limited to five articles. If someone is looking for something that is happening in an odd case or something like that, that could be quite limiting.

Ms McDonald: Sure.

MRS DUNNE: How do you think you might get around this?

Ms McDonald: I think we just need to clarify that there are many sources of information clinicians can access. The library is not the only source of references; there are many search engines that clinicians can access if they have a particular case.

We just need to be clear that the library is not the only source.

If there was a particular case that was difficult to find, we would certainly be flexible with that. We are trying to just spread the load and look at whether we need additional staff to meet the load. We would certainly be flexible. If a clinician came to the library and said they needed extra, we would certainly negotiate on that. But there are lots of other avenues that students and clinicians can use to do research and look for references. Not every reference that people are looking for is in relation to a patient at that time.

MRS DUNNE: I understand that. But they could be doing research; they could be preparing a paper; they could be doing all sorts of things. And libraries and institutions have subscriptions to a lot of journals that individual clinicians and students may not.

Ms McDonald: Yes. We are happy to access those for people as well. We just need to find a balance between the capacity of the library staff to meet the needs of as many of our clinicians and staff across the organisation as we can. One way is to try to spread that load, try to track it, and see whether we are meeting the needs or not.

MRS DUNNE: Can I go back to the local hospital network. I want to refer to the outcomes for emergency departments, reported on page 339 of the Health Directorate annual report. It shows that only 46 per cent of patients who presented to the emergency department were seen on time. That is down from, I think, 50 or 51 per cent last year. What were the outcomes for Canberra Hospital and Calvary hospital, respectively?

Ms Stephen-Smith: That is probably not a question for the LHN as much as it is for Canberra Health Services.

Ms McDonald: There are two parts; there is the Calvary performance and then there is our performance. I can find our performance specifically for you. I might get Lisa to join me with that data.

MRS DUNNE: It is page 339. On page 341, you have the reporting for Calvary and Canberra, but it is not reported for this reporting period.

Ms Stewart: We have the Calvary numbers here, the Calvary results for the emergency department.

MRS DUNNE: Category 1 is presumably 100 per cent.

Ms Stewart: Category 1 is 100 per cent; category 2, 79; category 3, 40; category 4, 56; and category 5, 88. They are all percentages.

MRS DUNNE: And all presentations?

Ms Stewart: All presentations: 52.

MRS DUNNE: Do we have TCH?

Ms Gilmore: I acknowledge the privilege statement. For category 1, it is 100 per cent; category 2, 74; category 3, 32; category 4, 47; and category 5, 83.

MRS DUNNE: And that takes us to—

Ms Gilmore: I do not have an overall number, sorry.

MRS DUNNE: Can we get the overall number in the course of the day?

Ms Gilmore: We can.

MRS DUNNE: How much of that can you measure? Do you have a gut feeling for how much of that was impacted by the flu season?

Ms McDonald: I can talk to that for Canberra Health Services, not for Calvary. As we have talked about previously, the flu season came early, in May, this year. It has had a big impact on our "seen on times" and all of our performance indicators from an emergency perspective.

MRS DUNNE: Would you have seen a fall-off in "seen on times" in the period May-June? That is the end of this reporting period.

Ms McDonald: Yes.

MRS DUNNE: To what extent would we have seen a—

Ms McDonald: To a significant extent. We were starting to see it very early on. In mid-May it was starting to be impacted. I do need to acknowledge that winter is one factor. We have been extremely busy. Our emergency department presentations had been going up prior to winter; from February of this year we started to see quite a significant increase on previous years. We are getting close to 90,000 presentations, which is one of the busiest emergency departments in the country. We are seeing a significant increase in presentations.

MRS DUNNE: I think I read somewhere that we are now third.

Ms McDonald: Second, I think.

MRS DUNNE: With Westmead.

Ms McDonald: Yes, second or third. All of those factors, not just winter, have an impact on our ability to process people through the emergency department in a timely way. We have initiated our timely care strategy to try to improve the flow through the emergency department, but, given the increasing number of presentations, it is extremely difficult to do. It is not an excuse; it is us looking at it to see what we can do, given the number of presentations.

MRS DUNNE: With the timely care strategy, which is an iterative process, can you see any changes that are statistically significant that could be attributed to the timely

care strategy?

Ms McDonald: At this point in time, no. We are working on a multitude of strategies across the whole organisation. Given that we started really initiating those strategies just prior to winter, and then we had our biggest flu season and biggest winter that we have had in a number of years, it is quite difficult to determine. Hopefully, we will start to see some improvements from now, given that winter has decreased right down and winter is, we hope, finished.

THE CHAIR: Maybe not the weather.

Ms McDonald: Maybe not the weather, but the presentations to the emergency department are starting to come back into line. They are still higher than they have been in previous years. We would hope to start to see some improvements in our performance.

MRS DUNNE: The quarterly report for the third quarter of the reporting period showed some fairly substantial declines, and that was before the winter, so—

Ms McDonald: That included some of winter. We were starting to see some of winter in that report. But also since February we have had a significant increase in presentations to the emergency department. This is what is driving a lot of the pressure across the whole organisation, not just in the emergency department.

Ms Stephen-Smith: In terms of what we have been doing about this, the expansion of Calvary's ED is a significant expansion for Calvary, more than 50 per cent of their ED capacity, but it is 20 per cent across the whole system, so we really are expecting that that will take some pressure off Canberra Hospital as well. It is a question of getting good information out to the Canberra community about what their alternatives are. We have also seen significant increased presentations at walk-in centres as people have got used to them and, although correlation does not equal causation, a 10 per cent reduction in category 5 presentations to the EDs over the last year compared to the year before.

There are a whole range of strategies around what we are trying to do to address this. It is partly around what Canberra Hospital itself is doing, its timely care strategies, but it is also a territory-wide approach to trying to take some pressure off Canberra Hospital's emergency department.

THE CHAIR: That was actually going to be one of my questions: how the nurse-led walk-in centres are working with helping to reduce some of the wait times at the ED. Do you want to add any more to that?

Ms Stephen-Smith: Ms McDonald often cautions me that we cannot say for sure, but I think we do now have some level of correlation. Certainly there is anecdotal advice from the nurses when you go to the walk-in centres, and indeed from people we know who go to walk-in centres rather than going—not you, Ms Cody, necessarily—to ED when they think they can get patched up by one of the nurses or nurse practitioners at the walk-in centre. At the moment it is very hard to prove that the two things are related, but we are definitely seeing a correlation and we definitely have that

anecdotal evidence that people are using this as an alternative.

Mr De'Ath: Obviously I work with my colleagues who are running health systems in other jurisdictions; I meet regularly and talk with them regularly. People have been under enormous pressure. You would have seen headlines in other jurisdictions that have even hit our papers here about what is happening and certainly what happened in the last season, just with increasing demand. But the real positive in engaging with those colleagues is their interest in what we are doing in things like walk-in centres. They are quite envious that we have that to at least alleviate some pressure in our system. I think there is a correlation. We have yet to really measure it, as has been mentioned, but we are certainly pleased to have them. I hate to think what it would have been like without them.

Ms Stephen-Smith: I think the other thing is the efforts that are going into things like RACC, trying to reduce avoidable hospital admissions from residential aged care—better for the patient but also better for the hospital system. Then we have talked a lot with my ministerial colleagues, commonwealth and state and territory, about the need to improve integrated care across primary care and hospitals to avoid hospital admissions or re-admissions. So there are a whole suite of things. It is partly around what Canberra Hospital does but it is also about what the rest of the system does to take the pressure off the only tertiary hospital between Sydney and Melbourne.

Ms McDonald: Mrs Dunne, we can add that our total seen on time average for 2018-19 is 43 per cent. I will add one other thing. Looking at our triage categories, we are seeing increased numbers in our categories 1 to 3, which demonstrates to us and to our clinicians that the complexity of patients coming to the emergency department is increasing, as well as the numbers of patients coming to the emergency department. A category 2 patient is quite complex and will take more time to work through the emergency department as well.

MRS DUNNE: If you could give us a breakdown over a couple of years of the changes in those triage categories, on notice, that would be great.

Ms McDonald: We will do it on notice.

Ms Stewart: I do have some system-wide information on that very point, Mrs Dunne, if you are interested.

MRS DUNNE: Yes.

Ms Stewart: In 2018-19 there was an increase of eight per cent in category 1. Category 2 increased by 10 per cent and category 3 by four per cent. Categories 4 and 5 presentations decreased by three per cent and 10 per cent respectively.

MS LE COUTEUR: We had some discussion about workforce issues earlier. Do we have different issues in recruitment depending on the different types of staff we are looking for? What are you doing about those issues? I am anecdotally aware of some problems, but I am confident that you have a lot more knowledge than I do.

Ms Stephen-Smith: The short answer is yes, there are different issues across different

specialties and different areas of the health system. Ms McDonald can talk much more about that.

MS LE COUTEUR: You have a strategy, or you have multiple strategies maybe?

Ms McDonald: You are correct. We do have multiple strategies across the organisation. The first key strategy that we have implemented is, as I mentioned before, a director of workforce planning. That role commenced a number of months ago and has worked closely with our executive team and our senior managers to prioritise where we have the most significant recruitment issues across the organisation.

I do not want to go into detail about the whole organisation, everywhere, but I can give you some examples. In pharmacy we have had over recent years quite a difficult time recruiting pharmacists. We have a very clear strategy in place now and we have recruited, I think, from the last numbers I saw, about six new pharmacists for the organisation. We are certainly not there yet in terms of recruitment but we have got a clear strategy.

In medical imaging we have successfully recruited six new medical radiologists, which we have had significant issues recruiting in the past. We continue to recruit, but the strategy is working and has been extremely useful in our medical imaging department.

Overall in maternity services we have difficulties recruiting midwives, but we have got a very clear strategy and we are working on that. I am not sure what the answer is for that one—I will be honest about that—other than really getting out there and seeing what we can do.

Mental health, in particular mental health nursing, has been a difficult area for us to recruit to, but we have got a clear strategy in that.

The other area you may not be aware of is anaesthetists. It is quite difficult to recruit anaesthetists to the ACT, so we are working on that and looking at different models like whether we have a mix of VMOs and staff specialists and that is the way we go forward in the future. We are certainly very open to that as well.

They are just some of the key areas. But having a director of workforce planning is critical in terms of working with each area on how we attract people to the ACT in the first place and then how we attract them to the hospital to work in particular areas as well.

MS LE COUTEUR: Are these areas where we are having problems, areas where other hospital services and health services in Australia are having problems? Or are they areas where people do not want to come to Canberra?

Ms McDonald: It is a mixture of both. I would say that in terms of mental health, both psychiatrists and nursing in mental health, it is difficult across the country to recruit into those areas. In terms of medical imaging, I would not say it is widespread. It is an ACT thing possibly, but I do not want to be definitive on that. I think we can

do much more work in attracting people to the ACT and talking about how wonderful it is to live in the ACT as well. A lot of people are unaware of that, so they are not necessarily looking at us as a first choice when they are graduating, from that perspective.

In terms of medical staff, having the ANU Medical School, working very closely with the medical school and providing clinical placements for our medical students is a fantastic thing. We are unique in in the ACT because we get a lot of those medical students coming in to fill our intern positions as well. So it is swings and roundabouts in terms of which area you are talking about.

Mr De'Ath: Ms McDonald is quite right: it is swings and roundabouts and obviously a question more related to the more direct health workforce. But what we are seeing in some very high-profile, significant appointments, such as the chief nursing and midwifery officer, is very strong fields now: a lot of interest and people wanting to come and work in health in the ACT. That appears to be quite a significant turnaround for us. The feedback from our recruitment consultants who work on these high-profile appointments is exactly that: that people can see there is a solid direction emerging. We are very pleased with that.

MS CHEYNE: Dr Coleman, I want to touch on something you said about not relying on the community sector to bear the load of getting out there to all the priority populations and basically getting people to come to us instead. Does that reflect an overall directional change for Canberra Health Services at the moment that we are not looking to do community outreach for priority populations?

Dr Coleman: No. I may have not said that as well as I could have.

MS CHEYNE: And I may have misunderstood.

Dr Coleman: What I was meaning to say is that there are really important roles for both the specialist Canberra sexual health service as well as our non-government organisations, particularly with accessing our hard to reach priority groups such as people who inject drugs, men who have sex with men and other quite focused priority groups. We were talking in the context of youth sexually transmitted infections, and there is a much bigger load that we need to get primary care to carry in terms of opportunistic screening and tackling this issue.

When people come in, talking about contraception or when they come in for their vaccinations or for other bits, it would be great if we could get GPs comfortable in asking, "Hey, guys, have you thought about having an STI screen? It is just peeing in a cup."

MS CHEYNE: This time last year we talked about opportunistic testing and utilising walk-in centres. I know there was a trial some 18 months ago that probably was not as successful as people hoped it would be. Has further work been done on utilising those centres, given their popularity and the opportunities they provide?

Dr Coleman: A bit of work needs to be done around the demographics of people who go to walk-in centres, what kinds of services we may be able to offer and whether

there is a useful benefit in offering STI screening in more of a long-term way to do that.

There are also other potential opportunities and community outreach models that we can look at. One bit of work our health advisory committee is doing is to look at what that might look like and where we would get the best bang for our buck. Certainly walk-in centres will be in the mix and having conversations with Canberra Health Services about that, hopefully.

MS CHEYNE: Am I right to assume that that comes from the motion that was passed in the Assembly in May calling for a greater community-based sexual health outreach model?

Dr Coleman: I think that is how we would address it, but I think it has always been within the mix. The national strategies, as well as the ACT statement of priorities, acknowledge those aspects as being very important to have a look at and the role that they need to play in different jurisdictions.

MS CHEYNE: I am conscious of the joint submission from the AIDS Action Council, Sexual Health and Family Planning ACT and Hepatitis ACT. How are things progressing in terms of this consultation on a community outreach model? The depth of the submission suggests to me that things have been a little slower moving than perhaps they had hoped for.

Dr Coleman: We have had two meetings, with a third meeting with the health advisory committee booked in for tomorrow afternoon. This is only one of four priority areas we are looking at with the committee, which the committee have agreed to and selected moving forward. Those include, if my memory serves me correctly, looking at data, which we have talked about. There are some questions around how we might improve the availability, the data quality, the integrity of our data and more visibility of that.

We are looking in particular at viral hepatitis. We had quite a lot of success in the HIV/AIDS area, and there are a lot of new treatments and a lot of stuff that we can do with hepatitis C and also hepatitis B. So that is the second priority group we will be looking at.

We are looking at our communications and resources. Part of that is addressing the thing I spoke about before with youth STI and how we best get out there and get our message across. The fourth one is looking very much at the different models or how we can get out there and get testing and treatment to increase, such as a community-based model. Hopefully tomorrow there will be more discussions about that.

As you are probably aware, there have a few pilot programs and we have worked hard in the last 12 months to pull all of that information together and look at what works, what might not work as well as we would like it to work and how we use that to target our priority groups where we are not quite getting it.

MS CHEYNE: The feedback we have had about these pilot approaches is that they

are great but we need a sustained way of testing, and you touched on this before when we were talking about walk-in centres. A pilot program needs to become an ongoing thing, which is why a permanent model would be good. I am pleased that work is happening. Is the proposed sexual health week still part of the mix in terms of those discussions?

Dr Coleman: Yes; whether we have a sexual health week or a sexual health day or whether we tap into some other mechanism to give greater visibility is all in the mix.

MS CHEYNE: Is the health advisory committee the committee that was formerly a ministerial council?

Dr Coleman: Yes.

MS CHEYNE: Why is it no longer a ministerial council?

Dr Coleman: This came up about 18 months ago, when the chair, who had been in that position for a long time, was stepping down and a number of the appointments on the committee were coming up for renewal. We did about a 12-month consultation process with the stakeholders on what they wanted to be getting out of the committee and what some of their frustrations were. That resulted in the majority agreeing to trial this health advisory committee, as opposed to a ministerial advisory committee, to give us a bit more flexibility and ability to interact on an operational level. One of the things the committee has sent to us to look at is how we leverage off and get maximum benefit from all three major stakeholders working together. The health advisory committee gives us more flexibility and ability to deal with that, rather than a MAC.

THE CHAIR: I have some questions about hoarding.

Ms Stephen-Smith: In relation to the trial we have been running with Woden Community Service?

THE CHAIR: Yes.

Ms Stephen-Smith: As the committee would be aware, earlier this year the Health Directorate funded a short-term trial for support, advocacy and case management for some of the complex hoarding cases in the community. Woden Community Service was contracted to run that trial, which ran from March to June. That really has facilitated consultation across stakeholders in and around some of the complex hoarding cases and built those positive relationships with the people involved.

That was a very short-term trial, but it has been evaluated. The evaluation report indicated positive improvements to the properties that were part of the trial, which is a really good outcome. The hoarding case management group, an across-government group, has considered the findings of the evaluation report and has made recommendations for a longer term project to further investigate how we can continue to improve the delivery of community-based support and case management. I am pleased to say that the ACT government will provide Woden Community Service with $300,000 to fund an 18-month extension of the trial.

We certainly recognise the need for holistic support in complex cases of hoarding. Given the success of the short-term trial, the directorate has been liaising with other directorates to put in place the funding solution to extend the trial for a longer period, which is really important in building relationships with the people who have these complexities in their lives. That trial, for 18 months, funded internally from across government, will provide a more comprehensive evidence base of the impact of community-based support and case management, build those personal and community contacts and provide more evidence about the community impacts of hoarding behaviour and how best to address those.

The Health Directorate will be liaising with Woden Community Service to put in place the arrangements for the extension of the HASS trial. I know it has been in the media over the weekend. Thank you for the opportunity to update the committee on where that work is up to and thank you to the officials who have been working really closely across government. It is led by the Health Directorate, but really it is a whole-of-government activity to address what we know is an important issue for the community but also a significant issue for the individuals involved and one that obviously needs to be handled with great sensitivity.

THE CHAIR: I am glad that the directorate and health services are working hard on this because I believe it is primarily a health-related matter. It is supporting those that are struggling.

Ms Stephen-Smith: Yes, and it obviously sits between mental health and health protection services.

THE CHAIR: Yes.

Ms Stephen-Smith: It is health protection services that convenes the hoarding case management group, but there is obviously a significant mental health element as well.

MRS DUNNE: What other elements of government are involved in this as well?

Dr Coleman: There are quite a number of different areas of government involved in this. Access Canberra is involved with a lot of the operational and regulatory functions; Transport Canberra and City Services; Housing ACT plays a really important role in assisting with the housing; Fire & Rescue and the Ambulance Service, in terms of whether the venue is safe and what fire risks are associated with it. The Public Trustee and Guardian are involved to make sure that the people affected by hoarding are adequately represented. Canberra Health Services also plays an important role in mental health service provision and support.

THE CHAIR: So you have a team, a committee, that sort of oversees the interaction between all of those different areas?

Dr Coleman: Yes. We run a case management working group at which each of those has a representative. The very high level, very complex hoarding cases come to sit there. That is around making sure that everyone knows what is happening in that space, that there can be a degree of coordination and identifying early when there is a

problem or a risk that needs addressing by one of the directorates.

MRS DUNNE: I am just going on the report in the paper over the weekend. It said that Woden Community Service received six months funding in February but the trial was concluded before the six months was over. Why was it concluded? Did you run out of money? Did you decide you had enough data?

Ms Stephen-Smith: I did have the same question, I have not had the opportunity to ask it yet. I do not know whether Dr Coleman has an answer for that.

Dr Coleman: No, I do not at the moment, sorry. When I took on board the job and became responsible for this, this was the duration of the trial that we were funding. We would need to have a look at getting some information—

MRS DUNNE: On notice, can we find out why the trial appears to have been truncated?

Dr Coleman: Yes.

MRS DUNNE: When was the evaluation? Has Woden Community Service been notified that there is an extension?

Ms Stephen-Smith: I understand that Woden Community Service has been notified, but possibly only this morning.

MRS DUNNE: Alright. In response to the—

Ms Stephen-Smith: This work has been ongoing for some time, Mrs Dunne. You cannot just magically find $300,000 in three hours on a Monday morning. I understand your comment about the timing, but this has been an ongoing piece of work by the directorate and the task force, the hoarding case management group, for some time.

MRS DUNNE: This extension of funding, the $300,000, will fund two or three people, I would presume, in Woden Community Service. Are there any other additional costs to the program? There is the staff time associated with the officials on the task force, but will there be other additional costs to Woden Community Service or is that envisaged to cover all their costs for how many cases?

Ms Stephen-Smith: That should cover their costs. There will, obviously, be some contract management, but that is standard government activity. Then, as you say, the hoarding case management group is ACT government employees' time. So that is a cost that is not factored into that $300,000.

MRS DUNNE: How many cases will that allow Woden Community Service to take on? There was some discussion that they could take on in the order of 20 cases. Will that allow them to meet the unmet demand?

Ms Jonasson: Mrs Dunne, no. I mean, it will not fund up to 20 cases. I think the costing that was developed through the working group was based on the information

we received from Woden Community Service for the original trial. We used information we had received from Woden Community Service through the original trial to develop what the arrangement would be for the further 18 months.

MRS DUNNE: Does that mean that—

MS LE COUTEUR: Do we know what that arrangement is, given that you did not answer the question?

Ms Jonasson: I am sorry; I do not understand the question.

MS LE COUTEUR: Do you know what the arrangement is? Mrs Dunne asked about what this was likely to deliver. Do you have an idea?

Dr Coleman: The intention is that this will continue the level of support and coordination that has been provided to date, to allow further evidence and information on how we move forward.

MRS DUNNE: So that is three cases?

Dr Coleman: Yes, three of the higher level cases that are required.

MS LE COUTEUR: This is funding for 18 months. Is it structured in a way that, if it is successful, it will continue? What is the idea here?

Dr Coleman: That is something that the 18 months will allow us to continue to work towards, depending on what the deliverables of the project will be. But that is definitely an intention: to look at what is the best model to put forward to get the best individual and community outcome from these high-level hoarding cases into the future.

Mr De'Ath: I think you can see that this is a very, very complex area. It is a small number of cases. It runs right across government. The trial and the evaluation, looking at how to go forward, are all very important pieces of work. As Dr Coleman has just said, we will look at that very closely as we go forward now and continue to refine it and provide advice to government on what the best approach is.

MRS DUNNE: But you have had a trial and an evaluation. The trial and the evaluation said that it is a good thing, it works, and it has worked for these admittedly quite high-level cases. You have expanded the funding but you have not expanded the scope of the work being delivered.

Ms Stephen-Smith: I think—

MRS DUNNE: You have extended the funding.

Ms Stephen-Smith: In the context of these being severe and complex cases, I think one of the comments that was made in the article in the paper on the weekend was that, because it was such a short-term trial, there was a limit to the level of dependency that Woden Community Service wanted to create in the people involved in the trial. So a

longer term trial will enable those richer relationships to develop. But there are only a handful of these very severe and complex hoarding cases in the ACT—

MRS DUNNE: No, there are at least two handfuls.

Ms Stephen-Smith: and for other cases of hoarding there is ongoing work. So this is about supporting and complementing the existing ACT government work, which will also continue for the less severe complex cases.

MRS DUNNE: Would it be fair to say that this is an extension of the trial rather than a rollout of the program?

Ms Stephen-Smith: I think that is how it has been described: an 18-month extension of the trial, yes.

MS LE COUTEUR: It is not expected to be enough to deal with all the cases?

Mr De'Ath: As the minister pointed out, there are lower level responses that come from various other parts of government, including Health; hence the working party and the way that they look at the cases, triage and work out who is doing what. That is the bit that Dr Coleman runs for us across government.

Dr Coleman: You will have read that one of the benefits and outcomes was that one of those very complex cases of hoarding was able to be transitioned out, to be managed outside the case management working group into a particular directorate. It is like going to the chiropractor or the physio; ideally, we would like to set up a system, with support from Woden Community Service, to enable people to set up those systems themselves, transition out and live a life that is independent and supported. This is there for those very high-level people who need a little bit more assistance with that coordination and advocacy. There is a little bit more work to be done around what that looks like and what might be the key criteria of those cases that will benefit from this support. That is why we are extending the trial.

Mr De'Ath: I think that is a really good way of describing it. Where I was going with my previous response is to say that we want to be efficient and effective about this. You do not want to put every single case that you identify straight into a top-tier response through Woden Community Service. There are other ways to deal with things.

MS LE COUTEUR: Sure.

MRS DUNNE: But at this stage we do not know whether there are more than three top-tier cases?

Dr Coleman: The hoarding case management group is aware of the top level of information. They triage the cases and push them through as appropriate. That is routine business and it has been functioning in that way for a while.

MRS DUNNE: How many cases of excessive, super-duper hoarding is the committee aware of?

Dr Coleman: I will have to get that information for you.

MRS DUNNE: Okay, thanks. Can someone talk to me about where we are with the election commitment in relation to meningococcal B?

Ms Stephen-Smith: I recently provided a statement in the Assembly in relation to that matter and nothing has changed since that statement.

MRS DUNNE: Do you want to refresh my memory on what was said in that statement? I do not think I held that one in my head.

Ms Stephen-Smith: Dr Coleman is well placed to talk about this matter. As you are aware, in considering the evidence of the cases of meningococcal as they have changed over time between B and A, C, W and Y, the government made a decision to fund, initially, the meningococcal ACWY vaccine, which has since gone on to the national immunisation program, and has held off on a decision in relation to meningococcal B, which is currently being considered at the national level by the PBAC, the Pharmaceutical Benefits Advisory Committee. I will hand over to Dr Coleman.

Dr Coleman: That is correct; I think you summarised it quite nicely. We provided advice that there was a changing pattern to meningococcal disease. There was a change, and meningococcal Y and meningococcal W were becoming much more of an issue nationally. We saw that here in the ACT in 2017 and 2018, and it was responded to in terms of funding this program.

MRS DUNNE: You funded ACWY. What is the cost of a dose of ACWY?

Dr Coleman: I will have to get that information for you.

MRS DUNNE: Thank you; take that on notice. Now that it has gone on to the national program, does that mean that the ACT does not have to meet that cost; that is met federally?

Dr Coleman: There are two components to the cost of implementing a vaccination program. One is the vaccine itself, and once it goes onto the national immunisation program the commonwealth manages the costs of the vaccine itself. However, there are significant costs associated with the implementation and rolling out of a program, and they stay within the jurisdictions. That includes funding the school-based vaccination program, the support to general practitioners, training—all of those kinds of programmatic costs.

MRS DUNNE: What were the costs associated with the rollout of ACWY—the vaccination delivery, as opposed to the vaccination, if they are the fixed costs that stay with us?

Dr Coleman: We will have to get that detail for you.

MRS DUNNE: Thank you. I note that South Australia has a $3 million program for

meningococcal B. I note that the South Australian population is bigger, but they have had a number of meningococcal B infections and deaths. They are doing that irrespective of whether the commonwealth comes on board. Why have we walked away from that, seeing as it was an election commitment and there was $2 million over four years to roll that out?

Ms Stephen-Smith: South Australia has seen a different pattern from other states and territories. They have made that decision on the basis of what they are seeing in their jurisdiction. We are not seeing that in our jurisdiction. I do not know whether Dr Coleman has the graph showing meningococcal cases in the ACT. I think it is correct to say that it has been some time since we have seen a case—

MRS DUNNE: It is a little while since we have seen a case, yes.

Ms Stephen-Smith: of men B. In relation to your question about how much it is costing to roll out the ACWY vaccinations, support for that program was funded in the budget—$320,000 in 2018-19, $328,000, $337,000 and $342,000, for a total of $1.327 million over the four years.

MRS DUNNE: That is the rollout?

Ms Stephen-Smith: That is our element of the costs, yes.

MRS DUNNE: Given that the target audience for B is different, would it be a reasonably comparable rollout for B? You would be doing it at the same time that you are doing other infant immunisations, for the most part, and probably a catch-up?

Dr Coleman: Men ACWY is a one-dose vaccine in the infant schedule, whereas meningococcal B is several doses, so a far more involved program is required to be rolled out. There are also aspects around safety, monitoring adverse events, and communications which are associated with vaccination programs. In the case of meningococcal B there is a potentially increased risk of fever and temperature which also needs to be considered when we are considering programmatic delivery.

MRS DUNNE: Is the potential more elevated than it is for triple antigen and the like?

Dr Coleman: Yes. With the new triple antigen, with the current vaccines that we are seeing, there is a slightly increased risk in that age group of having a fever. Some of the recommendations are around how you might manage that, and they need to be strengthened when you are rolling out a meningococcal B vaccination program.

MRS DUNNE: If you rolled out the meningococcal B, would you roll it out in the same sort of time frame as the triple antigen and other things that are done?

Dr Coleman: What do you mean by the time frame?

MRS DUNNE: Two, four and six months.

THE CHAIR: Is it 12 and 18?

MRS DUNNE: It is a long time since I—

THE CHAIR: Yes, me too.

Dr Coleman: I think you are correct.

MRS DUNNE: It used to be two, four and six months and a 12-month booster or something like that.

Dr Coleman: There is a new schedule which is based on two doses under six months of age and a booster dose at 18 or 12—something like that. There is a three-dose schedule required under two years of age.

MRS DUNNE: There is a three-dose schedule rather than a four-dose schedule. Meningococcal is a three-dose—

Dr Coleman: Men ACWY?

MRS DUNNE: No, B.

Dr Coleman: Yes, three doses under 18 months of age.

MS LE COUTEUR: I want to move to a new area, support for advance care planning. What is happening with that? How many of us have it and, possibly more importantly, how are the plans accessed if you do have one? How do clinicians see it so that it makes a difference?

Mr Culhane: I may be able to answer your question, but I would have to hear it again, sorry.

MS LE COUTEUR: It is about advance care planning. There are two sides to it. What are we doing in terms of facilitating, supporting and encouraging people to do an advance care plan? And if they do one, how are clinicians accessing them when they are needed? I am aware of difficulties on both sides.

Ms Lamb: I acknowledge the privilege statement. The advance care planning team for Canberra Health Services sit within my division. They work across all areas of health within the ACT to assist in people preparing their advance care plans. They work with GPs and with aged-care facilities. We also fund the ACT Health Care Consumers' Association to assist in promoting the development of plans with non-English-speaking background groups.

On ensuring that clinicians are able to access those plans, when somebody has a plan and it is brought into hospital with them, or to a facility, we have an alert on our ACTPAS system that identifies that somebody has a plan. That is then printed off and put into the person's notes so that wherever the individual person may be within the hospital, clinicians can access that.

MS LE COUTEUR: That is a very manual process. I guess some of us hoped that the digital My Health records would mean that if you had an advance care plan it would

be accessible. You are saying that this is just a little Canberra-based process and only available if you are in hospital? Or have I misunderstood what you are saying?

Ms Lamb: I am only able to speak from the perspective of Canberra Health Services. I am aware that GPs may hold the advance care plan; the individual also can hold that and take it with them.

MS LE COUTEUR: But you are saying that there is no electronic support? When you call the ambulance, someone has to pick up the plan and put it on your chest?

MRS DUNNE: If they can find it.

MS LE COUTEUR: If they can find it.

Ms McDonald: If a person has been a patient of ours, there will be an alert on their history. We can check when they come in to us whether or not they have made any changes to that or updated that from the alert, if they have been a patient of ours. But, yes, the onus is on the individual to make people aware that they have an advance care plan and that they would like that followed.

In terms of our digital health record, in the future we will be able to put that in electronically, once we have the digital health record in place. But for Canberra Health Services, how GPs manage that and other healthcare services is really about the relationship between the individual and those sorts of services.

MS LE COUTEUR: Maybe Mr O'Halloran can answer this better. I appreciate that you are looking at the hospital, but looking more broadly at the Health Directorate, it is not something that you are working to encourage the making of, so that if you have done one somewhere there is a reasonable chance that it will be found, rather than it just being found if you happen to have been a recent patient at Canberra Hospital? It seems entirely unsatisfactory.

Mr O'Halloran: I acknowledge the privilege statement. The short answer is that we are working towards having any advance care directive documentation that is uploaded to a My Health record by a patient or their carers made available directly to our clinical staff across the entire ACT public health system.

It is important, in noting that discussion, to mention that there is quite a manual process, as has been observed previously, undertaken at Canberra Health Services. That is for a very good reason, in that all of the documentation that could be uploaded to the My Health record may not actually meet our requirements under our legislation in terms of advance care planning and directives. I would also note that there are a very small number of these documents being uploaded to the My Health record. In fact, if we look at ACT residents, the most recent data I have is for July and August, and there were none uploaded to My Health record at all in those two months this year for any ACT residents. There were two of them that were viewed, however, across the entire territory.

At this point in time, they are not a well-used part of the My Heath record system. What we are doing is working with other areas across the public health system in the

ACT to identify, once we flag that a patient has been admitted who has a document of that type in the My Health record system, how that can flow directly across to the team under Ms Lamb to then look at the other processes that they would have to undertake. I note that that is a similar process to what other states and territories are looking at, but part of that process very much is then looking at those documents that are uploaded. They may or may not actually meet our requirements under our legislation, so there would still be the manual check for those to be examined and made available to the treating clinicians and their team for that patient.

MS LE COUTEUR: Very depressing. Do we have any idea how many advance care plans there are for ACT residents? Clearly, there will be more than two; hopefully, there are more.

Mr O'Halloran: That is all that were viewed in July and August in the My Health record.

MS LE COUTEUR: I am hopeful that there are more than two in the ACT.

Mr O'Halloran: There are very small numbers, to be honest. If we look at the total number of documents being uploaded, it is now in the millions for ACT residents for other document types in the My Health record. Advance care planning directives and so forth are quite minimal in that space at this point in time.

MS LE COUTEUR: Would you have an idea as to why that is the case? I personally, I am afraid, do not have one.

THE CHAIR: I do, but mine sits with my solicitor.

MRS DUNNE: That is the thing. This was one of the recommendations of the end of life committee, and it seems that we have not really made much progress. It is also our understanding that end of life planning is going to be more prominent in the next lot of hospital accreditation and how you manage that—I presume not only how you facilitate it but, once it is made, how you manage that. We are 18 months out from the next accreditation. Where are we up to with, say, the recommendations of the end of life committee? By the way, congratulations, Mr O'Halloran, on your award.

Ms McDonald: I might get Cathie to talk about the recommendations of the end of life committee, but in general, just to clarify the point, whilst not every end of life plan or advance care plan or directive is loaded up into the My Health record, we certainly do track numbers of patients who have advance care plans, and we can provide those numbers for you if you would like, if that would be helpful.

MS LE COUTEUR: Yes, please. It seems that they are about the only numbers you have for them.

Ms McDonald: I just need to clarify: we do track that across the organisation and we do have an advance care planning team who are facilitating advance care plans for our patients on a regular basis. That is our approach at CHS, from that perspective. In terms of recommendations from the end of life care review, I will let Cathie talk about that.

Ms O'Neill: I acknowledge the privilege statement. I was going to talk more around the end of life components of the accreditation standard rather than the response.

Ms McDonald: Yes, sure.

Ms O'Neill: Canberra Health Services formed an end of life working group late last year. We decided that, rather than going for divisional representation, we would put out expressions of interest. We were blown away; we had 28 people put their hands up to work on that working group. Our attendance at that meeting has increased over time. We have about 40 people on the mailing list for that working group at the moment. There is a huge interest and commitment around this area of work.

The standards component sits under the comprehensive care standard, and the specific standards around end of life are fairly brief in the national standards. The Australian commission on safety and quality have put out a national consensus statement on end of life care and we are working towards addressing that.

We have made significant progress in doing some good work around identifying when a person has transitioned into that end of life phase. We are also doing some really good work around increasing the amount of support for people at that end of life time. And in a couple of weeks, we will be launching our comfort care program, where we are doing some good work around making available resources for both the person themselves and, just as importantly, their carers and family, around items that can assist with that transition. So there is some good work happening.

As far as advance care plans go, in addition to what has already been stated, the advance care planning team are now also running clinics in conjunction with our palliative care specialist so that we are able to encourage people who are in that really acute palliative care phase to get their documents in order. That is proving to be very successful.

MS LE COUTEUR: I can see a recommendation here about a lot more work needing to be done in this area. I could keep on going on aged care.

THE CHAIR: I just note that we do not have very long left.

MS CHEYNE: My question is on organ donation, which I was told was in this area.

THE CHAIR: I too have organ donation questions.

Ms Stephen-Smith: Let us do that.

MS CHEYNE: I do not have many questions. I understand that, according to our legislation on organ donations, if a person has formally registered as an organ donor and there are reasonable but unsuccessful attempts to contact the next of kin, we presume consent. How often does this actually happen in the ACT?

Mr Philp: I acknowledge the privilege statement. In relation to the actual working of the consent, because it sits within Canberra Health Services, I cannot give you that

answer.

Ms McDonald: We would have to take that question on notice to find out how often that occurs, if it does occur at all.

MS CHEYNE: I appreciate that, while our rates are very high in terms of the per million population data set, that what that translates to in the ACT is between 10 and 15. I am just curious how often that happens. Perhaps on notice as well, could you advise whether this part of the legislation is widely understood by our health practitioners? More generally about organ donation rates, how satisfied are we with rates in the ACT and do we ever do analysis on—this is not a very delicate way of putting it, I suppose—missed opportunities?

Mr Philp: In relation to the missed opportunity, the Organ and Tissue Authority look after, at a national level, the program, and that works in combination with the state and territory medical directors as well as the Donate Life agencies. They have both the medical and the nursing specialties working within the acute care system. That combines the Donate Life network and that is run out of Canberra Health Services itself.

In terms of opportunity, the commonwealth have recognised that there are a couple of things going on. In fact, they have got a number of reviews going on in parallel. They are actually doing a review of the organ and tissue sector, including a review of the Australian organ donation retrieval and transplantation system. They are looking at that. That is phase 1of it.

MS CHEYNE: Is that the support that families are offered in terms of making that decision?

Mr Philp: It is looking at the whole picture, what actually is going on. Your point is the sensitivity around what actually happens in the acute care sector and, when families are approached, whether they are consenting or not. A member may well have consented at the time but in fact family members can override that at any particular time. It is very sensitive. The commonwealth have got the review going on.

That was precipitated by some work that had come out of the COAG Health Council last year. And we anticipate there are two phases to that review. We expect phase 1 of the review to be coming down soon and then that will go back to COAG Health Council with a view to looking at the second element of that.

The other element that they are looking at is the national eye and tissue sector as well because that is another component of the transplant work that we are actually going on. They are seeking to review those, and the recommendations will come back around: what does a national program actually look like and how do we improve the overall work at a state and territory level on the number of organ donors?

THE CHAIR: What are our organ donation rates like in the ACT?

Mr Philp: I am happy to take that. In 2018 there were 27 donor consents by the actual donor—and we are looking at what next year's figures are—but we are seeing a

decline. But that often is because of a range of issues around what actually goes on. It is basically about how many donors there are and how many recipients have actually matched the donor selection. It is one of those very tricky areas of looking at the numbers and seeing what is going on. But we are seeing some decline from the previous 2018 numbers.

Ms Stephen-Smith: I think, from recollection, when we launched the Donate Life Week the proportion of people who are on the organ donor register for the ACT is much lower than I would have expected. I had a level of expectation that it would be quite high in the ACT and in fact it is actually not high compared to national levels.

I was pleased to see, when I talked to the Donate Life people at Fair Day recently, that the Donate Life Week campaign had had an impact. They had a noticeable impact. But we all can do more to promote getting actually on the register rather than just thinking about it. It is very easy to do.

Mr Philp: And conversations with the family are really important around these times so that people, before they are confronted with the situation of actually having to make a decision, are very clear on what the person would want in that case. And that is often a very sensitive or tricky question.

THE CHAIR: I have a couple of questions on the cultural review oversight group. Is this the right space to ask that in or have I missed that opportunity? What practical steps has the—I think it is affectionately known as CROG—cultural review oversight group taken to impact the culture within Canberra Health Services?

Ms Stephen-Smith: Would you like to start, Michael?

Mr De'Ath: First of all, I think it is important to understand the different roles that exist here and the different structures that are in place.

THE CHAIR: Noting the time, it might have to be relatively brief.

Mr De'Ath: Yes, I will be as quick as I can. I have responsibility for the system oversight implementation of the review findings. Ms McDonald, as the CEO of Canberra Health Services, has responsibility for implementation within that organisation and for Calvary public health services—just to make that clear. The minister chairs the cultural review oversight group and I lead a cultural review implementation steering group. That is a whole lot of information there. There is a broad range of activity. It is a question of whether you want to know specifically in relation to Canberra Health Services or—

THE CHAIR: Maybe it is Canberra Health Services rather than the Health Directorate. I want to know what is visible. What are staff able to see? What are the impacts, both positive and negative, from the changes that have occurred?

Ms McDonald: We should take it on notice and give you the big list.

THE CHAIR: That would be great.

Ms McDonald: But, broadly, from the perspective of Canberra Health Services one of the recommendations was about our vision, role and values and that work has been completed. We have rolled that out across the organisation. We are about to complete our strategic plan which builds on the vision, roles and values. We have done deep diagnostic work and restorative work in 15 different departments across the organisation. An employee advocate has been in place for more than six months now and the staff are feeling safer to come to that person as well as other senior managers across the organisation. We have changed our HR business partner model to be far more focused on every area and providing support especially where there are areas of conflict across the organisation.

They are a few key things staff can see and feel. Not as part of the cultural review but as a follow-on we have just started our current culture survey across the organisation. We are doing a check-in with staff right now to see how they are feeling and see what else we can do moving forward. We are actively working on the 20 recommendations. We have just started a positive workplace working group and 80 people have put up their hand to join that and to become positive workplace champions across the organisation.

In this quarter the value we are focusing on is kind, and we are about to make awards for those staff members who have been nominated as exemplifying the value of kind across the organisation. These are just a few things which have happened in the past 12 months and which continue to happen. We are happy to provide a detailed overview of all of those activities.

THE CHAIR: The committee would like to see that. We may ask a few more questions on notice because there are some interesting things. The committee will suspend for lunch, but prior to doing so I thank all witnesses who have appeared this morning.

When available, a proof transcript will be forwarded to witnesses to provide an opportunity to check the transcript and suggest any corrections. For those members not coming back after lunch I advise them that any questions taken on notice should be provided to the committee's secretariat within five business days after receipt of the uncorrected proof *Hansard,* day one being the first business day after. If non-executive members want to lodge questions on notice they should be received by the committee's secretary within five days of this hearing. Responses to questions taken on notice should be provided to the committee office within five business days of receipt of the question, day one being the first business day after the questions are sent to the ministers and officials.

Hearing suspended from 12.31 to 1.46 pm.

THE CHAIR: We will resume the public hearing of the Standing Committee on Health, Ageing and Community Services inquiry into the 2018-19 annual and financial reports. I remind new witnesses who come to the table of the protections and obligations entailed by parliamentary privilege.

Minister, do you have a brief statement to make before we proceed to questions?

Ms Stephen-Smith: No, but I have an additional piece of information, and Ms McDonald has a couple of responses to questions that were taken on notice earlier. In relation to Ms Le Couteur's questions about advance care directives and advance care planning—I knew there were some bells ringing but I did not want to say anything until I had the information in front of me—at the latest COAG health council meeting the week before last, from 31 October to 1 November, the council agreed to write to the Medicare Benefits Schedule review task force to consider the efficacy of introducing a specific MBS item number for undertaking advance care planning and preparation of advance care directives with general practitioners.

THE CHAIR: Thank you, minister. Ms McDonald.

Ms McDonald: As to the question regarding the library, we have two staff providing references for clinical staff or staff across the organisation. We had a previous limit on requests for external libraries for information not contained in our library. That is no longer in place.

In regard to the questions about annual leave balances for nurses, our nurses have 789,074 hours with an average per nurse of 269 hours, which equates to an average of 33 days of annual leave accrual based on an eight-hour working day. We have 2,931 nurses and that is on average. Obviously it ranges between some people who have high excess annual leave balances and other people who use their annual leave when it is accrued.

MRS DUNNE: Does Canberra Health Services have a policy about people accruing large credits?

Ms McDonald: Yes, we are reviewing our policy at the moment across the whole organisation, not just for nurses, on excess annual leave. I have asked for a report of the top 200 staff across the organisation with a certain number of hours so we can target that. Our executives and senior managers will be working on an excess annual leave policy to ensure that people are taking their leave when it is accrued.

THE CHAIR: It becomes a work, health and safety issue when people are overworked.

Ms McDonald: It does. We have to ensure that people are taking it at the appropriate time to ensure that we can deliver our clinical business. People have preferences; some people do not want to take their annual leave. Some people try not to take it and try to accrue it so we have to find a balance to work through with all our staff.

THE CHAIR: I want to talk about cardiac ablation services because we have a new machine at the Canberra Hospital and I want to know how it is going. Has it been able to assist patients? Is it well utilised?

Ms Taylor: The service started officially in April. We have four lists a week with an average of two patients per list. It is going exceptionally well. Of the patients we see about 40 per cent have a curative process so do not have to come back at all. They have one follow-up appointment in cardiology and then they are discharged, so it is exceptional.

THE CHAIR: What about the other 60 per cent of patients?

Ms Taylor: They are monitored based on their clinical history and are then seen appropriately beyond that.

THE CHAIR: There are some patients for whom there is no cure but it gives them longevity and better results?

Ms Taylor: Absolutely.

THE CHAIR: And you have just said 40 per cent of patients are cured.

Ms Taylor: Yes.

THE CHAIR: Are a lot of patients from other jurisdictions using the service? Are we getting people travelling to Canberra rather than Sydney for that treatment now, so people from Queanbeyan, Cooma and those sorts of places?

Ms Taylor: Yes, we are taking out-of-area referrals. I would have to get the exact numbers for you, if I can take that on notice.

THE CHAIR: I am not worried about the exact numbers, but people who are not Canberrans are accessing the service?

Ms Taylor: Yes.

THE CHAIR: It is a regional health service?

Ms Taylor: Yes.

THE CHAIR: What other cardiac services have we introduced over the past 12 months or how have we changed the way we do things?

Ms Taylor: In terms of our process for the coronary care unit, we are looking at how we can increase their productivity. With the new ablation service, we are looking at extending our day service in the cath lab, so that we can keep more patients as day cases and discharge home from there. The next service we would want to start to look at is TAVI, but that is a big piece of work and there are many business cases to work through. In terms of making sure that cardiac patients get onto a cardiac unit and are in the right place, we are looking at the processes regarding how we refer patients and how we accept patients both locally and out of area.

Ms McDonald: TAVI is a valve replacement.

THE CHAIR: Having a father with major heart failure, you tend to learn the terms very quickly.

MRS DUNNE: This question is about cancer services or radiotherapy services; it covers both areas and it is a hardy perennial from me. For the strategic objective

"improving timeliness of access to radiotherapy services", there has been a modest improvement this year. I want to dwell on the long-term trajectory. In 2012-13 the performance for emergency, palliative and radical was 100 per cent, 100 per cent and 98 per cent. It hovered at around that until 2015-16, when it fell away at palliative and radical to 81 and 82 per cent. There were similar figures in 2016-17; then it plummeted in 2017-18 to 58 and 53 per cent. There has been a fairly reasonable recovery in palliative, 12 percentage points, to 70 and 50 per cent, and a decline in radical this year. Apart from taking the linear accelerators offline at the moment and in part of last year, what caused the fairly radical drop-off in 2015-16, and again in 2017-18?

Ms O'Neill: I am not exactly sure of what caused the drop-off back then. I can report that, for the past three weeks, we have met 100 per cent of all of our targets. We have had constant improvement over the past—

MRS DUNNE: Congratulations.

Ms O'Neill: few months. As I say, for the past three weeks we have hit 100 per cent in all three categories. A big thanks go to the team, who are doing an amazing job. We are still treating the same number of patients, so it is not because we have had less throughput. It is because we have significantly revamped our processes.

There are much more complex treatments coming through now. In those earlier years, as they were adjusting to those new treatments, that was in part what some of the drop-off was about. In preparation for the switch-out of the linear accelerators, we have increased the operating hours. We have done a lot of work around patient flow through the department, so that we can ensure that we are maximising throughput. The results are extremely pleasing.

MRS DUNNE: You were saying that that was the case for the past three weeks. Refresh my memory: will I see, in the quarterly reports, reporting on this? I do not think I do. We only report on it annually, is that right?

Ms O'Neill: Yes.

MS LE COUTEUR: My question is about the hospital redevelopment and SPIRE in particular. I note that three of us were at the same meeting—four of us. I am sorry, Mr Edghill; I should have counted you in that as well. We were at the same meeting on Wednesday of last week. It is probably fair to say that the vast majority of people accept the idea that there will be expansion on that site, with more or less enthusiasm, but that is not the issue, and the helicopter is not the issue. The major issue is: when there are two major roads that border on Canberra Hospital, Hindmarsh and Yarra Glen, why is the main entrance going to be, it seems, on Gilmore or Palmer? How is the traffic—

MRS DUNNE: Or at least having to traverse those to get there.

MS LE COUTEUR: Or at least having to traverse those. As was said at the meeting on Wednesday, the fate of Hospital Road is yet to be determined. This is also yet to be determined: how will people who are taking someone to emergency, rather than by

ambulance, get there? There appear to be a lot of unresolved traffic issues. The hospital is really important, and putting things where they work best is really important. No-one is arguing about that. But it does exist in certain surroundings, and it does not seem that those surroundings are being well looked at and integrated.

Ms Stephen-Smith: I will hand over to Mr Edghill in a moment. I will put a little bit of context around this. I did not have the information with me, unfortunately, last week. To be very clear, the location of SPIRE on the Canberra Hospital campus was announced in December last year. My understanding more recently is that there was a presentation to Woden Valley Community Council earlier in the year where that was discussed, and these concerns were not raised at that time. While I have apologised to people in the community that they have not felt they have been heard, and this has taken them by surprise, to be fair to officials, it has also taken them by surprise—the reaction at this point—when the site location has been public knowledge since December.

MS LE COUTEUR: I went to the Woden Valley presentation. I cannot remember the location being part of it—

Ms Stephen-Smith: There are some people—

MS LE COUTEUR: The presentation was about this wonderful, beautiful, big building that was going to be somewhere on the site. It was not about where it was going to be. I think that was the problem.

Ms Stephen-Smith: It was clear by February-March, certainly, where it was going to be. Anyway, to get to the nub of your issue, as we said at the meeting on Wednesday of last week, the design of a major project like this is an iterative process. We are at a preliminary design phase where we have enough information about what is going to be in the building and where it is going to be located to go out to expressions of interest for the main procurement works. But we still have design work to do in terms of those details, including how people will get to the emergency department under their own steam. It is pretty clear that the ambulance entrance will come off Palmer. That decision is pretty firm at this point. Howard Wren from ambulance was at the meeting on Wednesday and talked about the implications or otherwise of that for ambulance, which has been raised as a concern.

Certainly, we are very conscious more broadly of the traffic issues and impacts. As others have said to me, and as I said at the meeting, there are longstanding issues about traffic on Gilmore Crescent and Palmer Street and we now have an opportunity to work together to try to address some of those issues. We will be taking some of the traffic off that Gilmore-Hospital Road intersection, I expect, as part of this development. That is the conversation that we need to continue to have with the community.

Mr Edghill: Many of the questions that you identified are issues that we are working through now and will continue to work through over the course of not only this year and next year but into early 2021, to take a step back and to place some of the initial concept designs into context.

The procurement process for the project is kicking off, pretty much as we speak. The requests for expressions of interest will be released to the market on Thursday of this week. As that process carries forward, two things will happen. One is that we will be continuing with the development of schematic and concept designs ourselves. Once we have identified our project partner in the middle of next year we will bring their expertise to bear on those questions that you identified.

Certainly, with regard to traffic, there are works underway at the moment to analyse traffic as it exists today around the whole campus. That will help to inform design decisions. Parking is a key issue that we are conscious needs to be addressed. There are the clinical connections between the new facility and other areas of the Canberra Hospital. Obviously, that will need to be fed into the design process.

There is the functioning of Hospital Road and the future of Hospital Road. It has many competing demands upon it. One of the questions that we are working through is how that road will service the new facility, which is, again, tied into, as I think you mentioned, self-presentations to emergency and how that will function at the new facility.

There are broader questions around way finding, signage and how the broader campus sits. Those are design questions that one would not expect to be resolved at this early stage of the design process. We do have more than a year's worth of design ahead of us for this facility.

MS LE COUTEUR: I would have thought that they would have been a bit more resolved at this stage, given that you appear to have resolved the location. One of the other obvious questions is that you have just put out a request for tender to do a master plan of the hospital, and it does not seem to make an awful lot of sense to do the master plan after you have decided where the major investment is going to go. It is just—

Ms Stephen-Smith: I think this speaks to the iterative nature. In fact when you look back at the *Canberra Times* article from 12 December it is really clear that a lot of work had been done looking at the originally proposed site for the SPIRE project. In that work of planning and thinking about alternative sites on the campus, a lot of work went into that site location.

We also have the expansion at Centenary Hospital for Women and Children going on at the moment but we need to continually plan for the expansion and renewal or modernisation of Canberra Hospital. As Mr Mooney indicated last week as well, there are constantly infrastructure projects going on. You cannot put everything on hold to come up with a master plan that is then going to be set in concrete for the next 20 years. It is an iterative planning process.

But one of the things that came out of looking at SPIRE and looking at Centenary and the other projects that were going on on the campus was, "Okay, taking into account all of the things we have learnt from that and from our ongoing planning processes, let us bring all of that together in what we are calling a master plan." Liz may be in a position to talk about—

Ms Lopa: I thought that was a very good summary, Minister. On the master plan moving forward, yes, we have just gone out for a design consultant for the master plan. We will be working very closely with Major Projects Canberra and the work that they are doing on SPIRE and looking at roads and linkages across the campus. The master plan will take the location of SPIRE as a given. It is a government decision. It is going there, just like building 1 is where it is and the Centenary Hospital for Women and children is where it is.

The master plan will look at linkages across the campus to make sure that the campus is functioning well. But it will also set out the 20-year vision and horizon for what development on the campus might look like. That is looking at precincts in the campus too: where our critical care precinct is; where our research precinct is. It will team with a lot of work that has already been done on the strategic asset management plan for the campus. We know which buildings are coming to the end of their useful life and where all the buildings are up to. All that work was already done in 2017; that strategic asset management plan was done. The master plan will be bringing all of that together, and the work that is happening with Major Projects Canberra, to put a guiding document in place for the next 20 years.

MS LE COUTEUR: Is the master plan going to look at all outside the actual block of the hospital? One of the other comments frequently made to me is that, given the cost of the SPIRE proposal, a modest amount of purchasing of land around or, conversely, reorganising land around, while it would cost money, in the scheme of what is being spent would not be significant. There is the CIT site very close by. There is a whole sporting field very close by. There is not much private ownership; you have the CIT, you have the townhouses and then you have the car park. There is not a huge amount of space in between that, and some of that could be purchased. Also some of the people on Palmer Street have been suggesting that they would love not to be there any longer. I have even heard it suggested that Garran Primary, or at least the entrance to Garran Primary, could be reorganised so that you get those kids and their parents out of that corner. There are other suggestions as well. Are you going to be looking outward, or purely inward?

Ms Lopa: At the moment the master plan is very focused just on the existing Canberra Hospital campus, except I will say that I have met with the Garran Primary School school board chair and principal a couple of times. I first met them back in April and I did commit to them that we would look at their traffic issues as part of the master plan. But I think that has moved forward, because Major Projects Canberra are looking at that as part of the SPIRE work that they are doing on traffic now.

The school community does have some ideas about maybe relocating where the drop-off area is for the school and they were very keen to be involved in the master planning process. I have met with them a couple of times and I know that Duncan and Major Projects Canberra have been meeting with them, so that is definitely on the horizon and on the table.

Ms Stephen-Smith: You heard the commitment I made at the meeting last Wednesday. We have already committed to the establishment of a community panel for SPIRE and talked to Ms McDonald about establishing a community reference group for the hospital more generally which, obviously, will then link in with the

Health Directorate as well around planning. But the traffic issues that people from the primary school and local residents are raising with us are longstanding issues, which I think we now have an opportunity to all sit down and try to resolve with Education, Transport Canberra and City Services and the roads folk.

There have been iterations of this issue. When National Capital Private Hospital was built, there was a lot of construction traffic and there were parking issues in the neighbourhood, which we obviously want to avoid as much as we can as well. In fact some of the aerial photos on particular mapping apps will actually show when the National Capital Private Hospital was being built and where the parking was and some of the challenges there.

These are issues I think we need to work through for the long term. Ministers and directorates—there was a representative of the Education Directorate in our meeting with the Garran Primary School board the other day. Everyone is keen to work together and try to get this issue resolved.

MRS DUNNE: I think I have asked this in question time and I think I put a question on notice to which I did not get an answer. My research indicates that there is no major referral hospital with a similar geography to Canberra Hospital, with perhaps the exception of St George Hospital, which is on some moderately constrained roads but is in a sort of commercial area and has no school nearby.

Firstly, someone the other night—I do not recall who it was—alluded to the Northern Beaches Hospital as being in a similar situation because there was a school nearby. I understand that Frenchs Forest high school backs onto the new Northern Beaches Hospital. But the new Northern Beaches Hospital is a 450-bed, 50-station emergency department—it is more like Calvary, not a peer hospital with the Canberra Hospital—and has multi-lane roads on three sides of the hospital. So why did we come up with the Northern Beaches Hospital as a comparable hospital?

Mr Edghill: I understand that that was my reference. The simple point I was trying to make there is that, whilst the issues we will need to address through the build of the new facility are unique to us here in Canberra, they are not a million miles away from issues that are faced by other hospitals that exist or have been recently built or are being built elsewhere in Australia. Amongst the examples that I gave in terms of hospitals—

MRS DUNNE: I think it was the only example that was given.

Mr Edghill: No, I may have mentioned St George Hospital in the context of—

MRS DUNNE: Sorry—I stand corrected.

Mr Edghill: a hospital in a suburban environment. Box Hill, for example, is not so different. Northern Beaches Hospital is next door to a high school. I mentioned that in the context that through that build period, I know firsthand, the constructors had to give close consideration to what that meant for school operations as they were constructing. There are other hospital examples. On a slightly larger scale—I think it is 60,000 square metres as opposed to 40,000 square metres here—the new facility

which is currently being built at Westmead Hospital in Sydney, for example, is building on a constrained brownfields site. Some of the issues that they face around construction, truck movements, parking and so forth will all be issues that they have to address here.

The point I was making there goes to the question that came before: why every aspect of the hospital has not already been designed. Part of what we want to do through the procurement process is to make sure that we are not only giving the community and clinicians an opportunity to engage but also, when we get to the point where we have the private sector constructor on board with us, we are getting the benefit of their experience and the processes that they have been through on some of these other hospitals around Australia. Very definitely what we are trying to do here through the delivery phase of SPIRE is not only to create a state-of-the-art facility which is great at the end of the build but also to make sure that through the process we are also getting the benefit of those who have come before us in other places in Australia.

MRS DUNNE: I take the point, Mr Edghill, that there are issues associated with the delivery of it. Then you have a hospital which has at least its emergency entrance off a two-lane—one lane each way—single carriageway road, which is somewhat constrained. As the residents pointed out, it is on a crest and a curve. Those are problems. How will you ameliorate those problems? For instance, most of those places—possibly with the exception of St George Hospital, which is constrained—do not back up to residential areas. They do not back up to schools. They do not have a school on the other side of the road. How can you possibly ameliorate that for the life of SPIRE? The buildings that are there now are 40 to 50 years old. One would presume that you are building SPIRE for 40 or 50 years. How are you going to ameliorate that for the residents of Garran for 40 or 50 years to come after it is built?

Mr Edghill: As the minister noted before, some of the issues that exist for residents and for Garran Primary School in relation to the hospital campus are issues that exist today. So I very much take the view that rather than the new facility—

MRS DUNNE: They do not have ambulances on Gilmore Crescent or—

Mr Edghill: I think that rather than the new facility representing an additional problem, there is actually an opportunity here through the design process to look more broadly. The question was asked before about whether we are looking just inwards or whether we are looking outwardly. Very definitely, we are looking outwardly through the build of this facility.

MS LE COUTEUR: That is not what you said, though.

Mr Edghill: There was the question there about the master plan. In terms of the actual build of the SPIRE facility itself—to demonstrate that we are looking outwards—there are documents which are now in the public domain which were presented to the industry briefing that we held about a week and a half ago where we set out what the objectives are for the project.

Certainly, there is a very heavy emphasis upon the clinical and patient outcomes. But also within those objectives are very much outwardly facing objectives, not only

around ensuring that we are a good neighbour for the 40 to 50 years to come, but also the broader benefits that a significant infrastructure project like this can bring to workforce development and so forth in Canberra.

There is work which is going on at the moment around looking at traffic around the entirety of the site. That analysis, in conjunction with the discussions that were had with our colleagues in education and in other directorates across government, will all feed into the design process, which I am confident will be a catalyst for actually improving and addressing some of the issues that exist today.

Ms Stephen-Smith: I just add, drawing on something that Mr Wren said at the briefing, that someone asked about ambulances driving through school zones. He made the point that ambulances drive through school zones every single day in different parts of Canberra. So while we are talking about some residential streets around the Canberra Hospital campus, that is one small part of a journey that an ambulance or an individual coming to emergency is going to take. Their journeys are going to involve residential streets.

They might not be residential streets right next to the hospital, but all of those journeys, by and large, are going to involve travelling on residential streets, travelling through school zones. Those are challenges that are going to exist as part of each of those individual journeys. The streets right next to the hospital are one small part of that journey.

MS LE COUTEUR: Sure; I guess the point is that they are a small part and a part that does not have to be, given that the hospital, on two of its sides, has major roads that are designed for major amounts of transport. I guess the other difference compared to the other hospital redevelopments is that it is not actually necessarily a constrained site. There is a demolition site owned by the ACT government only a few hundred metres away.

Ms Stephen-Smith: But it is not feasible for the hospital itself to build SPIRE at the former CIT site, if that is what you are suggesting.

MS LE COUTEUR: No, but there is a lot of stuff on the hospital block which it would be feasible to move.

Ms Stephen-Smith: That is your assertion, Ms Le Couteur.

MS LE COUTEUR: That is my assertion and certainly looking at the—

Ms Stephen-Smith: I think, as Mr Edghill has said, we also need to consider parking. Parking is a very significant issue—

MS LE COUTEUR: Yes.

Ms Stephen-Smith: and we also need to have space for parking. So when you are thinking about potential future uses for the CIT site and its relationship to the Canberra Hospital, Ms Le Couteur, I do not want to pre-empt any—

MS LE COUTEUR: But I think we know where we can go, yes.

Ms Stephen-Smith: announcements that might be made, but you might want to consider all of the requirements that are necessary for a hospital site, which include parking.

MRS DUNNE: I have some other questions about that SPIRE thing. Somewhere during the election period in 2016 there was a move from the proposal, for which I understand multiple millions of dollars have been spent on design work, for the redevelopment of buildings 3 and 2. How much money have we spent on the redevelopment work that was done on buildings 3 and 2, because I have seen plans that are substantial? Somewhere along the line during the election period and the run-up to 2016, the government formally moved away from the redevelopment of building 3 and announced that they would build SPIRE, which we will call SPIRE 1 because it has moved since then.

In coming to the initiative to build SPIRE instead of rebuilding building 3, did the Health Directorate undertake work that formed the government policy at the 2016 election? There was some discussion about this in economic development last week, I had it reported to me. I have not read the transcript, but there was some indication that the government did approach the Health department to look at an alternative to rebuilding buildings 2 and 3. When did that happen? Did it happen during the election period? Did it happen during the caretaker period? How much work was done in Health before the SPIRE announcement was made in the election period? Can somebody answer that?

Ms Stephen-Smith: None of us was in the roles we are in now during that period; so we will probably have to take that on notice, unless Ms Lopa has some background.

Ms Lopa: Only that we will take it on notice, but I have been looking back at documents, Mrs Dunne; you have an FOI in at the moment on building 3-2 as well and—

MRS DUNNE: Indeed.

Ms Lopa: I am looking. You have got a question on notice about the cost of 3-2; so I have been looking back at some documents in order to get some of those answers. I am not sure that the proposal not to do building 3-2 was as late as 2016. I will take it on notice and we will get back to you with a time line.

MRS DUNNE: I would be really interested to know when that proposal was abandoned because, as far as I know, it was still on foot, although nothing had been done about it for some time. My understanding is that there was a lot of work done in 2012 to 2014. I have a wodge of designs an inch and a half to two inches thick. So it would be useful to know when that was departed from.

Also, in respect of the thinking about what I conveniently call SPIRE 1, to build it on the helipad in the car park—which was always going to be a problem and eventually people recognised that it was a problem—who made that decision? When was that decision made? What was the decision-making process about that? If the answer is

"Wait until you get the FOI, Mrs Dunne," that is fair enough. It is a very complex answer, but I will expect to see lots of documents in the FOI if that is the answer. Then, given that SPIRE 1 was substantially constrained from the get-go, what was the process and what was the time line for coming up with SPIRE 2? Did you consider going back to the building 3-2 option at that stage?

Ms Lopa: Thank you, I will take all of that on notice because obviously I was not in the Health Directorate at the time. Looking at things as we go through looking for your documents, I know that in the process between, using your words, SPIRE 1 and SPIRE 2 there was a lot of consultation with clinicians, there was a lot of consultation across government to inform the change of location. One of the issues that I understand was raised by clinicians and others was, as you say, the movement of the helipad and the car park. It was expensive and it was not really the best outcome for patients if you put a helipad somewhere else and then have to have an ambulance pick them up off the helipad and bring them into the hospital.

MRS DUNNE: Which we have done before we had a helipad on site; so—

Ms Lopa: Yes, we did.

THE CHAIR: Before we had that helipad, yes.

MRS DUNNE: Yes, and that was less than optimal.

Ms Lopa: Yes. So that led to the decision taken by government, which was announced in December last year, for the new site. I think the advantages of the new site are that we are building a new critical care acute services building on the campus with very little disruption to critical care services. The areas that are being decanted are being decanted out of very old buildings and are getting new buildings. But we are able to build new operating theatres, a new ICU and a new emergency department with no disruption to those very important services on the campus and without any disruption to the helipad.

I think that from a patient outcome point of view, being able to build on the hospital campus on a site that has very little disruption to the everyday running of the hospital was a clear advantage in making the decision to go for that site.

Mr De'Ath: More broadly, Mrs Dunne, I add that I stepped into this role at a time in the process when clinical people were starting to note and comment on the issues with that particular site and particularly, of course, in relation to patient safety and the efficiency and effectiveness of good hospital operations. That really kicked in a fairly comprehensive process. You will see this in the FOI, I am sure; so I will not go into a whole lot of detail. But we did a significant body of work at that point around site, around a range of issues.

I mentioned the sequence of 10 key meetings that we ran. I mentioned earlier that they were fundamental also in informing us through some reasonably significant engagement with clinical staff at that point. I think it was in about week 2 of the role when particularly the executive directors working on the hospital side of the business were feeding back information at that point. I think it was a very comprehensive

response that landed us in the place where we are today.

MRS DUNNE: One of the things that you said at the meeting last week, minister, was that patient flows require—I think this is a pretty accurate transcription, but errors and omissions accepted—that critical care areas be connected to the hospital and that that is why the notion of having it across the road or something is not a good idea. The chair of the meeting the other day said something along the lines that it seemed that building 3 would be ideal for patient flow. Would you disagree with the chair of the Woden community council, in her statement, that it seems that building 3 would be more ideally suited for patient flow given its proximity to the tower block and the like?

Ms Stephen-Smith: Patient flow is one issue.

MRS DUNNE: Yes, but I am asking about the patient flow.

Ms Stephen-Smith: Mr Mooney talked about some of the current uses for building 3, where clearly patient flow with the Canberra region cancer centre and wards 14A and 14B represents a very positive patient flow in terms of that collocation.

MRS DUNNE: Yes, but I am asking in relation to the critical care areas.

Ms Stephen-Smith: In theory, that point in the middle of the hospital campus is going to be close to other parts of the hospital campus, but it also has a current use and would be potentially a lot more disruptive to the ongoing management and operation of the hospital during the major construction project than other parts of the campus. There are many issues that needed to be taken into consideration in this decision, not one single issue.

MRS DUNNE: It is, without a doubt—like all planning issues, all matters of planning in any area—multifaceted, but you yourself made the point that patient flow was one of the key issues, and it has been put to many people around here that the current proposed location of SPIRE 2 is not necessarily conducive to good patient flow.

Ms Stephen-Smith: As you pointed out, Mrs Dunne, I think that was in response to propositions about relocating either SPIRE or other parts of the campus quite some distance away, for example on the former CIT site. I am not sure that the issues are connecting in the way that you are describing.

THE CHAIR: I know we are on cancer services, acute services, and alcohol and drug services, but I want to go to another question. I may have missed where to ask this question, so I apologise. There was an announcement—I am going to say earlier this year but it could have been last year—between Minister Fitzharris as health minister and Minister Berry as Minister for Women about programs to help women who are either victims of or trying to escape from domestic violence.

Ms Stephen-Smith: The health justice partnership?

THE CHAIR: It is about escaping domestic violence and assisted—

Ms Stephen-Smith: Is it about locating women's legal centre people into the health—

THE CHAIR: Is that with Minister Rattenbury?

Ms Stephen-Smith: No, not necessarily. It is a great example of a whole-of-government collaboration. People from the women's legal centre are collocated within Calvary, Canberra Hospital and, I think, two of the child and family centres. It may only be Gungahlin; I need to check that. So it relates to all three portfolios: Attorney-General's; Health; and the Community Services Directorate, with children, youth and families, and Minister Berry's responsibility as minister for the prevention of family violence. Probably someone else is better able to talk about the detail of what this means in terms of embedding those services within Canberra Hospital.

THE CHAIR: I was thinking that we had not heard from Ms Bracher today, and here we are.

Ms Stephen-Smith: Ms Bracher also is to be congratulated on a recent award for her mental health work. Well done.

Ms Bracher: Thank you, minister. I acknowledge the privilege statement. In relation to the justice partnership, I can speak to what we do in the Centenary hospital. There are a number of embedded lawyers who work in the hospital with the social work staff and the midwives, particularly in the maternity area. They connect women who might be at risk of domestic violence or experiencing that in their family with legal advice and support through the system.

THE CHAIR: That is a relatively new initiative, though, isn't it? It is only 12 months old?

Ms Bracher: Yes, 12 months to two years old. It had an establishment period, but over the past year it has been very active.

THE CHAIR: Have you found that women have—I do not know how to ask this delicately—found the services helpful?

Ms Bracher: Absolutely. From the contacts we have in Legal Aid, they have got very good data about how women have engaged with them. Our midwives and social workers have a very positive experience of connecting women and families into that service. It has been very positive for the hospital.

THE CHAIR: And for the women as well?

Ms Bracher: Absolutely, yes; that is our experience. Once the women are engaged with Legal Aid, we do not have as much visibility of what services they connect with, but there is very positive feedback from our clinical staff in supporting women into a supportive legal framework.

THE CHAIR: This might be something you need to take on notice, but how are we supporting women from an Aboriginal or Torres Strait Islander background or from a

CALD background? Do we have people who are better able to support those women?

Ms Bracher: Through the Legal Aid service, they support women from Aboriginal and Torres Strait Islander communities and women from CALD backgrounds.

The other thing that we are doing very actively in the domestic and family violence space is our Canberra Health Services response to domestic and family violence that has cascaded out of the office for family safety and the commissioner in there.

As recently as last week, Bernadette, as our chief executive, made a statement, a commitment, to all staff in Canberra Health Services about domestic and family violence: that it is not acceptable and not okay, and there is support for both staff and the patients and consumers who access our services. Over the past three months we have done an extensive body of work to support our staff who might be experiencing that.

We know that something like 40 to 50 per cent of health workers have an experience of domestic and family violence themselves. For those staff to be supported in the workplace so that they can then support women and families who might be consumers accessing our services is a very sensitive balance; we have to work with our staff to do that safely for all concerned. We have just launched our consultation process around the policies and procedures to support staff to do that.

Into next year, we will be rolling out some training across the board for all Canberra Health Services staff and much more highly technical training for managers to support staff and to support services and training in key areas of our service where we know many workers might come into contact with women as a first point of contact: the emergency department; women, youth and children; maternity services; and the mental health and justice health space.

THE CHAIR: You mentioned training. Jo Wood, the Coordinator-General for Family Safety, has appeared before me in other committees and talked about some of the training that they have on offer for ACT public servants. Is that the training you are talking about or are you doing something based on that but specialising it more because you are health professionals and a slightly different kettle of fish?

Ms Bracher: Absolutely. This is our Canberra Health Services commitment to a public service approach to frontline worker training. In the health service, because we can be a very important first point of contact for people experiencing family violence and have a trusted relationship in that patient-clinician relationship for people to disclose, we are going to roll out a program that we have looked at from Victoria, a program they have rolled out specifically for health workers. It is much more detailed than the general ACT public service training that is coming out of Jo Wood's office. Jo Wood sits on our steering committee and she is very supportive of this training program.

THE CHAIR: Fantastic. I will be interested to hear how the results go as you move along. I put on notice that I will be asking about these things as we move forward.

Ms Bracher: We would be very pleased to provide that information. The training

program is rolling out over the next two to three years. It will be slow and gradual. It is not without risk in exposing our staff and potentially other consumers, so we do need to be very cautious and careful about how we roll it out.

MRS DUNNE: When we look at peer hospitals, is the women's and children's hospital counted as part of the Canberra Hospital or is it classified against other peer women's and children's hospitals?

Ms Bracher: It depends on the context. We classify it as part of the Canberra Hospital campus. It is part of the hospital, it is managed through the hospital and the management structure of Canberra Health Services. When we do quality and safety benchmarking we benchmark against like peers through Women's Healthcare Australasia or Children's Healthcare Australasia. With the health roundtable data we look at benchmarking quality and service outcomes against peers.

MRS DUNNE: For instance, when you look at the cost of services, do you benchmark against referral hospitals or do you benchmark against women's and children's hospitals?

Ms Bracher: Referral hospitals. Our maternity and our neonatal services are the equivalent of New South Wales level six tertiary referral services, so we benchmark against those. Our paediatric service is a more general service; it is not like the big children's hospital in Sydney, for example. We would never benchmark against a children's hospital.

MRS DUNNE: Who has responsibility currently for the upgrade of the Canberra women's and children's hospital? Is that being done inside Health or is it being done by Major Projects Canberra.

Ms Stephen-Smith: Canberra Health Services.

Ms Bracher: I am the executive sponsor from a service perspective, but Colm Mooney is the executive lead for the infrastructure component.

MRS DUNNE: So the infrastructure is being managed within Canberra Health Services and not through Major Projects?

Ms McDonald: It is not quite that well delineated.

Mr Mooney: I acknowledge the privilege statement. The question refers to Canberra Health Services managing the project that is the expansion of Centenary hospital. Following the transition between the Health Directorate and Canberra Health Services, projects up to $50 million dollars in terms of project delivery are managed by Canberra Health Services' in-house capital project delivery team, which is part of the infrastructure and health support services area.

That team works very closely with Major Projects Canberra which has had an embedded project management team within Health for the best part of 10 years. There is a team of people who have been known as procurement capital works or infrastructure and finance capital works or shared services procurement over the years.

That team is part of Major Projects Canberra but it is the part of Major Projects Canberra that delivers projects on behalf of various directorates. The Major Projects SPIRE team is a separate entity and is specifically tasked with delivering that.

MRS DUNNE: What is the relationship between Canberra Health Services in its procurement and development of the women's and children's hospital and the unit that Ms Lopa runs in the Health Directorate?

Mr Mooney: Ms Lopa's team did the business case for the women's and children's expansion project and then it was handed over to Canberra Health Services to deliver. We are still work with Liz's team and the members within the Health Directorate from a health planning point of view to make sure that as the design develops it is aligned to the original intent of the business case which would have been informed by various health planning considerations.

MRS DUNNE: Where are we in the project? Is it still in the design stage?

Mr Mooney: No, it has been progressing. There are specifically three packages for the women's and children's expansion. Package 2 is the paediatric high-care unit improvements and that has already been let out to market. A contractor has evolved the design and we are starting later this week with the relocation of the current service into a temporary decanted area to allow for the improvements under that scope of work to proceed.

MRS DUNNE: What does the paediatric high-care work consist of?

Mr Mooney: It is primarily improving line of sight and observation; removing physical obstacles to vision within the space. They are essentially infrastructure changes that complement model of care improvements.

MRS DUNNE: Where precisely is that happening?

Mr Mooney: In the existing paediatric high-care unit. People will be decanted from there into another area within the women's and children's hospital that is currently vacant. It is our winter surge bed area so it is not in demand at the moment. We have a window between now and the next winter season where we will put those improvements in then the paediatric high-care unit will recommence in that space after works have been done.

MRS DUNNE: What does the paediatric high-care unit have that a normal paediatric ward does not?

Ms Bracher: It is a 12-bed unit on the ground floor in the paediatric wards. There is an adolescent ward and a babies ward and a high-care ward. The clinical staff make a clinical decision about the staff profile for caring for a child, so there is a higher staff profile. The children are monitored more closely in the high-care ward. Part of the reason for the refurbishment is consolidating our model of care in higher acuity care so we can work with the design and the models of care around what might go into the new intensive care beds in the SPIRE. It is differentiating between high care and intensive care for children. What we are doing is definitely not intensive care but

higher level monitoring and higher level treatment.

MRS DUNNE: As opposed to what would go on in the babies ward or the adolescent ward?

Ms Bracher: Yes.

Ms McDonald: Yes, a normal paediatric ward. There is a difference in the type of care.

MRS DUNNE: What is the patient profile in the high-care ward?

Ms Bracher: Children who might be deteriorating on the ward and who we need to watch more closely and make a decision about intensive care or transfer to one of the Sydney hospitals. We do that from time to time. Children who have much higher acuity respiratory concerns and complications. The diagnoses are varied.

MRS DUNNE: So that is package 2 and the time line is between now and when you need the winter surge beds next year?

Mr Mooney: April-May of next year, correct.

MRS DUNNE: The intensive care beds have been taken out of that package and have gone into the SPIRE package, is that correct?

Ms Bracher: The intensive care beds were never in that package.

MRS DUNNE: I thought they were because at one stage I asked about the apparent fall in the appropriation. I was told that that was because the intensive care beds were taken out of that.

Ms Bracher: My apologies. There are special care, neonatal and intensive care beds in the Centenary hospital expansion, but not paediatric.

Mr Mooney: On the question in relation to the apparent funding drop, that was when there was consideration, as part of the business case development, of additional beds in the tower block in levels eight and 10. They are not included now in the women's and children's expansion project. It is all within the footprint of the women's and children's expansion. The appropriation that we are working off is $50.05 million.

MRS DUNNE: Once it was a bit more than that. I cannot remember what. What is the time frame for packages one and three?

Mr Mooney: Where we are at with them is that in the next month we will be finished the preliminary sketch plan. We are going out to the market for a head contractor before Christmas, to then appoint in March-April next year, March-April 2020, and then, subject to clinical operational constraints, we would be targeting June 2022 for completion of all the works that are included under packages one and three.

MRS DUNNE: When do you plan to start?

Mr Mooney: It would be starting after appointment of the contractor. You are looking at quarter three of 2020.

MRS DUNNE: Do you have to do a DA?

Mr Mooney: There will be DAs being put in as part of the preliminary sketch plan works that will be completed, as I said, at the end of this year. We are expecting that the DAs will go in in the early part of next year.

MRS DUNNE: Canberra Health Services will be doing that, not the contractor?

Mr Mooney: Correct, yes. What we will be doing is, under our consultant, detail work to get us to a DA-approved state and, in parallel with that process going on, we will be looking to finalise the contract with the head contractor to deliver packages 1 and 3, and we will enter into a contract with them when we have the DA confirmed.

MRS DUNNE: This is not design and build, this is just build?

Mr Mooney: What we will be doing is taking it to a preliminary sketch plan with a DA approval process applied to that and then, with our head contractor, it will be a design and construct. But they will be taking our preliminary sketch plan design and developing that into a more detailed design which they will then construct.

MRS DUNNE: Is it likely that either Canberra Health Services or the head contractor will have to go back and modify the DA in that process?

Mr Mooney: In this project it is not anticipated but it is not unusual. I know in the case of the UCH project, under our preliminary sketch plan project, we had the DA before we progressed into contract and then the head contractor in that case put in an amendment to the DA. But the main de-risking is to make sure that the DA has been confirmed. I guess the DA elements that we have on the new expansion are primarily linked to the expansion of block F, which is an extension on an existing two-storey building to take it up to add another floor. It will incorporate the adolescent mental health unit wing as a clip-on to the existing block A of women's and children's.

MRS DUNNE: That is the bit that goes all the way up to Gilmore Crescent?

Mr Mooney: Yes, there is a—

MRS DUNNE: It sort of runs parallel to the—

Mr Mooney: Where you have the drop-off—

MRS DUNNE: That is where the drop-off is?

Mr Mooney: Yes, where you have the drop-off and then running towards Garran Primary School oval.

MRS DUNNE: Of the two packages, one is the mental health unit. Is it a separate

building?

Mr Mooney: It is a separate building, yes. It is an add-on to the actual existing block A of—

MRS DUNNE: But will there be connection through?

Mr Mooney: There will be connection through, yes.

MRS DUNNE: The other part is another floor on the—

Mr Mooney: On block F.

MRS DUNNE: Which is the bit that runs at right angles to the building we were just talking about?

Mr Mooney: Essentially, yes.

MRS DUNNE: You said "commence in third quarter 2020"—and complete in?

Mr Mooney: In June-July 2022.

MRS DUNNE: That seems to be almost as fast as building a 10-bed extension to Clare Holland House. I was surprised at the building time.

Mr Mooney: I am not involved in—

MRS DUNNE: I know but I was just surprised at the building time line for that. That is an eight, 10, 12-bed unit and it seemed to take just as long.

MS LE COUTEUR: Has the government considered options for psychiatric alcohol and non-prescription drug assessment such as the PANDA unit in the hospital? Would it be a better way of dealing with some of the presentations and lengths of stays in ED for psychoactive substances related to mental health presentations? Is it the wrong place?

Ms Stephen-Smith: This is the right place for hospital questions.

MS LE COUTEUR: Basically have you considered options for the PANDA, psychiatric alcohol and non-prescription drug assessment, unit in the hospital? And would this be a way of relieving pressure on emergency because you could deal with people in a way that was appropriate to why they were there?

Ms Grace: I acknowledge the privilege statement. The PANDA unit is certainly an example of an option that we have been looking at in terms of the design of SPIRE and the mental health flows within the emergency department within SPIRE, as well as the options for a mental health short-stay unit. Through the initial design work in relation to SPIRE we are considering a number of options from mental health assessment through behavioural assessment into short-stay mental health and then through to inpatient services and what the interface with the triage desk and

presentation to the emergency department might look like. With that, we are also looking at the adjacency to the acute area of the emergency department and design of de-escalation space within the emergency department footprint as well.

The PANDA service has been raised a couple of times in those discussions and is certainly a site that we will be visiting. We are about to commence a number of site visits in relation to the design of the mental health space within SPIRE and, as I say, the PANDA service will be one of those services that we look at. We are concerned that at the moment the current configuration of the emergency department means that good separation of behavioural assessment, acute intoxication and mental health assessment space is an ongoing challenge, and it is something that we would like to solve through SPIRE.

MS LE COUTEUR: So the answer is that you are looking at it, but it will not happen until after SPIRE is constructed? I think that is what you are saying. It is not going to happen earlier?

Ms Grace: We will look to determine what the ideal outcome is for SPIRE and then look at our options in the interim in terms of the existing emergency department to improve the flows through the emergency department. The answer is that we will be looking at both. We are also looking at the whole system in terms of mental health and the acute service; this is part of that discussion.

MS LE COUTEUR: So this could also relieve the pressure on mental health units themselves?

Ms Grace: Certainly, yes.

MRS DUNNE: Where is the unit physically located?

Ms Grace: The PANDA unit?

MRS DUNNE: Yes.

Ms Grace: I believe it is part of St Vincent's in Sydney.

Ms Stephen-Smith: We do not have one at the moment.

Ms Grace: We do not have one at the moment. It is a model for the management of people that are acutely intoxicated with drugs or alcohol and potentially have underlying mental health psychosis as well. It is a way of managing those patients until you get to the point where you can safely make a full mental health assessment, where they have the ability to come safely down from the drug or alcohol that they are under the influence of.

MRS DUNNE: At St Vincent's, is this associated with but separate from accident and emergency?

Ms Grace: My understanding is that it is integrated into their emergency department, similar to a behavioural assessment unit in other centres. That is why we are going to

go and have a look at it in practice and learn a bit more about it, along with a number of other options.

MRS DUNNE: Does St Vincent's have a mental health assessment unit similar to the one that has been established in the Canberra accident and emergency department, in addition?

Ms Grace: The PANDA unit has been designed specifically for the problem of acute intoxication alongside a mental health assessment area. I am not across the absolute detail of how the two function together, which is why it is important that we go and visit.

MS LE COUTEUR: You will be aware, minister, that the New South Wales Deputy Coroner recently said that pill testing would seem to be a good idea and could have potentially led to saving the lives of six kids, had it been in place. We have had a couple of trials in the ACT. What is the current status of pill testing? Are we looking at broadening it outside one-off festivals? And what commitments are there around legal safety, as distinct from drug-related safety?

Ms Stephen-Smith: The current status for government consideration is that we are awaiting the final independent evaluation of the last trial. That is expected to be completed by the end of the year. The government will consider a position on either future trials or permanent funding of pill testing at festivals. I am aware that the Greens have a position in relation to static pill testing as well. No doubt that will also be advocated for in the conversation. At the moment, the evaluation is expected to drive future decision about pill testing at festivals, in line with our harm reduction approach more generally.

THE CHAIR: What other harm minimisation policies or practices does the government have in place?

Ms Stephen-Smith: It is a guiding principle of our approach to drug and alcohol issues at a personal use level, treating these issues as a health issue rather than as a criminal issue—for example, supporting the cannabis legislation that recently passed the Assembly, but supporting it with information for the community about the risks of cannabis use and the reasons why it is not a good idea, treating that as a health issue rather than criminalising people for personal drug use. Also, as part of the drug strategy action plan, we are committed to looking at a safe injecting facility; that work is underway.

MS LE COUTEUR: I did not realise that was a live option. That legislation was passed 20 years ago or so. Tell us more.

MRS DUNNE: It has never been funded.

Ms Stephen-Smith: Someone else may need to tell us more about where the project is up to at this point.

MS LE COUTEUR: Is it funded? I thought it was dead.

Ms Stephen-Smith: There was a commitment from the drug strategy action plan that was released in December last year to look into it.

Mr Philp: That is right. We got some money over the last budget to look at a feasibility study to see what the demand is within Canberra.

MS LE COUTEUR: Is there anything to report as a result?

Mr Philp: Not at this stage, no.

MS LE COUTEUR: When will there be something to report?

Mr Philp: We anticipate that over the next six months we will be able to have the scoping study undertaken and back to us on the feasibility. We are visiting some of the other sites to see how they operate. That will inform some of the work that we need to do going forward.

Ms Stephen-Smith: In addition to officials visiting, Minister Ramsay and I will be visiting a drug and alcohol court and safe injecting facility in Sydney in December.

MS LE COUTEUR: Great.

Ms Jonasson: We are working very closely with the sector as well—looking at co-design and working closely with the NGO sector on this.

MS LE COUTEUR: And very closely with the police force as well, hopefully.

Ms Jonasson: Absolutely, yes.

MS LE COUTEUR: What role does your service have in terms of education about drugs? You have talked about a health approach rather than a legal approach. Where do you fit in with that?

Ms Stephen-Smith: There is a fairly recent response to a question taken on notice from question time that asked me for information about 10 years worth of drug education activities that you can look up.

Mr Philp: Harm minimisation is the approach that we are doing across the ACT, a range of programs. We also fund non-government organisations with small grants to undertake some of that work at a community level.

MS LE COUTEUR: Who was the recipient of the question on notice, to help to track it down?

Ms Stephen-Smith: We will find that for you.

THE CHAIR: I may not be in the right place, but I will give it a go: immunisation rates for Aboriginal and Torres Strait Islander children.

Ms Stephen-Smith: Immunisation rates for Aboriginal and Torres Strait Islander

children in the ACT are very, very good by national comparison and indeed by comparison with non-Indigenous children and young people as well, I think, in terms of our national outlook. I will hand over to Dr Coleman for the actual figures.

Dr Coleman: Was there anything in particular that you were after?

THE CHAIR: I was not sure I was in the right place. I did not actually have my question ready. I am terribly sorry.

Dr Coleman: I can run through what they currently are. For Aboriginals and Torres Strait Islanders in the ACT we have three rates that we give. The first is for those at about one year of age, and they are at 98 per cent, which is above the target rate. The challenging area is about two years of age, which is at 90 per cent. This is common across the nation, that at two years it is more of a delay in terms of their vaccination. As you can see, by the time they get to five years of age we are back up to 95 per cent. That is about a timeliness response. Around the nation, different things have been done to try to improve the timeliness of vaccination.

THE CHAIR: That was basically where my question was going. It seemed we were doing really well at both ends but in the middle we really dropped off. Are there any policies in particular that we have in Canberra to help maybe improve the timeliness?

Dr Coleman: Kylie was just correcting me. It was 97 per cent at five years, which is better than I said. We absolutely do a lot of work in this space. We have a particular officer who does recalls and reminders for parents in this particular space. They also, I believe, send out postcards to this population group. There is a lot that we are doing in this space, and I think that shows, in that by the time they get to six years of age they are at 97 per cent.

THE CHAIR: It is increasing again?

Dr Coleman: Yes.

MRS DUNNE: Does the 90 per cent get permanent immunity?

Dr Coleman: It depends on the disease, yes. For many diseases it will. We use 95 per cent because that is for measles, the most infectious disease that we have, yes.

MRS DUNNE: That was what I was thinking. I had read something about measles and heard immunity at 95 per cent.

Dr Coleman: Ninety-five has always been given as an aspirational target, and I cannot believe that in many cases we have achieved that. It is fantastic that, around both the ACT and Australia, we do it consistently.

Ms Stephen-Smith: At a more general level, in terms of contact in that first thousand days of life, the Health Directorate and children, youth and families, as part of the Community Services Directorate, are co-managing a first thousand days project to look at the development of the first thousand days strategy for the ACT. One element of that will be how we better maintain connections with vulnerable families who are

not engaging in other services. That might be something that we can look at.

Dr Coleman: Absolutely.

Ms Stephen-Smith: Essentially it is those families who are disappearing from the service sector between the end of their matched nurse visits and their children going to preschool or primary school that are missing out on those connections.

MRS DUNNE: Seeing that we are touching on Indigenous health, I had something that probably should have been asked this morning. If you cannot answer it I will be happy for it to be taken on notice. Your incoming minister's brief talked about the new health centre at Winnunga. The brief said that the appropriation of territory funds does not align with the contracted deed of payment milestones; that there is a risk that treasury will not be able to secure the funds for payment in July 2019; and that, to manage this risk, ACT Health Directorate's chief finance officer and treasury are expected to arrange for the drawdown of the 2020-21 budget to be brought forward to make the next payment. Has this problem been fixed and is the payment system for Winnunga on track?

Ms Stephen-Smith: The payments have been made. I understand we are up to date with our milestone payments to Winnunga.

MRS DUNNE: Is there a problem for other milestone payments?

Mr Culhane: I acknowledge the privilege statement. All the funds for that build have now been paid to Winnunga.

MRS DUNNE: All the milestones have been met?

Mr Culhane: All the milestones have been met. Full payments have been disbursed.

MRS DUNNE: Completion date?

Mr Culhane: October 2020 it is expected to be finished.

MRS DUNNE: Winnunga is managing that build?

Mr Culhane: That is correct, yes.

Ms Stephen-Smith: Ms Le Couteur, we found the response to a question taken on notice, but I do not know that it has a number because it was a question time question. The question was asked on 25 September and I submitted an answer on 5 November, if that helps you to find it. It was asked on 25 September and I signed off on the answer on 5 November.

Mr De'Ath: If I could also add, we took questions earlier on Clare Holland House.

THE CHAIR: Yes, please.

Mr De'Ath: The project agreement for the expansion of Clare Holland House was

countersigned by the commonwealth on 8 April 2019 and the expected completion date for the expansion is August 2021.

MRS DUNNE: That is a long time.

Mr De'Ath: We could take further questions on the time frame, if you like.

MRS DUNNE: Yes.

THE CHAIR: We have a couple of minutes remaining. I am assuming from answers you gave us before, Ms Lopa, that the design phase is probably one of the most difficult during this build. I am just guessing.

Ms Lopa: The design phase needs to take into consideration how it links in with the existing hostel. We are working with Major Projects Canberra, who are managing the projects for us. Of course, we will look to scrunch the program if we can. There is some contingency in there because it is being built on a live palliative care site and patients still will be occupying rooms. So there is some contingency in there at the moment if we have to stop work or if there are certain times when construction might not be able to take place. The preliminary designs that they are looking at include a wing where you could build all of it without really having to—

MRS DUNNE: They would knock through at the end, yes.

Ms Lopa: Then just knock through at the end. As to how that would happen, my understanding is that there is some contingency in there. When they are looking for a head contractor, one of the things that they will be speaking to them about is putting in an agreement with the clinicians who work there similar to what we did with the government office block here—for example, that they do not make heavy noise during sitting periods. We might have to have agreements about when construction can and cannot happen. I think there is some contingency in there for that at the moment, but obviously we will look to do it as quickly as we can.

MRS DUNNE: When you say contingency, do you mean time contingency?

Ms Lopa: Yes, time contingency.

MRS DUNNE: But I suppose it will drive up the build cost as well.

Ms Lopa: Yes.

MRS DUNNE: You have people standing around waiting for the window.

Ms Lopa: Yes, possibly, unless it is really well known at the beginning and they just plan that way, which hopefully is the way it will be. But you never know on any given day. If there is something happening, they need to stop work. I think when any program is done you are looking into the future and you are saying, "This is what we think it will look like." We will work to make sure it is done as quickly as it can be. The construction completion is due, I think, about the 12-month mark or a little after and then there is a commissioning period there too.

MRS DUNNE: Commissioning, of course, yes.

Ms Lopa: Yes, so fully occupied, everybody in, doing their thing, by August.

MRS DUNNE: I see.

Ms Lopa: I think the construction completion is earlier than that, but then there is that commissioning period, training of staff, all of that kind of stuff.

MRS DUNNE: Okay, so it is not just the build phase.

Ms Lopa: No.

MRS DUNNE: It is to occupancy.

Ms Lopa: Yes.

Ms McDonald: Ms Cody, could I answer one question we took earlier on organ donation?

THE CHAIR: Please, Ms McDonald.

Ms McDonald: The question was in relation to consent for organ donations and whether, if there are reasonable but unsuccessful attempts to contact the next of kin, we assume consent. We were asked how often this happens in the ACT. Our records from DonateLife indicate that not since the inception of DonateLife in 2009 has that happened. We were asked: is this part of the legislation widely understood by health practitioners? It is understood by staff at DonateLife ACT, who are always involved in donations. Designated officers who authorise donations are also educated to know this piece of legislation.

We were also asked how satisfied we are with donation rates in the ACT. Last year the ACT had the highest number of organ donors per million of population. We also saw the highest consent rates in the country. This year, to date, we are conscious that there have been a number of families who have declined to go ahead with organ donation. However, we are mindful that organ donation is raised at possibly the worst time in a family's history.

When a person is on the Australian organ donor register, their family are 90 per cent likely to give their blessing for organ donation to proceed. Therefore, a large focus for DonateLife and for all our donations activities has to be on ensuring that more of the eligible ACT community let their wishes be known once they register on the organ donation register.

THE CHAIR: It being 3.15, I will suspend the hearing for a break. Before we go to that break, I would like to thank Minister Stephen-Smith for her attendance today. We do not see you again until tomorrow.

MRS DUNNE: You have not got out yet.

THE CHAIR: The committee will resume at 3.30 for its hearings with Minister Rattenbury. Thank you.

Hearing suspended from 3.16 to 3.30 pm.

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

Health Directorate
Moore, Dr Elizabeth, Coordinator-General, Office for Mental Health and Wellbeing
Riordan, Dr Denise, Chief Psychiatrist

Canberra Health Services
McDonald, Ms Bernadette, Chief Executive Officer
Grace, Ms Karen, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services

THE ACTING CHAIR (Mrs Dunne): Welcome. For this afternoon's session the committee will examine mental health and corrections and justice health as it relates to the health portfolios, specifically relevant parts of the 2018-19 Health Directorate and Health Services annual reports relating to mental health, justice health, the Office for Mental Health and Wellbeing and the Chief Psychiatrist. I remind witnesses of the protections and obligations entailed in parliamentary privilege and draw your attention to the privilege statement which is set out on the table. Minister, can you confirm that you have read and understood the privilege implications of the statement?

Mr Rattenbury: Yes.

THE ACTING CHAIR: Thank you. Before we proceed, would you like to make an opening statement?

Mr Rattenbury: No, thank you.

THE ACTING CHAIR: I refer you to the Productivity Commission draft report that came down last week or the week before—

Mr Rattenbury: Last week.

THE ACTING CHAIR: and in particular to the commentary that was in the Productivity Commission report about adolescent mental health and the lack of adolescent health beds in the ACT. The commentary was not specifically directed at the ACT but was quite scathing about what will happen if we do not have adolescent mental health beds. In the absence of adolescent mental health beds and given the fact that we probably will not see any until—I have forgotten: 2020-21 or 2021-22—

Mr Rattenbury: 2021.

THE ACTING CHAIR: what interim steps are in place to protect adolescents in need of inpatient mental health services?

Mr Rattenbury: We have a range of services available to adolescents, as we discussed before. It ranges the full spectrum, from the preventive work we are doing and increasing through the newly announced program the YAM, the youth and adolescent mental health service, through to the capacity to put greater emphasis on supporting young people at home. Key advice that I am being given by the agency is that an inpatient admission should be the last possible scenario. That is why we have started up the service that now goes to young people in their homes. If we can intervene in their homes, where they are generally more comfortable, the advice I receive is that that is a better way to approach it and often is quite supportive for the family as well, because the family unit is essential.

THE ACTING CHAIR: Some of the commentary in the draft Productivity Commission report did centre around what they described as hospital in the home. Is that what you would see as an essential part of the mix?

Mr Rattenbury: We need that full spectrum. That is why we are moving to build the adolescent mental health inpatient unit. But my view, and certainly the view that I have been advised of by the directorates, is that those in-home services are preferable where suitable.

THE ACTING CHAIR: When it is not suitable, when you need an admission, what happens now?

Ms Grace: In last year's budget we were provided with funding to expand our intensive home support program, as well as our consultation liaison program for young people, which operates out of the Canberra Hospital emergency department. That is in recognition that the best place for young people is at home as far as is possible.

We do currently, on occasion, need to admit young people due to an acute episode that cannot be managed in the community. There are a number of options open to us in that regard. We can admit to the adolescent inpatient unit as it currently exists within the Centenary hospital. We can admit to the mental health short stay unit and we can, on occasion, admit to the adult mental health unit. Within the adult mental health unit we have a two-bed vulnerable person suite. We would segregate that suite and care for young people in there so that we are managing the vulnerability of having young people within an adult unit.

The decision on which of those units to admit to is made by the multidisciplinary team involving both paediatricians and the CAMHS psychiatrists and is ordinarily based on the age of the young person, their level of maturity and the reason for their admission. Then the clinicians as a group will make a decision about the best place of care.

THE ACTING CHAIR: Could you indicate—and I think it is only reasonable if we take this on notice—for, say, the reporting period, the number of actual adolescent mental health admissions that you had and what their destinations were?

Ms Grace: Yes. We can take that on notice. I do not have that detail.

THE ACTING CHAIR: Thank you. Minister, the Productivity Commission is quite clear in its statement that it believes that it is completely undesirable for adolescents to be admitted to adult mental health facilities. So we are clearly behind the eight ball. My recollection is that when there was a paediatric-adolescent ward in the tower block there was at least one secure room. Is there a secure room in the—

Ms Grace: There are two rooms in the adolescent ward as it is currently configured that we routinely use to care for people with mental illness. Those rooms can be separated from the rest of the unit as it stands. They are not built to the same level of mental health specific design as the new unit will be, but that certainly is our first-line option in the interim, until we have the new inpatient unit online.

MS LE COUTEUR: I think it was the same Productivity Commission report that talked about the determinants of mental health being not just through a health lens but through housing, education, employment, transport—all of these things. How are you looking at those determinants of mental health?

Mr Rattenbury: For me, this is very much where the discussion in mental health is going, in recognising that it is much broader than the acute admission of people. That remains a very important part of the mental health response, because those people are in a significant state of crisis, but the broader spectrum is quite important.

For me, that includes things like our move to build supported accommodation. That starts to provide people with somewhere secure to live. It is a recognition that some people will have an enduring mental health difficulty. They are capable of operating fairly independently in the community but perhaps should not be left to fend for themselves. The supported accommodation model, to my mind, goes to some of those questions that you are asking, Ms Le Couteur, around giving people the most fulfilling life they can have whilst also supporting them with the difficulties they have.

MS LE COUTEUR: You are not seeing these issues as in any way causing mental health issues—that, if you have mental health issues, a lack of employment or housing will make them worse?

Mr Rattenbury: I am sorry; I misunderstood your initial question.

Dr Moore: I acknowledge the statement. You speak to the heart of the social and economic determinants of mental health issues. Part of the role of the office was to look at those determinants, work with the whole of government to reduce those adverse events and work with the community in building community resilience.

It is very much the case that, yes, we know that poorer education, poverty and difficult housing all lead to higher rates of mental disorder, anxiety and depression. Also, as the minister said, if you have a severe mental illness, you are more likely to be unemployed; you are more likely to have poor housing and less social connectedness.

MS LE COUTEUR: With the government's current work on wellbeing indicators—because most of the things that you have just talked about qualify as wellbeing indicators—is this likely to have any positive impact on mental health?

Dr Moore: It certainly brings the different areas very much to mind and allows policy to be made so that the overall wellbeing of the ACT is considered in any policy.

THE CHAIR: I have a couple of quick questions. I know, Ms McDonald, that we have spoken a little bit about this. I know that the employment of mental health staff, nurses in particular, is a difficult area. What policies and procedures do you have in place to encourage people to join us here in Canberra, which is such a wonderful city?

Mr Rattenbury: It is. The key factor, to my mind, is to produce our own. We should do some out-of-jurisdiction recruitment, and we are actively recruiting out of jurisdiction, but in terms of people wanting to work in Canberra, the people who already live here and already know that it is a great place to be are the ones most likely to stay in the long term because they will have strong roots here and the like. For me, working with our universities is particularly important to ensure that we have good pathways and that they are offering the right courses. That, for me, is probably the most sustainable, long-term plan. As we have discussed before, there is a shortage of mental health trained staff in various fields across the country. Simply seeking to recruit from somewhere else—

THE CHAIR: Is not going to answer the—

Mr Rattenbury: It can answer part of the story, but it puts us into a salary race with other jurisdictions and the like. As a smaller jurisdiction, we will ultimately lose that race. I think localised recruitment and development of our own staff is the central and most important strategy.

THE CHAIR: Are some of those strategies currently in place? Are there strategies that are being worked on with the universities here in Canberra?

Ms Grace: Yes. We have a workforce committee that has three priority areas this year. One is recruitment, so it is looking at a broad recruitment strategy across different disciplines, both nationally and internationally. We are also focusing on workplace culture and occupational violence—minimising staff exposure to occupational violence to create a better workplace environment for our staff.

The other area is strengthening graduate pathways. We are working across disciplines with a number of universities. We have a strong relationship with the University of Canberra and we co-facilitate the mental health nursing postgraduate course that comes out of UC. We are hoping that in February we will establish an allied health graduate pathway for both occupational therapy and social work within the area of mental health, in partnership with the university as well.

That will be a new program kicking off formally next year. We have worked informally this year with the universities around what that might look like. Our office of allied health is leading the development of those two allied health pathways. We already have a graduate pathway program for psychologists.

In terms of our psychiatric pathways, we have a really strong program of psychiatric training in the territory. As we move forward, we will look to ensure that we recruit

from graduates across all of those disciplines into the workforce, as well as looking for a mix. The risk of only using graduate pathways to fill vacancies is that you end up with a bit of a problem in relation to the skill mix within your workforce. We have to make sure that we take a balanced approach, so we are building from the bottom up, while at the same time attracting into the territory and bringing some skill and expertise in.

THE CHAIR: Obviously, as you have pointed out, supporting staff who are employed and offering a safe and inclusive workplace is—

Ms Grace: Yes. Absolutely, one of our top priorities this year is to ensure that our staff feel valued and safe in the workplace.

MRS DUNNE: Is training for psychiatric nurses the same as it is for nurses generally? Do they do a medical stream and add to that a psychiatric speciality or do they just train as psych nurses?

Ms Grace: In this country mental health nursing is a postgraduate course for nurses that have been generally trained. A registered nurse would complete their general training. They would go through the usual transition to practice graduate program and at the end of that program they may choose to specialise in mental health nursing and undertake a graduate diploma in mental health nursing.

MRS DUNNE: There is no career path which is just—

Ms Grace: There is no direct entry pathway in Australia at this point in time.

MRS DUNNE: Is that a deficiency? What are the pluses and minuses of that?

Ms Grace: I would have to speak personally in answering that question. Certainly, it has been highlighted by several people within my division as potentially a challenge for us. There was a time when there was a separate register for mental health nurses in Australia. That register does not exist anymore through the board. At the moment there is not any direct entry pathway into mental health nursing. There are always people who would prefer that sort of pathway. At the moment, for them, it is a graduate pathway. We are trying to encourage graduates into our service and to support them through scholarships through the office of the Chief Nurse to achieve their postgraduate qualifications with us; then hopefully they will stay.

Dr Riordan: One of the recommendations of the draft Productivity Commission report is to consider the design of a three-year entry program for mental health nursing—going back to what had previously been the system. That is one of the recommendations in the draft Productivity Commission report.

MRS JONES: Will people finish their training faster?

Dr Riordan: It would have two consequences. One consequence would be that people would do a three-year training program in mental health. It would mean that they would finish their training more quickly. The other aspect would be that those people would come out with an awful lot more experience in mental health at the point that

they finish their undergraduate training, so there are advantages in both of those ways.

MS LE COUTEUR: I want to talk more broadly about older persons mental health and allied health. It is widely reported that most people in nursing homes are somewhere between depressed and severely depressed. Do you have anything to do with older people who are not in hospital?

Dr Riordan: The first thing to say is that depression is very much a condition that has increased prevalence in the ageing population. For most people presenting in senior life with mental health problems they will get support through their GPs, as would the rest of the community. Within mental health, justice health and alcohol and drug services we have a dedicated community-based older persons mental health team.

The older persons mental health service is split into the inpatient service based at Canberra Hospital and a community-based service which is currently in the process of relocating, having been based at Calvary hospital, to the University of Canberra Public Hospital. That service consists of a very comprehensive multidisciplinary team. I think it has the equivalent of 1.8 FTE staff specialist psychiatrists, possibly also some VMO time, a psychiatric registrar and a range of nursing staff, OTs, psychologists and social workers. They work into doing home-based assessments.

A big part of their philosophy is to recognise that when you are dealing with issues related to mental health in the ageing population, where there may also be concerns and issues about cognitive decline, it is much better for those assessments to take place in an environment that a person is familiar with. The main focus of that team is doing home-based assessments and delivering care into the home. That home-based assessment would also include assessments in residential aged-care facilities.

MS LE COUTEUR: You are probably aware that the royal commission into aged care has found that an awful lot of people in aged-care establishments are chemically restrained, as they call it. Do you have anything to do with that part of the world or is that purely the commonwealth, as far as you are concerned?

Dr Riordan: It is obviously a huge area. From a psychiatric perspective I struggle with the use of "chemical restraint" as a term. I think it is much more important for us to be very clear about why we are using psychotropic drugs in an ageing population or, indeed, in any population.

Going back to first principles, none of the drugs we use to treat major mental illness, for example, like schizophrenia and bipolar disorder, are a particular treatment for that illness; they treat the symptoms that present. We get caught up in the problem whereby we are looking at what we are treating here.

If people are being treated with medications that are targeting particular symptoms that are causing them distress, that is an appropriate use of medication because you are targeting the symptoms of distress that they are experiencing, regardless of whether they have a formal psychiatric diagnosis. However, if you are wanting to just blunt those symptoms of distress so that you have somebody who is not responding then that is a problem.

It would be fair to say that the mental health team working in older persons mental health would be very skilled at looking at appropriate use of medication. Obviously we do not have any direct oversight of prescriptions that might come through primary care. Having said that, it would also be fair to say that the older persons mental health team—indeed, as I would hope with all our clinicians—would liaise very closely with primary care and help colleagues in primary care to rationalise prescribing to try to make sure that an individual is getting any of the benefits of medication that may help them whilst reducing side effects.

MRS JONES: I have a question on justice health. I understand that on the day of the emergency declaration in the Alexander Maconochie Centre some of the regular dosing stopped for the lunchtime and evening medication. Are you able to describe how many doses were missed and for how many people?

Ms Grace: The day the emergency was declared within the Alexander Maconochie Centre, there were discussions with the health centre team and corrections in relation to how we could continue to provide health services within the environment. It was determined by the clinical team that essential medications would be administered for the evening. That included insulin, all cardiac medications, clozapine and any anti-convulsants. They were administered as usual and they were the only medications that were actually administered for that evening.

Following on from there, for the duration of the emergency all medications were administered but they were administered in two medication rounds per day, instead of three. That was due to the logistical challenges of being able to continue with medication rounds as usual in the prison whilst it was under the emergency declaration.

MRS JONES: Is there a policy document that describes how medications are managed under these circumstances, or was that a first event and you were trying to work out what the best thing to do would be?

Ms Grace: It was definitely a first event; that situation had never occurred in the prison before. We have had discussions both within our team and also with corrections in terms of the need to have a debrief and ensure that the appropriate policies and procedures are in place and clearly understood for subsequent events.

MRS JONES: You spoke about essential medication, but under what circumstances is the medication to control psychological conditions not considered essential? For example, they will not immediately cause the death of a person but the withdrawal of them can cause significant distress.

Dr Riordan: That is an important point. The comment that was made about the fact that clozapine, which is a very closely monitored drugs, was being administered was really important. Most of the psychotropic medications have what we call a relatively long half-life. With just about all of them a 24-hour break in medication, which would be the maximum that people would have had, is not likely to have caused any significant harm.

If people were on short-acting benzodiazepines that might be a problem, but I would

imagine that anybody using benzodiazepines in the prison is likely to be on a longer acting one. Medications such as olanzapine or risperidone can be used in a once-daily dosage or sometimes they are used in a twice-daily dosage. That is sometimes to do with trying to maximise the best effects of the medication, so it is unlikely that anybody would have experienced very significant physiological withdrawal or side effects or discontinuation syndromes from that sort of scenario.

MRS JONES: Before you continue, can I read you something that was written by one of the inmates, saying that he was worried he would have a "flip-out". In fact, a mate inside, probably his cellmate, had stopped him from having a "flip-out". He said:

> I told staff, and I just got brushed off because apparently my meds are not life or death. It is BS.

Excuse the language. He said:

> And my meds are similar to methadone—only work for a certain amount of time, and it has worn off, and I feel like I am going to do something silly.

That is an inmate inside the facility now who was denied medications on the day that the prison was locked down. While I accept that in many cases people can survive without them, at what price, depending on the individual and the underlying conditions that are being treated? Minister, do you have any thoughts about the way this has played out?

Mr Rattenbury: Obviously we had a very unusual situation where there were significant concerns about the safety and the security of the centre. That is why the declaration was made by the executive director. The emphasis was placed on the safety and security of both staff and detainees.

MRS JONES: Minister, this detainee was worried about his own ability to stay calm, which presumably can impact on the safety and security of him and his cellmate. I just wonder if you think that a future policy would ensure that these medications continue?

Mr Rattenbury: That is a hypothetical question in some ways, in that it will depend on the circumstances.

MRS JONES: No. Maybe I should rephrase. In a regular policy document about how such an event is managed, do you think it will have or it should have the continuation of medications such as methadone replacements and psychologically responsive drugs?

Mr Rattenbury: To be clear, everybody had received methadone dosing that day. Methadone only occurs in the mornings, so methadone dosing had already occurred. That has been a change of policy in recent years to increase the safety of detainees dosing on methadone. To your broader point, I was about to go on and say that there will be review and consideration of these circumstances, and undoubtedly there will be discussions of what would happen in future circumstances.

MRS JONES: When the dosing returned or was resumed, my understanding is that

detainees were able to get their medications the day after the emergency lockdown had begun but were not able to access medical advice about how they were feeling after resuming their medications. The medical advice that I have been told they had access to was only if it was a code pink, which is, at that point in time, a life and death situation. Is that correct?

Ms Grace: I do not believe so, but I will take that on notice and get some detail around that for you.

MRS JONES: Yes. I was informed that only code pink was able to access medical advice. I would like to hear if that is incorrect. And were external healthcare providers able to access the prison during the first stage of the declaration?

Ms Grace: "External" defined as?

MRS JONES: People who come in to take appointments with people. They were not, were they?

Ms Grace: No. There was only essential health care provided during that time.

MRS JONES: Did Winnunga Nimmityjah have full and regular access? No. They did not either?

Ms Grace: Winnunga had a level of access, the same as justice health services.

MRS JONES: The same as justice health? Did any appointments occur or was advice taken from justice health other than for code pinks? Did that actually occur? Did anyone ask for it, and were they given it?

Ms Grace: I will have to take that on notice, but my understanding is that absolutely they did. We had the same arrangements in place for after hours as we have at any other time on any other day. During the entire action towards the end of last week and over the weekend, there were justice health staff within the AMC during the hours of operation that they would ordinarily be there.

MRS JONES: Were they visiting units or were they in their health centre?

Ms Grace: They had full access, as I understand it, after that first evening. The future medication rounds were provided in the same way as they would ordinarily have been, except that they were contained to two rounds during the day rather than three. But that included all medications.

MRS JONES: So some people were being given medications to take later on in the day during the second round or something like that if they had three lots of medications during the day or if they had an evening dose?

Ms Grace: I asked the question about three times daily dosing and I have been advised that it is really unusual for anyone to be on a three times daily dose, so worst-case scenario is that somebody would have received their midday dose later in the day and that would have been under the supervision of a medical practitioner.

MRS JONES: So they just would have taken it at a slightly different time in the day?

Ms Grace: Yes.

MRS JONES: All right. And any inmates who were on medications to assist with sleep were getting it at a different time to when they normally do?

Ms Grace: I do not believe so, because I believe that the two rounds were morning and evening as opposed to lunchtime.

THE CHAIR: I have a couple of question for Dr Riordan about emergency apprehensions.

Mr Rattenbury: It was always going to come up.

MRS DUNNE: We are on the wavelength today.

THE CHAIR: Yes, we are all interlinked. I note that there has been a reduction in medical practitioner emergency apprehensions. What do you call them—referrals, I guess?

Mr Rattenbury: Yes.

THE CHAIR: But there has been quite a significant increase in authorised ambulance paramedics. Can you talk us through why you think that is the case on both sides?

Dr Riordan: Yes, on both sides. Thank you for that question. I think that they are both really important questions. They are obviously things that we put our minds to. We have also done that by talking with staff within Health, the Ambulance Service and, indeed, the police service. I think that is the first thing to say about this.

I think it speaks to several things. First and foremost, I think what stands out for me is that this represents a significant increase in the number of people being able to access—regardless of whether or not they are under an emergency action—and accessing an emergency mental health assessment. I think that what has increasingly been happening since the 2015 Mental Health Act came into being in 2016 is that section 80 of the act gave ambulance officers and paramedics for the first time the authority to be able to use an emergency action to bring somebody into hospital.

I think it would be fair to say that there is an interpretation of that legislation where maybe the wording of the legislation is not as helpful as it could be. It is something that we will be looking into. The wording of the legislation—I cannot quote that particular section exactly—is of the order that if the ambulance officer or paramedic has reason to believe that an individual has a mental illness or disorder and may be at risk of harming themselves, they enact the order. It does not say anything in the legislation about whether or not that person is declining to seek assistance.

I think what has happened is that there has been an interpretation that anybody ringing for an ambulance, either for themselves or on behalf of anybody, is somebody that

needs to go under the act. We have had a couple of conversations with the Ambulance Service and on one occasion as well with the police service in relation to that. We are looking at how we can sort of work collaboratively to get a shared understanding of that interpretation.

Obviously, the definitive way of doing that is going to be to change the legislation and to put a caveat around that but that may take some time. We started some discussions with our legal advisers, most importantly with the ambulance people, with the police and, very critically, with the Mental Health Community Coalition—it has also raised this and I have spoken with them about this—to see whether we can come up with a shared understanding pending any legislative change.

The other thing I think this speaks to is the significant increase in the number of presentations to the emergency department, particularly for mental health-related presentations. That is something that is happening both nationally and internationally. So ACT is not particularly unusual in terms of the increased numbers of presentations. I think that where we are standing out is in respect of the increased use of the legislation in this way.

The other thing that has come to my attention—I think it is something that will be really important for us to explore and may also speak to why we stand out a little bit differently from other jurisdictions—is that this use of the legislation will also include ambulance or paramedic service people bringing into hospital people who are intoxicated in any way, because they may be presenting in a way that is behaviourally disturbed. That may lead the ambulance and paramedic crew to be concerned that they may be a risk to themselves or to others. So they are using the legislation in that way.

Other jurisdictions actually utilise different legislation to cover the transport of somebody in those circumstances. Again, I think that is a nuance of our legislation that we need to look at. Obviously, it is not unusual with many pieces of legislation to kind of pick up some of these things once the legislation has been up and running for a while.

MRS DUNNE: But it has been running for three or four years. We saw the numbers year on year. We saw year on year that the numbers doubled in the first instance and then increase by 500 per cent. What suddenly happened in the reporting period that had not happened in the previous two years of operation?

Dr Riordan: My understanding is that a determination was made within the ambulance and emergency services that they should apply this to everyone, whereas I think that perhaps previously there had been levels of discretion used. That is the only way I can understand it. To a degree, that is borne out by conversation with the services. But because we did not collect the data previously of where people made a different determination, it is very difficult to respond to that.

MRS DUNNE: When did the change in the operating guideline happen in ACTAS? Did it happen back in 2016 or did it happen more recently?

Dr Riordan: My understanding is that they made a determination to do this. I cannot remember the exact date, but I think that it was in this more recent reporting period.

MRS DUNNE: So there was a change in policy inside ACTAS?

Dr Riordan: I do not know whether it was done as a specific policy or as a guidance. But once we became aware of the increased figures, that was when we started trying to having some dialogue with—

MRS DUNNE: When did you notice an increase? If it has gone up fivefold, you must have started noticing it pretty early in the reporting period?

Dr Riordan: Yes, we noticed it and I had some initial conversations with the Ambulance Service and the police in I think it was probably December last year. I think it would be fair to say that we were trying to look at getting a better understanding of an almost different interpretation of the legislation. My advice was to think about interpreting the legislation based on the objective and principles of the act whereas I think that the Ambulance Service were more concerned to take the particular piece of legislation.

There has been further dialogue about that. I think that there is much more of a willingness for us to work together to kind of come up with a shared understanding. I was going to say that I think that part of what was driving the approach from the Ambulance Service was that because part of the legislation further down in the act states that if somebody is brought in under an emergency apprehension or an emergency action, that person then has to be seen within four hours in the emergency department. So I think that there was a view that if you brought people in under an act, that actually meant that people would be getting seen more promptly than they might have otherwise.

THE CHAIR: I guess that was going to be my question. Was it about looking after people—

Dr Riordan: I think it was incredibly well intentioned, for sure. I think that it has obviously had a significant impact on the workload within the emergency department in terms of an expectation that people presenting on emergency actions then have to be seen very quickly. Obviously, we try to see everybody as quickly as possible and we use the triage system to do that. But obviously in respect of somebody coming in under an emergency action, because there is a legal requirement, it has meant that there have been times when we have been in breach of the act. If at 11 o'clock at night four different people are brought in under an emergency apprehension, it is actually very difficult for them all to be seen within the same time frame. We keep data on any of those times that go over and report that back to—

MRS DUNNE: Could I try to drill down here? Of these 1,171 emergency actions, do you have a feel for how many of them were legitimate arising out of a clinical need and how much was it precautionary intervention? Do you know?

Dr Riordan: All I can comment on is the outcome of those people, so how many were put on to an emergency detention order. An ED3 is where the order has been upheld.

MRS DUNNE: Which is nearly all that number.

Dr Riordan: No, that is not the case.

MRS DUNNE: No?

Dr Riordan: I think the number of emergency detentions does not necessarily relate to the number of emergency actions. People could be put on an emergency detention order if they are already in the hospital. For example, if somebody is already a consumer in the adult mental health ward and then they are saying that they want to leave and the medical staff may think that they are not well enough to leave, because they are already in the facility they do not need to go onto an emergency action. They can be put straight onto an ED3.

MRS DUNNE: The 2,059 emergency apprehensions does not necessarily bear any relationship to the 1,056—

Dr Riordan: No.

MRS DUNNE: ED3s over the page or the 499 extensions?

Dr Riordan: My understanding is that 16 per cent of the people brought in under the emergency actions had those emergency actions upheld into an ED3.

MRS DUNNE: So 16 per cent of the whole 2,059?

Dr Riordan: Yes.

MRS DUNNE: Right.

Dr Riordan: And the other people were assessed and it was felt, based on those assessments, that they were willing and keen to accept treatment voluntarily, that they were willing to come into hospital voluntarily or that they did not need a hospital admission and were very willing to accept care in the community without the need for a legal requirement.

MRS DUNNE: Could the committee draw from this—I do not want my language to appear critical but there has been an up-tick because of a zealousness in a part of the community to ensure that they are compliant with the law and are assisting people in distress—that that has had a knock-on effect through the acute mental health system?

Dr Riordan: I think it would be absolutely fair to say that there has been a more literal interpretation of the legislation than perhaps had been anticipated. I think that that has absolutely been very well intentioned. It has meant that people have been getting an assessment when they need it.

I think it would also be fair to say that the significant increase in the emergency actions will have put a pressure on the staff in the emergency department to do things in a time frame that might have been different to what they would have been doing otherwise, which is not to say that we would be thinking, "If somebody is not on an

emergency, that is okay; people can just wait."

From a clinical perspective, the feedback I have had from my colleagues in the emergency department is that clinicians have often been left with the challenge that there may be somebody in the emergency department who is there as a voluntary client and who may be more unwell than somebody who is brought in under an emergency action. Then they have had to use clinical judgement to determine whether they prioritise clinical need versus legislative need.

MRS DUNNE: I want to touch on the ACT branch of the college of psychiatrists' issues in relation to psychiatry workforce shortages and their ongoing concerns about the psychiatry workforce. It is comforting, in a way, to know that other people have been saying the same things. It is also at the same time not very comforting to come to the conclusion that we have a bit of a problem.

We have touched on workforce already but this is specifically about the psychiatry workforce. Is it the case, as has been reported by the college, that there are issues with staff not being able to take leave and the like and that there is still a significant undersupply of psychiatry staff? Seeing that the college has been raising this with you for some time, what actions had you taken before they went public?

Mr Rattenbury: The comments you are referring to are in their budget submission for this year. I am aware of some of those issues. It is fair to say that some of the points raised in the submission are contested.

MRS DUNNE: Which bits are contested?

Mr Rattenbury: Dr Riordan will speak to that in detail.

Dr Riordan: Obviously the letter raised a significant number of points. I suppose I should declare a conflict of interest here and say that I am also a fellow of the Royal Australian and New Zealand College of Psychiatrists and I am a member of the branch but I had not been aware of the letter until it was sent to me by email—just to clarify that.

You mentioned particularly the issues about recruitment, access to study and training and various other points in the letter. Is there any particular order you want me to address them in or do you just want—

MRS DUNNE: Take it from the top.

Dr Riordan: One of the comments raised in the letter was a statement that there has been only one staff specialist working at the adult mental health unit in routine business hours. I can assure the committee that the usual staffing ratio is to have one clinical director, four staff specialists and four registrars during business hours, along with additional support for RMOs. I think that what the person may have been referring to was a suggestion that there was only one permanent staff member in the—

MRS DUNNE: That was my understanding of it.

Dr Riordan: That is also not correct. For most of this year we have had two or three permanent staff members, and that continues to be the case at the moment. Where we have been using locum staff it would be very fair to say that that has shifted significantly from what was happening previously and, I think, particularly prior to my joining the ACT, which is that we have had very long-term locums. We have had people who have been doing locum posts with us for periods of six, nine months at a time. They prefer to work in that way, for a variety of personal reasons, but we certainly do not have the churn of staff specialists going through there as had been the case previously.

MRS DUNNE: At the moment what would be the ratio? How many permanent staff do we have and how many locums are we employing?

Dr Riordan: At the moment we have three permanent staff. We have two staff specialists—I am sorry, I am just trying to remember the exact numbers—who are working there and then a third permanent staff member who is currently on maternity leave.

We have a locum who is the clinical director. He has been in the post for about 10 months. We have substantively appointed to that post. The person who will be taking up that post permanently is currently overseas. He is one of our graduates. He has been overseas with his partner's posting. He will be taking up that post permanently in February. That will mean that we will have three staff specialists plus a clinical director who will be permanent.

MRS DUNNE: But you are supposed to have a clinical director, three staff—

Dr Riordan: A clinical director, four staff specialists, plus four registrars.

MRS DUNNE: But that is on at any one time; so you need more than that, do you not, to fill the gaps?

Dr Riordan: Sorry. I do not—

MRS DUNNE: That is what is rostered on. They are not rostered on seven days doing that?

Dr Riordan: No. That would be the normal complement of staff, business hours, Monday to Friday. That is how many people we would have.

MRS DUNNE: Plus registrars.

Dr Riordan: Yes; four staff specialists, four registrars and two RMOs who would be the more junior doctors who would help particularly in relation to physical healthcare of consumers on the ward. All this year we have had that number of staff on the ward floor during business hours.

MRS DUNNE: A significant proportion of them, more than half, have been locums, albeit longish term locums?

Dr Riordan: Yes.

MRS DUNNE: We have no registrars. Does that mean we are not training?

Dr Riordan: Sorry, the registrars are not locums. That is the staff specialists. The four registrars that we have—

MRS DUNNE: There are four registrars?

Dr Riordan: There are four registrars. With registrars, it is a little different and, I guess, reflects what Ms McDonald was saying earlier about the training programs. They would not be permanent staff members but they would be predominantly registrars who are trainees under the college training program.

MRS DUNNE: If there has not been staff continuity and you have not had a permanent clinical director, what impacts does that have on training?

Dr Riordan: The impact on training is a very different issue. All our locums are accredited as supervisors within the college. Just in August this year we had a college accreditation visit. The royal college does accreditation of training schemes. The draft report of the college accreditation visit came out in August just for clarification of details, but the conclusion of that report describes a training program that is mature and impressive, delivering a positive education and training experience for trainees.

MRS DUNNE: When was that?

Dr Riordan: That was in August this year. The college accreditation visit took place in August this year. It also talks about the comprehensive range of experiences; that all the mandatory experiences in basic training are offered; that the training program is well organised, locally delivered; and that the formal education program is highly valued by trainees. It describes good trainee morale and that trainees were positive about the support they received from the director of training and from supervisors.

MRS DUNNE: There seems to be a disconnect between that and what the ACT branch of the college says:

> The … Branch has significant concerns about the effect on trainee psychiatrists of the ongoing workforce shortages. Trainees are at risk of burnout from prolonged, increased workloads. The greater workload also impacts on trainees' ability to receive adequate supervision and support.

That was written in February.

Mr Rattenbury: That submission probably would have come in about August-September as well.

Dr Riordan: Yes. The submission would have been written by the same—

MRS DUNNE: The budget submission came in in August. So at the same time you have two areas of the college saying quite contradictory things.

Dr Riordan: Absolutely.

MRS DUNNE: Have you sat down and talked to the college about squaring that circle?

Dr Riordan: We just got the letter last week from the college. We have arranged to have a conversation in the first instance with the division of psychiatry, which is all the psychiatrists working within the service. Karen Grace, the executive director for the division, and I have a meeting scheduled to have that conversation next Wednesday. We have also planned, but have not yet scheduled in, that the executive director and I will invite Professor Looi to a conversation to discuss the concerns he has raised.

I think it would also be fair to say that Ms Grace and I did meet with Professor Looi—forgive me; I cannot remember the exact date—in late May or early June. We had a conversation with him. He raised some of the concerns in this letter. We described to him the plans that were in place. We invited him to make direct contact with us if he had any further concerns. He has not done that at this point in time. Obviously he has written to you, the letter that you have.

MRS DUNNE: But you are undertaking to have a conversation with Professor Looi and the college about their concerns?

Dr Riordan: Absolutely, yes.

MRS DUNNE: This is by no means unimportant, but I do note that there is also discussion about a recommendation that there should be a perinatal mental health unit in the Centenary hospital. We have never had inpatient perinatal mental health beds. What is the thinking about that?

Dr Riordan: My understanding is that in the past there have been mothers and babies admitted jointly to 2N at the Calvary hospital, but that has been on an as-needed basis as opposed to a kind of well-developed service. We have a perinatal community-based service, and that has grown over the years to have more staff—specialist, registrar, allied health and nursing—input to it.

In relation to the need for a perinatal inpatient service, that is not something that I have looked at specifically as an issue here in the ACT and I am not sure that that is something that is part of the ongoing discussion at this point in time. Like what has been described, we have been focusing a lot more on delivering community-based services.

The point that you make is an important one, because I did note that in the Productivity Commission report that was an area that was raised as a cause of concern. I am sure it is something that we will be looking at.

MRS DUNNE: Regularly, but not on a frequent basis, I come across young mothers who have gone interstate for residential care because there is no service provided here. That is extraordinarily disruptive and traumatic in itself.

Dr Riordan: Sure.

MRS DUNNE: Do we keep records of that? Can we quantify the number of people who go interstate?

Dr Riordan: It is very difficult for us to do that, because they are not necessarily going to be people who have accessed our service. For example, it might be that they have seen either a local psychiatrist or their GP privately. I am aware of a couple of psychiatrists within the ACT who work in the private sector who have a special interest in perinatal mental health. They may have made those arrangements for people to go interstate, but that data would not be something that we would have access to.

MS LE COUTEUR: I understand that a lot of work has been done to try to reduce the amount of time in emergency for people who present with mental health issues. Assuming I am correct, would you like to walk us through what you have done?

Ms Grace: Certainly; it would be my pleasure. To set the scene a little, I will give some statistics in relation to emergency department demand over time. Since 2014-15 we have seen a 137 per cent increase in presentations to the Canberra Hospital emergency department with mental health.

MS LE COUTEUR: That is 137 per cent since 2014?

Mr Rattenbury: In five years.

Ms Grace: Yes, since the 2014-15 year. During the year in review, we saw 4,670 patients presenting to the Canberra Hospital emergency department with mental health type presentations. Of those, 1,645 were subsequently admitted to one of our inpatient units, 35 per cent of all presentations. The average bed block time during that year was 11.2 hours for people with mental illness who were waiting for an admission.

MS LE COUTEUR: That is someone who has turned up at ED, been through triage and been told, "Yes, you have an issue; we think we should admit you."

Ms Grace: Yes.

MS LE COUTEUR: They then have 11 hours until they actually get to a bed. Is that right, just to be clear?

Ms Grace: Yes. What we have seen, though, in the first quarter of this year compared to the same quarter last year is a 24 per cent reduction in that number. We believe that that is an indication that some of the strategies that I am about to talk about in practice are actually starting to have an impact.

In terms of what we have done, in May of this year we implemented a territory-wide patient flow coordinator role. That was introduced as a project position to look at how we could get a better understanding across the territory of our bed capacity. That

includes 2N and older persons at Calvary hospital as well as the adult mental health rehabilitation unit in UCH.

The role of that coordinator is to be the conduit between the emergency department and all of those inpatient areas across the territory in terms of identifying people who need to be admitted and the best place for that admission to take place, and then to work out how we can get them to the most appropriate bed. Sometimes that might mean that we need to look at options to transfer other people. For example, if we need a bed in the high dependency unit, we might need to look at whether there is anybody suitable for less high level care, either in a lower dependency unit or in 2N at Calvary, for example. That is the first initiative. That has been running now, as I said, since 1 May and will continue in place.

We have also introduced a five-bed subacute pod in the adult mental health rehabilitation unit out at the University of Canberra Hospital. That hospital opened a year ago in July, as you would be aware, and the rehabilitation unit opened at that time. Over time, with a three to 12-month admission model of care, we had seen a number of people transition out of the rehabilitation unit into the community. At about July time we realised that we have the potential to use those beds for something a bit different.

We had also received some feedback from the Official Visitor around people in the adult mental health unit who were only there because there were barriers to discharge for some people. Keeping them in a restrictive environment was not necessarily in the best interests of those individuals. What we have done is develop a bit of a pilot around segregating one of those pods. The rehab unit comprises four distinct five-bed pods. Since August one of those pods has been used for subacute patients and has remained full since that time. The benefit of that is that it gives a less restrictive environment for people. It also provides them with access to the day program that exists at the rehab unit, so it helps to facilitate transition back out into the community. And the allied health teams attached to both the inpatient and outpatient units can help to work through some of those blocks to discharge within a slower paced environment where there is not so much pressure on beds.

We have introduced a dedicated full-time consultant psychiatrist to the emergency department. We refer to that as "managing the front door". On Monday to Friday during business hours we have a dedicated consultant who can provide timely assessment of people presenting and make fairly quick decisions in relation to what the plan of care for that individual should be. Previously, that role had been the responsibility of one of the registrars, so it is having the seniority in the emergency department. That person is also permanently located in the department, which has helped with relationships with the emergency department consultants and building the relationships between mental health and the emergency department.

We have established regular meetings with the Justice and Community Safety Directorate, which includes the emergency services, to address the issues we have already heard outlined by Dr Riordan in relation to emergency actions. The other area that we are discussing through that group is around the management of section 309 assessments from the courts. Some people are referred to us from the court for a full mental health assessment; we are working with the courts on what our options are

in terms of those assessments.

Because the Canberra Hospital is the only gazetted emergency department in the territory, all people who are brought in under the Mental Health Act or under—

MS LE COUTEUR: Have to go there.

Ms Grace: Yes. People who are brought in for section 309 assessments need to be brought to the Canberra Hospital emergency department.

The other thing we have done is create a four-bed area in one of our inpatient units. We have a plan to do full ligature minimisation work within that space. Currently, when we admit to those beds, they are our surge capacity for mental health. A standard process within any clinical service area within the hospital is to have surge beds for busy periods. In mental health, that is difficult because of the nature of the types of spaces that we need in terms of facility design. We are working with the division of medicine within Canberra Health Services around making a more purpose-built pod for that purpose.

In the interim, we are managing admission to those beds by careful selection of patients based on criteria and also by increasing the staffing profile for that four-bed pod so that we can ensure that we have good observation of people while they are there.

That is a bit of an overview. We are also developing a business case for next year's budget to look at more medium-term and long-term solutions to help to address the capacity issues that we are experiencing.

MS LE COUTEUR: You said that typically there was an 11-hour wait from when it was determined that someone should be admitted to when they are. What happens during that 11 hours?

Ms Grace: We have a number of areas within the emergency department where people can be safely cared for. We are confident that everybody within the emergency department that has to remain there for a significant period is safe and in the best environment we can provide. For example, if we had fairly high numbers, we might segregate a bay within the emergency department and staff accordingly. It is similar to the tower block solution—we would cordon off an area of the emergency department and we would staff it appropriately to ensure that those patients were cared for safely.

MS LE COUTEUR: They would basically be admitted into the emergency department but not their final destination.

Ms Grace: Yes; eventually they would be transferred to their final destination, but they would need to stay within the emergency department until there was an appropriate bed available. Some of those delays are caused by the location of the acute mental health unit being at the other end of the campus. We have to use motor vehicle transport to transport people from the emergency department. If people require a significant amount of sedation, for example, in the emergency department, we would need ambulance transport. Sometimes that can impact on the time frame as

well. A number of different variables in each individual's presentation add to some of those time frames.

MRS JONES: For how many nights in the reporting period did we have over 300 presentations at the emergency department?

Ms McDonald: How many nights or how many days?

MRS JONES: How many 24-hour periods.

Ms McDonald: I would have to take that on notice because it is quite variable. We have had some where we have been over 300.

MRS JONES: Which unit is the one where the four-bed spillover is available?

Ms Grace: It is on level 7 of the tower block. Currently that is the ward where people with a mental health condition who have not been medically cleared would be admitted anyway.

MRS JONES: What is the unit called?

Ms Grace: It is 7B.

MRS JONES: As to the timings of the lockdown, I am trying to get clear the nature of what has occurred over the last six days. I understand the hole in the perimeter fence was made on Sunday but not discovered until Monday.

Mr Rattenbury: Correct.

MRS JONES: I also understand that a section of the prison was initially emptied and then searched, but then the decision was taken on the Wednesday to go into the emergency section 26 lockdown.

Mr Rattenbury: Correct.

MRS JONES: Why did it take that long for all those things to occur? The lockdown obviously affected everybody and everybody's medicines, as we have heard. The hole in the fence was found on the Monday but 5 pm on Sunday is when the alarm went off. What occurred during the time the alarm went off and the hole was found? Are you aware?

Mr Rattenbury: That is the subject of internal management review by Corrective Services at the moment. Until that report is completed I do not intend to speculate on those outcomes.

MRS JONES: So they do not know yet?

Mr Rattenbury: They are gathering the evidence at the moment so that they can draw a conclusive view rather than a speculative view.

MRS JONES: The section of the prison that was cleared to be checked, was that the cottages?

Mr Rattenbury: I believe so, yes.

MRS JONES: Is there an issue with the security of the cottages overnight, where people are getting out into the grounds?

Mr Rattenbury: Not that I am aware of. These are obviously matters for Corrective Services. But I have no knowledge of any problems in that regard.

MRS JONES: When were justice health or other Corrective Services staff briefed on the security breach and the hole in the fence being discovered?

Mr Rattenbury: Given that you want a view specific answer we will take that on notice.

MRS JONES: Did that briefing include specifics of what was being done in the facility regarding the searching and what they were searching for?

Ms Grace: I can answer from Wednesday, when the emergency was put in place, but I am not sure about the timing of what happened prior to that. We will take that on notice and we can provide that. On Wednesday the staff were advised that the executive director of corrections had enacted section 26. We were advised that the prison was in lockdown and that there would be limitations in accessing the prison and detainees. We were advised that the entire prison would be searched. Not all the staff at that time were advised of any further detail than that.

MRS JONES: Was the medical centre searched as part of the search operation?

Ms Grace: I will have to take that on notice. I would assume so, but I could not say for sure.

MRS JONES: Did fewer staff attend the facility during that time or were the same staff sitting there in the medical centre as per usual?

Ms Grace: We redeployed some staff because we were only able to provide essential services within the prison. Staff were deployed to both 1 Moore Street and Bimberi.

MRS JONES: The advice to staff you mentioned when section 26 was enacted on the Wednesday, was that given after the emergency declaration or before it?

Ms Grace: I will take that on notice; I am not sure of the exact timing.

MRS JONES: Are our health staff protected by people who have any training in how to deal with unauthorised weapons in the facility?

Ms Grace: All health care provided during that time was with corrections officers.

MRS JONES: No, I mean as a standard procedure in the medical centre are only the

medical staff there or are there people to assist if weapons or other items are found in the medical facility at any point in time? Is someone trained on how to handle that situation?

Ms Grace: There are always corrections officers in the health centre.

MRS JONES: It is my understanding that corrections officers are not trained in how to deal with weapons or firearms that are found.

Ms Grace: I would not be sure about that.

Mr Rattenbury: That is a surprising assertion, Mrs Jones.

MRS JONES: Not my assertion, but yes. I am happy to detail more, if you like.

MRS DUNNE: Could we move to questions about Dhulwa?

Mr Rattenbury: Yes, of course.

MRS DUNNE: Who is on the admission panel for Dhulwa, and what matters does the panel consider when deciding whether a person who is subject to a psychiatric treatment order, that is not a detainee, is admitted to Dhulwa?

Dr Riordan: Obviously, Dhulwa provides a secure mental health facility, and it was always designed to take both civil patients and detainees. Some of those civil patients will be people who are under the Mental Health Act. As far as I am aware, we have not ever had anybody who is not under the Mental Health Act who was not a detainee who has gone there.

There is a careful assessment process of civil patients who may present because they are being detained—so they have been cared for in the adult mental health unit and there is a concern that their therapeutic needs are not being met there and they may need that more complex interplay of both environmental containment and the relational and therapeutic containment that they require.

Our admission panel sits. The clinical director, the operational director and the unit manager would make up the admission panel. They would invite other people who may be involved in an individual's care to contribute to that assessment process. They do use a formalised structure tool, which is something called the Dundrum. Please do not ask me what Dundrum stands for. It might actually be—

Ms Grace: It is a place in Ireland.

Dr Riordan: I was going to say that I think it is the name of the place where it was first established.

Ms Grace: It is a hospital.

Dr Riordan: It is a very structured, forensically driven assessment of somebody's needs and the risk that they may potentially pose to themselves, to other individuals

and to the community as a whole.

MRS DUNNE: It is not axiomatic that if you are under an order, you would go to Dhulwa?

Dr Riordan: No, not at all. The vast majority of people who are treated under the Mental Health Act are treated either in the community or at the adult mental health unit, AMHU, or the older persons unit. Very few people would be transferred from the adult mental health unit, for example, to Dhulwa. The majority of people going to Dhulwa would be people who were detainees.

MRS DUNNE: Is there a policy to keep, as you described them, civil patients segregated from detainees?

Dr Riordan: No, that is not a policy of that unit. As a more full answer to your question, it would be fair to say that there are times when detainees may need to have their mental healthcare needs met in the adult mental health unit; so not all detainees who require mental health care will get it at Dhulwa. Some detainees will still come to the adult mental health unit. They would be nursed and cared for within the high-dependency unit, with other clients who are in that unit.

MS LE COUTEUR: Auditor-General's report No 6 of 2017, in recommendation 2, talked about better recording of patient information in MHAGIC. Has this better procedure on record keeping been beneficial for mental health patients?

MRS DUNNE: Has it been implemented?

MS LE COUTEUR: Okay, sorry; you are slightly more cynical than me.

MRS DUNNE: No, something that PAC is interested in is going through Auditor-General's reports to see what has been implemented.

MS LE COUTEUR: Has it been implemented and, if so, did it work well?

Ms Grace: We have a new version of MHAGIC called MHAGICR. Overseeing MHAGICR is an advisory committee. The advisory committee make recommendations in relation to any improvements to the record and/or forms contained within it. The system goes through a regular process of enhancements and improvements in terms of the way information is recorded and is able to be pulled out of the system. As far as I am aware, that recommendation has been met through the implementation.

MS LE COUTEUR: In meeting it, have there been any actual improvements for mental health patient care?

Ms Grace: The main improvement would be that, across the whole division, there is easy access to any patient's records. Any place that you receive care across our division, whether it is in the AMC, our alcohol and drug service or any of our mental health services, has access to the complete medical record; it is available to everybody.

We also provide access to Calvary. Calvary also are able to view the electronic record. Any other service provider, including the adolescent ward within the Centenary hospital—as I said earlier, they sometimes admit adolescents with mental health conditions to the adolescent ward—also has access to the system. It is fair to say that there have been some significant improvements in terms of the completeness of the record and the availability of it to any healthcare professional where a person seeks assistance.

MRS DUNNE: Elsewhere in the Health Directorate annual report some of the reporting on government responses was a bit on the opaque side, but I cannot find it, so I will not go there at the moment. It may not actually relate to mental health.

THE CHAIR: Mrs Dunne, do you have a quick question?

MRS DUNNE: I have a quick question. Typically, what conditions and circumstances would the ACAT take into consideration when it is making orders in relation to ECT?

Dr Riordan: The commonest disorders for which ECT would be used would be major depression, often with catatonic features. Those are particularly likely to occur in elderly patients. We would actually utilise ECT more for our senior population, perhaps, than for other populations. Psychosis that is proving unresponsive to medication treatments would be the other main group. Interestingly, and linking to the question you raised earlier about perinatal services, puerperal psychosis or major depressions that are associated with that also tend to respond quite well to ECT.

Although ECT has a reputation in some areas as being quite an intrusive procedure, the benefits of ECT are that you can get much quicker responses to treatment. Although, obviously, they have side effects, particularly if you are thinking about the elderly population or women who have just had babies, and particularly if they are wanting to breastfeed, you are weighing up the benefits of ECT versus the risks of having medications which may then lead to increased side effects.

Ms McDonald: Ms Cody, before we end, to save answering a question on notice, there was a question about how many days Canberra Health Services had presentations to our ED greater than 300. There were four days when we had presentations greater than 300.

MRS DUNNE: Four days in the reporting period?

Ms McDonald: In the reporting period. Those four days all happened in this calendar year, but it was in that reporting period.

THE CHAIR: Before closing the public hearing, I have a number of administrative matters to highlight. When available, a proof transcript will be forwarded to witnesses to provide an opportunity to check the transcript and suggest any corrections, should they be required.

In relation to all proceedings heard today, I would like to advise members and witnesses that answers to questions on notice should be provided to the committee secretariat within five business days after receipt of the proof *Hansard*, with day one

being the first business day after the proof *Hansard* is sent out by the committee office.

All non-executive members may lodge questions on notice, which should be received by the committee secretariat within five days of this hearing. Responses to questions on notice should be provided to the committee office within five business days of receipt of the question, with day one being the first business day after the questions are sent to ministers by the committee secretariat. I would like to thank Minister Rattenbury and officials for appearing. I will now close the hearing.

The committee adjourned at 5 pm.