*Estimates - QTON No. E17- 501

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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- 3 JUL 2017
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COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Ms Bec Cody MLA on 26 June 2017: Doris Gibb took on notice the following question(s):

Ref: Hansard Transcript 26 June 2017 PAGE 114

In relation to: Service Standards

Ms Cody How long does it take to do a full investigation into complaints? ... is there some sort of average or is there a procedure that you have in place that recommends certain lengths of time for certain inquiries.

ACT Ombudsman The answer to the Member's question is as follows:–

Approaches to the ACT Ombudsman's Office are categorised by the complexity and degree of effort to finalise. Each category has a service standard for time taken to completion.

The table below sets out the description of each category and the service standard.

Category	Description	Service Standard
1	Involves a single telephone call or in-person approach. Resolved without investigation. Limited data entry required	3 Days
2	Involves the assessment of all approaches received in writing. Includes approaches where further assessment is required. An agency may be contacted to obtain publicly available or 'open-source' information	14 days
3	Investigation involving contact with the agency – generally resolved with one substantive contact with the agency in relation to the specific complaint	90 days
4	Requires further investigation. More than one substantive agency contact. Sensitive or complex complaints. Allows for use of coercive powers	180 days
5	Approaches that cannot be resolved at category 4. Use of formal reporting (s 15)	365 days

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: [signature] Date: 3 July 2017

By the Acting Deputy Ombudsman , Doris Gibb

*Estimates - QTON No. E17-502

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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ANSWER TO QUESTION ON NOTICE

Mr Wall MLA to ask the Minister for Education and Early Childhood Development:

Reference : Expenses associated with infrastructure and captial initiatives – 2017-18 Budget Paper 3, Page 93, ETD Budget Statement F, pp. 8-9, 11-12

1. What is the status of upgrades or plans to upgrade:

   a) Miles Franklin School?
   b) Aranda Primary School?
   c) Southern Cross Pre-School?
   d) Harrison School?
   e) Ngunnawal Primary School?
   f) Neville Bonner Primary School?
   g) Giralang Primary School?
   h) Red Hill Primary School?
   i) Narrabundah Pre-School?

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Minister Berry: The answer to the Member's question is as follows:–

a) Miles Franklin School – no capital works have been recently undertaken or are planned for the coming year;

b) Aranda Primary School – two toilet blocks were upgraded in 2016-17 and a new transportable classroom is planned for 2017-18;

c) Southern Cross Early Childhood School – no capital works have been recently undertaken or are planned for the coming year;

d) Harrison School – a new two storey building with eight learning spaces was constructed this year;

e) Ngunnawal Primary School – no capital works have been recently undertaken or are planned for the coming year;

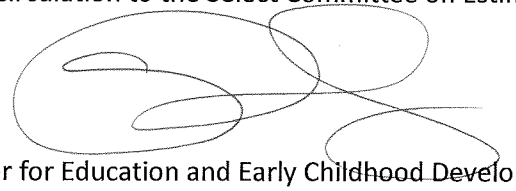
f) Neville Bonner Primary School – two kindergarten rooms were converted into preschool classrooms and two transportable buildings (four classrooms) were delivered for the start of 2017 school year. A further two transportable buildings are planned to be delivered for the start of 2018;

g) Giralang Primary School – two student toilet blocks are currently in the process of being upgraded and a conservation management plan was developed for the school over 2016-17. The first stage of conservation works in the school hall are planned for 2017-18;

h) Red Hill Primary School – no capital works have been recently undertaken or are planned for the coming year; and

i) Narrabundah Early Childhood School – the boundary wall with the adjoining residential development was replaced during 2016-17, the development of an appropriate cultural space as part of the Education Reconciliation Action Plan is planned for the coming year.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:  Date: 12/07/17

By the Minister for Education and Early Childhood Development, Yvette Berry MLA

*Estimates - QON No. E17-503

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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17 JUL 2017
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ANSWER TO QUESTION ON NOTICE

Andrew Wall MLA to ask the Minister for Education and Early Childhood Development:

Reference: Works in Progress – 2017-18 Budget Paper 3, Page 199, ETD Budget Statement F, pp. 7, 11-12

In relation to the ACT Government's commitment to improve ICT in schools:

1) How much of the $24 million is being invested in improving ACT Government (i) primary schools, (ii) high schools and (iii) secondary colleges' ICT?

2) How will this $24 million make a tangible difference to the way NAPLAN tests will be rolled out online in the future?

3) How many instances of technical issues were experienced in ACT Government and non-Government schools during NAPLAN online trial in 2016?

    a. What was the nature of these issues?

Minister Berry: The answer to the Member's question is as follows:

1) The $24 million for this 2015-16 Budget initiative is not allocated by sector.
2) ACT government schools are ready for NAPLAN Online as much of the groundwork to ensure it can be delivered effectively and efficiently was completed in previous financial years. Over the last three financial years network upgrades have been completed to make sure schools have reliable access and the network can support the full load of ACT students taking the test.
3) Over the 10 day test period issues were reported at 11 schools of 115 involved in the test.
    a. Disruptions in seven schools related to device issues (screens freezing, low battery, headphones not working properly) and the disruptions in four schools related to network issues.

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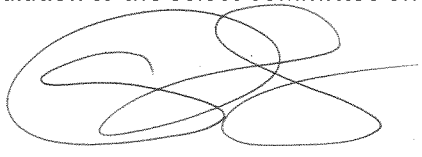
Signature: 

Date: 14/07/17

By the Minister for Education, and Early Childhood Development , Yvette Berry MLA

*Estimates - QON No. E17-504

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Andrew Wall MLA to ask the Minister for Education and Early Childhood Development:

Reference: Better schools for our kids – Safe workplaces for teachers, educators and support staff – 2017-18 Budget Paper 3, Page 70, ETD Budget Statement F, pp. 8-9, 11-12

1) How many instances of violence were recorded last year between (i) two school staff members (ii) school staff member and student (iii) parent and school staff member and (iv) two students?

    a. How many of these instances relate to sexuality, gender identity, race or religion?

2) How many instances of non-physical bullying were recorded last year between (i) two school staff members, (ii) school staff member and student (iii) parent and school staff member and (iv) two students?

    a. How many of these instances relate to sexuality, gender identity, race or religion?

Minister Berry: The answer to the Member's question is as follows:

1) In Financial Year (FY) 2016-17 there were no reported instances of violence between staff. As of 30 April 2017, there were a total of 1,068 reported incidents of occupational violence in schools for FY 2016-17, compared to 674 in FY 2015-16. This figure includes incidents involving students and parents/guardians. Lower levels of aggregation are not readily available.

    a. The Directorate occupational accident incident database does not capture data with the details requested in question 1a.

2) In FY 2016-17 there were two active cases of alleged non-physical bullying between staff and one active case of alleged non-physical bullying between staff and students. Reports of bullying between students and by parents/guardians are a matter for individual schools and these records are not held centrally.

    a. The Directorate's internal database does not capture data with the details requested in question 2a.

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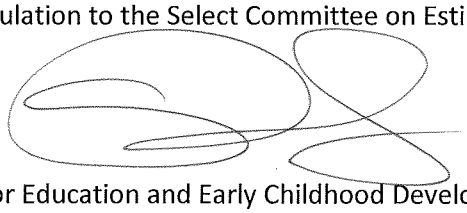
Signature:  Date: 12/07/17

By the Minister for Education and Early Childhood Development, Yvette Berry MLA

*Estimates - QON No. E17-505

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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COMMITTEE SUPPORT

QUESTION ON NOTICE

Ms Nicole Lawder MLA: To ask the Minister for Planning and Land Management

BHH Strategic Indicator 3.1 p 14: Deliver light rail and integrate light rail with buses

In relation to: Light rail contracts

1. How many local companies have been awarded contracts for work on Light Rail Stage 1?
    a. What value of work is this?
    b. what is the value of the work awarded to ACT companies compared to the value of contracts awarded overall for Stage 1?
2. How many ACT based companies have been unsuccessful in bidding for Stage 1 work?
    a. What value of work have they missed out on?
3. What loading is given to ACT based companies in the tender process?
4. How are you going to make sure ACT companies build capacity to enable them to participate more in Stage 2 and future stages if they cannot win work on stage 1?
5. How does awarding contracts to out of state contractors bring a benefit to the ACT community?
6. Have the MBA or any other body engaged the government to seek clarification as to why ACT companies are missing out on Stage 1 work?

Ms Meegan Fitzharris MLA: The answer to the Member's question is as follows:–

1. As at 31 May 2017, 127 of the 221 work packages that have been released have been awarded to local ACT companies.
    a. Canberra Metro cannot provide this information – commercial in confidence; and
    b. Canberra Metro cannot provide this information – commercial in confidence.

2. Canberra Metro cannot provide this information – commercial in confidence.
    a. Canberra Metro cannot provide this information – commercial in confidence.

3. Canberra Metro has a standard procurement process that it follows which applies to all tender processes.

4. The Territory will continue to investigate options to support local business as part of the planning for Stage 2 such as the Local Industry Participation inclusions in the Stage 1 agreement.

5. Awarding contracts to companies outside of the ACT benefits the community by bringing additional revenue into the ACT along with specialised expertise in light rail construction and operation.

6. No

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:

Date: 17/7/17

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QON No. E17-506

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION ON NOTICE

Ms Nicole Lawder: To ask the Minister for Planning and Land Management

Ref: EPSDD, Budget Paper E, Page 24

In relation to: Pialligo Master Plan

1. Has there been any capital works undertaken to implement the recommendations outlined in the Pialligo master plan

MICK GENTLEMAN: The answer to the Member's question is as follows:–

The Pialligo Master Plan (2013) recommendations improved pedestrian connectivity and safety upgrades in Pialligo and the surrounding area. In this respect, capital works that have been completed in 2016/17 include a new footpath that links Beltana Road to the Canberra Airport pedestrian network and the Canberra Airport shared path.

Additionally, a main stormwater culvert under Beltana Road will be upgraded this financial year to improve stormwater flows and flood prevention in Pialligo.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: MG Date: 17/7/17

By the Minister for Planning and Land Management, Mick Gentleman

*Estimates - QON No. E17-507

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Ms Nicole Lawder: To ask the Minister for Planning and Land Management

Ref: EPSDD, Budget Paper E, Page 6

In relation to: Reviewing the Territory Plan

1. Does the Government have any intention on reviewing the territory plan as a whole using a holistic approach?

MICK GENTLEMAN: The answer to the Member's question is as follows:–

The *Planning and Development Act 2007* requires the planning and land authority to consider, at least once every five years, whether the territory plan should be reviewed. This consideration is due in 2018. If a review was undertaken, a holistic approach would be used.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 12/7/17

By the Minister for Planning and Land Management, Mick Gentleman

*Estimates - QON No. E17-508

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION ON NOTICE

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

Ms Nicole Lawder: To ask the Minister for Planning and Land Management

Ref: EPSDD

In relation to: FOY Group Inquiry policy

1. Under the Planning and Land Development Act 2007 (s233, p 287) the government can recover direct and indirect costs for an Inquiry Panel from a proponent:
    a. Does the Government intend to recover the cost of the Inquiry Panel from FOY?
        i. if not, why not?
    b. What is the process by which a decision is reached not to recover the costs of an Inquiry Panel?
    c. Who made this decision in this instance?

2. How much did the Inquiry Panel cost the ACT?
    a. Direct costs – principal's time and materials and secondary reports?
    b. Indirect costs – staff support by ACTPLA?
    c. Other costs not listed

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1. Although there is capacity for the ACT to recover costs associated with the inquiry, the ACT determined that in this case it was not reasonable to do so. The reason for this is that the Government was keen to be sure that this new technology would be suitable for the relevant site, and other industrial sites, and, if so, what conditions would need to be considered for a proposal. The panel's report provides guidance that extends further than the Foy Group's proposed development. In addition, the FOY Group was previously asked to pay for the independent review of the EIS undertaken during the planning and land authority's assessment of the draft EIS.

2. The costs of the inquiry were approximately $91,000. This cost included the high level expertise provided by the panel to investigate a proposal of this nature and also expert opinions from external consultants to contribute to the panel's findings. This also included the necessary costs in organising public meetings such as the venue hirer, catering, posters and printing. Support provided by the planning and land authority was provided in the normal course of business.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 14/7/17

By the Minister for Planning and Land Management, Mick Gentleman

*Estimates - QON No. E17-509

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

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ANSWER TO QUESTION ON NOTICE

Ms Nicole Lawder: To ask the Minister for Planning and Land Management

Ref: EPSDD, Planning Policy, Budget Paper E, Page 17 – accountability indicators

In relation to: Erindale Master Plan

1. Are there any plans to refresh or upgrade the Erindale master plan?

MICK GENTLEMAN: The answer to the Member's question is as follows:–

There are no plans to refresh or upgrade the Erindale Group Centre Master Plan at this time.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 12/7/17

By the Minister for Planning and Land Management, Mick Gentleman

*Estimates - QON No. E17-510

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
- 7 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Ms Nicole Lawder: To ask the Minister for Planning and Land Management

Ref: EPSDD, Planning Strategy

In relation to: Dickson Section 72 - Community housing

1. On page 26 of the uncorrected proof Hansard for the Estimate hearing on Wednesday the 28th of July you stated, "*I do not think the Community has raised that discussion point...of having social housing in [section] 72 apart from...* " Minister could you please clarify your meaning? What has the community raised regarding section 72?

MICK GENTLEMAN: The answer to the Member's question is as follows:–

I am advised that community representatives have met with Directorate officials and raised the prospect of a community-led process to examine future planning for Section 72. No formal proposal has been presented, nor has any decision been made. We are very enthusiastic about the opportunity to work with the Community on such a project.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: MG Date: 7/7/17

By the Minister for Planning and Land Management, Mick Gentleman

*Estimates - QON No. E17-511

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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ANSWER TO QUESTION ON NOTICE

Ms Nicole Lawder: To ask the Minister for Planning and Land Management

Ref: EPSDD, Planning Policy, Budget Paper E, Page 24

In relation to: Dickson Section 72

1. On page 29 of the uncorrected proof Hansard for the Estimate hearing on Wednesday the 28th of July. Mr Rake stated *"We have had a request from the community to talk about a process that the community could lead, and I think it is important for us to leave space for the community to help us shape that vision."* Could the Government please provide further information about this community request, including:
    a. Was the request made by an individual or from a community council/group?
    b. When was the request made?
    c. How was this request made?
        i. Could you please provide a copy of the request?

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1a. Two individuals on behalf of Community Groups made the request.
1b. The request was made on 7June 2017
1c. The request was a verbal discussion therefore no copy is available.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 7/7/17

By the Minister for Planning and Land Management, Mick Gentleman

*Estimates - QON No. E17-512

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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ANSWER TO QUESTION ON NOTICE

Ms Nicole Lawder: To ask the Minister for Planning and Land Management

Ref: EPSDD, Budget Paper E, Page 24

In relation to: Time to complete Master Plans

1. On average how long does it take for a master plan to be completed?
2. Could you please provide a list of all master plans undertaken by the ACT Government, could this list please be sorted by year and include:
   a) How long the original consultation period took;
   b) How long it took to get to the draft stage;
   c) How long each master plan took to complete;
   d) How many people were consulted in each stage.

MICK GENTLEMAN: The answer to the Member's question is as follows:–

Master plans generally take between 18-24 months to be completed. The Master plan process includes community engagement activities, such as 'meet the planners' sessions and workshops, and preparation of the Master plan and community engagement reports.

The following information is provided for each completed master plan:

Dickson Group Centre Master Plan (2011)

- Stage 1 community engagement - 2 weeks with 92 submissions received and approximately 100 people attending the 'meet the planners' sessions.
- Stage 2 community engagement – 4 weeks with 9 submissions received and approximately 200 people attending the 'meet the planners' sessions.
- Stage 3 community engagement – 4 weeks with 27 submissions received
- 2.5 weeks between Stage 1 and Stage 2 community engagement
- Approximately 10 months between Stage 2 and Stage 3 community engagement
- Approximately 18 months to complete the master plan

Kingston Group Centre Master Plan (2011)

- Stage 1 community engagement (visioning) - 4 weeks with approximately 150 people attending the 'meet the planners' sessions. Approximately 120 people attended the community workshop.
- Stage 2 community engagement (comment on draft plans) – 2 weeks with approximately 200 people attending the 'meet the planners' session and approximately 50 people attending the planning workshop.
- Stage 3 community engagement (Framework Report review) – 4 weeks with 24 submissions received

- 4 weeks between Stage 1 and Stage 2 community engagement
- Approximately 10 months between Stage 2 and Stage 3 community engagement
- Approximately 23 months to complete the master plan

Erindale Group Centre and Tuggeranong Town Centre Master Plans (2012)

- Stage 1 community engagement - 5 weeks with 32 submissions received and approximately 34 people attending the workshop and interviews
- Stage 2 community engagement – Held community information displays (with a total of 4 meet the planner sessions) and approximately 250 people attended.
- Stage 3 community engagement (initial draft master plans for each centre) – 3 days – Community drop-in-sessions/displays – 31 feedback forms for Tuggeranong and 46 for Erindale
- Stage 4 community engagement (draft master plan) – 9 weeks – 34 email submission received for Tuggeranong and 34 submissions for Erindale
- 16 weeks between Stage 1 and stage 2 community engagement
- 10 weeks between Stage 2 and Stage 3 community engagement for Tuggeranong
- 15 weeks between Stage 2 and Stage 3 community engagement for Erindale
- 19 weeks between Stage 3 and Stage 4 community engagement for Tuggeranong
- 13 weeks between Stage 3 and Stage 4 community engagement for Erindale
- Approximately 23 months to complete both master plans

Kambah Group Centre Master Plan (2012)

- Stage 1 and Stage 2 community engagement - 10 weeks total with 27 submissions received and approximately 200 people attending the 'meet the planners' sessions.
- Stage 3 community engagement (draft plan) – 6 weeks with 98 submissions received.
- Approximately 1 month between Stage 1 and Stage 2 community engagement
- Approximately 3 months between Stage 2 and Stage 3 community engagement
- Approximately 17 months to complete the master plan.

Pialligo Master Plan (2013)

- Stage 1 community engagement - 6 weeks with 22 submissions received and approximately 20 people attending the 'meet the planners' sessions.
- Stage 2 community engagement (draft plan) – 7 weeks with 26 submissions received approximately 20 people attending the public display in Pialligo.
- Approximately 8 months between Stage 1 and stage 2 community engagement
- Approximately 23 months to complete the master plan

Weston Group Centre Master Plan (2014)

- Stage 1 – community engagement - 6 weeks with 186 submissions received and approximately 180 people attending the 'meet the planners' sessions. Approximately 40 people attended an Ideas Workshop
- Stage 2 – 52 people attended a design workshop
- Stage 3 – community engagement - 6 weeks with 83 submissions received and approximately 380 people attending the 'meet the planners' sessions
- Stage 4 – community engagement - 8 weeks with 102 submissions received and approximately 350 people attending the 'meet the planners' sessions
- Stakeholder Reference Group, representing local community and businesses, met 6 times throughout the process to review proposed directions and draft plans
- 3 months between Stage 1 and Stage 2 community engagement, 3 months between Stage 2 and Stage 3 community engagement, 20 months between Stage 3 and Stage 4 community engagement
- Approximately 36 months to complete the master plan

Oaks Estate Master Plan (2014)

- Stage 1 community engagement - 8 weeks with 45 submissions received and approximately 86 people attending workshops
- Stage 2 community engagement - 8 weeks with 29 submissions received and approximately 35 people attending the 'meet the planners' sessions
- Individual meetings with the Progress Association throughout the master plan process
- 24 months between Stage 1 and stage 2 community engagement
- Approximately 33 months to complete the master plan

Woden Town Centre Master Plan (2015)

- Stage 1 community engagement - 6 weeks with 174 submissions received and approximately 139 people attending the 'meet the planners' sessions.
- Stage 2 community engagement (draft plan) – 6 weeks with 123 submissions received and approximately 161 people attending the 'meet the planners' sessions.
- Approximately 8 months between Stage 1 and stage 2 community engagement
- Approximately 23 months to complete the master plan

Mawson Group Centre Master Plan (2015)

- Stage 1 community engagement - 6 weeks with 135 submissions received and approximately 175 people attending the 'meet the planners' sessions.
- Stage 2 community engagement (draft plan) – 6 weeks with 105 submissions received approximately 215 people attending the 'meet the planners' sessions.
- Approximately 8 months between Stage 1 and stage 2 community engagement
- Approximately 23 months to complete the master plan

Belconnen Town Centre Master Plan (2016)

- Stage 1 community engagement - 12 weeks with 286 submissions received and approximately 310 people attending the 'meet the planners' sessions.
- Stage 2 community engagement (draft plan) – 12 weeks with 157 submissions received and approximately 161 people attending the 'meet the planners' sessions.
- Approximately 8 months between Stage 1 and Stage 2 community engagement
- Approximately 23 months to complete the master plan

Calwell Group Centre Master Plan (2016)

- Stage 1 community engagement - 6 weeks with 87 submissions received and approximately 70 people attending the 'meet the planners' sessions. A workshop was held with local schools
- Stage 2 community engagement - 6 weeks with 25 submissions received and approximately 55 people attending the 'meet the planners' sessions. A workshop held with local schools
- Approximately 8 months between Stage 1 and stage 2 community engagement
- Approximately 17 months to complete the master plan

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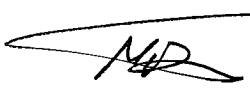
Signature:  Date: 13/7/17

By the Minister for Planning and Land Management, Mick Gentleman

*Estimates - QON No. E17-513

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION ON NOTICE

RECEIVED
12 JUL 2017
ACT LA
COMMITTEE SUPPORT

Ms Nicole Lawder: To ask the Minister for Planning and Land Management

Ref: EPSDD, Planning Policy, Budget Paper E, Page 17 – accountability indicators

In relation to: Outstanding Master Plans

1. What master plans are still outstanding?
2. Could you please the current status of the;
    a. Tharwa Village master plan
    b. Curtin Group Centre master plan?
3. How will the outcome of these masterplans be reported on if they have been discontinued as an indicator.

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1. The master plans that are being finalised include the Curtin and Kippax Group Centre master plans, and the Tharwa Village Plan.

2a. The draft Tharwa Village Plan has been prepared and will shortly be released for community engagement.

2b. A Curtin Community Panel has been convened and will meet this month to seek further community input into the master planning process. The community panel will guide the broader community engagement program including consideration of an additional stage of engagement to finalise the Curtin Group Centre Master Plan.

3. The final master plans will be published on the Environment, Planning and Sustainable Development (EPSDD) website and reported in the EPSDD 2017/18 Annual Report and consideration will be given to including information in the 2018/19 budget papers.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 12/7/17

By the Minister for Planning and Land Management, Mick Gentleman

*Estimates - QON No. E17-514

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION ON NOTICE

RECEIVED
12 JUL 2017
ACT LA
COMMITTEE SUPPORT

Ms Nicole Lawder: To ask the Minister for Planning and Land Management

Ref: EPSDD, Planning Policy, Budget Paper E, Page 24

In relation to: Master plan reviews

1. How long does a master plan last?
2. Could you please provide a list of all Master plans undertaken by the ACT Government, could this list please be sorted by year and include any information outlining whether any refresh of the master plan has been undertaken or is planned?

MICK GENTLEMAN: The answer to the Member's question is as follows:–

The Environment, Planning and Sustainable Development Directorate (EPSDD) has prepared master plans as part of the ACT Government's Master Plan Program. Master plans provide a vision, a spatial framework and strategies to guide the development of a centre or precinct over the next 20 to 30 years.

Master plans that have been completed by EPSDD include:

1. Dickson Group Centre Master Plan (2011)
2. Kingston Group Centre Master Plan (2011)
3. Tuggeranong Town Centre Master Plan (2012)
4. Erindale Group Centre Master Plan (2012)
5. Kambah Group Centre Master Plan (2012)
6. Pialligo Master Plan (2013)
7. Weston Group Centre Master Plan (2014)
8. Oaks Estate Master Plan (2014)
9. Woden Town Centre Master Plan (2015)
10. Mawson Group Centre Master Plan (2015)
11. Calwell Group Centre Master Plan (2016)
12. Belconnen Town Centre Master Plan (2016)

All master plans (listed above) are current. No refreshment of these are planned at this time.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:

Date: 12/7/17

By the Minister for Planning and Land Management, Mick Gentleman

*Estimates - QON No. E17-515

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION ON NOTICE

RECEIVED
13 JUL 2017
ACT LA
COMMITTEE SUPPORT

Ms Nicole Lawder MLA: To ask the Minister for Planning and Land Management

Master plan program BPE p 24

In relation to: Curtin master plan

1. When will the Curtin Group Centre Master plan be completed?
2. How many people have engaged in the consultation of this master plan
3. Has there been any unexpected challenges face in the production of this master plan?

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1. The current schedule for the current Group Centre Master plan is anticipated for mid 2018. This includes community engagement and Government approval timeframes.
2. The following community engagement activities have been undertaken for the Curtin Group Centre Master Plan:
    a. Stage 1, Identification of challenges and opportunities
        i. 293 people attended the two 'meet the planners' sessions.
        ii. 211 feedback forms and 63 'have your say' postcards were received.
        iii. 15 written submissions were received.
        iv. Four school workshops with local schools were held with approximately 168 school students in attendance.
    b. Stage 2, the Curtin Group Centre Draft Master Plan
        i. Approximately 160 people attended the two 'meet the planners' sessions.
        ii. 97 submissions were received (written submissions and feedback forms).
        iii. Poster displays were set up at Woden Library and in a shop front at the Curtin Group Centre.
        iv. Approximately 40 people attended a presentation to the Woden Valley Community Council.
    c. Individual stakeholder meetings were held with lessees and community groups, such as the Curtin Residents Association and the Curtin Garden Group in both stages of community engagement.
    d. Postcards providing information about the Curtin Group Centre Master Plan were sent to residents in Curtin, Deakin, Hughes, Yarralumla, Lyons and Phillip for both stages of community engagement.
    e. Online information has been provided through EPSDD's website, Engagement HQ/Your Say, Time to Talk, Facebook and Twitter.
3. Yes

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 13/7/17

By the Minister for Planning and Land Management, Mick Gentleman

*Estimates - QON No. E17-516

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA : To ask the Minister for Health and Wellbeing

Ref: Budget Statements C

In relation to: Whole Portfolio

1. Why did your incoming minister's brief not include information about the risk status of the electrical system at Canberra Hospital (ref QTON 9 May 2017)?
2. Did your brief provide detailed information about the AECOM report?
3. If no, why?
4. If yes, what specifically was the detail provided?
5. Will you provide a copy of your incoming minister's brief?
6. If no, why?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. The purpose of the incoming Minister's briefs was to provide the new Minister with an update on key priorities, issues and projects as at the time of the briefing. The 'Health Infrastructure projects' brief identified the major capital works projects occurring within Health and the project status.

2. No.

3. The Health Infrastructure projects brief outlined only the status of the major capital works projects occurring within Health and not the history regarding how the projects arose. Reference was made to the Upgrade and Maintain ACT Health Assets (UMAHA) appropriation of $93.5 million in the 2016/17 ACT Budget.

4. Not applicable.

5. No.

6. The brief contains information on other projects not related to the main electrical switchboard.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: [signature] Date: 17/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-517

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
17 JUL 2017
ACT LA COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA : To ask the Minister for Health and Wellbeing

Ref: Budget Statements C

In relation to: ACT Local Hospital Network – Centenary Women's and Children's Hospital

1. Last year during Estimates, Mr Corbell stated that he was "comfortable" with the capacity of the Centenary Women's and Children's Hospital. This year the government has announced significant upgrades to the Hospital. When did ACT Health recognise that there was inadequate capacity at the Canberra Women's and Children's Hospital?
2. Given the Centenary Women's and Children Hospital is less than five years old, why did the government, in planning the hospital initially, underestimate the capacity so significantly?
3. Since the opening of the hospital, have there been any instances of women and children being discharged from the hospital before it was clinically appropriate to do so?
4. If yes, on how many occasions, and what out-of-hospital support services were arranged?
5. Have there been any instances of perinatal women being accommodated other than in an appropriate ward and room within that ward?
6. If yes, on how many occasions, and where were they accommodated?
7. Have there been instances of women in advanced labour being accommodated other than in the delivery suite?
8. If yes, on how many occasions, and where were they accommodated?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. ACT Health commenced planning an upgrade to the Centenary Hospital for Women and Children (CHWC) as part of a review of services in 2016, in anticipation of a rise in demand for more specialist care, due to an increased number of patients presenting with complex co-morbidities, including gestational diabetes, overweight and obesity. In 2016, the criteria for diagnosing gestational diabetes broadened, leading to an increasing number of women being appropriate for obstetric treatment at a level three tertiary hospital in the ACT and Southern New South Wales (NSW).

2. In addition to the aforementioned factors, the CHWC experienced unexpected demand, as more Canberra families have been attracted to the state-of-the-art facilities, particularly single room accommodation and the capacity for partners/carers to stay with women during their stay, and have chosen this hospital over other options.

3. No woman has been inappropriately discharged.

4. Refer to above response.

5. No.

6. Refer to above response.

7. No.

8. Refer to response to question 7.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 17/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-518

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION ON NOTICE

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C

In relation to: ACT Local Hospital Network – SPIRE

1. Given Labor's election promise to build and open a new Surgical Procedures, Interventional Radiology and Emergency (SPIRE) Centre by 2023 and that most of the funding for this project has been pushed beyond the Forward Estimates, will the government confirm its commitment to build and open this building by 2023?
2. Has the forecast expenditure for the construction of SPIRE been reviewed since the 2016 ACT election?
3. If yes, to what extent does it vary from the initial forecast of $500 million?
4. If no, when will such a review be made?
5. When will planning, design and approvals work for this infrastructure begin and how long will that phase take?
6. When will the first sod be turned?
7. Given budget funding for a previously-promised new tower block was reallocated to Stage 1 of light rail, will the government guarantee that the funding for the SPIRE Centre will not be pushed out beyond 2023 to free-up earlier funding for Stage 2 of light rail?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. The ACT Government remains committed to completing the Surgical Procedures, Interventional Radiology and Emergency (SPIRE) Centre in 2023.
2. The forecast cost is unchanged at this stage.
3. Not applicable.
4. Construction cost estimates will be updated over the coming 12-18 months to inform a detailed business case for Government's consideration in late 2018. Notwithstanding, Government will provide updated estimates where practical through the 2018-19 Budget process.
5. The early planning and forward design for the SPIRE Centre at Canberra Hospital has commenced.
6. The construction timetable is subject to detailed planning and delivery model assessment; however the ACT Government has predicated existing cash-flows on a construction commencement in 2020.

7. Previously allocated planning and design funding, for major redevelopment of the Canberra Hospital campus, was primarily redirected to the delivery of health service reforms and capital priorities which will improve clinical outcomes. Funding for ACT Health's clinical infrastructure is independent of transport infrastructure funding commitments.

Approved for circulation to the Select Committee on Estimates 2017-18

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Date: 17/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-519

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C

In relation to: ACT Local Hospital Network – Budget Statements C, p43 – Strategic objectives and indicators

1. How can the estimated outcomes for 2016-17 and the targets for 2017-18 be made in the absence of reliable under-pinning data?
2. Given the absence of reliable data, what information was used to inform the calculation of estimated outcomes for 2016-17 and the targets for 2017-18?
3. *(Ref Note 1, Table 1, p43)* – Are the reported performance measures different as to public and internal reporting?
4. If yes, why and how do they differ?
5. In relation to strategic indicator 1, why is the target for 2017-18 not building on the estimated outcome for 2016-17, which was higher than the target for that year?
6. In relation to strategic indicator 1, what does it mean when it sets a target of 91% of patients being admitted for non-urgent elective surgery "at some time in the future"?
7. What is represented in the 9% thereby emerging as patients seeking non-urgent elective surgery, but not being admitted "at some time in the future"?
8. In relation to strategic indicator 2, which has the objective of ***improving*** ED timeliness, why did all but one of the estimated outcomes for 2016-17 fall well short of the target?
9. In relation to strategic objective 3, what are the actual rates for peer hospitals for each line item in each strategic indicator?
10. In relation to strategic indicator 3.4, why are the targets for 2017-18 not building on the estimated outcome for 2016-17, which was higher than the target for that year?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. For the purposes of both estimating outcomes and setting targets in the budget papers, ACT Health has adopted a number of known methodologies to both set targets for the new financial year and determine estimations for expected outcomes for the current financial year. For particular strategic indicators where there were known dataset limitations and issues, ACT Health staff accessed source system information directly to inform the analysis undertaken to mitigate the known issues. Furthermore, the estimated outcomes calculated for 2016-17 are still estimations based on modelling of data including historical trend analysis.

2. Refer to response question 1.

3. There is no difference between public and internal reporting.

4. Not applicable.

5. ACT Health exceeded the 2016-17 target in the semi-urgent category, but not in the urgent or non-urgent categories. ACT Health continues to work on strategies to meet these targets, and expects to gain further improvements in the coming financial year. With further, sustained improvements to consolidate our position in all categories, ACT Health will be in a position to re-evaluate the targets for elective surgery in forward years.

6. The target used on Page 43 of the Budget Statements C, Strategic indicator 1, Percentage of Elective Surgery Cases Admitted on Time by Clinical Urgency shows a category of 'Non urgent admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is not likely to deteriorate quickly and which does not have the potential to become an emergency'.

   This definition was an AIHW Metadata Online Register definition that has now been superseded with a new definition 'Procedures that are clinically indicated within 365 days'.

   ACT Health used a previous template for the Strategic Indicators without updating the definition. ACT Health applies a clinical recommendation of 365 days for clinical urgency Category three patients.

7. The nine per cent are those outside of the 365 day threshold who will wait longer.

8. In relation to category one, 100 per cent of these patients were seen on time. The one per cent shortfall in the reported estimated outcome is due to the fact that in the most time critical situations, ED staff are fully dedicated to treating the patient, and recording of the treatment time is sometimes delayed until after the patient is stabilised. This documentation is not retrospectively corrected.

   In relation to categories two, three and four, the estimated outcomes are short of the targets due to multiple factors, which include increased activity, both number of presentations and levels of acuity, leading to a higher proportion of ED presentations requiring admission, which in turn raises bed occupancy. ED activity increased by approximately 10 per cent in the last 12 months, and around two thirds of those presentations required admission.

9. There is no consolidated location for all four safety and quality related strategic indicators in the national space. The Australian Institute of Health and Welfare reports on strategic indicator 3.3 (Staphylococcus aureus bacteraemia (SAB) rates) where the national benchmark is currently less than 2.00 cases per 10,000 bed days. Historically, the National Hospital Performance Authority in collaboration with My Hospitals benchmarked and reported on both hand hygiene and SAB rates by hospital and compared hospitals to their respective peer groups.

10. This target is set at a national level by an expert working group from the Australian Commission on Safety and Quality in Healthcare in conjunction with Hand Hygiene Australia. The target is reviewed three times per year with the view to increasing the national target.
Canberra Hospital and Health Services continues to be above the national level and continues to educate and strive for a continued improvement in compliance rate.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:

Date: 16/7/2017

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-520

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION ON NOTICE

RECEIVED
25 JUL 2017
ACT LA
COMMITTEE SUPPORT

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: CMTEDD – Budget Statements C

In relation to: BP3, pp 102-106 – Expense initiatives

1. (*BP3, p102 – Helping patients navigate the health system.*) What work has been done to prepare for the development of the framework for patient care navigators?
2. Who will be involved in developing the framework?
3. What is the reporting deadline?
4. How many new nurses, under the "More Nurses for Canberra" initiative, will be engaged each year?
5. What quantitative research has the directorate made as to the number of graduate nurses that will become available each year?
6. If there are insufficient local graduate nurses, what strategies does the directorate have in place to attract new graduates to Canberra?
7. In general, what process is followed when seeking to divert funds in the directorate to expense initiatives?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. A one-off grant of $100,000 will be provided to the Health Care Consumers Association (HCCA) to develop a model for patient care navigators.
2. Refer to the response to question 1.
3. Refer to the response to question 1.
4. The "More Nurses for Canberra" initiative will provide new nurses, including additional new graduate nurses each year over four years, Nurse Navigator positions, Maternal and Child Health nurses and roving school nurses.
5. The ACT Chief Nurse works closely with the local universities and the vocational sector to plan the numbers of newly graduated nurses and midwives and to quarantine places in the Transition to Practice Programs.

   As part of their role in workforce planning, the ACT Chief Nurse works with other State and Territory Chief Nurses to look at national and international employment patterns, availability, overseas recruitment and data from the Nursing and Midwifery Board of Australia regarding registration patterns, to plan the numbers of nurses and midwives required and to ensure there are sufficient strategies in place to provide both an affordable and sustainable nursing and midwifery workforce.

Health Workforce Australia undertook research related to long term national projections for nurses and midwives across Australia to the year 2025 based on workforce reform, geographical distribution, training and immigration. ACT Health contributed to this work.

6. It is unlikely that there will be insufficient local graduate nurses in the foreseeable future as both local universities and the vocational sector have made positive moves to increase student enrolments. Currently there are in excess of three applicants for every new graduate nurse position advertised and through a process of assessment, the best candidates are offered positions. The majority of successful applicants are from local universities and the Canberra Institute of Technology (CIT).

   At the commencement of 2016, the ACT Chief Nurse negotiated with CIT to double its intake of nursing students and ensured these students would all receive clinical placements within ACT Health. As a result, the numbers of newly graduated enrolled nurses in 2017 are the highest experienced in the past five years.

   ACT Health does accept requests for clinical placements from student nurses in other States and Territories as a means of marketing our health services more broadly. Subsequently, we also receive applications for new graduate positions from other than local nurses, ensuring our processes remain competitive. In 2016, ACT Health offered more than 36,000 clinical placement days for nursing and midwifery students.

7. ACT Health Directorate is engaged in a comprehensive reform program aimed at improving efficiency in the health sector. The efficiencies generated through the System Innovation Program (SIP) are subject to a comprehensive governance process and are to be retained by the Health Directorate for reinvestment in services. For this reason, a number of new initiatives in the 2017-18 Budget Papers are shown to be internally funded.

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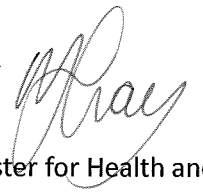
Signature: 

Date: 25/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-521

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C – Output 1.3 – Population Health

In relation to: Cystic Fibrosis services (ref Hansard, Estimates, day 1- community and industry groups)

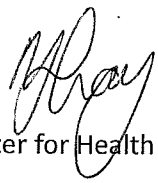
1. Does the government consider there are gaps in cystic fibrosis treatment services that generally are filled by Cystic Fibrosis ACT?
2. Why does the government provide no funding support to Cystic Fibrosis ACT?
3. Do the services provided by ACT Health comply with the national standards for the treatment of cystic fibrosis, published in 2008?
4. If no, why, and where are the shortcomings?
5. What strategies are in place to meet the shortcomings in the future?
6. How long will it take before ACT Health meets the national standards?
7. What strategies are in place to ensure treatment always complies with national standards according to their currency?
8. What needs to be done to ensure equity of treatment services of CF sufferers, regardless of whether they are hospital or hospital-in-the-home patients?
9. Is this inequality indicative of inequalities in the services being provided to hospital and hospital-in-the-home patients suffering other illnesses or conditions?
10. If yes, what is being done to eliminate those inequalities?
11. What budget funding is provided for CF services in 2017-18 and in each of the out-years?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. No.
2. ACT Health is not aware of any funding applications for the support of cystic fibrosis.
3. The cystic fibrosis clinic and the inpatient services provided to cystic fibrosis patients comply with the national standards for treatment of cystic fibrosis.
4. Refer to response to question 3.
5. Refer to response to question 3.
6. Refer to response to question 3.

7. In March 2017, ACT Health underwent an external peer review, conducted by Cystic Fibrosis Australia's peer review group. The purpose of the review is to benchmark how ACT Health's Cystic Fibrosis services compare in clinical practice with other centres nationally, and identify gaps in service provision. ACT Health is currently awaiting recommendations of the review and will respond accordingly.
8. Refer to response to Question 7.
9. Refer to response Question 7.
10. Not applicable.
11. There is no specific budget funding for Cystic Fibrosis services.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: 

Date: 16/7/2017

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-523

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C – Output 1.4 – Cancer Services

In relation to: Colonoscopy services

1. In relation to the answer given to Question on Notice Number 71, why, as of February 2017, were more than 60 per cent of patients on the category one list for colonoscopies waiting more than the recommended 30 days for a colonoscopy?
2. Why were nearly 600 people on the category one waiting list for colonoscopies waiting more than 80 days?
3. Currently, how many category one patients undergo a colonoscopy procedure within 30 days?
4. Currently, how many category one patients are waiting more than:
   a. 30 days;
   b. 60 days; and
   c. 90 days?
5. What are the potential clinical consequences for category one patients not undergoing a colonoscopy procedure within the recommended period of 30 days?
6. What are the government's strategies to improve wait times for colonoscopies?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. The wait for procedures is due to increased demand. ACT Health has undertaken substantial work to improve the reduce waiting time for endoscopy, including putting on additional lists and referring appropriate patients to have their procedure done at Queanbeyan Hospital.
2. The high demand for endoscopy procedures at Canberra Hospital has led to this number of nearly 600 people not being seen within the timeframe for their triage category.
   Canberra Hospital has put in place a number of strategies to reduce the waiting list, as referred to response to question 1. Since February 2017, this has resulted in a significant decrease in the number of urgent patients waiting longer than clinically recommended.
3. For the 2016-17 financial year, 532 category one patients underwent a colonoscopy procedure within 30 days.

4. As at 30 June 2017, the waiting times are:
   - 38 patients waiting between 31 and 60 days.
   - 51 patients waiting between 61 and 90 days.
   - 90 patients waiting more than 90 days.

5. The potential clinical consequences would depend on the presentation of the patient.

6. Canberra Hospital is utilising the following strategies which has led to improvements in wait times for colonoscopies:
   - Increasing utilisation of available endoscopy sessions;
   - Increasing the number of locum lists;
   - Weekend endoscopy lists from August – November 2016; and
   - Transfer of suitable patients to Southern NSW Local Health District for procedure.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 17/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-524

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION ON NOTICE

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C – Output 1.4 – Cancer Services

In relation to: Dermatology services

1. Is there a shortage of dermatology specialists in Canberra?
2. What strategies does the government have to attract and retain more dermatologists?
3. What funding is provided to train dermatologists?
4. What are the current wait times for patients to see dermatology specialists?
5. Do those wait times put patients at a clinical risk, particularly as it may relate to cancerous conditions?
6. On what basis is that conclusion reached?
7. Are patients having to travel interstate for diagnosis and treatment of dermatology conditions, including, but not limited to, cancerous conditions?
8. What feedback has the government received during 2015-16 and 2016-17 from dermatology patients and specialists about the level of dermatology diagnosis and treatment services available in the ACT?
9. What has the government done in response?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. ACT Health recognises that similar to many specialities, there is a shortage of dermatology consultants in Australia, particularly in regional areas.
2. ACT Health is currently in consultation with the existing group of public dermatologists about a new Model of Care that would increase service activity and address succession planning, including in-principle support for an additional dermatology trainee.
3. Canberra Hospital currently has a Commonwealth funded Specialist Training Program advanced trainee registrar, which is an Australasian College of Dermatologists accredited vocational training position.
4. The average waiting time for a patient to see a dermatology specialist at Canberra Hospital for 2016-17 was 242 days.
5. The clinical risk for the patient would depend on the presentation of their condition.

6. This is a determination made by a specialist.
7. ACT has not sent any patients interstate for treatment due to wait times at Canberra Hospital.
8. ACT Health has not received any feedback during the period of 2015-16 and 2016-17 relating to the dermatology services provided by ACT Health from patients. ACT Health has received feedback from specialists about the Model of Care, succession planning, and dermatology trainees.
9. Please refer to response 2.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:

Date: 17/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-525

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
14 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C – Output 1.5 – Rehabilitation, Aged and Community Care

In relation to: ACAT Assessments and aged care

1. Given that appropriate wait times for Aged Care Assessment Team assessments is a key priority in this output, does ACT Health measure wait times?
2. If no, why, and how do you know if this key priority is met?
3. Why are there no accountability indicators for aged citizens getting access to ACAT assessments?
4. During 2015-16 and 2016-17 what were the average wait times for access to the ACAT?
5. What was the benchmark?
6. During 2015-16 and 2016-17 what were the average turn-around times between having the ACAT assessment and getting the report?
7. What was the benchmark?
8. Why, according to the Productivity Commission Report on Government Services, do ACT residents face a median wait time of 185 days, more than three months higher than the national average, between receiving an ACAT report and being admitted to an aged care facility?
9. Why has the median elapsed time increased by 135 days over 5 years?
10. Why are 40 per cent of Canberrans who need aged care forced to wait more than 9 months for a place?
11. What was the growth in aged care facility bed numbers in the ACT in 2016-17?
12. What is the forecast growth over the next three years?
13. What strategies does the government have to allow for growth in aged care capacity in the medium- to long- term?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. A hospital assessment is now available through the My Aged Care data reporting system. This data is owned by the Commonwealth and is not for public distribution. It can be noted that the ACT ACAT response time is well within the KPI.

2. The ACT ACAT has been one of the few jurisdictions to successfully meet all KPIs and continues to implement initiatives as directed by the Commonwealth.

3. ACAT performance against KPIs is reported to the Department of Health on a six-monthly basis. ACAT data is recorded and stored on the My Aged Care system and used by the Commonwealth Government to inform national policy.

4. My Aged Care does not measure average wait times for ACAT assessment. The ACT ACAT's measures for all of those processes were within acceptable KPIs for 2015–2016 and 2016–2017.

5. The benchmark for ACAT wait times is determined by the priority given to the referral when accepted by the ACAT.

   - Priority 1 referrals require contact of a clinical nature within 48 hours.
   - Priority 2 referrals contact of a clinical nature within three to 14 days.
   - Priority 3 referrals contact of a clinical nature more than 14 days.

6. With the ACAT program now linked to the My Aged Care system, distribution of an ACAT report has ceased. Clients now receive a one page report summary and a referral code list that links to each service approved. Aged care providers then use this code to access client information through the My Aged Care system. Generation of these codes is automatic once the ACAT assessment is completed.

7. There are no benchmarks for the average turn-around times between having the ACAT assessment and getting the report.

8. Aged Care, including residential aged care, is the responsibility of the Commonwealth Government. In the ACT, residential aged care is fully funded by the Commonwealth Government and services are delivered primarily by the non-government sector. The Productivity Commission Report on Government Services refers to data from 2015-16.

9. Aged Care, including residential aged care, is the responsibility of the Commonwealth Government. A range of reasons contribute to waiting times for residential aged care placement, including the availability of residential aged care beds (due to delays in construction of new facilities or renovation of existing facilities), mismatch between the type of accommodation available and the needs of the person, and importantly person/family choice not to commence care immediately, or in selecting a facility.

10. People have a right to choose how they will be cared for as they age. This includes the services they access and whether they wish to reside in an aged care facility. Delays in accessing residential aged care may be due to a range of reasons as already mentioned.

11. This data is administered and stored by the Commonwealth Government.

12. This data is administered and stored by the Commonwealth Government.

13. Aged Care, including residential aged care, is the responsibility of the Commonwealth Government. This may be influenced by state and territory planning, such as the ACT Health Territory-wide Health Services Framework 2017-2027 (Framework), which underpins the planning and delivery of future health services and provides a foundation for ACT Health to engage with stakeholders in the development of health services, including clinicians, non-government organisations and community-based organisations.

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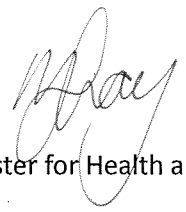
Signature: 

Date: 14/7/2017

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-526

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
14 JUL 2017
COMMITTEE SUPPORT
ACT LA

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C – Output 1.5 – Rehabilitation, Aged and Community Care

In relation to: Aged care bed-block

1. Why, according to the Productivity Commission Report on Government Services, did the ACT have the highest number of days spent by patients in hospital beds waiting for aged care places?
2. On average, in 2016-17, for how long did in-hospital aged care patients remain in hospital after they were cleared clinically for discharge to an aged care facility?
3. In general, why did they remain in hospital?
4. What are the comparative statistics for the previous five years?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. Length of stay in hospital can be impacted by a range of reasons including:
   - The discussion /negotiation with some families can be extensive while a decision is made to accept residential care;
   - The completion of the Centrelink assessment process can be time consuming;
   - Families may limit their preference to particular Residential Aged Care Facilities (RACFs).
   - Access to specific types of RACF beds may be limited.
   - Families need to visit facilities, and some facilities only offer one tour a week. In some circumstances, facility staff also assess the patients while they are in hospital. Finally, once a bed is available, families may go and inspect the room.
   - Some facilities limit the number of new admissions that occur each day and/or on the day of admission.
   - Delays may occur if the Public Guardian and/or Public Trustee are involved.
2. On average patients remained in hospital for 34 days after they were clinically cleared for discharge to an aged care facility.
3. For the reasons given in the answer to question 1.

4. The comparative statistics for the previous five years are:

2011-2012 40 days
2012-2013 39 days
2013-2014 44 days
2014-2015 38 days
2015-2016 47 days

Approved for circulation to the Select Committee on Estimates 2017-18

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By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

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LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C – Output 1.5 – Rehabilitation, Aged and Community Care

In relation to: Community-based health care

1. What assessment has been made of the adequacy of community-based nursing, allied health and other support services for the heathcare needs of acute and post-acute patients?
2. What did that assessment conclude?
3. What is being done to fill any identified gaps?
4. What are the longer-term strategies and goals to meet the needs of an ageing and longer-living population.

Minister Fitzharris: The answer to the Member's question is as follows:–

1. Managers of the Community-based Nursing and Allied Health Services regularly review access to services by monitoring outputs such as Occasions of Service and Units of Service; reviewing waiting times for appointments; appropriate clinical prioritisation processing and monitoring of clinical incidents. These are reported to Executive on a monthly basis. Consumer feedback and other quantity indicators are also monitored by Service Managers and Executive, and thoroughly investigated and responded to as required.
2. Accountability Indicators 1.5a and 1.5b report that services are tracking within target, or within a five per cent variable close to target Outputs. Waiting times for appointments are being met as appropriate to the clinical priority of the individual's presenting condition.
3. Consideration of identified gaps will be progressed through the ACT Health Territory-wide Health Services Framework 2017-2027 (Framework). The Framework underpins the planning and delivery of future health services and provides a foundation for ACT Health to engage with stakeholders in the development of health services, including clinicians, non-government organisations and community-based organisations. Development on the first tranche of Speciality Service Plans commenced in July 2017.

4. The ACT Budget 2017-18 delivers a number of initiatives to help older Canberrans with the cost of living and stay connected to our community. These include free off-peak bus travel for seniors and concession card holders, new and expanded bulk billing services, refurbished and upgraded acute aged care and oncology wards at Canberra Hospital. Aged Care, including residential aged care, is the responsibility of the Commonwealth Government nationally. ACT works collaboratively with the Commonwealth to meet the needs of older Canberrans. In addition, as described above, the Territory-wide Health Services Framework will guide the planning and delivery of Territory-side clinical and community-based health services over the next decade.

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Date: 17/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

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LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C – Output 1.5 – Rehabilitation, Aged and Community Care

In relation to: Nurse-led walk-in clinics

1. Where will the inner-north nurse-led walk-in clinic, scoping for which was funded in the 2017-18 budget, be located?
2. Will the facility be completed and operational in the current budget cycle?
3. If no, what assurance can the government give that the inner-north nurse-led walk-in clinic will be built?
4. How common is it for someone to enter a nurse-led walk-in centre and leave because it is unable to provide the service the client needs?
5. What consideration has been given to widening the scope of the clinics by adding access to doctors?
6. To what measurable extent have nurse-led walk-in clinics directly relieved the pressure on hospital emergency departments in each year since 2012-13?
7. To what measurable extent have emergency department wait times improved directly as a result of the provision of nurse-led walk-in clinics?
8. What consultation has taken place, and with whom, on the proposal for a nurse-led walk-in clinic in Gungahlin?
9. What was the feedback from those consultations, including, but not limited to, local general practices?
10. What consultation is planned, with whom and when, on the proposal for a nurse-led walk-in clinic in Gungahlin?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. The purpose of the scoping study will be to inform the options presented to the ACT Government on the most appropriate location for the new inner-north walk-in centre.
2. No.
3. It is anticipated that the new facility would be complete in 2020.
4. In the 2016-17 financial year, 21 per cent of patients who presented to a Nurse-led Walk-in Centre (WIC) were re-directed to an alternate clinical service as they did not fall within the scope of practice for the nurse-led walk-in centres.

5. Options are being explored to enhance the WIC Model of Care, including consideration of the involvement of medical staff in the model, with appropriate stakeholder consultation required on this question.
6. ACT Health is unable to provide a direct correlation between WIC and Emergency Department activity, because the issue is multi-factorial.
7. ACT Health is unable to draw a direct correlation between WIC and Emergency Department waiting times, because the issue is multi-factorial.
8. In May 2017 ACT Health officers met with representatives of the Capital Health Network (CHN) to discuss the participation of General Practitioners (GPs) (in the Gungahlin area) in the development of the WIC's model of care. Representatives from the Academic Unit of General Practice and the Health Care Consumers Association are members of the WIC Steering Committee that has been established to support the establishment of the WIC in Gungahlin.
9. Planning is underway to consult with GPs.
10. Representatives from CHN and ACT Health have agreed consultation will occur later this year.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 16/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-529

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C

In relation to: Output Class 1 – Health and Community Care – Hospital elective surgery waiting times

1. As at the end of each quarter up to and including June 2017, since September 2015, when there were 1,442 patients on the long wait list for elective surgery, how many patients, by surgical specialty, were on the long wait list?
2. What was the average clinical recommendation for elective surgery waiting times in 2014-15, 2015-16 and 2016-17?
3. In each of those years, how many patients were on waiting lists for elective surgery for longer than the clinically recommended time?
4. What is the average weekly occupancy rate, against a baseline of 24/7 theoretical availability, for surgical suites and related facilities, such as, but not limited to, surgical equipment and ICUs?
5. What strategic options are available for reducing waiting times for elective surgery?
6. Which of those options are considered to be viable?
7. How much of the additional budget funding will be allocated to the task of reducing elective surgery wait times in 2017-18 and in each of the out-years?
8. In what specific areas and at what specific cost will that additional budget funding be spent in each year of the budget cycle?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. Please refer to table below:

Specialty	30/09/2015	31/12/2015	31/03/2016	30/06/2016	30/09/2016	31/12/2016	31/03/2017	30/06/2017
Cardiothoracic surgery	3	1	0	0	0	0	0	0
Ear nose and throat	349	354	278	161	96	63	83	137
General surgery	64	63	37	15	12	9	28	42
Gynaecology	55	43	37	15	5	6	6	14
Gynaecological oncology	0	1	0	0	0	0	0	0
Head and neck surgery	0	2	4	4	0	0	1	0
Neurosurgery	6	4	1	1	1	2	4	3
Ophthalmology	47	35	42	6	3	9	17	28
Oral maxillofacial surgery	13	5	5	0	0	2	4	6
Orthopaedics	540	501	278	119	49	29	51	47
Oral Surgery	2	5	1	3	7	8	10	16
Paediatric day surgery	58	43	31	7	0	0	11	30
Plastic surgery	28	32	26	13	7	5	10	18
Thoracic surgery	1	0	0	0	0	0	0	0
Urology	156	162	169	12	32	38	96	119
Vascular surgery	129	150	144	14	0	5	4	4
Total	**1451**	**1401**	**1053**	**370**	**212**	**176**	**325**	**464**

2. The Australian Institute of Health and Welfare (AIHW) provides a national definition for clinically recommended wait times for elective surgery. The national clinically recommended wait time for Category 1 is 30 days, Category 2 is 90 days and Category 3 is 365 days. These timeframes have remained consistent over the three year period.
3. Please refer to table below:

Year	Unique Overdue Waiting List Entries
2014-15	4,699
2015-16	5,500
2016-17	2,791

4. ACT Health does not operate elective surgery on a 24/7 theoretical availability for quality and safety, clinical, operational and financial reasons.

   The average occupancy rate (theatre utilisation) for elective surgery sessions for Canberra Hospital for 2016-17 to 28 June 2017 is 79 per cent. For ACT Public hospitals for the same period the theatre utilisation was 84 per cent.

5. ACT Health has modelled the required resources to minimise the number of long wait patients for elective surgery by the end of the 2018 financial year. This work will be divided between Canberra Hospital and Health Services, Calvary Public Hospital Bruce, Calvary John James Hospital Elective Joint Replacement Program, and other private providers.

6. These options are all viable.

7. There is no new funding allocated in the 2017-18 Budget to the task of reducing elective surgery waiting times. ACT Health Directorate is engaged in a comprehensive reform program aimed at improving efficiency, which includes managing our elective surgery wait times.

8. Refer to response to question 7.

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Signature:

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By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-530

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
10 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C

In relation to: Output Class 1 – Health and Community Care – The Canberra Hospital – AECOM Report

1. What high and extreme risks did the AECOM report identify?
2. What did AECOM say about the urgency required to mitigate those high and extreme risks?
3. What estimate did AECOM make as to the cost to mitigate those risks?
4. What assessment has the directorate made as to the urgency of the need to mitigate those risks and when was that assessment made?
5. What is the estimated cost and timeframe to mitigate those risks?
6. How much is allocated in the 2017-18 budget and each of the out-years for work to mitigate those risks?
7. Has the capital asset life cycle maintenance program been finalised?
8. If no, why and when will it be?
9. If yes, is the program available publicly?
10. If the program is not available publicly, why?
11. If the program is available publicly, will you provide a copy?
12. What are the main elements of maintenance in the program?
13. Has the program been activated?
14. What budget allocations are made for 2017-18 and each of the out-years for activity identified in the program?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. The AECOM Report identified four extreme risks and 143 high risks.
2. The AECOM report identified 2016 for commencement of planned expenditure on extreme risks and 2017-18 for commencement of planned expenditure on high risks.
3. The cost estimate within the AECOM report informed the business case development that ultimately led to the Upgrade and Maintain ACT Health Assets (UMAHA) budget appropriation.

4. A risk assessment was conducted in accordance with the Whole of Government risk (WoG) assessment guidelines in respect of likelihood and consequence of risk. The risk assessment was conducted as part of the development of the AECOM report and is continuously reviewed as part of the ACT Health's approach to risk management.
5. $82.5 million up to June 2019 to address all extreme and high risk items identified in the AECOM Condition Assessment Report.
6. As per the Budget paper, $39 million in 2017-18 and $35 million in 2018-19.
7. No.
8. Draft preliminary Strategic Asset Management Plans are being developed for Canberra Hospital, non Canberra Hospital sites and Calvary Public Hospital. Expected completion dates for initial drafts is August 2017 and thereafter plans will be continuously reviewed by Health Infrastructure Services personnel.
9. Not Applicable.
10. Developed Strategic Asset Management Plans will not be publicly available as they will contain commercial in confidence information as well as information about the operational security of public health facilities within the Territory.
11. Not Applicable.
12. Facilities Management has a maintenance plan in place for the regular planned maintenance of all areas and non-clinical equipment across ACT Health. This includes substantial plant and equipment such as generators, chillers, electrical distribution infrastructure, cooling towers, gas boilers, air handling units, fire management systems, lifts and water handling systems. In addition, a diverse range of minor plant and equipment is repaired and maintained such as clinical beds, sanitisers, plumbing fixtures and refrigeration equipment.
13. Yes.
14. $15.4 million in 2017-2018, plus indexation in outer years, is allocated for repairs and maintenance across all ACT Health properties. This funding is part of the ACT Health's recurrent funding within the Health Funding Envelope. In addition, 36 staff are employed within ACT Health for maintenance activities.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:

Date: 17/7/2017

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-531

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C

In relation to: Output Class 1 – Health and Community Care – The Canberra Hospital – Data

1. What is the status of the review of hospital data collection, management and governance?
2. What specific issues have been discovered so far?
3. Has any rectification work been able to be done yet?
4. If yes, what, specifically?
5. Given the Commonwealth is changing the funding system so that it will no longer pay for mistakes in the health system from July 1, is ACT Health well prepared for the change in funding?
6. Given the Canberra Times report of 11 May 2017 that a 2015 internal audit found that up to 75% of incident reports prepared at the Canberra Hospital in 2014 were "unclear and inadequate" and up to 96% were incomplete, has there been a follow-up internal audit done?
7. If no, why, and when will it be done?
8. If yes, when was it done and what did if find?
9. Is sentinel reporting being reviewed as part of the overall review of health data?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. The Terms of Reference (ToR) for the system-wide review of ACT Health data and reporting were announced on 28 March 2017. The program of work for the ACT Health System-Wide Data Review is on track. The review is expected to be completed by 31 March 2018 with packages of work due for completion by 30 June 2017, 30 September 2017, and 31 March 2018.

2. To date, a range of issues have been previously identified over a series of external reviews and audits undertaken by ACT Health. All recommendations from the external reviews and audits have been consolidated and mapped against the new ACT Health Informatics Domain for addressing during the ACT Health System-Wide Data Review.

3. Works as defined in the ACT Health System-Wide Data Review ToR due by 30 June 2017 have been addressed.

4. See response at question 1.

5. ACT Health is prepared for the change and is working hard with hospital management and staff in improving patient quality and safety.

6. No.

7. Since the audit in 2015, work has been ongoing to implement the recommendations. Progress on the agreed recommendations is regularly monitored by the ACT Audit and Risk Management Committee via a status report on each of the recommendations. We anticipate that all the recommendations will be implemented by end of September 2017. A second audit will be done 12 months after the full implementation of the recommendations.

8. Not applicable.

9. No.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:

Date: 16/7/2017

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-532

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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- 8 SEP 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C

In relation to: Output Class 1 – Health and Community Care – The Canberra Hospital – Insurances

1. What insurance policies are held in relation to the Canberra Hospital, including but not limited to infrastructure, building services, and operational functions?
2. What was the premium cost of each policy in 2015-16 and 2016-17?
3. What individual claims were made under each policy during 2015-16 and 2016-17?
4. For claims made in relation to operational functions, to which hospital ward does each claim relate?
5. What insurance payout was received for each claim?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. ACT Health holds the following insurance policies with the ACT Insurance Authority (ACTIA) –
   a. Medical Negligence;
   b. Public and Product Liability;
   c. Professional Indemnity;
   d. Directors and Officer's Legal Liability;
   e. Property and Business interruption;
   f. Money/Fidelity;
   g. Principally controlled Contract works;
   h. Overseas Business Travel;
   i. Personal accident cover for Aero Medical retrieval activities; and
   j. Personal accident cover for ACT Health volunteers.

2. The following table sets out ACT Health's premium cost for 2015-16 and 2016-17 against each class of insurance and are provided GST exclusive. Please note that the figures below are not specific to the Canberra Hospital as premiums are invoiced by ACTIA at Directorate level only.

Insurance Class	2015-16	2016-17
Medical Negligence	$29,744,800.00	$25,488,214.00
Public and Product Liability	$551,939.00	$545,859.00
Professional Indemnity	$78,173.00	$58,561.00
Directors and Officer's Legal Liability	$184,515.00	$109,070.00
Property and Business interruption	$546,953.00	$534,988.00
Money/Fidelity	$15,055.00	$12,588.00
Overseas Travel	$9,890.42	$7,126.73
Personal Accident - Volunteers	$1,246.33	$804.04
Personal Accident - Aero Medical retrieval	$60,772.50	$52,784.50
Principally controlled Contract works – Projects below $30 million and less than 24 months construction time	$28,537.04	$80,965.55*
Grand Total	**$31,221,881.29**	**$26,890,960.82**

* This is a deposit premium, based on the estimated cost of construction. An additional premium, or return of premium, may be due once the actual cost of construction has been reconciled.

3. The following table provides a summary of claims that were made under each policy during 2015-16 and 2016-17 relating to Canberra Hospital operations. Please note that 52 per cent of the claims identified below relate to incidents prior to 2015-16 that were received during 2015-16 and 2016-17.

Insurance Class	2015-16	2016-17	Total
Medical Negligence	50	44	94
Property & Business Interruption	4	7	11
Public & Products Liability	1	0	1
Grand Total	**55**	**51**	**106**

4. Claims made in 2015-16 and 2016-17 are not devolved to ward level but rather the clinical service location where the incident primarily arises. The following table summarises the clinical service location for claims relating to operational functions and fall within the Medical Negligence class of insurance.

Clinical Service Location	**Number of claims**
Emergency department	16
Obstetrics	16
Orthopaedics	13
Urology	9
Gynaecology	9
General surgery	7
Oncology	5
Cardiology	4
Neurosurgery	4
General medicine (including internal medicine)	3
Vascular surgery	3
Intensive care	2
Otolaryngology	1
Hospital outpatient department	1
Paediatrics	1

5. From the number of claims listed in Question 3, the following table lists the payouts of the insurance claims that were finalised for individual claims that were made under each policy during 2015-16 and 2016-17 relating to the Canberra Hospital campus.

Insurance payout
$390,000.00
$96,898.00
$140,000.00
$360,000.00
$6,070.00
$17,615.43
$4,727.42
$2,842.00
$12,585.56
$11,923.42
$23,800.28
$21,255.34
$6,806.64

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Signature: Date: 8/9/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-532

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C

In relation to: Output Class 1 – Health and Community Care – The Canberra Hospital – Insurances

1. What insurance policies are held in relation to the Canberra Hospital, including but not limited to infrastructure, building services, and operational functions?
2. What was the premium cost of each policy in 2015-16 and 2016-17?
3. What individual claims were made under each policy during 2015-16 and 2016-17?
4. For claims made in relation to operational functions, to which hospital ward does each claim relate?
5. What insurance payout was received for each claim?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. ACT Health holds the following insurance policies with the ACT Insurance Authority (ACTIA) –
   a. Medical Negligence;
   b. Public and Product Liability;
   c. Professional Indemnity;
   d. Directors and Officer's Legal Liability;
   e. Property and Business interruption;
   f. Money/Fidelity;
   g. Principally controlled Contract works;
   h. Overseas Business Travel;
   i. Personal accident cover for Aero Medical retrieval activities; and
   j. Personal accident cover for ACT Health volunteers.

2. The following table sets out ACT Health's premium cost for 2015-16 and 2016-17 against each class of insurance and are provided GST exclusive. Please note that the figures below are not specific to the Canberra Hospital as premiums are invoiced by ACTIA at Directorate level only.

Insurance Class	2015-16	2016-17
Medical Negligence	$29,744,800.00	$25,488,214.00
Public and Product Liability	$551,939.00	$545,859.00
Professional Indemnity	$78,173.00	$58,561.00
Directors and Officer's Legal Liability	$184,515.00	$109,070.00
Property and Business interruption	$546,953.00	$534,988.00
Money/Fidelity	$15,055.00	$12,588.00
Overseas Travel	$9,890.42	$7,126.73
Personal Accident - Volunteers	$1,246.33	$804.04
Personal Accident - Aero Medical retrieval	$60,772.50	$52,784.50
Principally controlled Contract works – Projects below $30 million and less than 24 months construction time	$28,537.04	$80,965.55*
Grand Total	**$31,221,881.29**	**$26,890,960.82**

* This is a deposit premium, based on the estimated cost of construction. An additional premium, or return of premium, may be due once the actual cost of construction has been reconciled.

3. The following table provides a summary of claims that were made under each policy during 2015-16 and 2016-17 relating to Canberra Hospital operations. Please note that 52 per cent of the claims identified below relate to incidents prior to 2015-16 that were received during 2015-16 and 2016-17.

Insurance Class	2015-16	2016-17	Total
Medical Negligence	50	44	94
Property & Business Interruption	4	7	11
Public & Products Liability	1	0	1
Grand Total	**55**	**51**	**106**

4. Claims made in 2015-16 and 2016-17 are not devolved to ward level but rather the clinical service location where the incident primarily arises. The following table summarises the clinical service location for claims relating to operational functions.

Clinical Service Location	Number of claims
Emergency department	16
Obstetrics	16
Orthopaedics	13
Urology	9
Gynaecology	9
General surgery	7
Oncology	5
Cardiology	4
Neurosurgery	4
General medicine (including internal medicine)	3
Vascular surgery	3
Intensive care	2
Otolaryngology	1
Hospital outpatient department	1
Paediatrics	1

5. From the number of claims listed in Question 3, the following table lists the payouts of the insurance claims that were finalised for individual claims that were made under each policy during 2015-16 and 2016-17 relating to the Canberra Hospital campus.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 14/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-533

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION ON NOTICE

RECEIVED
14 JUL 2017
ACT LA
COMMITTEE SUPPORT

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C

In relation to: Output Class 1 – Health and Community Care – The Canberra Hospital – Upgrading and Maintaining ACT Health Assets

1. In relation to the investment of $93 million in the Upgrading and Maintaining ACT Health Assets program:
   a. What is the breakdown of the investment of $93 million, including job, cost and timeline;
   b. Which jobs have been completed;
   c. What was the cost for each completed job;
   d. How long did each completed job take;
2. What is the purpose of the two generators standing outside Building 2 at The Canberra Hospital?
3. Once the new electrical switchboard at The Canberra Hospital is installed, will those generators be retained for back-up?
4. If no, what back-up arrangements will be in place?
5. When will a request for tender be issued for replacement of the electrical switchboard in Building 12 at The Canberra Hospital?
6. What is the estimated cost for that work?
7. How long will it take to complete the work once the contract is let?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. a) The Upgrade and Maintaining ACT Health Assets (UMAHA) program of works includes projects related to the following:
   - Electrical Main Switchboard
   - Electrical upgrades
   - Lift upgrades
   - Hydraulic upgrades
   - Fire system upgrades
   - Heating, Ventilation and Air Conditioning (HVAC) upgrades
   - ICT infrastructure upgrades
   - Building facade upgrades and
   - Minor medical equipment upgrades

Construction Contracts are in place for the Electrical Main Switch Board, Lift upgrades, Hydraulic upgrades package and various engineering consultancies associated with the UMAHA program.

b) All aspects of the UMAHA program have commenced and are scheduled to be completed by June 2019.

c) The breakdown of budget packages is commercial in confidence.

d) The UMAHA scope is scheduled to be completed by June 2019.

2. To provide backup power to Building 2 Electrical Main Switch Board (EMSB) during the course of EMSB replacement works.

3. No.

4. New installation will incorporate backup arrangements as part of the scope.

5. The request for tender included replacement of both Building 2 and Building 12 EMSBs and is already complete with the Contract awarded to Shaw Building Group.

6. Contract award is $9.8 million (GST incl).

7. Building 2 program is due to be completed in June 2018 and Building 12 to be completed in February 2019.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 14/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-534

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C - Output Class 1.1 – Acute Services

In relation to: Budget Statement C, p16 – Accountability Indicators

1. What is the National Efficient Price for the Canberra Hospital for 2017-18?
2. What was the National Efficient Price for the Canberra Hospital for each year from and including 2012-13?
3. What factors lead to changes in the National Efficient Price?
4. What was the average Cost of Care per National Weighted Activity Unit for peer (major metropolitan) hospitals in NSW, Victoria, Tasmania, South Australia and Queensland in 2014-15 and 2015-16?
5. What is the National Efficient Price for non- major metropolitan hospitals in NSW?
6. In cases in which the ACT treats NSW patients who otherwise would have been treated by a non-major metropolitan hospital, is the cost recovery made by the ACT from NSW paid at the National Efficient Price applicable to a major metropolitan hospital?
7. If no, why and to what extent does the rate vary?
8. In cases where the ACT does not recover from NSW a National Efficient Price as applicable to a major metropolitan hospital, does the ACT receive any other recompense for that differential figure?
9. If yes, from which source and to what extent?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. The National Efficient Price (NEP) applying to Canberra Hospital for 2017-18 is $4,910 per National Weighted Activity Unit (NWAU).
2. The NEP applying to Canberra Hospital for each year from and including 2012-13 is as follows:

Canberra Hospital	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
NEP	$4,808	$4,993	$5,007	$4,971	$4,883	$4,910

3. The NEP is determined using public hospital cost data supplied to the Independent Hospital Pricing Authority (IHPA) by states and territories on an annual basis. The most influential factor driving changes in the NEP is the variation in total costs, year-on-year, of providing patient hospital services which includes labour and non-labour costs such as pharmaceuticals, prosthesis and pathology test consumables.

4. The average cost of care per NWAU for major metropolitan peer group hospitals in New South Wales (NSW), Victoria, Tasmania, South Australia and Queensland in 2014-15 is as follows:

Peer Group	State	Average Cost per NWAU 2014-15
Major hospital city	New South Wales	$4,272
Major hospital city	Victoria	$4,407
Major hospital city	Queensland	$4,525
Major hospital city	South Australia	$5,062

The 2015-16 results for this have not been released as yet by the IHPA. It is expected that this information will be able sometime around September 2017 in line with historical business processes of the IHPA.

5. There is no specific NEP for non-major metropolitan hospitals in NSW. The NEP for major and non-major metropolitan hospitals in NSW is the NEP published annually by the IHPA. The table immediately below provides the NEP since 2012-13.

Non-Major Metropolitan Hospitals NSW	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
NEP	$4,808	$4,993	$5,007	$4,971	$4,883	$4,910

6. In such cases where ACT treats NSW patients who otherwise would have been treated by a non-major metropolitan hospital, the cost recovery made by the ACT from NSW is paid at the NEP applicable to the year in which the public hospital service was provided. It should be noted that under the current funding system, NSW pays around 55 per cent of the NEP with the Commonwealth paying the residual 45 per cent.

7. As per the answer to Question 6, the ACT receives full 100 per cent of the NEP payment for treating NSW patients in the ACT public hospital system.

8. There have been no cases to date where the ACT has not received 100 per cent payment of the NEP for treating NSW patients in the ACT public hospital system.

9. Not applicable.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: [signature] Date: 16/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-535

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C

In relation to: Whole of Portfolio – Property Maintenance

1. Which buildings, including, but not limited to, the University of Canberra Hospital, does ACT Health own, manage or maintain?
2. What is the age profile of those buildings?
3. Have maintenance issues with those buildings and associated building services been identified in recent years?
4. If yes, what maintenance issues have been identified?
5. Has work been undertaken in order to rectify these issues?
6. Has ACT Health made a detailed inspection of building services in all buildings?
7. If no, why, and when will it be done?
8. If yes, what maintenance issues have been identified with buildings and building services?
9. What plans does ACT Health have to upgrade/update buildings and building services?
10. Is external cladding, where used on buildings owned, managed or maintained by ACT Health, including, but not limited to, the University of Canberra Hospital, fire rated?
11. For any cladding that is not fire-rated, what plans does the government have, including, but not limited to, timelines and cost, to replace this cladding with a fire-rated product?
12. If no plans, why?
13. Does ACT Health maintain a risk register for buildings it owns, manages or maintains?
14. Does that risk register extend to building services?
15. Who maintains and reviews the risk register?
16. If the risk register is managed and reviewed by a risk management committee, or similar, who are the members of the committee?
17. How often is the risk register reviewed and by whom?
18. What external advice does the committee seek as to identified risks?
19. For risks identified as having a high or extreme profile, what strategies does ACT Health have to mitigate those high or extreme risks?
20. Will you provide a copy of the risk register in relation to buildings and building services?
21. If no, why?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. A list of the buildings in the ACT Health Directorate's property portfolio is at Attachment A.
2. This information is difficult to ascertain for all of the 83 buildings however ACT Health Directorate's property portfolio includes recent buildings completed within the last 10 years eg: Community Health Centres in Belconnen, Tuggeranong and Gungahlin and buildings that were completed nearly 50 years ago eg: Canberra Hospital Buildings 1 and 3.
3. Yes.
4. There are three distinct areas of maintenance issues that have been identified:
   a. Building
   b. Mechanical and Hydraulic and
   c. Electrical, Refrigeration and Heating, Ventilation and Air Conditioning.

   All buildings inherently have both reactive and planned maintenance carried out as a matter of process. Planned and reactive maintenance on ACT Health owned buildings are conducted by both ACT Health and ACT Property Group.
5. Yes.
6. ACT Health completed an inspection of 52 of the 83 sites, including Canberra Hospital and Calvary Bruce Public Hospital Campus, as part of the AECOM Health Asset Condition Assessment report in February 2016. The AECOM report covered the majority of ACT Health's property portfolio with a focus on Acute Tertiary Hospital, Community Healthcare and Accommodation facilities.
7. Any buildings not covered in the AECOM report are being incorporated into Strategic Asset Management Plans (SAMP) currently being developed for all ACT properties at Canberra Hospital Campus and off Campus buildings, as well as Calvary Bruce Public Hospital buildings (expected to be complete September 2017). Once the SAMPs are approved, ACT Health Directorate will review the strategic priorities of the plan, and conduct condition audits accordingly.
8. Maintenance work orders are completed across a range of building services and general facility issues which are identified as follows:
   a. Building (2391)
   b. Mechanical and Hydraulic (5866) and
   c. Electrical, Refrigeration and Heating, Ventilation and Air Conditioning (3363).
9. ACT Health is continuously undertaking maintenance works across the Directorate's portfolio. Once Strategic Asset Management Plans are finalised (expected September 2017), ACT Health will review the strategic priorities of the plans to conduct condition audits accordingly and plan/implement upgrade/repair works as required.
10. All ACT Health buildings constructed since 2008, utilising facade cladding, have been reviewed for compliance with the Building Code of Australia. All buildings have received Certificates of Occupancy. ACT Health is liaising with the recently set up ACT Government Facade Cladding Taskforce to coordinate/consolidate assessment of all buildings.
11. ACT Health will work with the ACT Government Facade Cladding Taskforce to implement any changes arising from the Taskforce's review.

12. Not applicable.
13. Yes.
14. Yes.
15. The Health Infrastructure Services (HIS) risk register is maintained by the HIS Safety and Risk Manager. The HIS Risk register is continually evolving and reviews are undertaken by multiple stakeholders.
16. A monthly risk report is provided to and reviewed by the risk owners. Two committees are in place to facilitate this process; Health Infrastructure Operations Working Group which is chaired by Executive Director for Health Infrastructure Services and Business Support Infrastructure Executive Committee which is chaired by Deputy Director-General Corporate. Members of these committees include representatives from; Treasury, Canberra Hospital and Health Services Executives, Chief Financial Officer for Health, Procurement and Capital Works, Health Services Planning Unit and Health Infrastructure Services.
17. The risk report is provided monthly to both committees. Prior to development of the report the Safety and Risk Manager works with each risk owner to update the status of controls for each risk, and close where appropriate.
18. External advice is sought as and when necessary from a variety of subject matter experts.
19. Risk Control Action Plans (RCAP) are developed for risks with high and extreme risk profile. Officers are assigned against identified actions within the RCAP and given timeframes to meet those actions to ensure the risk can be both managed and mitigated as early as possible.
20. No.
21. The Health Infrastructure Services Risk Register is a confidential document and contains information with the potential to impact on the security and operations of ACT Health Directorate properties.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:

Date: 16/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

ACT Health owned buildings

Building	Details	Address	Suburb	Region
Health Protection Service	Transportable shed Air monitoring System	Allara Strret	Civic	North Canberra
Health Protection Service	Transportable shed Air monitoring System	Neumann Place	Florey	Belconnen
Health Protection Service -	Air monitoring system	Cockcroft Ave	Monash	Tuggeranong
Adult Secure Mental Health	Mental Health	Mugga Lane	Symonston	South Canberra
Brian Hennessy House	Mental Health	Haydon Drive	Bruce	Belconnen
Arcadia Demountable	Meeting room	Haydon Drive	Bruce	Belconnen
Arcadia House	Directions ACT	Haydon Drive	Bruce	Belconnen
Burrangiri Respite Care Centre	Burrangiri Respite Care Centre	Rivett Place	Rivett	Weston Creek
Calvary Residence A	OPMHU Community team	Haydon Drive	Bruce	Belconnen
Clare Holland House	Pallative Care - Calvary Hospital	Menindee Drive	Barton	North Canberra
Lanyon FCC	Lanyon Family Care Centre	23 Sidney Nolan St	Conder	Tuggeranong
Ngunnawal Child Health Clinic	Child Health Clinic	103 Wanganeen Ave	Ngunnawal	Gungahlin
Duffy House	Acomodation for families and Cancer patients	Jemalong St	Duffy	Weston Creek
Gaunt Place	Renal Dialysis	Palmer Street	Garran	South Canberra
Gaunt Place	RILU	Palmer Street	Garran	South Canberra
Gaunt Place	Mental Health	Palmer Street	Garran	South Canberra
Enhanced Belconnen	Community based Services	Lathlain St	Belconnen	Belconnen
Belconnen Health Centre	Vacant	Cnr Benjamin Way & Swanson Crt	Belconnen	Belconnen
Dickson HC	Community based Services	Dickson Place	Dickson	North Canberra
Gungahlin HC	Community based Services	57 Earnest Cavanaugh St	Gungahlin	Gungahlin
Phillip HC	Community based Services	Cnr Corrina & Keltie Sts	Phillip	Woden
Tugg HC	Tuggeranong Health Centre	Cnr Anketell & Pitman St	Greenway	Tuggeranong
Weston HC	Weston Health Centre - ILC / Community	Parkinson St	Weston	Weston Creek
Health Protection Service - Holder	Prevents and responds to Public Health	25 Mulley Street	Holder	Weston Creek
Karralika – Fadden	Drug and Alcohol	Bugden Ave	Fadden	Tuggeranong
Karralika – Isabella Plains	Drug and Alcohol	Keverstone Crt	Isabella Plains	Tuggeranong
YMH -Step Up Step Down	Youth Step Up step Down	30 Fimister	Kambah	Tuggeranong
Miowera	Bush Healing Farm - COTTAGE	425 Tidbinbilla Rd	Paddys River	Tuggeranong
Mental Illness Fellowship	O'Connor	41A David St	O'Connor	North Canberra
Mental Illness Fellowship	O'Connor	41B David St	O'Connor	North Canberra
QEII	QEII Family Care Centre	129 Carruthers St	Curtin	Woden
Main Hospital	Levl 1 - 10	Yamba Drive	Garran	South Canberra
Pathology services	Clinical Services	Yamba Drive	Garran	South Canberra
Centanary Hospital for	Centanary Hospital for Women and Children	Yamba Drive	Garran	South Canberra

Building	Details	Address	Suburb	Region
Clinical	Clinical	Yamba Drive	Garran	South Canberra
Helipad	Helipad			South Canberra
Demountable	demountable	Yamba Drive	Garran	South Canberra
Asset Shed	Asset Shed	Yamba Drive	Garran	South Canberra
Capital Region Cancer Centre	Cancer Centre	Yamba Drive	Garran	South Canberra
Main Hospital		Yamba Drive	Garran	South Canberra
Radiation Oncology	Radiation Oncology	Yamba Drive	Garran	South Canberra
Administration	Demountable	Yamba Drive	Garran	South Canberra
Executive and administration	Executive Building	Yamba Drive	Garran	South Canberra
Mental Health	Adult Mental Health	Dann Close	Garran	South Canberra
Multi Storey Carpark	Multi Storey Carpark			South Canberra
Substation	Yamba Drive Substation	Dann Cl / Yamba Drive	Garran	South Canberra
TCH B3	Level 1 - 2	Yamba Drive	Garran	South Canberra
ANU Medical school	ANU Medical school	Yamba Drive	Garran	South Canberra
Administration/Clinical -	Administration/Clinical - Residences and Medi	Yamba Drive	Garran	South Canberra
Administration	Various	Yamba Drive	Garran	South Canberra
Drug and Alcohol	Clinical	Yamba Drive	Garran	South Canberra
Pain management	Pain unit	Yamba Drive	Garran	South Canberra
Accomodation facility	Dr quarters	Yamba Drive	Garran	South Canberra
TCH B1/B12 to B10/B11/Nat Cap	over ground	Yamba Drive	Garran	South Canberra
TCH B2 to B5/B6	under ground	Yamba Drive	Garran	South Canberra
Level 4 of Southern Car	Link Bridge	Bateson Road	Garran	South Canberra
Universitiy of Canberra Public	Not yet complete	University of Canberra Campus	Bruce	Belconnen
Watson Hostel	Ted Noffs - Catholicare - ATODA	Antill Street	Watson	North Canberra
Woden Valley Childare centre		Woden Valley Childcare Centre	Garran	South Canberra

ACT Health leased buildings

Building	Details	Address	Suburb	Region
1 Moore street	Ground Floor	Moore Street	Civic	North Canberra
1 Moore street	1st Floor	Moore Street	Civic	North Canberra
1 Moore street	2nd Floor	Moore Street	Civic	North Canberra
1 Moore street	3rd Floor	Moore Street	Civic	North Canberra
1 Moore street	Basement storage	Moore Street	Civic	North Canberra
2-6 Bowes	2, 3, 4, 5	Bowes place Woden	Woden	Woden
Callam Offices - A2	CAMHS	Callam & Launceston St	Woden	Woden
Callam Offices - A2	CAMHS	Callam & Launceston St	Woden	Woden
Narrabundah Early childhood school	Child Health Clinics	25 Kootara street	Narrabundah	South Canberra
Tuggeranong child and family clinic	Child Health Clinics	159 Anketell street	Greenway	Tuggeranong
Gungahlin Child and Family centre	Child Health Clinics	51 Ernest Cavanagh st	Gungahlin	Gungahlin
West Belconnen Child HC	Child Health Clinics	6 Luke St	Holt	Belconnen
Florey Child HC	Child Health Clinics	Ratcliffe Crescent	Florey	Belconnen
Curtin	Health admin	Carruthers Street	Curtin	Woden
Hume Warehouse	Record storage	48 Sheppard St	Hume	South Canberra
Hume Warehouse	Record storage	68 Sheppard St	Hume	South Canberra
O'Connor Pathology	Collection centre	1/15 Sarsgood street	O'Connor	North Canberra
Sterilising Mitchell	Sterilising Mitchell (TAMS) - Building 4	Sandford Street	Mitchell	Gungahlin
Supply Warehouse	Supply Warehouse (TAMS) - Building 3	Sandford Street	Mitchell	Gungahlin
Health Records	Health Records (TAMS) - Building 3	Sandford Street	Mitchell	Gungahlin
PM&M	Supply Admin	Sandford Street	Mitchell	Gungahlin
Demountable	Information Services Branch	Yamba Drive	Garran	Woden
ACRS Village Creek	Rehabilitation Aged and Community Care	Kingsmill Street	Kambah	Tuggeranong
Mitchell Records	Warehouse	17 Essington St	Mitchell	Gungahlin

*Estimates - QON No. E17-536

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Health and Wellbeing

Ref: Budget Statements C

In relation to: Whole Portfolio

1. What was the budget funding growth in the portfolio for 2016-17 and in the previous four financial years?
2. What is the benchmark for funding growth and from where is that benchmark sourced?
3. How, in measurable terms, does the quality and standard of service provided by ACT Health compare to those of other Australian jurisdictions?
4. What is the status of the introduction of e-health in the ACT?
5. How much money has been spent so far?
6. What was the initial target introduction date and will it be met?
7. If no, why and what is the new target?
8. Why does ACT Health spend at least $100,000 per month on travel?
9. In relation to the announced grants to assist with bulk billing:
   a. What strategy underpins the policy;
   b. What criteria will be followed in assessing grant recipients;
   c. What is the government's strategy to ensure grant recipients continue bulk billing after grant periods expire; and
   d. What is the government's strategy in general for continued and increased bulk billing after the budget allocation for grant funding is fully expended?
10. In relation to the System Innovation Program:
    a. For how long has the program been running;
    b. For each year, what did it cost to run the program;
    c. For each year, what efficiencies were identified;
    d. For each year, how much money was saved through efficiencies; and
    e. For each year, to what health programs were cost savings re-directed and how much of the saved money was allocated to each?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. The growth in funding in the 2016-17 Published Budget ($1.532 billion) from the 2015-16 Published Budget ($1.462 billion) was $69.3 million or 4.74 per cent. The growth in funding in each of the four years prior is tabulated below:

	2012-13 Budget $ billion	2013-14 Budget $ billion	2014-15 Budget $ billion	2015-16 Budget $ billion	2016-17 Budget $ billion	2017-18 Budget $ billion
Total Health	1.236	1.299	1.390	1.462	1.532	1.616
Growth	0.090	0.062	0.091	0.072	0.069	0.084
Percentage	7.84%	5.06%	7.02%	5.21%	4.74%	5.50%

2. There is no benchmark for funding growth in the Health sector. All States and Territories are working to become more efficient and reduce the growth in health spending. According to the Australian Institute of Health and Welfare Hospital resources 2014-15: Australian hospital statistics report (page 49) the average growth in public hospital services between 2010-11 and 2014-15 was 6.3 per cent (weighted average).

3. ACT Health was surveyed by the Australian Council of Healthcare Standards (ACHS) in May 2015 and was successful in achieving accreditation against the 10 National Standards Safety and Quality Health Service Standards.

4. The status of the Health e-futures program by stream is:
   - Digital Health Infrastructure Program – completed
   - Support Services Program – completed
   - Clinical Systems Program – in progress and scheduled for completion in June 2018.

5. The total budget allocation to the Health-e-Futures Program was $90,185,000. As of 30 April 2017 $77,411,199 had been spent against this program. The remaining $12,773,801 will be used to complete the Clinical Systems Program elements identified above.

6. All components of the Health-e-Futures Program were expected to be completed in the 2015/16 Financial Year. All components will be delivered by the end of the 2017/18 Financial Year.

7. The new target of 2017/18 was required to allow time for the more complicated clinical systems to be configured and tested appropriately before first clinical use. The clinical systems also had dependencies on the digital health infrastructure components to operate appropriately.

8. ACT Health has medical practitioners and administrative staff participate in various national and international meetings, conferences, forums and training opportunities.

9a. Better access to primary health services for all Canberrans.

b. The proposal is to put out a tender, inviting general practice groups with a demonstrated commitment to bulk-billing GP services to extend their commitment to bulk-billed allied health services. Centres that offer the provision of low or no cost primary care services, particularly allied health services such as psychology, diabetes support and physiotherapy will be looked on favourably. Specific criteria will be announced in time.

c. The competitive tender process will ensure the additional funds are built into sustainable business practices.

d. The ACT Government is committed to strengthening primary care, including through the Territory-wide Services Plan.

10a. The System Innovation Program (SIP) commenced in late 2015 and is ongoing.

b. Expenditure against the SIP for 2015-16 was $6.0 million.

Expenditure against the SIP for 2016-17 was $7.4 million.

c. A focus area of the SIP has been projects addressing Access and Sustainability issues.

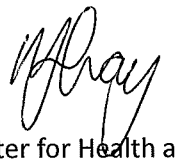
Efficiencies have been identified in the increased throughput and improved access to services for ACT public hospitals, including improvements in National Emergency Access Target, National Elective Surgery Target and total bed days and episodes of care for inpatient admissions.

d. To date, the SIP has supported efficiencies allowing growth in inpatient admissions and total episodes of care to be accommodated.

To accommodate this growth, additional funding would have been required without these efficiencies. This has been avoided.

e. Across the SIP, project efficiency savings have been reinvested in programs to support improved access, efficiency and sustainability of services.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:  Date: 16/7/2017

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-537

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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14 JUL 2017
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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Ms Le Couteur MLA: To ask the Minister for Health and Wellbeing

Ref: Output Class 1.2 - Public Sector Management (Budget Statement B, page 16-17, 30)

In relation to: In relation to the merging of the Healthy Weight Initiative into the Preventative Health Strategy

1) What elements of the Healthy Weight Initiative will be continued under the new Preventative Health Strategy?
2) Which elements will be discontinued

Minister Fitzharris: The answer to the Member's question is as follows:–

1) The Government is committed to building on the momentum and success of the Healthy Weight Initiative (HWI), which has seen no increase in the rates of overweight and obesity in the ACT since the initiative was implemented. Careful consideration is being given to the ongoing alignment of preventative health activities with the evidence-base, and broader government policies, programs and strategies.

2) The Government has yet to make a decision on what will be encompassed by the Preventative Health Strategy.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: MFray Date: 14/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-538

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Ms Le Couteur MLA: To ask the Minister for Health and Wellbeing

Ref: Health - Output Class 1.4 - Cancer Services (Budget Statement C, page 5)

In relation to: In relation to participation in Breast Screen programmes, and I note that the percentage of women (aged 50-69) participating is below the target level, and that the target itself is low:

1) What strategies are you implementing to increase participation?
2) Which stakeholders are you working with on this?

Minister Fitzharris: The answer to the Member's question is as follows:–

1) BreastScreen ACT has the third highest participation rate in the country (AIHW Australian Monitoring report for 2015-16 www.aihw.gov.au/cancer/screening/).

   The participation rate has been gradually increasing however the BreastScreen Program has developed a comprehensive action plan and implemented a range of strategies to increase the participation rates of women in the target age group.

   Key strategies to increase participation include:

   - Opening a third site for screening at the Belconnen Health Centre to increase convenience for women in Canberra's north.
   - Use of the electoral roll data to directly invite women following their 50th birthday to attend the screening program.
   - Continuing to sending letters to lapsed attendees. In 2016 7,097 letters were sent and 309 phone calls were made.
   - Development and dissemination of targeted resource materials to general practitioners and relevant community groups.
   - Education sessions delivered to health practitioners and the community.
   - Conducting research into the enablers and barriers for women attending BreastScreen ACT which included three focus groups and 250 telephone surveys.
   - Utilisation of social media to promote the service with a video and targeted messages developed for local services.
   - Actively seeking opportunities to participate in media interviews to promote breast screening.
   - Attend expos and displays relevant to the target age cohort.
   - In 2017 a BreastScreen nurse visited GP practices with the aim of increasing awareness and promoting BreastScreen ACT.
   - In July 2017 research will be undertaken with GPs to review their referral strategies.
   - Delivering education sessions to GPs and practice nurses.

2) BreastScreen ACT works with a cross section of the community to increase the knowledge and understanding of the importance of early detection of breast cancer through screening. BreastScreen ACT has three key forums that provide a structure to work with representatives from breast cancer organisations (Cancer Council, BCNA, Bosom Buddies), as well as primary health care providers, relevant community organisations that represent the general population as well as the more vulnerable women in the community. These forums are the BreastScreen ACT Advisory committee, the BreastScreen ACT Quality committee and the Consumer Reference Group.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 17/7/17.

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-539

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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ANSWER TO QUESTION ON NOTICE

Ms Le Couteur MLA: To ask the Minister for Health and Wellbeing

Ref: Health - Output Class 1.2 – Alcohol and Drug Services (Budget Statement C, page 13)

In relation to: The detoxification beds at Calvary and Canberra Hospitals:

1) What is the occupancy rate of these beds?
2) Is the Government considering increasing the number of beds?
3) Are there sufficient alcohol and drug specialists in the ACT to appropriately staff these acute services?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. The occupancy rate for detoxification beds at Canberra Hospital for 2016-17 was 66 per cent. Calvary Public Hospital Bruce does not provide this service.

2. ACT Health has no plans to increase the number of beds at Canberra Hospital.

3. Yes.

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Signature: Date: 17/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-540

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Ms Le Couteur MLA: To ask the Minister for Health and Wellbeing

Ref: Health - Output Class 1.2 – Alcohol and Drug Services (Budget Statement C, page 13)

In relation to the use of methamphetamines in the ACT:
1) Does ACT Health have figures on the level of methamphetamine (or "ice") use in the ACT?
2) How prevalent is it compared to other drugs?
3) Has the prevalence of Ice use increased over recent years in the ACT?
4) Does the ACT have any drug treatment or detox services specifically targeting methamphetamine use?
5) Did the ACT receive any funding through the Commonwealth's National Ice Action Strategy?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. In 2013 approximately 6,600 people or 2.2 per cent of ACT residents aged fourteen years and older reported using methamphetamine in the past year according to the National Drug Household Survey. ACT figures from the Household Survey for 2016 have not yet been released.

   Nationally, the number of people reporting using methamphetamine declined between 2013 and 2016 from 2.1 per cent to 1.4 per cent of the population aged fourteen years and older according to the Household Survey.

   Of people who inject drugs surveyed as part of the Illicit Drug Reporting System in the ACT, the rate who report injecting crystal methamphetamine in the preceding six months increased from 61 per cent in 2013 to 78 per cent in 2016.

2. Nationally according to the National Drug Household Survey, in 2016 the most common illicit drug used in the last year was cannabis 10.4 per cent, followed by ecstasy 2.2 percent and then methamphetamine 1.4 per cent.

   In the ACT, the main 'drug of concern' that led clients to seek treatment for their 'own drug use' in 2015-16 was:

   - Alcohol (42 per cent of treatment episodes);
   - Amphetamines (24 per cent of treatment episodes);
   - Cannabis (15 per cent of treatment episodes); and
   - Heroin (nine per cent of treatment episodes).

3. See answer to question 1.

4. No.

5. In 2016, the Capital Health Network (CHN) was allocated $903,429 per year for three years (2016 – 2019) by the Commonwealth Department of Health to commission specialist Alcohol and Other Drug (AOD) treatment services in the ACT. The two priorities for the funding are specialist AOD counselling and specialist AOD treatment for Aboriginal and Torres Strait Islander people.

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Signature: Date: 14/7/2017

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-541

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Ms Le Couteur MLA: To ask the Minister for Health and Wellbeing

Ref: Health - Output Class 1.2 – Alcohol and Drug Services (Budget Statement C, page 13)

In relation to: the statement made by the Minister for Racing and Gaming during Estimates that the Government is taking a public health approach to addressing problem gambling:

1) Has ACT Health been involved in discussions with JACS or the Gambling and Racing Commission about policies to reduce gambling harm?
2) Does ACT Health have any specific programs which address gambling harm from a health perspective?

Minister Fitzharris: The answer to the Member's question is as follows:–

1) No.
2) No.

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Signature: [signature] Date: 16/7/2017

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-542

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Ms Le Couteur MLA: To ask the Minister for Health and Wellbeing

Ref: Health - Output Class 1.6 – Early Intervention (Budget Statement C, page 15)

In relation to: ACAT assessments

1) Is the provision of ACAT assessments a Commonwealth responsibility?
2) What role does the ACT Government play in arranging these assessments and ensuring appropriate follow-up?
3) What is the average wait time for older persons in hospital to receive an assessment by an Aged Care Assessment Team?

Minister Fitzharris: The answer to the Member's question is as follows:–

1) The Aged Care Assessment Program is a Commonwealth funded program that is run in agreement between the Commonwealth Department of Health and ACT Health.

2) ACT Health supports one Aged Care Assessment Team (ACAT) with an FTE of 11.5 staff with either Nursing or Allied Health qualifications. The Aged Care Assessment Program guidelines clearly outlines the role and responsibilities of the ACAT. The ACAT has no ongoing involvement with the individual and/or their family once the assessment has been completed.

3) The Commonwealth KPI for the completion of an assessment for a client in either a public or private hospital is between three and 14 days. ACT Health meets this KPI.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: [signature] Date: 17/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-543

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Ms Le Couteur MLA: To ask the Minister for Health and Wellbeing

Ref: Health - Output Class 1.6 – Early Intervention (Budget Statement C, page 145)

In relation to: the new health centre for Winnunga Nimmityjah:

1) Do you have any information about what services and facilities the new centre will have?
2) Will it expand the current range of services Winnunga provides?
3) In terms of the partnership approach, is Winnunga leading decisions about design and facilities?
4) What role does ACT Health have in that process?

Minister Fitzharris: The answer to the Member's question is as follows:–

1) The ACT Government has committed to replacing the current aged Winnunga Nimmityjah facility, focussing primarily on existing services and an appropriate level of growth. Any additional health services provided in the new facility will be subject to a detailed planning process over coming months.
2) As a Non-Government Organisation, Winnunga Nimmityjah determines the services they provide. Notwithstanding, the new infrastructure will primarily support the existing services, with any additional functionality considered in a detailed planning process.
3) ACT Health is in discussions with Winnunga Nimmityjah regarding the governance process for the planning, design and construction of the new facility. Site selection, ownership and scope of services will each impact on the appropriate governance framework.
4) See response to question 3.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:

Date: 16/7/2017

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-544

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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18 JUL 2017
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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Ms Le Couteur MLA: To ask the Minister for Health and Wellbeing

Ref: Health - Output Class 1.6 – Early Intervention (Budget Statement C, page 145)

In relation to: mobile dental vans:

1) How often will the two new mobile dental vans be operating at each community centre?
2) What will be their hours of operation?
3) Will there be a co-payment for patients using these services
4) Who will be entitled to services with no out-of-pocket expense?
5) What are the criteria for accessing services through these vans
6) Will patients require a Commonwealth Health Care Card or other concession identification?
7) Is there an income threshold for accessing services?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. The ACT Dental Health Program is currently engaging with stakeholders to identify how best the two new mobile dental clinical (MDC) can service the most vulnerable populations. The frequency and location of the new MDCs will be determined through this process.

2. The hours of operation of the new MDCs will be determined through the consultation process.

3. Co-payments may be required for this service, due to legislation of fees and charges. The cost of dental services is an identified barrier for vulnerable people to access care and will be taken into consideration when developing the Business Rules and Model of Care for the new MDCs.

4. As part of the consultation process, consideration will be given to providing particular consumer groups with access to services with no out-of-pocket expense, based on the index of Community and Socio-economic Advantage.

5. These details are currently being worked through.

6. These details are currently being worked through.

7. These details are currently being worked through.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 17/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-545

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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ANSWER TO QUESTION ON NOTICE

Ms Le Couteur MLA: To ask the Minister for Health and Wellbeing

Ref: Health - Output Class 1.6 – Early Intervention (Budget Statement C, page 15)

In relation to: Year 7 student health checks:

1) What was the reason for choosing year 7 students as the age group for student health checks?
2) Which health professionals will be conducting those checks?
3) Will specialist mental health professionals have a role?
4) How will parents and students be notified of any issues identified through those checks?
5) Will the school or ACT Health have a role in arranging any follow-up if needed?

Minister Fitzharris: The answer to the Member's question is as follows:–

Please note that the final design of the Year 7 Health Check will depend on the outcome of the initial evidence review phase and extensive consultation with stakeholders.

1) Monitoring students in their first year of high school allows follow-up to occur within the same school system. In addition, the aggregation of students in fewer high schools (than primary schools) helps the logistics of conducting the health check.

   Because Year 7 students are generally starting four years at their high school, this allows any issues identified in Health Checks to be analysed and followed-up in a relatively stable population.

2) It is not yet clear which health professionals will be directly involved in the Year 7 Health Check. There are opportunities to leverage and draw efficiencies through existing services (e.g. school immunisation programs). These opportunities will be explored as part of the program planning phase.

3) The exact role of specialist mental health professionals will be determined during the planning phase. Mental Health professionals will be consulted in the design of the Year 7 Health Check Program.

4) The planning phase of the Year 7 Health Check will involve extensive consultation with the Education Department, schools and relevant health professionals. These questions will be addressed as part of the planning phase.

5) Refer to question 4 above.

Approved for circulation to the Select Committee on Estimates 2017-18

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By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-546

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Ms Le Couteur MLA: To ask the Minister for Health and Wellbeing

Ref: Health - Output Class 1.6 – Early Intervention (Budget Statement C, page 15)

In relation to: table 9 "accountability indicators for the Local Hospital Network" on page 48, and I note that the estimated outcome for subacute services in 2016/2017 is well below the target and the 2017/2018 target has been reduced:

1) Is this an indication that patients are accessing emergency or admitted services when subacute care would be appropriate?
2) Do the emergency departments at ACT Hospitals have a way of redirecting non-urgent cases to subacute services where appropriate?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. No.

   The decrease in the targets for subacute services is a result of the Independent Hospital Pricing Authority adjusting the National Weighted Activity Unit price weights. The back-casting adjustment has reduced the 2017-18 target by approximately 7 per cent. This is not a reflection on any reduction in patient caseload for subacute services.

2. Following review by a Medical Officer, some patients presenting to the Emergency Department are referred to the subacute setting for routine care and follow up.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: [signature] Date: 17/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-548

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Ms Le Couteur MLA: To ask the Minister for Health and Wellbeing

Ref: Health - Output Class 1 - ACT Local Hospital Network (Budget Statement C, page 12)

In relation to hospital stays:

1) What is the average length of stay for patients in acute hospitals in the ACT?
2) Can you provide a breakdown of where patients get discharged to? (e.g. aged care, rehab, home etc.)
3) Are there instances where a lack of available beds in subacute settings mean patients have to extend their stay in acute care?
   a) How frequently does this occur?
   b) Which subacute sectors face bed shortages?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. The average length of stay for patients in the public acute hospitals in the ACT was 3.3 days as reported in the 2015-16 Australian Hospital Statistics Admitted Patient care report published by the Australian Institute for Health and Welfare.
2. The following table shows where patients were discharged after their episode of care from ACT public hospitals in 2016-17:

Discharge ACT Public Acute Hospitals 2016-17	Percentage
Home	90.34%
Change of Care Type	3.45%
Transfer to Acute Hospital	3.42%
Died	0.94%
Left Against Medical Advice	0.54%
Nursing Home/Hostel	0.42%
Nursing Home Return	0.32%
Other/ Welfare Institution	0.24%
Other/ Care- QEII /Hospice/ ACS	0.13%
TCH Residences	0.11%
Psychiatric Hospital	0.05%
Other (For example organ procurement, hospital boarder)	0.04%

3. Yes, there are instances where a lack of available beds in subacute settings means patients have an extended stay in the Canberra Hospital.

(a) The frequency varies on a daily basis.

(b) The subacute sectors that face bed shortages, which impacts on the length of stay of patients, include:

- First placement for nursing home (income and assets tests can take up to 120 days);
- National Disability Insurance Scheme (NDIS);
- Housing and accommodation;
- Aged Care Rehabilitation Unit (ACRU) and Older Persons Mental Health (OPMH) beds
- Respite; and
- Housing and nursing homes for patients with behavioural issues or increased physical needs, such as tracheotomy.

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Signature:

Date: 17/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-549

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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ANSWER TO QUESTION ON NOTICE

Ms Le Couteur MLA: To ask the Minister for Health and Wellbeing

Ref: ACT Health - Patient Care Navigators (Budget Paper 3, page 102)

In relation to: Patient Care Navigators

1) Can you provide further information about the investment in patient care navigators?
2) What types of health professionals will fill these roles?
3) How will patients be granted access to this program?
4) What are the requirements for entry?
5) Will they have a role in discharge planning?
6) How will they connect with primary care services such as GPs which are Commonwealth funded?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. A one off grant of $100,000 will be provided to the Health Care Consumers Association (HCCA) to develop a model for patient care navigators to work with Canberrans with chronic health conditions.

   This investment will be used for research into any existing national and international models and an assessment of the demand for the service. Key stakeholders will be engaged to consider options, including chronic care services, to develop a proposed model that could be taken to a trial and evaluation stage in the future.

2. This will be determined once the model has been developed.
3. Refer to response to question 2.
4. Refer to response to question 2.
5. Refer to response to question 2.
6. Refer to response to question 2.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: [signature] Date: 17/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-551

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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ANSWER TO QUESTION ON NOTICE

Mr Milligan MLA: To ask the Minister for Health

Ref: Health, Budget Paper 3, Budget Statement C, Output Class 1

In relation to: Indigenous Health drug and alcohol rehabilitation

1. Ngunnawal Bush Healing Farm I refer to Table 31 Changes to Appropriation on page 26 of the Health Directorate Statement which shows that expenditure worth $1.7 million being carried over for the Ngunnawal Bush Healing Farm. Why was this expenditure being carried over from last year and what will the expenditure be for?
   a) Why has the site of the Bush Healing Farm been sitting empty since November 2016?
   b) When did the ACT Government find out about the restrictions on the services that could be offered at the site?
   c) Why did the ACT Government proceed with the development of the Bush Healing Farm given the restrictions on the services that could be offered at that site?
   d) Who will be running the Bush Healing Farm now that Winnunga Nimmityjah has pulled out?
   e) In the public accounts hearings, Mrs Dunne/I was advised that the Bush Healing Farm would open in May or June. What is the revised opening date for the Ngunnawal Bush Healing Farm?
   f) How much money did the government spend on the Ngunnawal Bush Healing Farm in each year since 2003-04?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. I refer the Member to the answer to QoN 289.

   a) A number of minor but essential works to the facility were needed to be completed before the facility could open, this included the construction of an access road for the facility.

   b) I refer the member to my statement in the Hansard of 7 June 2017:
   "In relation to the confusion over the zoning of the bush healing farm and its consequence, it is important to be clear as to the precise nature of what occurred. The issue at the centre of this matter is not a failure on behalf of ACT Health to understand the zoning, rather, ACT Health did not adequately communicate to the organisations which were contracted in 2016 the precise nature of this zoning. This unfortunately resulted in Winnunga, ATODA and others developing a model of care that was not compatible with the site and created an inaccurate view as to the purpose of the Ngunnawal bush healing farm."

c) I refer the member to my statement in the Hansard of 7 June 2017:
"It has never been the intention of the bush healing farm to be an alcohol or other drug rehabilitation centre. Some of this comes down to specific definitions. The bush healing farm is designed to address root-cause issues that lead to substance abuse and treatment relapses, with services revolving around reconnecting Aboriginal and Torres Strait Islander peoples to land and culture with the aim of assisting them to better respond to life's challenges.

Ultimately, the purpose of the bush healing farm is to provide a place of healing whereby Aboriginal and Torres Strait Islander peoples will feel safe and supported by the traditional custodians, community leaders and elders, respected role models as well as cultural healers to make ongoing and meaningful change in their lives, and to break the cycle of drug and alcohol dependency."

d) Winnunga Nimmityjah was not contracted to manage or provide service at the Ngunnawal Bush Healing Farm (NBHF). We are currently in advanced conversations with a range of providers to deliver services that will align with the NBHF program. Given the stage of the conversations it would not be appropriate to detail these providers.

Once the negotiations are completed we will be able to detail more clearly the providers and the program.

e) I refer the member to my statement in the Hansard of 7 June 2017:
"I fully expect that the bush healing farm will have a phased opening by around August of this year."

f) Funding for NBHF was appropriated in the supplementary appropriation in 2007/2008 Since that time funding has been provided as follows:

Recurrent Expenditure by Financial Year is

2009-10	$183,000
2010-11	$235,000
2011-12	$237,000
2012-13	$235,000
2013-14	$122,000
2014-15	$582,000
2015-16	$622,000
2016-17 (YTD to May)	$169,000
	$2,348,000

Capital expenditure by financial year is

2008-09	$1,400,000
2009-10	$221,000
2010-11	$5,000
2011-12	$249,000
2012-13	$291,000
2013-14	$77,000
2014-15	$5,000
2015-16	$6,343,000
2016-17 (YTD)	$1,119,000
	$9,710,000

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: [signature] Date: 16/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-552

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Mental Health

Ref: Budget Statements C – Output 1.2 – Mental Health

In relation to: Auditor-General Report No 6/2017 – Mental Health Services – Transition from Acute Care

1. Will the directorate require additional appropriation funding to meet the timeframes given in the government's responses to the report recommendations?
2. If yes, how much?
3. If no, from where will the funding be sourced?
4. How does the directorate intend to keep the Assembly and the community informed as to progress in relation to the government responses?
5. In relation to recommendation 6, why is ACT Health not enforcing its own policy to complete the suicide vulnerability assessment tool every three months for all patients?

Minister Rattenbury: The answer to the Member's question is as follows:–

1. ACT Health is currently preparing advice to me as Minister for Mental Health for consideration.
2. As above, this has not been determined at this time.
3. As above, this has not been determined at this time.
4. The Minister for Mental Health is required under the *Auditor General Act 1996* to provide a government response to the report within four months.
5. ACT Health has acknowledged that a Suicide Vulnerability Assessment Tool (SVAT) is a vital component of comprehensive mental health care. ACT Health is currently reviewing the policy, data collection and documentation requirements for use of this assessment tool. For example, the current data collection methodology for this target does not account for:
   - services where a SVAT may not be specifically required;
   - where suicide vulnerability assessment has actually been documented in the body of a clinical record rather than specifically using the SVAT Form; and
   - where the SVAT has actually been completed, but just outside of the three month period.

ACT Health is currently considering adjusting the SVAT Policy to account for these reasonable clinical variations.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:

Date: 12/7/17

By the Minister for Mental Health, Shane Rattenbury MLA

*Estimates - QON No. E17-553

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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14 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Mental Health

Ref: Budget Statements C

In relation to: Output 1.2 – Drug services

1. Is the government negotiating or intending to negotiate with the Ted Noffs Foundation or any other NGO to conduct pill-testing at the Spilt Milk Festival?
2. What funding is allocated for pill-testing at the Spilt Milk Festival?
3. What is the risk that pill-testing will not detect all chemical elements of synthetic drugs?
4. What services will be available for any person who takes a tested drug but suffers adverse effects?
5. What legal indemnity protections will be put in place for the government or any person or organisation associated with the pill-testing service?
6. What counselling services will be available or given to persons wishing to take tested drugs?
7. What psychological screening services will be available for persons wishing to take tested drugs, to determine the likelihood of them entering a psychotic state after taking stimulants (ref: Chapter 7 National Drug Strategy)?
8. What psychological screening services will be available for persons with an existing psychotic disorder, to determine whether their condition will be exacerbated by taking tested drugs (ref: Chapter 7 National Drug Strategy)?
9. What services will be available to protect the personal safety and security of other attendees?
10. Will the location of a pill-testing service concentrate drug-taking in the vicinity of that location?
11. If yes, what additional security services will be provided in the area?
12. Will the availability of pill-testing services increase and intensify the availability of drugs at an event?
13. If no, what evaluation methodology drew that conclusion?
14. If yes, what anti-drug-trafficking security arrangements will be put in place?
15. Will the availability of pill-testing services increase the scope of the drug-trafficking market more generally in the ACT?
16. If no, what evaluation methodology drew that conclusion?
17. If yes, what strategies does the government have to combat a potential increase in drug-trafficking more generally in the ACT?

18. If a person consumes tested illicit drugs does it remain open to police to make an arrest if they observe the activity at the Spilt Milk Festival?
19. Notwithstanding the presence of pill-testing facilities, will illicit drug trafficking remain illegal if conducted at the Spilt Milk Festival?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. The ACT Government has publically committed to exploring pill testing options further. ACT Health has been tasked with leading this process.
2. Not applicable.
3. There is a small chance that a component of a pill will not be detected using mobile analytical pill testing equipment.
4. Refer to Question 1.
5. Refer to Question1.
6. Refer to Question 1.
7. Refer to Question 1.
8. Refer to Question 1.
9. Refer to Question 1.
10. Refer to Question 1.
11. Refer to Question 1.
12. Refer to Question 1.
13. See question 1.
14. See question 1.
15. Not applicable.
16. Not applicable.
17. See question 15.
18. Not applicable.

19. Not applicable.

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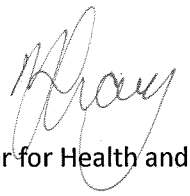
Signature:  Date: 14/7/17

By the Minister for Health and Wellbeing, Meegan Fitzharris MLA

*Estimates - QON No. E17-554

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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18 JUL 2017
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ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Mental Health

Ref: Budget Statements C – Output 1.2 – Mental Health

In relation to: Community-based mental health programs

1. What feedback did the government receive during 2016-17 from NGOs about the adequacy of funding for community-based supports for people with a mental health illness?
2. What analysis has the government commissioned as to the extent to which community-based supports help to keep people with a mental health illness out of hospital beds and clinics and the mental health units?
3. Who did the analysis?
4. What did that analysis conclude?
5. Specifically, what did that analysis say about the adequacy of funding to NGOs for the purpose?
6. If no analysis was made, when does the government intend to commission such work?
7. If no commission is planned, why?
8. How much funding was provided to NGOs for community-based mental health support services in each of 2012-13, 2013-14, 2014-15, 2015-16 and 2016-17?

Minister Rattenbury: The answer to the Member's question is as follows:–

1. NDIS service providers are reporting an impact on their funding streams as a result of consumers resourcing their service provision through their individual NDIS funding packages.

2. Outcomes from research undertaken both nationally and internationally highlight the extent to which community based supports help to keep people with a mental health illness out of hospital beds, clinics and mental health units.

   The National Mental Health Commission Review 2014; Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Services states that support through the NGO sector has been identified as fundamental to keeping people with complex needs well, participating within their communities, and leading contributing lives. It recommended actively building up hospital avoidance services which keep people well and in the community, participating in education and employment.

   The ACT Government is committed to keeping people well and provides the highest level of funding to community based mental health services compared to other Australian jurisdictions.

The ACT Government also has significant investment in alternative options to hospital for those people with a sub-acute mental illness that requires support. These include funding three Step Up Step Down community based residential facilities equating to 16 beds. The ACT Government also funds an additional eight beds for short to medium term supported accommodation to women.

In addition, outreach Step Up Step Down programs are provided where intensive support is delivered to no less than 30 people at any one time.

Other outreach programs include the Detention Exit Community Outreach program which received additional funding in the 2017 – 18 ACT Budget to enhance the delivery to 20 people at one time.

A range of additional community mental health support programs aimed at keeping people well and participating in the community are also funded by ACT Government where there is ineligibility for the National Disability Insurance Scheme to fund such programs.

3. No specific analysis has been undertaken in the ACT due to the lessons available from other sources.

4. Conclusions from other sources both nationally and internationally identify that community based mental health support is important in keeping people out of hospital beds, clinics and mental health units.

5. As previously mentioned, the ACT Government has a commitment to funding NGOs to assist in keeping people out of hospital beds, clinics and mental health units. The most recent Mental Health Services in Australia report indicates that in 2014-15 the ACT Government funded community based mental health services at a higher level per capita than any other jurisdiction in Australia.

6. See response to question 5.

7. See response to question 6.

8. Funding provided to NGO for community-based mental health support services for the years you have requested are:

2012-2013	$13,856,940
2013-2014	$14,017,201
2014-2015	$14,845,349
2015-2016	$14,571,865
2016-2017	$10,620,890

The funding identified above is monies that have gone directly to NGOs and excludes additional funding to other Government Organisations including the Australian National University, Canberra Institute of Technology, and Emergency Services which were also funded in these years.

What appears to be a decrease in funding in 2015-2016 and 2016-2017 of $4.1 million was due to the staged transition of NGO's that were previously funded by ACT Health to the NDIS. This $4.1 million is part of the monies now administered by the National Disability Insurance Agency.

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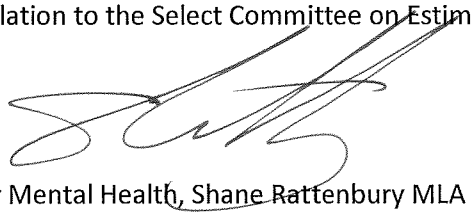
Signature: 

Date: 18/7/17

By the Minister for Mental Health, Shane Rattenbury MLA

*Estimates - QON No. E17-555

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
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ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Mental Health

Ref: Budget Statements C

In relation to: Output 1.2 – Mental health – Office for mental health

1. What will be the role and functions of the Office for Mental Health?
2. What will be the staffing profile, including staff numbers, classifications, functions and roles?
3. What sector consultation was undertaken to establish the role, functions and staffing of the Office?
4. Where will the Office be located?
5. When will the Office commence business?
6. What strategies and measurable accountability indicators are in place to ensure the Office is tasked with delivering practical outcomes that will be of direct benefit to consumers of mental health services?

Minister Rattenbury : The answer to the Member's question is as follows:–

1) The role and functions of the Office for Mental Health will be developed in consultation with mental health stakeholders, as well as the Canberra community more broadly. The initiative provides an exciting opportunity to provide leadership to the mental health service system and to be a shaping force in moving ACT mental health services towards a coordinated and integrated system.

2) This information is not currently known and will be contingent on the final model.

3) A four-staged consultation process will feed into the design and development of the Office for Mental Health. Targeted stakeholder consultation is anticipated to commence shortly with a 'conversation starter' paper being released, for the purpose of stimulating thought and prompting discussion.

   There will be many opportunities to engage in the process and I'd encourage everyone to participate and feed into this process to ensure that the community's views are fully considered in the development of this new body.

4) This information is not currently known and will be contingent on the final model.

5) It is imperative that the model for the Office is the right fit for the needs of the ACT and can provide best value for money. As such, it is anticipated that the Office will commence operations in late 2018, ensuring ample opportunity for model development and design in close consultation with the community. This does not mean that if developed ahead of time, the Office cannot commence sooner.

6) Consideration for an appropriate evaluation framework will be incorporated into the development and design of the Office. With the role and function still unknown, it is too early to comment on appropriate indicators.

   Appropriate mechanisms for progress monitoring throughout the life of the Office will also be included in the development and design of the Office for Mental Health in 2017-18.

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Signature:

Date: 16/7/17

By the Minister for Mental Health, Shane Rattenbury MLA

*Estimates - QON No. E17-556

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
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ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Mental Health

Ref: Budget Statements C

In relation to: Budget Statements C, p6: Strategic Objective 5 – Reducing the usage of seclusion in mental health episodes

1. Why did ACT Health fail to meet its target for reducing the usage of seclusion in 2016-17?
2. What strategies are in place to ensure ACT Health meets the target for using seclusion on mental health clients during 2017-18?
3. What were the non-correctional patient seclusion rates individually for Dhulwa, Canberra Hospital and Calvary during 2016-17?
4. What strategies are in place to ensure non-correctional patient seclusion policies and practices are not being informed by policies and practices in use in a correctional setting?

Minister Rattenbury: The answer to the Member's question is as follows:–

1. Mental Health Justice Health Alcohol and Drug Services (MHJHADS) is a national leader in reducing Seclusion and Restraint in mental health inpatient settings.
   The higher than expected result for 2016-17 is due to the Dhulwa Mental Health Unit (Dhulwa) becoming operational midway through 2016-17. Dhulwa is specifically used to treat complex patients and increases in seclusion can be expected. ACT Health will maintain the target of less than 3 per cent into 2017-18 but will closely monitor the incidents of seclusion at Dhulwa before adjusting the target in 2018-19 for this measure.

2. The strategies in place to ensure ACT Health meets the target for use of seclusion on mental health clients in 2017-18 are aimed at ensuring seclusion is a last resort. These include:
   - The publishment of a guideline, *Identification, Mitigation and Management of Aggression and Violence for Mental Health Justice Health Alcohol and Drug Services Inpatient Units* (Attachment A) on 22 September 2016. The guideline includes evidence based assessment tools, escalation plans for alerting clinical concern, tools for the measurement and management of ward acuity and pathways for incident management.
   - A roll out of the clinical guideline across MHJHADS inpatient units is occurring, with staff being trained in how to apply the tools in dealing with patient aggression.
   - Staff are also trained in de-escalation techniques, and to observe patient behaviour and intervene early to prevent situations from escalating.

3. Within ACT Health mental health facilities there is no distinction between correctional and non correctional patients for the purposes of providing health care.

   For the financial year to date at May 2017:
   - The Acute Mental Health Unit had 38 episodes of seclusion involving 23 admitted people.
   - The Mental Health Short Stay Unit had six episodes of seclusion involving four admitted people.
   - Dhulwa had 19 episodes of seclusion involving six admitted people.

4. Within ACT Health mental health facilities there is no distinction between correctional and non correctional patients for the purposes of providing health care.

   All ACT Health staff must adhere to the CHHS Clinical Procedure for Seclusion of Persons with Mental Illness or Mental Disorder Detained under the *Mental Health Act 2015*.

   The Official Visitors attend all units on a monthly basis and review the MHJHADS legislative responsibilities regarding documentation.

   All episodes of seclusion are reviewed by the Assistant Director of Nursing and the Consultant Psychiatrist in the units.

   The Seclusion and Restraint Review Committee meets monthly and review all episodes of seclusion. This committee includes consumer and carers representatives.

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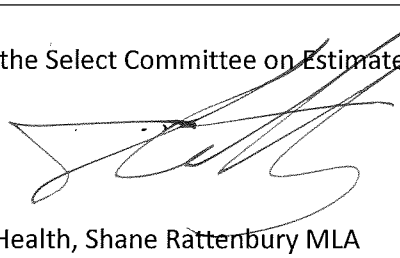
Signature:  Date: 12/7/17

By the Minister for Mental Health, Shane Rattenbury MLA

Canberra Hospital and Health Services Clinical Guideline

Identification, Mitigation and Management of Aggression and Violence for Mental Health Justice Health Alcohol and Drug Services Inpatient Units

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Guideline Statement

Background

This guideline will guide clinical and operational practices improving systems of work that are safe and guide ACT Health staff to better identify, mitigate and manage episodes of clinical aggression and violence in Mental Health, Justice Health Alcohol and Drug Services (MHJHADS) inpatient units.

In support of the MHJHADS Framework for the Management of Aggression and Violence and the ACT Health Violence and Aggression by Patients Consumers or Visitors Prevention and Management Policy, this clinical guideline aims to provide specific clarification of clinical and operational processes relating to the identification, mitigation and management of aggression and violence within MHJHADS Inpatient Units.

It is well documented that violence and aggression towards staff and others is a known risk in inpatient services. While it cannot be guaranteed that exposure to an incident of aggression or violence can be avoided in all circumstances, the risk can be identified and actively managed.

Key Objectives

The key objectives of this document are to:

- Establish a safe system of work for MHJHADS inpatient units which supports the MHJHADS Framework for the Management of Aggression and Violence,
- Guide the implementation of safe clinical practices in identifying, mitigating and managing incidents of aggression and violence for MHJHADS inpatient units,
- Highlight the importance of the interrelated environmental, procedural and relational elements in supporting a safe environment,
- Implement the Brøset Violence Checklist (BVC) as an identified inpatient clinical tool to supplement current clinical practice,
- Support the adoption of best practice principles in the medical management of acute agitation,
- Provide guidelines to escalate clinical concern to the multidisciplinary team ,
- Promote clinical leadership and teamwork that is supportive of safe work practices,
- Identify staff training requirements and opportunities that support this guideline and further develop staff knowledge and skill to safely manage situations when these presentations occur

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Scope

This guideline applies to all ACT Health staff working in MHJHADS Inpatient Units. This guideline provides a clarification of clinical expectations and is to be used in conjunction with

professional clinical skill and judgement, sound clinical leadership and supported by the implementation of staff training targeted at the management of mental health and behavioural emergencies.

Safety is the responsibility of all staff. A safe environment provides a framework in which the treatment and management of acute agitation and behavioural disturbance can be undertaken in the least restrictive environment, with person centred care at the fore and offered in the safest and most respectful manner possible.

A consistent approach from staff is required to maintain a safe environment, to establish safe work systems and safe work practices, and build team confidence in each other's support in the event that a problem occurs. To achieve a safe work environment, the MHJHADS Framework has adopted three interrelated elements. These include environmental, procedural and relational approaches to safety (See, Think, Act. NHS, 2010).

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Section 1 – Safe Work Practices

A consistent approach from all staff is required to maintain and support a safe work environment and establish safe work practices. The MHJHADS Framework for the management of Aggression and Violence has adopted an environmental, procedural and relational approach to inpatient security and safety.

1.1 Environmental Security

The physical safety of people, staff and visitors is paramount and requires that all staff remain diligent in carrying out clinical duties and ensuring a safe physical environment.

Physical security in the health care environment refers to the management of an environment that keeps people safe by the use of duress alarms, fences, locks, bedroom access, egress and electric swipe cards and security and CCTV systems. Environmental factors are important determinants in managing aggressive and violent behaviour in inpatient settings. The aim is to promote a therapeutic environment which allows the person to enjoy safety and security, privacy, dignity, choice and independence, without compromising the clinical objectives of their care. Comfort, noise control, light, colour and access to space will all have an impact on a person's care and, if not managed, it can contribute to frustration and heightened levels of agitation by the person.

Factors which contribute to the environmental safety of an admitted person, staff and visitors in the inpatient setting can include, but is not limited to:

- Supporting safe clinical practices and taking responsibility for personal safety and the safety of others,
- The monitoring of items which may be brought into the inpatient unit which may prove to be a personal or environmental risk to others,
- Monitoring and removal of contraband including illicit substances and weapons,

- Maintaining visual observations of patients, visitors and the environment,
- Conducting environmental checks and risk assessments,
- Being cognisant of patients, staff and visitor whereabouts,
- Ensuring staff are trained in the use of all relevant equipment and procedures that support safety systems,
- Staff acting immediately to respond to any identified risks or escalate concerns, and
- Understanding and being confident in initiating and responding to emergency procedures.

Staff must conduct regular environmental checks to identify hazards, assess risk and implement controls. All staff must be familiar with, and comply with, the specific local shift to shift procedures for the completion of environmental checks. These environmental checks are specific to each clinical environment and may include but not limited to, ensuring that fire doors and exits are secure, treatment rooms are locked, there are no plastic bin liners on the unit or that contrabands or items which may lead to a safety concern within the unit are removed. All environmental checks must be in line with ACT Health policies and procedures included in the related policies at the end of this document, and include gaining the collaboration and cooperation of people admitted to the unit wherever possible to ensure their clinical space is safe.

Any risks identified during the environmental checks must be mitigated immediately where possible (i.e. removal the prohibited items), or reported by escalating the risk to the Clinical Nurse Consultant (CNC) or Unit Manager. Environmental checks are to be documented each shift by the Nurse in Charge of the shift in the person's clinical record.

While formalised environmental checks are a useful way of focussing on risk at certain times, all staff should be alert to any departure from a safe environment and act or escalate as required.

To increase the environmental security prohibited items must be reduced and/or eliminated from the Unit. This can be monitored by searching belongings at admission, as well as by checking for prohibited items on return from leave. When visitors arrive, the Unit policy on prohibited items must be made known to them so that they can declare any items before proceeding to visit persons admitted in the Unit.

Where there is suspicion of the visitor bringing prohibited items into the Unit, staff should consider limiting the visitor's access to the Unit. These limits can range from supervised visits through to cancelation of visitation rights, with least restrictive options trialled in the first instance. If the decision to refuse a visitor to the Unit is made, any ongoing restrictions should only occur after discussion with the multidisciplinary team, and documentation of the rationale is recorded the person's clinical record and in Riskman. People and their visitors should be advised of any restrictions in place.

It is important for everyone, including visitors, to be aware of the rules of the Unit as part of the orientation process. Mutual understanding of the limits of the Unit promotes

collaboration and buy-in from all parties. Where rules are not explained, there can be a sense that staff are being punitive which can lead to aggressive and violent incidents.

To maintain a therapeutic environment and promote engagement people need to feel safe and be able to move freely without duress of any kind. Individuals or groups for example may be able to take control of common areas such as recreation spaces within a Unit, excluding others or making them feel uncomfortable. Alternatively, some people may not respect the privacy of others and enter bedrooms without permission. It is important that these types of situations are addressed immediately at team level, without delay. Increasing observation of these areas can mitigate these risks.

Personal Protective Equipment (PPE) in the form of electronic personal duress alarms are provided in all AMHS bed based areas to ensure timely responses in preventing and responding to situations leading to injuries to the person admitted, other people , visitors and staff. All staff are required to wear personal duress alarms at all times while on the unit and must be familiar and comply with local procedures specific to the area.

1.2 Procedural Security

Procedural security relates to all of the policies and procedures and work practices which have been developed to maintain safety and security in the inpatient setting. These include meeting Legislative responsibilities, ACT Health Policy, Canberra Hospital and Health Services Policy and Procedures, in addition to local MHJHADS Divisional and Team Procedures and Guidelines.

MHJHADS staff working in the inpatient setting are required to:

- Understand and comply with ACT Health Policy, Operational Procedures and Clinical Guidelines relating to Aggression and Violence located on the CHHS Policy Register,
- Undertake ACT Health and MHJHADS mandatory training as outlined in the Essential Education Policy,
- Undertake unit based orientation of safety systems for staff,
- Wear personal duress alarms in accordance with local procedure,
- Ensure personal and professional behaviour does not contribute to the potential for violence or aggression,
- Understand code and de-escalation options and apply interventions when confronted with violence or aggression,
- Apply safe work practices that involve proactive assessment, mitigation and, management of risk and the completion of associated documentation as a record of clinical intervention,
- Supervise the clinical environment at all times,
- Undertake assigned duties maintaining observation of people at required times,
- Promptly report all incidents of violence and aggression using Riskman,
- Report acts of violence to ACT Policing when appropriate and in consultation with managers, and
- Participate in clinical review of incidents to support a culture of learning and quality improvement.

1.3 Relational Security

Relational security is about the formation of safe and effective therapeutic relationships between staff and people which are purposeful and support ongoing assessment and risk management. Relational security is described as the understanding and knowledge that staff have of a patient and their environment and how this information translates in order to guide and support appropriate responses and treatment. Relational security is interactive and requires a sound therapeutic use of self and a repertoire of interpersonal skills. Relational security is also concerned with staff to patient ratios.

Four key areas that help staff maintain relational security are (NHS, 2010):

1. The whole care TEAM e.g. establishing boundaries and therapeutic relationships
2. OTHER people on the unit e.g. people mix and dynamics
3. INSIDE WORLD. The milieu experienced by the person e.g. physical environment and personal world
4. OUTSIDE WORLD. The connections the person has to the outside world e.g. visitors and outward connections.

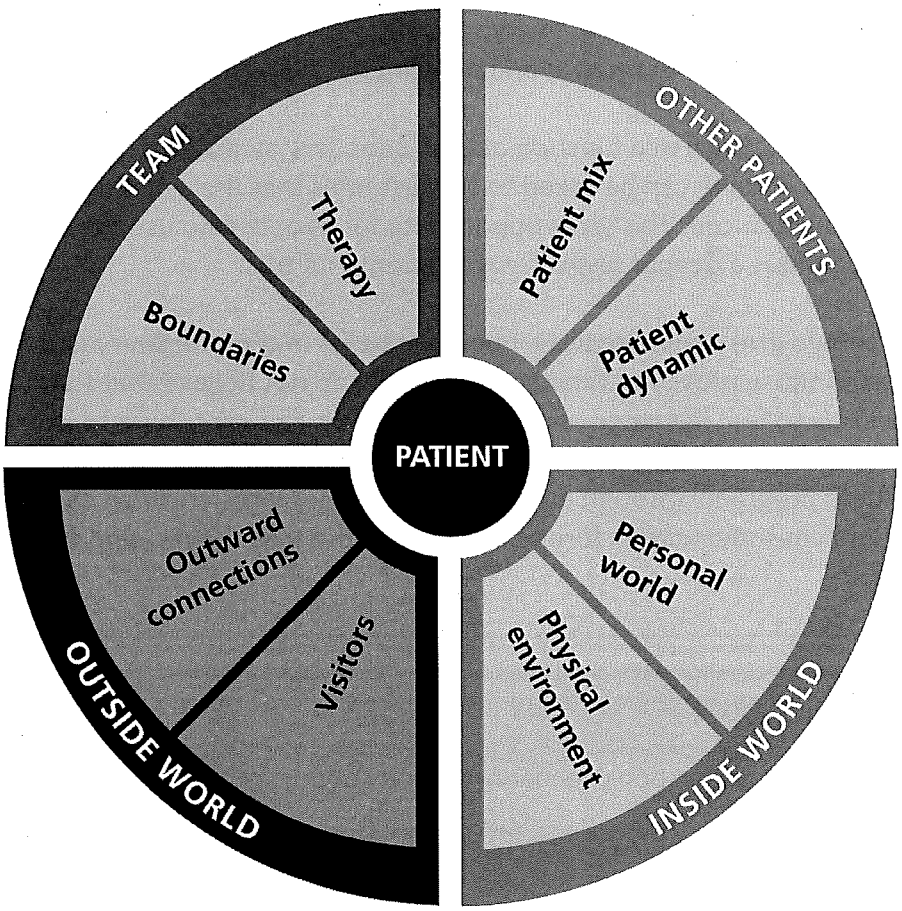

Figure 1 – *See, Think, Act (NHS, 2010)*

1.3.1 Team – Therapy and Clear Boundaries

Everyone has a responsibility for relational security. "Team" does not just refer to the clinical team but to every member of staff who works in MHJHADS Inpatient units. That includes security staff, cleaners, visiting community staff, food services staff and casual staff.

A reflective and responsive management team can support clinical care and therefore relational security. Management needs to be able to attend to the internal demands and pressures contained within the organisation whilst also interacting positively with those outside the organisation, including key stakeholders and statutory bodies. Leadership is a complex task in bed based settings as there conflicting pressures on staff working with people who use our service and a high level of external scrutiny. Clear leadership within and external to inpatient facilities affects staff morale which is a key element in supporting relational security (Beales, 2012).

Clinical supervision and reflective practice are also key elements of relational security.

Clearly defined boundaries keep everyone safe. They ensure that people receive the kind of care they need in order to recover and develop the skills they need to function in society. It is important that staff, people who use our services and visitors know and understand rules; this helps the whole service function better. Boundary awareness is a key component of safe inpatient units. People can be asked to suggest rules that they would like to see changed, removed or introduced. This gives opportunity for people who use the services to own the rules and provides a deeper level of engagement and trust.

Therapy should give people realistic hope and belief in their recovery and allow them to build trust in those providing their care. If people do not believe that therapy is meaningful, they are likely to feel detached and disengaged. This can contribute to isolation, self-harm or an incident of aggression and violence (NHS, 2010). The person should be asked to review and evaluate programs through discussion at unit meetings, through consumer feedback systems and consumer carers forums and have input into the development of new therapy programs.

Key Points:
• Relational security is the whole team's responsibility. This includes contracted staff
• Reflective and responsive managers can support relational security
• Clinical supervision and reflective practice are key elements of relational security
• Boundary awareness training is important for all staff
• Everyone needs to understand the rules
• People who use our services can help create the rules

• Therapy needs to be meaningful
• The person can help develop therapy programs that are meaningful to them

1.3.2 Other people admitted – Person Mix and Dynamic

Inpatient units are dynamic. The interaction between individual people and between groups of people admitted and the staff can alter between two shifts, over lunchtime, or in a conversation between two people (NHS, 2010).

The mix of people admitted and the dynamic that exists between them has a fundamental effect on an inpatient unit's ability to provide safe and effective services. The whole group can be affected by the arrival or departure of just one person (Gillespie, 2012).

The 'persons mix', is the combined effect and potential risk of all the people that make up the secure unit community. Establishing the potential impact of the mix of people relies on understanding as much about the person as possible. That means not just understanding their current state of well-being, but working with carers and other agencies to understand past histories and experiences in other places such as other mental health units, prison and the community.

When a new person is considered for admission, it is important to not simply think about how they will function on the unit, but about how that person might change the overall risk profile of the whole group.

Continuity of care is important for a person's progress, but there may be some circumstances where it is necessary and appropriate to move a person from one clinical area to another or to manage a person at their current location before moving that person to the secure unit. This should not be viewed as a failure. If it is managed appropriately, it can disrupt plans for absconding, allow other people to disclose information without fear of intimidation, provide respite to fatigued staff, enable reflection and re-establish a healthy therapeutic environment (NHS, 2010).

Sometimes people might exert pressure on others to disengage from treatment. Or collusion between people might result in the undermining of staff and security. This can result in violence towards people and staff or the victimisation of vulnerable people. Staff must act and help to take control of the unit again before a serious incident happens. Understanding what is going on between people is key to relational security.

The relationships that exist between people using our service form how an inpatient unit feels and can influence the team's ability to promote a positive culture of recovery. Inpatient units are similar to the community, in that everyone is healthier if they feel positive, safe, have common values and are co-operative. In this type of environment people recover more quickly and staff satisfaction is higher. This means healthier, happier and more experienced staff and better continuity of service (NHS, 2010).

Key Points:
• Inpatient units are dynamic
• The person mix can affect security and continuity of care
• Some people may need to be moved to another clinical area or treated at their current location
• Staff need to work with carers and other agencies to understand a person's history and experiences
• Staff need to be vigilant to what is going on in the secure unit and sensitive to change

1.3.3 Inside World - Personal World and Physical Environment

How people feel inside their own world makes a big difference to the risk they present. Like everyone else, they can have good days and bad days. This will affect how well people will engage with treatment, how connected they will feel with the service and their ability to take responsibility for their own actions (Gillespie, 2012). Some events can act as triggers for people. Understanding the person's history and information from carers regarding triggers can help inform a person's relapse prevention plan. Clinical staff can be responsive their person's internal world by understanding, recognising, and responding to the effects of trauma and lived experience of mental illness (Muskett, 2014).

Essential to relational security is the practice of staff communicating with each other during the shift and at handover. Staff need to communicate with one another about what has occurred during the day and talk about what they think about how people are feeling. This will assist in developing meaningful care plans and risk assessments. This also is important for continuity of care between shifts, especially if a particular person is feeling vulnerable.

Key Points:
• How people feel inside their own world makes a big difference to the risk they present.
• Understanding the person's history and information from carers regarding triggers can help inform a person's relapse prevention plan
• Clinical staff can be responsive the person's internal world by understanding, recognising, and responding to the effects of trauma and lived experience
• Essential to relational security is the practice of staff communicating with each other during the shift and handing over

1.3.4 Outside World – Visitors and Outward Connections

When people have positive relationships and connections with the community, it not only provides a safeguard for the unit but can directly support the person's recovery. This can include telephone contact, visitors to the unit and escorted and unescorted leave. People can place immense importance on the value of visits from family, friends, carers and advocates. Visitors should feel safe and comfortable in their engagement with the admitted people and staff on the unit (NHS, 2010).

While outward connections can have a positive effect, they can also lead to some risk for people. On occasion, visitors will not have the person's best interest at heart. It is the staff's responsibility to ensure the person is protected and safe from any potential damage a visit or contact may cause. Staff need to be responsive to unusual or suspicious behaviour (NHS, 2010).

Visitors and admitted people should be advised of the rules and boundaries of the unit which promote safety, the reasons for them and the consequences if broken. Staff are responsible for consistently monitoring and enforcing the rules of the unit as violations that occur that are undetected or are not addressed, can increase the risk to people admitted and to staff.

Relational security can be improved by ensuring people admitted have clear management plans for when they go on and when they are returning from leave. Staff can also improve relational security by staying alert to changes in an admitted person's behaviour, such as staying alert for signs of unusual behaviour that may indicate the person is planning to abscond and for staff to use their judgement and act quickly if anything unexpected happens (NHS, 2010).

Key Points:
• The person should be encouraged to have positive relationships and community connections
• The inpatient unit should be safe and welcoming of visitors
• People admitted and Visitors should be advised of the rules of the unit which support safety, the reasons for them and the consequences if broken
• Staff should be aware and responsive to suspicious or unexpected behaviours which may indicate a breach of safety

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Section 2 – Predicting and Identifying Risk

Predicting risk and the possibility of an in incident occurring is not always possible. It is possible however, to identify some of the many factors which can lead to an episode of aggression or violence.

Comprehensive assessments relevant to the clinical speciality area, including risk assessments, should be completed to capture the presenting issues, mental state and historical information. All assessments should involve the person and or their nominated person (*Mental Health Act 2015*) as they are best placed to identify their own aggression and violence trigger factors, early warning signs and other vulnerabilities and the things they are able to do in order to mitigate them. Importantly, collateral information must be collected and collated from as wide a range of sources and agencies as practicable. Carer and family involvement is central to this process.

Being familiar with factors which can increase the risk of aggression and violence is a clinical skill expected of clinicians working in a MHJHADS environment.

2.1 Clinical Assessment

Comprehensive assessment from a bio-psycho-social perspective is vital in the identification and care planning for all people in order to increase awareness of potential for aggression and violence.

When the risk of aggression and violence is assessed there are two main types of risk which can be considered - static risk and dynamic risk.

2.1.1 Static Risks

Static Risks are those factors that are relatively stable or do not change over time. These include factors such as age, gender and previous history. Static risks make up a person's long term risk of aggression and can provide clinicians with an indication of an individual's capacity for tolerating dynamic risk factors. Essentially a person who has a high level of static risk factors present will be able to tolerate less dynamic risk factors, than a person who has low static risk (NSW Health, Clinical Risk Assessment & Management, 2010). Static risk factors are captured by the facilitation of a comprehensive bio-psycho-social assessment and should be clearly documented in the person's clinical record at the time of assessment.

2.1.2 Dynamic Risk

Dynamic risk factors are those that fluctuate and when present cause an individual to move away from their base-line behaviours toward increased risk. Application of interventions can reduce the nature of the dynamic risk factors, reducing an individual's risk of aggressive behaviours. Assessment of dynamic risk factors in MHJHADS inpatient services is facilitated with the use of the Brøset Violence Checklist (BVC) (see Attachment 1) and documented in the person's electronic clinical record. The BVC is used internationally and has been validated in many research studies.

During the assessment phase the following documentation is to be completed:

- Full assessment documentation, including presenting issues, mental state assessment, suicide risk assessment, alcohol and drug use and a full history taken including personal, medical and mental health information,
- Fagerstrom assessment for the identification of nicotine dependence, and
- The Brøset Violence Checklist has been adopted by MHJHADS inpatient Services to monitor clinical escalation and any increase in risk of violence or aggression.

2.2 Environmental Risk Assessment

In addition to being aware of an individual's potential for violence and aggression, it is important to have a clear understanding of the level of acuity on the unit as a whole.

2.2.1 Patient Staff Conflict Checklist

The Patient -Staff Conflict Checklist (PCC) (see Attachment 6) tracks a number of factors that raise acuity within the unit, in particular incidents of conflict and containment. The PCC has been used extensively with the Safewards Model developed in the United Kingdom (UK) by Len Bowers, and permission has been sought for its use in MHJHADS Inpatient Units.

In the Safewards Model, Bowers outlines definitions of conflict and containment as follows:

- **Conflict** collectively names all those behaviours that threaten the person's safety or the safety of others (violence, suicide, self harm, absconding etc).
- **Containment** collectively names all the things staff do to prevent conflict events from occurring or seek to minimise the harmful outcomes (e.g. as required (PRN) medication, special observation, seclusion, etc).

Each shift the Nurse in Charge will complete the PCC, which will assist in the identification of flashpoint areas on the Unit, with the resulting information being used in the ISBAR handover to the next shift. The PCC will assist the Nurse in Charge making decisions in regards to staffing requirements on the unit as it provides an objective measure of the acuity on the unit.

A PCC will be completed each shift by Nurse in Charge. Copies of the PCC will be stored in a designated folder and reviewed by CNC or Team Leader in the review of incidents on the unit and periodically to monitor compliance.

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Section 3 – Managing and Monitoring Risk

3.1 Planning for Admission to a MHJHADS Inpatient Unit

Following assessment, people identified for an inpatient admission to an MHJHADS service including the Mental Health Short Stay (MHSSU), the Adult Mental Health Unit (AMHU), Brian Hennessey Rehabilitation Centre (BHRC) and the Alcohol and Drug Withdrawal Unit will have in addition to the above:

- Comprehensive medical assessment including the completion of a physical examination,
- Admission and treatment plan,
- For Amber or Red Alert BVC scores a management plan in line with BVC guidelines must be developed and documented in the person's clinical record prior to transfer,
- A completed BVC with re-assessment each shift changeover or as indicated in an acute treatment plan,
- Clinical Risk Assessment (CRA) and allocation of an At Risk Category (ARC score for MHSSU, AMHU and BHRC) that considers the BVC score, and
- Medication chart written including routine, PRN oral medication, and consideration for Intra Muscular Injection (IMI) medication options. Medications should be in line with the *Prescribing Guidelines for the Short-Term Management of Acute Behavioural Disturbance* for MHSSU, AMHU and BHRC (see Attachment 4) and the *Management of Agitated and/or Aggressive Patients in the Withdrawal Unit Alcohol and Drug Services (ADS)* (see Attachment 8).

The outcome of a comprehensive risk assessment should inform the development of an inpatient care and recovery plan in which the patient centred interventions for the short term management of the risks should be identified.

3.2 Brøset Violence Checklist (BVC)

The BVC (see Attachment 1) is a well researched tool which has been adopted by MHJHADS to compliment clinical practice and to assist in identifying the dynamic risk of aggression and violence over a 24 hour period for people admitted to MHJHADS inpatient beds (Clarke D, Brown AM, & Griffith P. 2010).

The BVC must be commenced at the time of an admission decision and then completed and documented formally once each shift at 0600, 1230, and 2000hrs by the nursing staff allocated. Informal monitoring of each person's presentation should be conducted by all clinical staff at all times so that potential for violence and aggression is identified and responded to as quickly as possible.

The BVC measures three characteristics and three behaviours as either being present and providing a score of 1 if a characteristic is evident, or a score of 0 if a characteristic is absent, then providing a total score of 0-6. These scores are collated and graphed over a 7 day period on the BVC Form.

The items scored are as follows:

Confused	Appears obviously confused and disorientated. May be unaware of time place or person.
Irritable	Easily annoyed or angered. Unable to tolerate the presence of others.
Boisterous	Behaviour is overtly "loud" or noisy. For example slams doors, shouts when talking etc.
Physical Threats	Where there is a definite intent to physically threaten another person. E.g. the taking of an aggressive stance; grabbing of another person's clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.

Verbal Threats	A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person. E.g. verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.
Attacking Objects	An attack directed at an object and not an individual. E.g. the indiscriminate throwing of an object; banging or smashing windows; kicking, banging or head-butting an object; or the smashing of furniture.

The BVC only rates as positive, **items that are different to a person's known base-line presentation**. For example where a person's base-line presentation includes a degree of irritability, this is considered to be part of the static risk, and only incidents of irritability above the base-line are scored as positive on the BVC.

The BVC score will be associated with a traffic light alert system and will inform review of the CRA. Each of the alerts will have associated response, review and planning requirements as outlined in BVC Response Matrix (see Attachment 1).

Additional benefits of using a tool for the measurement of violence and aggression include improved communication between team members as it provides a common language that all staff are familiar with. Completing the BVC improves awareness of predictors of violence and aggression and with heightened awareness staff are able to respond earlier.

3.3 Management of BVC Score

Where a person has an increase in their BVC score from the previous shift, or is not responding to the treatment plan from the previous shift the following steps must be followed (see Attachment 2):

3.3.1 Clinical Risk Assessment (CRA)

A review (as soon as practicable) of the patients clinical risk should be completed to ensure any increased risk of aggression and violence is incorporated into the patients overall risk management strategy. A person's observation level must be adjusted based on any changes to an allocated At Risk Category (ARC) for MHSSU, AMHU and BHRC.

3.3.2 Green Alert - BVC 0

- No change in current treatment plan required,
- Interpersonal de-escalation as required,

If this rating is indicative of a 24 hour reduction in BVC score it should prompt a collaborative discussion between nursing and treating medical team regarding consideration to reducing a previously increased ARC score for MHSSU, AMHU and BHRC .

3.3.3 Amber Alert - BVC 1-2

- Ascertain the cause of the person's distress and attempt to meet immediate needs using interpersonal de-escalation techniques,
- Consider transfer to a low stimulus or de-escalation area of the unit and engage de-escalation techniques,
- Offer of PRN medication,

- Review CRA and consider increase At Risk Checklist (ARC) score (for MHSSU, AMHU and BHRC),
- Advise the Nurse in Charge and Psychiatry Registrar of the score(for MHSSU, AMHU and BHRC),
- Nurse in Charge to contact the Psychiatry Registrar or the Consultant Psychiatrist or the ADS Medical Service to discuss presentation and develop plan, which may include the need for a face to face review of the person. Consultation or review should include but not be limited to:
    - Consider prescribing medication in keeping with the *Prescribing Guidelines for the Short-Term Management of Acute Behavioural Disturbance* for MHSSU, AMHU and BHRC(Attachment 4*)* or the ADS Medical Service (Attachment 8)
    - Review routine oral medication to optimise dose and frequency.
    - Ensure PRN medication (both oral and IMI) are prescribed appropriately to be used if aggressive behaviour continues or recurs.
- Use of increased observation/change of ARC(for MHSSU, AMHU and BHRC), with review time frame
    - Review of legal status
- An updated plan will be communicated to staff caring for the person, and documented in the clinical record, either by medical staff during business hours, or Nurse in Charge where phone consultation has occurred.
- The Nurse in Charge will review effectiveness of plan after 2 hours or before the end of shift and where necessary will re-contact Psychiatry Registrar for MHSSU, AMHU and BHRC or the ADS Medical Service for Withdraw Unit (WU) for consultation.

3.3.4 Red Alert - BVC 3+

- Ascertain the cause of the person's distress and attempt to meet immediate needs using interpersonal de-escalation techniques,
- Consider activating Code Black,
- CRA review and consideration given to increasing ARC score for MHSSU, AMHU and BHRC,
- Administration of PRN medication, either oral or IMI medication if oral medication refused,
- Nurse in Charge to immediately contact the Psychiatry Registrar or the Consultant Psychiatrist for MHSSU, AMHU and BHRC or ADS Medical Service for Withdrawal Unit to discuss presentation and develop plan. Plan may include the need for a face to face review of the person. With consideration to time of day, and clinical presentation face to face medical review may be required. Consultation or review should include but not be limited to:
- Prescribe oral/IMI medication in keeping with *Prescribing Guidelines for the Short-Term Management of Acute Behavioural Disturbance Adult Bed Based Services* for MHSSU, AMHU and BHRC (Attachment 4) or *Management of Agitated and/or Aggressive People in the Withdrawal Unit ADS* (see Attachment 8).
    - Use of de-escalation or low stimulus area in the unit
    - Review all routine medication and optimise dose and frequency

- Ensure PRN medication (both oral and IMI) are prescribed appropriately to be used if aggressive behaviour continues or reoccurs.
- Use of increased observation/change of ARC for MHSSU, AMHU and BHRC with review time frame
- Review of legal status
- Suggested options for further intervention if current plan is not effective

- Updated plan will be communicated to the staff caring for the person, and documented on the clinical record within 60 minutes, by either medical staff during business hours, or Nurse in Charge where phone consultation has occurred.
- Nurse in Charge will review outcome of plan after 2 hours or before end of shift, and where necessary will re-contact the Psychiatry Registrar for MHSSU, AMHU and BHRC or ADS Medical Service for the Withdrawal Unit for further input.

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Section 4 – Medication Refusal

Acute symptoms of mental illness are known clinical risk factors for increased potential for aggression. Medication management is an integral part of the treatment of these presentations.

Medications prescribed by the medical team for admitted people must be explained to the person including any intended and unintended effects, and should only be taken by the person for whom they are prescribed. The medical team must be made aware of any instances in which the person (involuntary or voluntary) does not adhere to the medication treatment plan, this includes: refusing medications, or attempting to secrete medications.

A persons legal status in accordance with the *Mental Health Act 2015,* and or the *Guardianship and Management of Property Act 1991* need to be considered if medication is refused by a person. Where there is a known issue with compliance and when other interventions are unsuccessful this must be communicated with medical staff. If an IMI alternative has been prescribed this must be administered if oral medication is refused. In instances where a 'statum' order has been prescribed for a person, this must be given as charted.

Non-adherence with treatment must be included in the clinical documentation, acknowledged in the clinical plan and handed over from one nursing shift to the next in the inpatient setting and be brought to the attention of all the members of the treating team.

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Section 5 – Communication of Risk

Consistent with ACT Health Policy, Clinical Handover must be conducted utilising an ISBAR format i.e. Introduction, Situation, Background, Assessment, Recommendation. This includes clinician to clinician handover, team to team handover, or reporting of care at a multidisciplinary team meeting and ward rounds. The handing over of risk is an integral part of this handover to improve safe outcomes for everyone.

All clinical documentation is to be entered using the person's electronic clinical record. This provides consistency between clinicians working in different parts of the MHJHADS Division. This file format will clearly identify risk factors as well as other clinically relevant information set out using the ISBAR format.

Clinical handover between clinicians caring for a person must include a clear identification of any risks and the steps which have been taken in order to mitigate them. These risks include, but are not limited to the risk of harm to self and or others, risk of misadventure, risk to reputation, risk of absconding and/or any risks or potential for aggression and violence.

The handover of clinical risk should identify three main domains:

- Risk of Aggression and Violence
  - Static
  - Dynamic
- Suicide Vulnerability; and
- Other Risk Issues which may include, but not limited to, risk to self and risks associated with vulnerabilities (i.e. age, psychosis, absconding etc).

The clinical record will identify the level of risk of aggression using a traffic light colour coded system for dynamic and static risk factors (see Attachment 3).

The degree of risk is rated in accordance with the outcome of the medical assessment, the Clinical Risk Assessment (CRA), Brøset Violence Checklist (BVC) and formally flagged through ISBAR at each clinical handover, using a colour coded traffic light system:

- Green – Low Risk
- Amber – Medium Risk
- Red – High Risk

It is the responsibility of clinicians to ensure there is an alert placed on the electronic clinical record and ACT Patient Administration System (ACTPAS). Where clinicians do not have access to ACTPAS, administrative support officer assistance should be sought. In addition, all identified risk must be supported by an appropriate clinical plan of care to support the management of that risk.

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Section 6 - Escalation of Clinical Concern

All staff are responsible to ensure the appropriate management and or an escalation of resources and clinical support to prevent potential episodes of aggression or violence. The expertise of allied health, nursing and medical staff should be utilised through the multidisciplinary team when seeking to address the complex issues relating to the prevention and management of aggression and violence.

When staff have concerns that a person's behaviour is becoming increasingly disturbed or there are issues of clinical concern, it is an expectation that they be supported by their colleagues in escalating these concerns to other more senior members of the treating team. Their concerns must be proactively followed up in a timelier manner by the implementation of a multidisciplinary review of the treatment plan as a priority.

ISBAR principles must be used in the verbal and documented hand over of any clinical concerns. In addition, details of risk assessment observations, the use of prescribed medications and clinical interventions should also be outlined. Response to strategies already implemented should also form part of the discussion when escalating issues (See Attachment 5).

People identified by the team as presenting with challenging mental state and complex behaviours will require a whole team level clinical review. This process can be conducted through a Complex Management Forum facilitated by the Clinical Director, Operational Director, Team Leader, Clinical Nurse Consultants, Allied Health Team and the relevant Community Team Clinicians. This forum will provide peak clinical decision making and oversight of the revision of the treatment and recovery plan for people presenting with complex and challenging dimensions to their clinical care and recovery.

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Section 7 – Post Incident Management

All staff members are to familiarise themselves and practice in accordance with ACT Health Policy - Incidents Management and ACT Health SOP – Incidents Management. When an incident has occurred, immediate action should take place to ensure the safety of people involved and the environment where the incident took place.

A comprehensive clinical review of the person with the behavioural disturbance must be immediately completed by the treating team and include the documentation of an updated management plan and medication review.

A Riskman Report and Staff Accident Incident Report (SAIR), where appropriate, must be completed by the staff in attendance during the incident. The Nurse in Charge is responsible for ensuring the completion of such reports; SAIRs must be completed by the individual involved in the incident, not a third party.

The Unit Manager must be notified of any incident and they will notify the Operational Director of all significant incidents. After hours the After Hours Hospital Manager and Director on Call must be notified.

Any victim of an assault has the right to report the assault to police, and must be provided with the necessary support and advocacy for the person to do so. If the person is unable to report the incident themselves, a report can be made on their behalf by the Team leader or Inpatient Nurse in Charge.

Post incident support should be offered to all persons witnessing or involved in an incident. It is acknowledged that individuals require different types of support and this will guide what is offered. There are a range of support options, including but not limited to psychosocial review session led by clinical psychologist or appropriately qualified staff member. Every effort should be made to allow opportunity for staff members involved in an incident to have some time away. Additional staff support and debriefing can be facilitated through the Employee Assistance Program, either for an individual or for a group of staff members. Participation in post incident follow up is on a strictly voluntary basis. No staff member should be made to feel that they should or must attend post incident support sessions.

If staff are the victim of verbal or physical assault that causes harm and significant distress to that individual they are to be relieved of their duties immediately so as they can receive first aid and can report the incident to the appropriate authorities. The After Hours Hospital Managers (AAHM) should be contacted to assist with replacement staff to facilitate this while maintaining security on the unit.

If a visitor perpetrates the incident, security must be contacted and a report to the police be made, with a request they attend the unit.

As part of the clinical handover process any events of aggression and or violence are to be reported at shift handover and at the next clinical multidisciplinary team meeting.

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Section 8 – Post Incident Evaluation (SOAS- R)

Following the occurrence of an incident of aggression or violence it is imperative that the circumstances surrounding the incident are clearly documented in a consistent way. The Staff Observed Aggression Scale–Revised (SOAS-R) (see Attachment 7) has been chosen as the tool to capture this information. The SOAS-R is evidence based, and is simple to complete, capturing not only the incident but also the antecedents, measures implemented to stop aggression, and staff perception of the severity of the incident. The SOAS-R is primarily completed with tick boxes, making the tool quite user friendly and not time consuming.

The nurse caring for the person, or the staff member who observes the incident should complete the form as soon as practicable. Once completed the forms are to be kept in the person's clinical record.

The SOAS-R does not replace Riskman or SAIR reporting requirements; however it can be uploaded to the Riskman report. The SOAS-R provides information that will assist in the investigation of the incident.

The SOAS-R has also been chosen as the preferred tool as it can be scored. The CNC reviewing the incident will complete the scoring and incidents scoring as 15 or higher will be referred to the Incident Review and Feedback Committee (IRFC) or ADS Work Safety meetings. Reference should be made to the Post Incident Evaluation section of this document for additional information.

The CNC or delegate, will initiate investigations following an incident within 72 hours and complete a Post Incident Assessment Review. Priority actions will be identified and implemented as required. As part of the review process the CNC will score the SOAS-R, using scale recommended by Nijman et al (1999), incidents rated with a score of 15 or more should prompt a multidisciplinary clinical review to promote team learning and development. Significant incidents will be to the MHJHADS Morbidity and Mortality Committee with findings fed back through team meetings to staff.

At a minimum, the MDT Clinical Review Team should comprise of;

- Team Leader
- CNC presenting the incident
- Consultant Psychiatrist or Psychiatry Registrar or ADS Medical Specialists
- Health and Safety Representative
- Nursing Representative inclusive of a minimum of one RN2 and one other nurse
- Allied Health Representatives
- Program Consumer Consultant for Mental Health Services

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Section 9 - Responsibilities

9.1 Management of Nursing Resources

At the commencement of each shift the Nurse in charge of shift is responsible for the allocation of admitted people to nurses' ratio working that shift and in accordance with local rostering practices. At this time, consideration needs to be given to ensure an equitable distribution of workload and acuity, with clinical presentation, BVC score of individuals, experience of nursing staff, and continuity of care being some of the factors taken into account. An equitable allocation of workload may result in some nurses with a higher or lower number of people to care for on the shift.

Standard nursing numbers on the unit may be supplemented by the flexibility permitted within the Nursing Hours Per Patient Day (NHPPD) rostering principles (if adopted by the unit) or the allocation additional nursing or non-nursing staff. A decision regarding the use of additional nursing staff will be done in conjunction with Senior Management, including Operational Director/Director On-Call, and be based on the most clinically appropriate option. Non-nursing staff may include Allied Health Staff, Assistants in Nursing, Health Services Officers and Wards services.

9.2 Inpatient Senior Management Team Responsibilities

- Provide clinical leadership,
- This clinical guideline is to be integrated within MHJHADS inpatient Program area,
- Clinical Guidelines are to be included in all levels of MHJHADS staff orientation programs,
- Ensure Clinical Staff are appropriately trained and comply with local work area procedures,
- Ensure risk assessments are carried out and acted upon ,
- Ensure staff have access to the necessary equipment (e.g. duress alarms, Personal Protective Equipment etc) relevant to their work area,
- Ensure records of the employee's contact details are up to date,
- Comply with statutory requirements,
- Where clinical complexity is identified and escalated, timely decisions are made to actively manage and lead a clinical response,
- CNC's, Clinical Development Nurses (CDN's) and the Level 2 Registered Nurses are expected to take the clinical lead in the implementation of this guideline in the provision of nursing care in MHJHADS inpatient units. Additionally, the extended Multidisciplinary Team will be accountable for the implementation of this guideline in the review and provision of safe patient care,
- On-site support and training will be available prior to and following the introduction of this guideline to provide staff with assistance, particularly in the use of the new assessment tool,

- Management Teams within each inpatient area will provide on-going support for the adherence to this guideline with any recommendations for up-dates or amendments will be tabled through the MHJHADS Aggression and Violence Steering Committee.

9.3 MHJHADS Staff Responsibilities

- Ensure compliance with this clinical guideline,
- Provide on shift clinical leadership to promote the principles and actions promoted in this clinical guideline,
- Undertake training (e.g. PART) and comply with the local procedures of their work area;
- Identify risks utilising local work area assessment tools and implement the most appropriate measures to manage identified risks and hazards,
- Report and act upon all risks and hazards via Riskman and to a senior manager,
- Use appropriate equipment as deemed necessary to undertake a safe work practice,
- Provide an up to date record of employee details to the manager.

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Implementation

This guideline will provided to staff as part of local orientation to all MHJHADS inpatient units.

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Related Policies, Procedures, Guidelines and Legislation

Legislation

- *ACT Human Rights Act 2004*
- *Carers Recognition Act 2010*
- *Guardianship and Management of Property Act 1991*
- *Mental Health Act 2015*

Policies and Procedures

- MHJHADS Assessment and Intervention for People Vulnerable to Suicide Procedure, CHHS16/034
- Clinical Handover Procedure, CHHS15/069
- Clinical Handover within MJHADS Procedure (MHJHADS), CHH13/535
- Clinical Risk Assessment SOP for MHAU and AMHU (MHJHADS)
- AMHU - Code Black in the AMHU (MHJHADS)
- MHJHADS MHAU Code Black SOP
- Consumer and Carer Participation Policy, DGD15-005
- MHJHADS Director on Call SOP
- Incident Management Policy, DGD12-047
- Medications Handling Policy, CHHS15/086

- Significant Incident SOP, DGD12-047
- Violence and Aggression by Patients or Visitors Prevention and Management Policy, DGD15-019
- Violence and Aggression by Patients Consumers or Visitors SOP, DGD15-019
- MHJHADS Framework for the Management of Aggression and Violence

- Searching during Admission to MHJHADS Bed Based Services Procedure (MHJHADS), CHHS16/24
- Seclusion of Persons with Mental Illness or Mental Disorder Detained under the Mental Health Act 2015 Procedure (MHJHADS), CHHS16/033
- MHJHADS -Significant Incidents Reporting SOP, CHHS14-024

Standards

- National Standards for Mental Health Services 2010
- National Safety and Quality Health Services Standards 2012

Conventions

- ACT Charter of Rights for people who experience mental health issues
- Australian Charter of Healthcare Rights 2008
- Mental Health Statement of Rights and Responsibilities 2012

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Definition of Terms

ADS: Alcohol and Drug Services
AMHU: Adult Mental Health Unit at Canberra Hospital. 35 bed unit gazetted as defined in the *Mental Health Act 2015*.
Aggression: Feelings of anger or antipathy resulting in hostile or violent behaviour; readiness to attack or confront.
ARC: At Risk Category
BHRC: Brian Hennessy Rehabilitation Centre
BVC: Brøset Violence Checklist
CDN: Clinical Development Nurse
CNC: Clinical Nurse Consultant of bed based services
CRA: Clinical Risk Assessment
ISBAR: Acronym adopted by CHHS to facilitate clinical handover. Introduction. Situation. Background. Assessment. Recommendations
MDT: Multidisciplinary Team
MHSSU: Mental Health Short Stay Unit. 6 bed inpatient mental health unit adjacent to the Emergency Department facilitating admissions for up to 48 hours
Nominated person: A person with a mental disorder or illness, who has decision making capacity, may, in writing nominate someone else to be the person's nominated person (s.19 Mental Health Act 2015)

Nurse in Charge (NIC): The Nurse in Charge is the allocated RN2 or senior RN1 in charge of each shift.
PART: Professional Assault Response Training
PCC: Patient Staff Conflict Checklist
PPE: Personal Protective equipment
Risk – Dynamic: risk factors which can fluctuates and when present, cause an individual to move away from their base-line, increasing risk. Dynamic risk factors are able to be affected by interventions, as they are able to be manipulated and changed. Implementing interventions to address dynamic risks will reduce an individual's risk of aggressive behaviours.
Risk - Static: those risk factors that are relatively stable or do not change over time. These include factors such as age, gender and history. Static risks make up a person's long term risk of aggression, and can provide clinicians with an indication of an individual's capacity for tolerating dynamic risk factors. For example a person who has a high level of static risk factors present will be able to tolerate less dynamic risk factors, than a person who has low static risk. (NSW Health, Clinical Risk Assessment & Management, 2010).
SOAS-R: Staff observed Aggression Scale - Revised
Violence: Behaviour involving physical force intended to hurt or damage someone or something
Withdrawal Unit: An inpatient unit based on site at the Canberra Hospital which provides inpatient and outpatient withdrawal from alcohol and other drugs

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References

Abderhalden C, Needham I, Dassen T, Halfens R, Haug H, Fischer J, *Structured Risk Assessment and Violence in Acute Psychiatric Wards: Randomised Control Trial.* The British Journal of Psychiatry. 2008, 193, 44–50. doi: 10.1192/bjp.bp.107.045534

ACT Health Violence and Aggression by Patients Consumers or Visitors SOP

ACT Health. (2014). Secure Mental Health Unit Model of Care: Mental Health, Justice Health and Alcohol & Drug Services.

Allnutt, S., O'Driscoll, C., Ogloff, J.R.P., Daffern, M. & Adams, J. (2010) *Clinical Risk Assessment & Management: A Practical Manual for Mental Health Clinicians*

Beales, D. (2012). Supporting Relational Security in a Time of Change. *Forensic College Centre for Quality Improvement*(20), 1 - 3.

Bowers L. *Safewards: A New Model Of Conflict and Containment on Psychiatric Wards. Journal Psychiatric Mental Health Nursing.* 2014 Aug;21(6):499-508.

Clarke D, Brown AM, & Griffith P, *The Brøset Violence Checklist: Clinical utility in a secure psychiatric intensive care setting.* Journal of Psychiatric and Mental Health Nursing. 2010, 17 (7), 614-620

Nijman H, Muris P, Merckelbach H, Palmstierna T, Wistedt B, Vos A, Rixtel A, Allertz W, *The Staff Observateion Aggression Scale – Revised (SOAS-R).* Aggressive Behaviour. 1999: V25:197-209

Foster C, Bowers L, Nijman H, *Aggressinve Behaviour on Acute Psychiatric Wards: Prevalence, Severity and Management.* Journal of Advanced Nursing. 2007, V58(2): 140-148
Gillespie, A. (2012). Patient Engagement in Relational Security of a New Unit. *Forensic College Centre for Quality Improvement*(20), 4 - 5

JCP-MH. (2013). *Guidance for Commissioners of Mental Health Services* (pp. 1 - 24): Joint Commissioning Panel for Mental Health

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing, 23*(1), 51 - 59.
NHS. (2010). See, Think, Act. *Your Guide to Relational Security* (pp. 1 - 25): UK Department of Health.

NICE Pathways. *Violence Overview* 2014.
Sandhu, J., & Vatta, N. (2012). Maintaining Professional Boundaries. *Forensic College Centre for Quality Improvement*(20), 6 - 7.

Tigh J, Gisli H, 2012. *See, Think, Act Scale: preliminary development and validation measure of rational security in medium – and low secure units.* The Journal of Forensic Psychiatry & Psychology. 23 (2): 184-199

Department of Health Secure Services, NHS. 2010. *Your Guide to Relational Security: See, Think, Act*

Van de Sande R, Nijman H, Noorthoorn E, Wierdsma A, Hellendoorn E, Van der Staak C, Mulder C, *Aggression and Seclusion on Acute Psychiatric Wards: Effect of Short-Term Risk Assessment.* British Journal of Psychiatry. 2011, 10.1192/bjp.bp.111.095141

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Search Terms

Aggression, Violence, Medication, Inpatient, Mental health, Involuntary, Alcohol and Drug, Brian Hennessey, AMHU, MHSSU.

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Date Amended	Section Amended	Approved By
E.g.: 17 August 2014	*Section 1*	*ED/CHHSPC Chair*

Attachment 1 - Brøset Violence Checklist (BVC)

ACT Health

The Brøset Violence Checklist (BVC)

Complete details or affix label

UR Number: _____

Family name: _____

Given names: _____

DOB: _____ Gender: _____

The Brøset Violence Checklist © (BVC) - quick instructions:

Score and initial at agreed time on every shift.

If behaviour is normal for a well known client, only an increase in behaviour scores 1, e.g. if a well know client normally is confused, has been so for a long time, this will give a score of 0.

If an increase in confusion is observed this gives a score of 1.

Absence of behaviour	0
Presence of behaviour	1
Maximum score (TOTAL) is 6	

Monday Date:				Tuesday Date:			
Behaviours	**M (1200)**	**E (2000)**	**N (0600)**	**Behaviours**	**M (1200)**	**E (2000)**	**N (0600)**
Confused				Confused			
Irritable				Irritable			
Boisterous				Boisterous			
Verbal threats				Verbal threats			
Physical threats				Physical threats			
Attacking objects				Attacking objects			
TOTAL				TOTAL			
Initial				Initial			

Wednesday Date:				Thursday Date:			
Behaviours	**M (1200)**	**E (2000)**	**N (0600)**	**Behaviours**	**M (1200)**	**E (2000)**	**N (0600)**
Confused				Confused			
Irritable				Irritable			
Boisterous				Boisterous			
Verbal threats				Verbal threats			
Physical threats				Physical threats			
Attacking objects				Attacking objects			
TOTAL				TOTAL			
Initial				Initial			

Friday Date:				Saturday Date:			
Behaviours	**M (1200)**	**E (2000)**	**N (0600)**	**Behaviours**	**M (1200)**	**E (2000)**	**N (0600)**
Confused				Confused			
Irritable				Irritable			
Boisterous				Boisterous			
Verbal threats				Verbal threats			
Physical threats				Physical threats			
Attacking objects				Attacking objects			
TOTAL				TOTAL			
Initial				Initial			

Sunday Date:					Mon			Tues			Wed			Thurs			Fri			Sat			Sun		
Behaviours	**M (1200)**	**E (2000)**	**N (0600)**		M	E	N	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N
Confused				6																					
Irritable				5																					
Boisterous				4																					
Verbal threats				3																					
Physical threats				2																					
Attacking objects				1																					
TOTAL				0																					
Initial																									

The Brøset Violence Checklist (BVC)

The Brøset Violence Checklist	
Interpretation and Operationalisation	
Interpretation of scoring: Score = 0 GREEN: The risk of violence is small Score = 1-2 AMBER: The risk of violence is moderate. Preventive measures should be taken. Score > +3 RED: The risk of violence is very high. Preventive measures should be taken. In addition, a plan should be developed to manage the potential violence.	
Operationalisation of behaviours/items:	
Confused	Appears obviously confused and disorientated. May be unaware of time, place or person.
Irritable	Easily annoyed or angered. Unable to tolerate the presence of others.
Boisterous	Behaviour is overtly "loud" or noisy. For example slams doors, shouts out when talking etc.
Verbally threatening	A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person. For example verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.
Physically threatening	Where there is a definite intent to physically threaten another person. For example the taking of an aggressive stance; the grabbing of another person's clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.
Attacking objects	An attack directed at an object and not an individual. For example the indiscriminate throwing of an object; banging or smashing windows; kicking, banging or head-butting an object; or the smashing of furniture.
NB: For the behaviours/items physically threatening, verbally threatening and attacking objects, the operationalisation was adapted from the Behavioural Status Index (Reed, Woods & Robinson, 2000) by one of the authors (Woods).	

Attachment 2 - BVC Response Matrix

	Brøset 0 Green Alert - Low Risk	Brøset 1-2 Amber Alert - Moderate Risk	Brøset 3+ Red Alert - High Risk
Report	• Handover to next shift	• Immediately report to Nurse in Charge • Nurse in Charge to advise Psychiatric Registrar • Handover score, interventions and plan to next shift	• Immediately report to Nurse in Charge • Nurse in Charge to advise Psychiatric Registrar • Handover score, interventions and plan to next shift
Nursing Response	• Nursing observations to continue as per current CRA	• Utilise Coping and Safety Tool - Top Three Strategies • Implement individual de-escalation strategies (see over) • Consider use of Early Support & Intervention Team • Consider increasing nursing observations until immediate issue is resolved. • Review CRA and consider increasing ARC accordingly • Offer oral medication, consider IMI if oral refused • Conduct physical observations as per Medication Guidelines • Nurse in Charge to review consumer as per plan and re-contact psychiatric registrar if required.	• Utilise Coping and Safety Tool - Top Three Strategies • Implement individual de-escalation strategies (see over) • Consideration of increase in ARC and update CRA • Consider transfer to HDU and/or use of de-escalation area • Administer prn medication, including IMI if oral is refused • Consider contacting Wardsmen's Supervisor for assistance • Consider calling Code Black • Consider use of seclusion if risk unable to be managed in any other way. • Conduct physical observations as per Medication Guidelines • Nurse in Charge to review consumer as per plan and re-contact psychiatric registrar if required.
Medical Response	• No additional medical review required	• Consultation between nursing and psychiatric registrar to discuss and develop plan. • Should include but not limited on review of: - PRN medication - are there oral and IMI options? - Review of routine medication (frequency and dose, compliance) - Consider prescribing as per Management of Behaviourally disturbed patients. - Ratify ARC if changed - Legal status - voluntary vs Emergency Detention/PTO	• Consultation between nursing and psychiatric registrar within 30 min to discuss and develop plan. • Review plan with consultant psychiatrist at earliest opportunity (see guideline for details) • Should include but not limited on review of: - Prescribe oral/IMI in line with Management of Behaviourally Disturbed Patients protocol. - PRN medication - ensure there are oral and IMI options - Routine medication (dose, frequency, compliance) - Review CRA - Review legal status
Allied Health Response	• No additional allied health review required unless identified during	• Allied health team member from ES&IT Roster to be contacted for assistance in de-escalation response	• Allied health team member from the person's treating team and/or ES&IT Roster to support and input into the change in plan.
Plan & Document	• No change to plan required • Consider reducing previously increased ARC as appropriate • Document in clinical file	• Psychiatric Registrar or Nurse in Charge (see guideline) to document plan in MHAGIC. Plan should include contingency for the next 24hours if current plan is not effective. • Allocated nurse to document score and response to interventions in clinical file. • If required complete SOAS-R, Riskman Report and/or SAIR	• Psychiatric Registrar or Nurse in Charge (see guideline) to document plan in MHAGIC within 60min. Plan should include contingency for the next 24hours if current plan is not effective. • Allocated nurse to document score and response to interventions in clinical file • If required complete SOAS-R, Riskman Report and/or SAIR

NOTE: Additional detail can be located in the *Clinical Guideline for the Identification, Mitigation and Management of Aggression and Violence in Mental Health Bed Based Services*

Interpersonal De-Escalation Strategies

Respect all individuals' personal space:
- The amount of space someone needs to fee comfortable varies. Anxiety rises when personal space is invaded, increase anxiety increases the chance a person will act out in a more serious way
- Maintain at least arm's-length distance from the other person.
- If entering an individual's personal space to carry out a procedure, it is important to explain what you are doing and why.

Be aware of body position:
- Avoid a body stance in which you are eye-to-eye or toe-to-toe with the other person. These can bee interpreted as challenging and may invoke a 'fight or flight' response.
- Stand at a slight angle and off to the side. This also improves your ability to more easily withdraw.

Be Empathic:
- Avoid being judgemental or discounting of the other persons feelings.
- The feelings are real for the other person, even if you do not think they are justified.
- Don't be afraid of silence, a supportive presence can be more important than words.

Non-threatening Non-verbal Cues:
- As a person becomes less rational they are more in tune with non-verbal cues.
- It is important to keep your non-verbal cues as non-threatening as possible.
- These include - gestures, facial expressions, tone of voice, eye contact, movements and body stance.

Ignore Challenging Questions:
- Individuals may try and challenge your authority - "who are you to tell me what to do?"
- It is better to avoid the power struggle by re-stating your request in a calm manner. "Smoking isn't permitted in the unit, can I get you an inhaler or a patch?"

Set and Enforce Limits:
- Establish limits clearly and concisely. Avoid punitive responses.
- It is important that people are made aware of behaviour that is not acceptable. This can include: physical or verbal abuse (including on phone calls), threats and violence.
- Ensure consequences set are fair and reasonable, and are enforceable.

Permit Verbal Venting:
- Where possible allow the person to ventilate their emotions, even with shouting.
- Allowing venting will allow the person to release energy without escalating into physical aggression.

Identify the Reason for the Behaviour:
- Identification of the cause of the behaviour is key to resolving the issue.
- Hear the feelings behind the words, remember to re-state the message to ensure there are no misunderstandings.

Stay Composed:
- It is important to remain calm and professional, at least on the outside.
- Calm professional response will influence the other person's behaviour in a positive way.

Use Physical Restraint Only as Last Resort:
- Physical restraint should only be used when the person's behaviour is dangerous to themselves or others.
- Only use physical restraint in accordance with ACT Health Policy and Procedures.

Undivided Attention:
- Paying attention to a person makes them feel validated, the opposite is also true.
- Use active listening skills when interacting with the person.

Be Non-Judgemental and Focus on Feelings:
- Having an internal judgemental stance can influence your body language.
- Remaining non-judgemental and responding to the person's distress can help diffuse a situation. "I can see that is really distressing for you" "Can you tell me what that feels like" are ways to focus on the feelings behind the words.

Allow Silences:
- Allowing silence allows the other person time to formulate a response.
- People experiencing psychotic phenomenon may require more time to process a question before responding and allowing silence in the conversation provides them with the opportunity to do this.

Clarify Messages:
- Don't assume you have understood with the other person's issue is. It is important to check in. "Let me check that I understand what the problem is ...."
- Not clarifying the message can lead to increased frustration and an increase in escalation.

Develop a Plan:
- This applies when dealing with the person directly, but also before entering the situation.
- Know what the outcome you want is, and work toward that goal.
- When working with the person, develop a plan with them for "where to from here". Is there something they need you to do to resolve the issue.
- Include in the plan a time frame for reporting back to them. "I will be back within 30min to give you an outcome/update"

Know Your Limits & Use a Team Approach:
- You don't need to be able to excel at everything and in every situation. Knowing your own limits and using a team approach to support in de-escalation is vital.
- Use Early Support & Intervention Team

Use Positive Self-talk:
- Your internal monologue will be reflected in your non-verbal communication. Using positive self talk will help you feel, and therefore appear, more confident.

Unpack the incident:
- Take some time to talk to co-workers/Nurse in Charge/CNCs about how an incident went.
- Reviewing what went well and what you might change next time will enhance practice and improve outcomes for everyone on the unit.

Adapted from
"CPI Training and consulting in behaviour management & dementia care"

Attachment 3 - MHAGIC File note

Clinical Notes **(File note, MDT Review, Handover)** BARCODE and Form Number	Complete details or affix label URN: _____ Surname: _____ Given name: _____ DOB: _____ Gender: _____

Introduction (details about who the consumer is and/or who was present at the review):

- Legal Status:

Situation (Diagnosis and Presenting Problem):

Background (lead up to admission, other history):

Static Risk

_____

Coloured Sticker here when printed

Assessment:

Dynamic Risk

_____

BVC_____

Coloured Sticker here when printed

Other Known Risks (vulnerability, self harm, promiscuity, etc):

Medication:

Mental State:

Physical State/MEWS:

Psychosocial Issues:

Interventions during shift/contact:

Recommendations (Plan for the admission and any outstanding issues):

Medication

Observation Frequency (ARC and physical observations)

Behavioural/Interpersonal interventions

Next Review

Attachment 4 - Short term medical management of acute behavioural disturbance

Prescribing Guidelines for the Short-Term Management of Acute Behavioural Disturbance Adult Bed Based Services

Step 1: Non-pharmacological

When:

- Brosset 0
- Use interpersonal de-escalation strategies
  - Coping and Safety Tool
  - Early Support and Intervention
  - Utilise more experienced staff

Checklist for All Steps

- Review notes and drug chart
- Review previous management
- Physical exam (if possible)
- Be aware of medical problems
- Assess – hydration, blood pressure, pulse, temperature, abnormal movements, alcohol/drug use
- Review recent ECG – QTc interval
- Review recent Bloods – U+Es, LFTs

Step 2: Oral medication

When:

- Brosset 1-2
- If accepting oral medication and it is effective do not proceed to step 3.

Oral medication prescribing

Lorazepam 1-2mg

- Repeat after 60 mins, max 6mg/24h
- Can be combined with an oral antipsychotic;

Either

Olanzapine 5-10mg wafer (max 20mg in 24hrs)

- Alternative

Or

Haloperidol 2.5-10mg (max 20mg in 24hrs)

- Note high risk of EPSE: Check Benztropine, ECG, EPSE

Oral Medication Monitoring

WHAT

- Monitor blood pressure, temperature pulse, respiratory rate, oxygen saturation

HOW OFTEN

- After one hour then every 30 mins until ambulatory

Other considerations

- Must be access to resus equipment
- Must have access to Benztropine and Flumazenil

Step 3: IMI Medication Short Acting

When:

- Brosset 3+
- If refusing oral medication
- If oral medication is infective
- If there is acute risk

IMI Medication Prescribing

Lorazepam IMI 1-2mg max 6mg/24h

OR

Promethazine IMI 50mg max 100mg/24h (if benzodiazepine tolerant)

- Consider combining with IMI antipsychotic;

Haloperidol IMI 2.5-10mg

- note high risk of EPSE: Check Benztropine, ECG, EPSE

OR

Olanzapine rapid-acting IMI 10mg

- Up to 20mg/24h, at least 2 hours apart

Considerations

- AVOID IM Olanzapine and IM benzodiazepines being given within 2 hours of each other

IMI Monitoring

WHAT

- Monitor BP, temp, pulse, respiratory rate, sats

HOW OFTEN

- Every 15 mins for 30 mins then every 30 mins until ambulatory
- It is acknowledged that some flexibility in observations is accepted, so as not to unnecessarily wake/irritate the patient further and to permit sufficient patient rest

Other Considerations

- Must be access to resus equipment
- Must have access to benztropine and flumazenil
- ECG if cardiac problems, or otherwise indicated

Step 4: IMI Medication Longer-Acting**

When

- Brosset 3+
- If not responding to short-acting IMI medication

If repeated short-acting IMI medication has been required or not effective

Considerations

Do not use if susceptible to EPSE or Antipsychotic naive

** Consultant Psychiatrist approval for long acting IMI medication use

Other medications that can be considered

- Clonazepam IM 0.5-2mg
  - [add dose/24hrs]
- Zuclopenthixol Acetate (Accuphase)
  - add dose range and schedule [ie 3rd daily for three doses]

Medication	Time to Max plasma concentration (IM)	Time to Max plasma concentration (oral)	Plasma half life
Lorazepam	60-90 mins	2 hours	12-16 hours
Olanzapine	15-45 mins	5-8 hours	32-50 hours
Haloperidol	15-60 mins	2-6 hours	10-36 hours
Zuclopenthixol Acetate (Accuphase)	24-48 hours	N/A	20-72 hours
Clonazepam	3 hours	1-4 hours	30-40 hours
Midazolam	45 mins	20-50 mins	2-6 hours

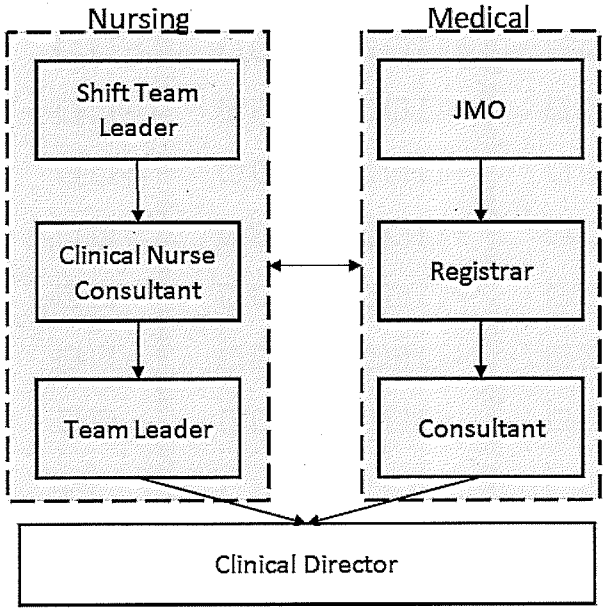
General prescribing guidelines

- Refer to MIMS
- Take care when adding additional medication to regular medication
- Seek senior advice if you are unsure
- Special cases: over 65, under 18, delirium, medical problems, antipsychotic naive, low BMI, dementia, pregnancy.
- Be aware of half lives and medication combinations

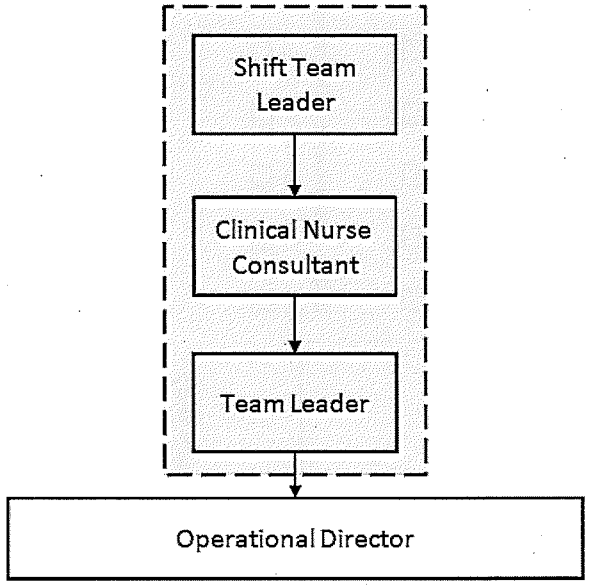
Attachment 5 - Escalation of issues flowchart

ATTACHMENT 5 – ESCALATION OF ISSUES FLOWCHART

Clinical Escalation



Non-Clinical Escalation



Note:

- Medical staff and Directors have equivalent on-call option after hours. For nursing issues after hours contact the After Hours Hospital Managers.
- After hours, or when the next point of escalation is unavailable, progress to the next tier. Eg:
  - For clinical issues on an evening shift contact the on-call JMO or registrar, if the issue is unresolved contact the Consultant on-call.
  - For non-clinical issues where the CNC and Team Leader are unavailable, contact the After Hours Hospital Managers. If the issue remains unresolved contact the Director on Call.
- In all instances advise senior management and the Director on Call of incidents as per MHJHADS Director On Call

MHJHADS CLINICAL GUIDELINE – IDENTIFICATION, MITIGATION AND MNAGEMENTOF AGGRESSION AND VIOLENCE FOR MHJHADS INPATIENT UNITS

Attachment 6- Patient- Staff conflict checklist

Patient-Staff Conflict Checklist

Please complete in blue or black biro. Keep the text in the boxes. Tick the boxes that apply. If you make a mistake cross it out and tick the correct box. Please answer all the questions about admissions if possible. If the information is not known about an admission, leave the question blank.
Please complete both sides of this questionnaire carefully and accurately at the end of t each shift.
Please file in the PCC Folder in CNC office at the end of each shift after handover to the next Shift Team Leader.

Q1.1 Date the shift started (dd/mm/yy)

Q 1.2 Shift

AM.....☐ PM.....☐ Night.....☐

Q 2.1 Number of admissions this shift

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

Q 2.2 Number of discharges completed this shift

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

Q 1.3 Number of staff at the start of each shift (count each staff member only once)

	1	2	3	4	5
Registerd Nurse	☐	☐	☐	☐	☐
Enrolled Nurse	☐	☐	☐	☐	☐
Relief/Casual RN	☐	☐	☐	☐	☐
Relief/Causal EN	☐	☐	☐	☐	☐
Supernumerary	☐	☐	☐	☐	☐

Q 3.1 How many incidents of aggression have there been during the shift?

	1	2	3	4	5	6	7	8	9	10	11+
Verbal Aggression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physical aggression against objects	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physical aggression against others	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3.2 How many suicide or self-harm attempts have tehre been during the shift?

	1	2	3	4	5	6	7	8	9	10	11+
Suicide attempts	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Self-harm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3.3 How many incidents of general rule breaking have there been during the shift?

	1	2	3	4	5	6	7	8	9	10	11+
Smoking on the ward	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refusing to eat	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refusing to drink	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refusing to attend to personal hygiene	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refusing to get up and out of bed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refusing to go to bed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refusing to see workers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3.4 How many incidents of drug or alcohol use have there been during the shift?

	1	2	3	4	5	6	7	8	9	10	11+
Alcohol use (suspected or confirmed)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other substances (suspected or confirmed)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3.5 How many incidents of absconding behaviour have there been during the shift? (count absconds who depart during this shift only, or who are officially reported during this shift)

	1	2	3	4	5	6	7	8	9	10	11+
Attempting to abscond	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Absconding (missing without permission)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Absconding from the unit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3.6 How many incidents of medication related behaviours have there been during the shift?

	1	2	3	4	5	6	7	8	9	10	11+
Refused regular medication (accepted)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refused regular medication (did not accept)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refused PRN medication (accepted)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refused PRN medication (did not accept)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Demanding PRN medication	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q4.1 How many uses of these containment measures have there been during the shift?

Given PRN medication (psychotropic)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Given IMI medication (enforced)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Transferred to HDU	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Use of De-escalation area	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seclusion	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Special observation (intermittent)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Special observation (continuous)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Show of force	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physically restrained	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Use of time out	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PCC Scoring

This section is to be scored at the completion of the shift by the Nurse in Charge.

Q5.1 Conflict Score (number of checks in Q3.1-3.6)

.....

Q5.2 Containment Score (number of checks in Q4.1-4.2)

.....

Q5.3 Total Score (combined Conflict and Containment Scores)

.....

Recognition to L Bowers and Safewards for the development of the PCC tool. Permission has been granted to alter the tool for use at AMHU.

Attachment 7- SOAS-R

The Staff Observation Aggression Scale – Revised

Patient Initials:	PMI UR:	Ward:
Riskman No.:	Date:	Time (hh:mm):

This form is to be completed by staff members witnessing aggressive behaviour of a patient whereby aggression is defined as: any verbal, non-verbal, or physical behaviour that was threatening (to self, others or property), or physical behaviour that actually did harm (to self, others, or property) (in: Morrison, 1990). In the case of an aggressive incident please note the initials of the patient and / or the other aggressive person, date and the time on which the incident started, and put at least one mark in each column.

1. Provocation	2. Means used by the patient	3.Target of aggression	4. Consequence/s for victim	5. Measures to stop aggression
No understandable provocation	verbal aggression	nothing / nobody	no	None
PROVOKED BY:	**ORDINARY OBJECTS:**	object(s)	**OBJECTS:**	talk to patient
other patient(s)	chair(s)	other patient(s)	damaged, replacement not necessary	calmly brought away
help with ADL	glass(ware)	patient self	damaged, replacement necessary	oral medication
patient being denied something	other, namely:	staff member(s)	**PERSONS:**	imi/iv medication
staff requiring patient to take medication	**PARTS OF THE BODY:**	other persons, namely:	felt threatened	held with force
Other provocations, namely:	hand (hitting, punching etc)		pain < 10 min	seclusion/isolation (locked door)
	foot (kicking)		pain > 10 min	Mechanical restraints
	teeth (biting)		visible injury	other measures, namely: ....
	other, namely:		need for treatment	
	DANGEROUS OBJECTS OR METHODS:		need for treatment by a physician	
	knife		Other, namely:	
	strangulation			
	other, namely:			

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Staff Observation Aggression Scale – Revised SOAS-R

Please give a brief description of what happened

(In the case of verbal aggression: what did the person say or shout?)

_____

_____

_____

_____

Where did the incident take place?

(Specify the exact location)

In your opinion, how sever was the incident?
(Please put a mark on the scale that represents the severity of the incident in your opinion)

This aggressive incident was"

Not severe at all — Extremely severe

Were enough colleagues present during the incident?

☐ Yes
☐ No

Had there been any warning signals suggesting an increased risk of aggression?

☐ Yes
☐ No (skip the next question)

Which warning signs were observed?

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Attachment 8 – Management of Agitated and/or Aggressive People in the Withdrawal Unit ADS

Guideline for Management of Agitated and/or Aggressive People in the Withdrawal Unit ADS

General Principles

- Agitation is a behavioural emergency
- Maintain safety of staff and people within the Withdrawal Unit
- Screen for and treat medical abnormalities
- Treat psychiatric symptoms (e.g. Anxiety, psychosis)
- Use Medications if needed
- Always use the least restrictive means possible

Assessment

A general physical examination including neurological examination looking for higher function and orientation should be performed as soon as possible. Measure the pulse, blood pressure, temperature, respiratory rate and if possible, oxygen saturation and blood glucose.

Non-Pharmacological Management

Behavioural interventions

- Use good eye contact (avoid staring)
- Watch the interpersonal space
- Don't touch
- Use distractions (food, drink, blanket)
- Report patient what you observe

Environmental Interventions

- Remove all potentially dangerous objects
- Isolate (decrease interpersonal stimulation)
- Decrease external stimuli (quiet room)
- Use show of force (security)
- Provide one to one observation

Pharmacological Management

Oral Medication
Lorazepam 1-2 mg
Midazolam 10-20mg
Diazepam 10mg
Olanzapine 5-10mg
Haloperidol 2.5-5mg

Intramuscular
Haloperidol 5mg
Olanzapine5-10mg
Clonazepam 2mg
Lorazepam 1-2mg

Intravenous (slow IV)
Diazepam 2-5mg
Midazolam 1-2.5mg
Clonazepam 1mg

Please Note:
Benzodiazepines are the mainstay of treatment.
Benzodiazepines can be combined with antipsychotic medication.
Watch out for drug interactions with other sedatives and Opioid analgesics.
Monitor and review, wait 30-60min before remediating.
Lorazepam IM preparation – SAS application only.

Reference:

- *Managing aggressive and violent patients Australian Prescriber Volume 34 | NUMBER 4 | AUGUST 2011*
- *Canberra Hospital and Health Services Clinical Guideline Identification, Mitigation & Management of Aggressive & Violence for MHAJADS Inpatient Unit*
- *ACT Mental Health Act 2015.*

*Estimates - QON No. E17-557

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Mental Health

Ref: Budget Statements C – Output 1.2 – Mental Health

In relation to: Secure Mental Health Unit funding profile – Budget Statement C, p26, Table 31

1. Why was the capital injection of $700,000 for the secure mental health unit rolled over from 2016-17?
2. What is the purpose for this funding?

Minister Rattenbury : The answer to the Member's question is as follows:–

1. To enable completion of final works in 2017-18.
2. The funding is for facility related operational improvements.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:

Date: 12/7/17

By the Minister for Mental Health, Shane Rattenbury MLA

*Estimates - QON No. E17-558

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Mental Health

Ref: Budget Statements C

In relation to: Budget Paper 3, p105: Supporting mental health for vulnerable Canberrans

1. What is the nature of the activities the government will support?
2. Who will provide those activities?
3. How much is provided for the upgrades to the Brian Hennessey Rehabilitation Centre?
4. What advice has the government received as to the scope of the upgrade work that would be required to bring the Centre up-to-date in terms of contemporary mental health residential rehabilitation and therapy practices?
5. Will the upgrade works address fully the scope of work that is needed?
6. What is the nature of the intended upgrade work?
7. Who will/has the government consult/ed on the nature of the upgrade work to be undertaken?
8. Have residents and their families been informed of the government's intention to refurbish the facility?
9. If no, why and when will they be?
10. Have residents and their families been consulted on how the refurbishment budget will be spent?
11. If no, why and when will they be?

Minister Rattenbury : The answer to the Member's question is as follows:–

1. ACT Health will continue to provide support to consumers at Brian Hennessey Rehabilitation Centre (BHRC), with the type of service changing from clinical support to supported accommodation following the opening of the University of Canberra Public Hospital. The detail of this service delivery will be articulated in the transition planning process for the University of Canberra Public Hospital.
2. ACT Health will continue to provide these services for the foreseeable future, and will review the potential for non-government organisation support in the planning process.
3. $500,000.

4. A condition assessment has been undertaken to determine the scope for facility improvement works.
5. See the response to Question 4.
6. See the response to Question 4.
7. The governance for the Building Health Services Program includes mechanisms for consultation with consumer representatives. Additionally, ACT Health provides regular updates to families, carers and residents.
8. ACT Health has provided regular updates to families, carers and residents, along with several community organisations about the transition from BHRC to new accommodation arrangements. Individual meetings and ongoing forums will continue to be held to share information, seek input and to keep residents, families, staff and stakeholders informed.
9. Ongoing communication has occurred with consumers and families.
10. The Mental Health Consumer Network, Carers ACT and the Mental Health Community Coalition were consulted throughout the feasibility study regarding the requirements for supported accommodation.
11. See response to question 10.

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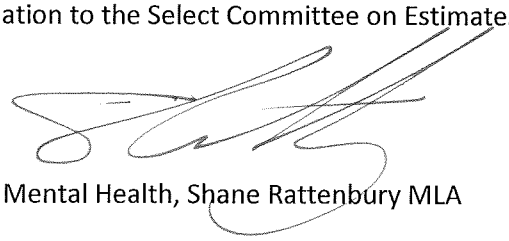
Signature: 

Date: 17/7/17

By the Minister for Mental Health, Shane Rattenbury MLA

*Estimates - QON No. E17-559

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Mental Health

Ref: Budget Statements C – Output 1.2 – Mental Health

In relation to: Transition to NDIS

1. Will all people in the ACT with a mental illness who need care receive it after the transition to the NDIS?
2. If yes, to what extent?
3. If no, why, and what strategies are in place to ensure continued and appropriate care and support?
4. Is the quality of care for people with a mental health illness being overlooked or in any way reducing in the transition to the NDIS?
5. If yes, why, and what strategies are in place to ensure people with a mental health illness do not "fall through the cracks"?
6. Have any areas of unmet need for people with a mental illness in the ACT been identified in the transition to the NDIS?
7. If yes, what are they, and what strategies are in place to meet that need?

Minister Rattenbury: The answer to the Member's question is as follows:–

1. Yes.

2. Consistently throughout the ACT's transition to the NDIS and currently, the ACT Government has continued to contract mental health services from the community sector in the following domains:
   - step-up step-down residential care;
   - in-home psychosocial support;
   - mental health promotion;
   - mental health respite;
   - mental health advocacy;
   - self-help support groups;
   - counselling; and
   - Aboriginal and Torres Strait Islander social and emotional wellbeing.

   With respect to these domains, the ACT Government provided $10.6 million in 2016-17 to individual mental health community service providers through established Service Funding Agreements (SFA) to provide services not funded by NDIS.

3. Not applicable.

4. No.

5. Not applicable.

6. Yes.

7. The transition of mental health psychosocial disability programs to NDIS resourcing was due to be completed by June 2106 however, due to the significant delays with the National Disability Insurance Agency (NDIA) accepting applications and undertaking assessment of eligible consumers, the transition was not completed until the end of September 2016.

   ACT Health provided an additional (approx) $500,000 during the NDIS trial (transition) to community providers to support eligible mental health consumers, whose transition to NDIS was delayed.

   Funding is available through ACT Health to cover consumers currently receiving ACT Health funded accommodation and outreach support services who are found to be NDIS ineligible, or whom in the immediate term are unable/not agreeable to be assessed by the NDIS.

   I have been advised that with the transition to NDIS some psychosocial services eg: group programs have been discontinued as the NDIS model does not provide sufficient funding to maintain sustainability for the providers. This has reduced choice of program options for people with a mental illness. Both myself and the Directorate are continuously engaging with service providers, advocates and consumers to monitor the transition and address issues that are arising. The ACT Government is also seeking further information on how to access funding announced by the Federal Government in the 2017-18 Commonwealth budget to enhance transition services and ensure continuity of support as the implementation of the NDIS continues.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:

Date: 17/7/17

By the Minister for Mental Health, Shane Rattenbury MLA

*Estimates - QON No. E17-560

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Mental Health

Ref: Budget Statements C

In relation to: Output 1.2 – Alcohol and drug services - Budget Statements C, p17 - Accountability Indicators

1. What was the extent of the allied health workforce shortage, which caused an estimated outcome against accountability indicator h of only 85% of the target for 2016-17?
2. What is being done to recover the allied health workforce to enable this indicator to be met?
3. How long will it take to recover the workforce?
4. What allied health workforce attraction and retention strategies are being adopted to mitigate future shortages?

Minister Rattenbury : The answer to the Member's question is as follows:–

1. There were approximately five full time equivalent allied health staff and 2.5 full time equivalent nursing staff vacancies across the Alcohol and Drug Services for 2016-17.

2. Recruitment strategies are in place to fill these vacancies, with three allied health positions already recruited. Psychology interns are being utilised to assist with workforce cover. Currently the service is recruiting to two allied health positions and ongoing recruitment for vacant nursing positions.

3. Despite bringing new staff into the service, it is difficult to provide definitive advice given the unpredictable nature of staff separations.

4. Alcohol and Drug Services (ADS) utilises new graduates including nurses and psychology interns to ensure ongoing sustainability of the workforce.

   Allied health and nursing student placements are pathways to encourage new graduates to seek employment within ADS.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 12/7/17

By the Minister for Mental Health, Shane Rattenbury MLA

*Estimates - QON No. E17-561

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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ANSWER TO QUESTION ON NOTICE

Mrs Dunne MLA: To ask the Minister for Mental Health

Ref: Budget Statements C – ACT Local Hospital Network

In relation to: Accountability Indicators – Budget Statements C, p48

1. In relation to accountability indicator g why does the budgeted performance outcome for 2017-18 anticipate a poorer result than the estimated outcome for 2016-17?
2. In relation to accountability indicator h:
   a. on average how many mental health patients are discharged each year;
   b. what is involved in preparing for and then making post-discharge contact with patients;
   c. on average, how long does it take to establish contact with a discharged patient;
   d. what matters are covered once contact with the patient is established; and
   e. on average, how long does it take to deal with the matters to be covered once contact is made with the patient?

Minister Rattenbury: The answer to the Member's question is as follows:–

1. This outcome improved in 2016-17 compared to previous years. ACT Health is committed to sustaining this improvement for two consecutive years, and consideration will be given to adjusting the target for 2018-19.

2a. Over the past 3 financial years, the number of discharges from public mental health inpatient units was 1278 in 2014/15, 1375 in 2015/16, and 1644 at financial year to date May 2017.

b. Preparation for discharge may vary between patients dependent on their particular recovery needs. Prior to discharge a discharge plan will be discussed with patients as well as their families and carers.

Patients are given periods of leave from inpatient units prior to discharge, when safe and appropriate to do so. This includes overnight and weekend leave, and allows for a more gradual transition to community living. Discharge planning includes information about:

- the persons treatment (e.g. prescribed medications, referrals to other services);
- information regarding follow-up arrangements once back in the community, including any future appointments;
- the name and contact details of the service that will be contacting them; and
- after-hours contact numbers for mental health crisis services should earlier contact be required.

Mental health clinicians will generally attempt to contact the person first by phone and then as required, organise a suitable place and time for review.

c. ACT Health does not routinely collect this data. The current measure only indicates whether or not contact with the patient has occurred within seven days of discharge.

d. The matters discussed with a patient during post-discharge contact vary, dependent on the person's particular recovery needs, but typically include:

- Review of the person's mental health status including an assessment of any risk issues pertaining to their mental state.
- Discussion of any residual or re-emerging symptoms of concern (e.g. poor sleep, reduced appetite, low mood etc) or any possible side-effects from medications.
- Discussion of the person's overall functioning and recovery including adjustment back to the community.
- Discussion and confirmation of the person's ongoing follow-up plans (e.g. future appointments with mental health services, General Practitioner, or other services, including non-governmental organisations).

e. ACT Health does not routinely collect this data.

The time spent with people during the first post-discharge contact varies depending on the type of contact made and the person's individual recovery needs and complexity, but is typically one hour or less.

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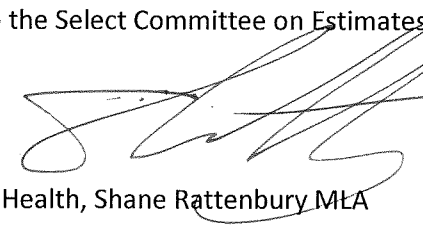
Signature: 

Date: 12/7/17

By the Minister for Mental Health, Shane Rattenbury MLA

*Estimates - QTON No. E17- 562

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
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ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Andrew Wall MLA on 29 June 2017: Mr Jim Corrigan took on notice the following question(s):

Ref: Hansard Transcript - 29 June 2017 – Page 6

In relation to: Waste per Capita

THE CHAIR: Okay. What—Mr Corrigan, are you able to remove the impact of Mr Fluffy from those figures and inform the committee how we are actually tracking then in real terms?

Mr Corrigan: Yes, Mr Wall. Approximately we would be around 73 per cent resource recovery. I mean—

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THE CHAIR: Okay.

Mr Corrigan: —I might just ask Mr Trushell to join us, while he is joining us.

THE CHAIR: That is okay.

Mr Corrigan: Mr Trushell, Director of NoWaste. So it is approximately about 73 per cent if you take the Mr Fluffy out, yes.

THE CHAIR: Mr Fluffy out, okay. And what does that then equate to on a weight per capita basis?

Mr Corrigan: So, yes, I might have to take that one on notice unless Michael can—weight per capita? We will take that on notice.

Minister Fitzharris MLA: The answer to the Member's question is as follows:–

Table 1 below shows the annual tonnes of waste to landfill per head of population since 2011-12, with the impact of Mr Fluffy included and excluded. The data shows the amount of waste to landfill per capita, excluding Mr Fluffy, has been trending down since 2011-12.

Table 1		2011-12 Result	2012-13 Result	2013-14 Result	2014-15 Result	2015-16 Result	2016-17 Estimated Outcome
Annual tonnes of waste to landfill per head of population	Including Fluffy	n/a	n/a	n/a	0.57	0.73	1.01
	Excluding Fluffy	0.78	0.60	0.56	0.56	0.55	0.54

Table 2 shows the Territory resource recovery rate with the impact of Mr Fluffy landfill waste included and excluded.

Table 2		2011-12 Result	2012-13 Result	2013-14 Result	2014-15 Result	2015-16 Result	2016-17 Estimated Outcome
Percentage of material recovered from the total waste stream	Including Fluffy	n/a	n/a	n/a	73%	68%	61%
	Excluding Fluffy	70%	72%	74%	73%	74%	75%

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Signature: Date: 5/7/2017

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17-563

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Ms Tara Cheyne MLA on 29 June 2017: Ms Vanessa Little took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 – Page 18

In relation to: Library Memberships

MS CHEYNE: Thank you. Just going back to the percentage of population who are registered library members, you said we are one of the leaders. Are we the leader?

Ms Little: I can say that we are the leader when you look at the major jurisdictions. So we are definitely the leader compared to South Australia, Victoria. I have not gone into the data about any individual library service anywhere else, so you know, I could not tell you about City of Sydney. I could certainly take that on notice. But certainly in terms of jurisdictions we are way out there.

MS CHEYNE: Only take it on notice if it is an easy answer to find...

Minister Fitzharris MLA: The answer to the Member's question is as follows:–

National library statistics for states and territories are available for 2014-15. In 2014-15 the ACT was the best performing state or territory with regard to membership. 61% of the ACT population were members compared with 40% in NSW, 22% in the NT, 44% in Queensland, 36% in SA, 19% in Victoria and 37% in WA. In 2015–16 library membership in the ACT was 62% of the population.

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Signature: [signature] Date: 5/7/17

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17- 564

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Ms Cheyne on 29 June 2017: Ms Meegan Fitzharris took on notice the following question(s):

[Ref: Hansard Transcript - 27 June 2017 - Page 24

In relation to: Playgrounds

MS CHEYNE: How many requests do you get a year for playground augmentation? And I guess by that I mean, like, shade sails and things like that. That is something that I have had a little bit of is people saying, you know, the playground is great but it is really hot in the summer months, and hot to touch, and you know, a little bit dangerous for small bodies. And is that—are shade sails really quite expensive, going to what the minister is talking about in terms of, you know, there is only so much available to do both?

Ms Fitzharris: We have had—we might have to take on notice how many requests we get a year, so—but the question of shade sails was one that the last year's budget invested quite a lot in a number of—20, 22 playgrounds with shade sails. They will generally be the larger parks, so regional parks and town parks, because they are the highest use parks, so those do come, and again it is certainly the case that in some parts—in some periods throughout the year you will get a peak of requests for shade sails in sort of the summer months, and none over winter, so—but again, I think the natural play spaces that were spoken about earlier are a new way of delivering different types of play spaces.

We had a discussion I recall last year in Estimates around natural play spaces, where there was one that had been built that probably did not—was not as well developed with the local community as the ones we have done now in Telopea Park, O'Connor and Tuggeranong that have had a really good piece of community engagement and community design. And so we have seen those completed, all three of those completed, with a lot of local input. Being completed.

MS CHEYNE: And just for areas that do not have a large playground or, like, a regional playground, but a high population of young children and a few smaller playgrounds, would they potentially be considered for shade sails? I guess I am wondering—

Ms Flanery: I think shade sails is one thing. So we certainly look at usage and where there are greater numbers you put your infrastructure into them because you have the ability to protect the greatest number of kids, the young people that use it. But also do shade monitoring. So trees have provided wonderful shade in Canberra for a long time before shade sails and they have many other environmental benefits, you know, along with having shade sails there is cleaning them, taking them back and all of those kind of maintenance considerations. So in some cases it is more appropriate to have trees because they let light in, in winter and so frost does not settle. Playgrounds, they are quite tricky to manage because you want shade on them in summer but you

do not want them to be shaded in winter so that where shade sails, and I know there are different types of fabric that can be used and things, but in essence we do monitor shade and in most cases there is a playground with some form of shading pretty close to people's houses. There is a playground within a radius of 400 metres of everyone's house so if it is not 200 metres that way it is 200 metres the other way.

MS CHEYNE: Thank you.

Minister Fitzharris MLA: The answer to the Member's question is as follows:–

Public enquires specifically for shade sails is not available on the TCCS records management database, however, the number of recorded public enquiries relating to playgrounds are approximately:

2014	2015	2016	2017 (to date)
764	853	990	549

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 5/7/2017

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17- 565

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Pettersson MLA on 29 June 2017: Ms Fleur Flanery took on notice the following question(s):

Ref: Hansard Transcript - 29 June 2017 – Page 25

In relation to: Shade Sails

MS CHEYNE: Thank you.

MR PETTERSSON: How much does a shade sail cost? I know there are a wide range of them but what is the kind of price scale we are talking about here?

Ms Flanery: I would have to take that on notice. It is size, material. I do not know even if taking it on notice will be that helpful.

MR PETTERSSON: If you can tell us this, how much is the smallest one and how much is the largest biggest one? Just so I can get an understanding of how much it actually costs when—

Ms Fitzharris: Well, it is the sail but it is also the structure, the supports. Can I say to Ms Cheyne's question around high usage parks particularly in town centres where we do see people, you know, we do see a lot of young families now living in not just in suburban houses but closer into town centre that do mean that town centres can start to provide a more active space for kids. We know that where there are a lot of young children, where there are a lot of services and I mean Belconnen, Gungahlin Town Centre that I know well, we do see a lot of other services there that are really great for young kids. Our library is in the town centre. Child and family centres, community health centres, there seems to be a walk-in-centre all in the Gungahlin Town Centre.

How we, you know, we have got a lot to slow down traffic and remove traffic from parts of the town centre but that also does mean where you have got good places where kids can play but one of the things behind the natural play spaces was that there is, you know, there is also some other thinking around play spaces are not necessarily traditional, just traditional slides and swings. Kids can play in all sorts of environments. One of the ones I think about in the Gungahlin Town Centre is a piece of public art that the kids play a lot on. Kids will find different ways to play. It does not have to be all necessarily contrived play through a playground but that is where the natural play spaces come in and provide a different type of play environment for kids.

Minister Fitzharris MLA: The answer to the Member's question is as follows:–

The cost of shade sails relates directly to the size of the structure and the materials used. The following costs are examples and have been sourced from the 2016-17 shade sail project for playgrounds.

The prices for the installation of shade structures in the 2016-17 program vary varies between $300/m2 to $400/m2 and is subject to site conditions and design of the structure. This price includes the project design and management, footings, poles, installation, safety fittings and civil engineers certification.

A **small** shade sail covering approximately 45 square metres of shade surface has an average cost of $15,750.

A **large** shade sail covering 170 square metres of shade surface has an average cost of $59,500.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 5/7/17

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17-566

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION TAKEN ON NOTICE
DURING PUBLIC HEARINGS

Asked by Mr Steve Doszpot MLA on 29 June 2017: Mr Stephen Alegria took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 – Page 28 and 29

In relation to: Dog Attacks

How many dogs have been declared dangerous in the 16-17 financial year?

What is the average number of events (investigations) are being processed at the moment?

Minister Fitzharris MLA: The answer to the Member's question is as follows:–

From 1 July 2016 to date, eight dogs have been declared dangerous.

There are 12 current investigations underway into incidents relating to dogs.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: [signature] Date: 5/7/2017

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17-567

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Steve Doszpot MLA on 29 June 2017: Ms Meegan Fitzharris took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 – Pages 32 and 33

In relation to: Dog Attack Responsibilities

MR DOSZPOT: Minister, my final question to you, and I would like you to take this on board, is, the incident we are talking about happened seven years ago. Now, that should have no impact on the way we should look at it. Seven years ago something serious happened in someone's private residence. A child was severely injured, taken to hospital and as Mr Wall explained we would like to know the process what should have happened if it did not happen. I think it is incumbent on you as the current Minister to come back, take this on notice, and let us know what are the agencies that are meant to take the lead in this? Is it DAS? Is it the police? Is it the hospital but somebody has to take to the lead?

Ms Fitzharris: Certainly and what I was saying, Mr Doszpot, and I said a number of times I have enormous sympathy for these situations but we did not come prepared today to provide you all the answers that you are looking for on an incident that happened seven years which has been thoroughly investigated but I will take those points on notice.

Minister Fitzharris MLA: The answer to the Member's question is as follows:–

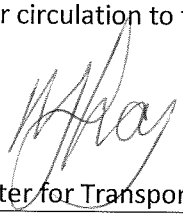
In accordance with the legislative provisions stipulated in the *Domestic Animals Act 2000*, and the associated Administrative Arrangements, Domestic Animal Services (DAS) is the primary agency responsible for managing and investigating domestic animal attack incidents.

Where an attack is underway and police are notified, ACT Policing will generally attend as first responders to protect life and property. When safe to do so, ACT Policing will hand over carriage of the incident and subsequent investigations to DAS to manage.

Like many offences, it is up to the victim or an advocate of the victim or witnesses to notify DAS of an attack incident.

Domestic animal attack incidents can be reported through Access Canberra 13 22 81, via the Access Canberra online portal, via email at dogcontrol@act.gov.au or in person at the Domestic Animal Services, facility located on Mugga Way, Symonston.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: 

Date: 5/7/2017

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17-568

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Ms Tara Cheyne MLA on 29 June 2017: Ms Emma Thomas took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 – Page 40

In relation to: TCCS Customer Survey

MS CHEYNE: Roads. Customer satisfaction with roads. Page 21 on the accountability indicators, so percentage of customers satisfied with the road network. I see that we are aiming for over 75 per cent in 2017-18. How do you determine whether a customer is satisfied?

Mr Marshall: Ken Marshall, director, Roads. The outcome against this accountability indicator is determined from the results of a public survey.

MS CHEYNE: And how many people are surveyed?

Ms Fitzharris: Perhaps we could talk more broadly. So there is an annual customers survey that TCCS does, so perhaps Ms Thomas could talk about that in broad terms to give us some context.

MS CHEYNE: Yes, please. That would be great.

Ms Thomas: Yes. Good morning, again. We, every year, to meet our accountability indicators across the board, you will notice there is a lot of customer satisfaction measures throughout the accountability indicators. So we do largely through a phone survey every year, we survey a number of Canberrans. I am not sure the exact number. We will have to take on notice. I think it is more than 1,000. Yes, so happy to take that on notice, the exact number, but we phone a number of residents throughout Canberra, and they are asked a number of questions to rate our service across the board. And as a result of those, they are fed into the accountability indicators for this survey.

So it is not just road quality, but there will be, there is customer survey measures across for action, libraries, the whole suite of TCCS services. That data is busy being collected currently, in preparation for these measures for this year. I believe the surveys have actually finished. We are just waiting for the data collection survey company to pull all those results together so we can feed that into our annual report every year.

Minister Fitzharris MLA: The answer to the Member's question is as follows:–

For the purpose of reporting against the accountability indicators TCCS assesses customer satisfaction with the road network through an annual community survey. The survey is conducted via telephone asking a representative panel of 1,000 Canberrans for their views on all of the

services TCCS provides. Due to its size the survey is delivered through a number of components but specifically for roads panel members are asked to rate their satisfaction against the following statements:

1. Management of the public road network.
2. Construction and maintenance of roads.
3. Safety and operation of the public road network.
4. Safety and operation of the road network during roadworks and/or special events.
5. Safety and operation of the traffic light system.
6. Safety and operation around school zones.

The response to the statement "Management of the public road network" is used to determine overall satisfaction and is the reported measure against our accountability indicators.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 5/7/12

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17-569

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mrs Vicki Dunne MLA on 29 June 2017: Ms Meegan Fitzharris MLA took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 – Page 42 & 43

In relation to: Spalding Street and Kingsford Smith Drive Duplication

MRS DUNNE: Yes. And are we looking at any works at the intersection of Spalding Street in Flynn.

Ms Fitzharris: We might have to take that one on notice, in terms of the work that has come out of the—often, just a general comment, often those consultations raise a number of issues. Not all can be implemented in one go, but they are prioritised and implemented based on priority measures that have been identified, both through the technical work and the community consultation. ...(indistinct)... [11.46.36].

MRS DUNNE: With your indulgence, Mr Chairman, could I just move us a little bit east to Kingsford Smith Drive?

Beyond the issue of the intersection with Kuringa Drive, there is a lot of traffic, it seems to me increased traffic on that because of the construction of Clarrie Hermes Drive. Is there any consideration of duplication of Kingford Smith Drive? I mean, it is quite a wide road, and there is quite a wide road reserve, and there are also issues, there are black spot issues which have been ameliorated to some extent by reducing the speed limit over the time. But is there any consideration to the duplication of Kingsford Smith?

Ms Fitzharris: No, not to my knowledge, no. And as a general rule—

MRS DUNNE: Well I mean, it is duplicated up until Spalding Street, or just before Spalding Street, so it is—

Ms Fitzharris: Duplication generally makes it less amenable to walking, cycling. Given those black spot issues, I do not believe there is—

MRS DUNNE: Well, it is already a duplicated road for most of its, from Drake-Brockman Drive all the way up to Spalding Street. So it is only the last sort of kilometre or so which is not duplicated. And constituents talk to me a lot about the increased traffic flow since the construction of Clarrie Hermes and those suburbs that are fed by Clarrie Hermes.

Ms Fitzharris: We can take the specifics on notice, but again, also increased volume does not necessarily mean that the road is at capacity. It may be that the road has been—an increase in volume may not mean that the road is at capacity. It just may mean there is more traffic on it.

MRS DUNNE: Yes, I understand that.

Ms Fitzharris: Yes, we will take those specifics on notice.

Minister Fitzharris MLA: The answer to the Member's question is as follows:–

As part of the Local Area Traffic Management study (LATM) on Tillyard Drive, Spalding Street was investigated.

Spalding Street is identified as a major collector, an on road cycle route, and is the only east west on road cycle link between Kuringa Drive and Ginninderra Drive.

As such, the proposed priority treatment is lane narrowing, which should reduce travel speeds to some extent and to provide cycle lanes on both sides, indicatively 1.5m wide. Associated improvements to the line marking at the Barber Crescent intersection were also identified and would be subject to a review on the effectiveness of crash reductions of the priority treatment, which would also indicate if there are further requirements to calm the traffic on Spalding Street.

There are no current plans to duplicate Kingsford Smith Drive for the last kilometre.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 5/7/2017

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17-570

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Ms Nicole Lawder MLA on 29 June 2017: Ms Meegan Fitzharris MLA took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 – Page 46 and 47

In relation to: Traffic Calming Measures on Budgen Avenue

MS LAWDER: So what analysis was done of speeding along Bugden Avenue in that area?

MS LAWDER: Sure. So I will go back to the consultation, the letter I got from the Director-General. Can you outline what, apart from the survey and I cannot recall the company, there was a survey maybe in 2015 about the local area, Coyne Street and Bugden and all around there, apart from that what other consultation with affected residents took place?

MS LAWDER: That is great. So that one and also if you could take on notice the measurement of speeds along there prior to the implementation and it is relatively recent so I presume there has been no follow up monitoring of speeds but do you know when that might take place.

THE CHAIR: I have got one as well. From my recollection, Minister, when those consultations were done around particularly Fadden, Macarthur, Gowrie that speed humps on Bugden were seen as one of the least preference options and in fact it was a realignment of Coyne Street. Why was the decision take to simply install speed humps as opposed to the realignment or the introduction of a roundabout at the Coyne/Bugden intersection as was largely chosen by residents?

Ms Fitzharris: How about we take it on notice issues around the original consultation, the range of issues that were raised and what has been implemented since and what may still be to come.

Minister Fitzharris MLA: The answer to the Member's question is as follows:–

Traffic conditions on Bugden Avenue were assessed as part of a traffic study on roads in Macarthur, Fadden and Gowrie and treatments developed in consultation with the community in December 2012 and March 2013. This resulted in the finalisation of a traffic management master plan for the area in mid 2013. The master plan was developed based on the technical analysis of traffic data and community feedback, and lists proposed improvements for the area and priorities for implementation.

The Priority 1 measures (three sets of speed cushions and a pedestrian refuge island on Coyne Street) were implemented in August 2014 and their effectiveness evaluated in June 2015.

The evaluation found that travel speeds and traffic volumes had reduced on Coyne Street, which had improved safety for all road users. The evaluation also recommended that traffic conditions on Coyne Street, Bugden Avenue and surrounding streets in the area should continue to be monitored and any improvements, if required, considered in future programs in consultation with residents of the street.

The master plan for the area and traffic data were reviewed in 2016, and some locations in the area were found to require additional traffic calming measures to improve road safety. The recommended measures were reviewed and replaced with devices such as speed cushions to enable implementation. These devices are suitable for use in 60 km/h speed environments, and are implemented on many other similar streets in the ACT as effective speed management treatments.

As part of the 2016-17 Residential Street Improvements project, work on Bugden Avenue was undertaken. Directly affected residents (residents where speed humps were installed directly out the front of their homes) were consulted between the 23 and 27 of September 2016. Additional letters were also distributed to these residents two weeks prior to construction.

Prior to the installation of speed humps on Bugden Avenue the average speed of a vehicle from data collected in March 2015 and October 2016 is summarised in the table below:

Location	85% Speed (km/h)
232 - Bugden Ave - Near Property 104	61.0
242 - Bugden Ave - North Of Kellett St	63.3
243 - Bugden Ave - Near Property 289	66.9
244 - Bugden Ave - Near Property 365	52.6
245 - Bugden Ave - Near Property 171	66.3
246 - Bugden Ave - Near Property 59	63.3
Along Bugden Avenue, between Chataway Cr and Nicklin Cr (Westbound)	65.2
Along Bugden Avenue, between Chataway Cr and Nicklin Cr (Eastbound)	63.0

The effectiveness of the Bugden Avenue treatments will be evaluated in mid 2018. This evaluation will include a technical analysis of before and after traffic speed, volume and crash data to determine if the traffic calming devices have met their primary objective in creating the desired traffic calming along Bugden Avenue.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 5/7/2017

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17- 571

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Ms Tara Cheyne on 29 June 2017: Mr Jim Corrigan took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 – Page 46 & 47

In relation to: 40km Speed Zones in Belconnen

Mr Marshall: It is, I guess, a very science specific question the evaluation of how effective a given measure is. So the measures can be looked in the context of overall compliance. You are right, in various circumstances it may be more or less difficult to determine what the exact contribution of one intervention against others is where really all we can evaluate is the net effect. But I guess we can monitor the contribution of a given measure against its undesired effects and weigh that up in consideration of whether consideration might be given to a change.

But certainly any scheme is implemented not with a view that on the day of implementation that is what will remain in place forever. There is certainly a very open attitude to evaluation post identification and modifying to improve and refine the outcomes.

MS CHEYNE: And I know in the town centre there has already been one, at least one, post-implementation evaluation. Is there another one planned?

Mr Corrigan: Sorry, is that Belconnen?

MS CHEYNE: Yes, yes, sorry, yes.

Mr Corrigan: I do not have at hand exact detail of what is scheduled in Belconnen. I can take that on notice.

Ms Meegan Fitzharris MLA: The answer to the Member's question is as follows:–

Prior to the implementation of the 40km/h precincts existing travel speeds were measured. Within the determined precincts traffic calming devices such as speed cushions were only provided in locations where the average travel speed was above 40Km/h.

In relation to the Belconnen Town Centre the post-implementation evaluation of the 40km/h precinct was completed in 2014. The results indicated that the initiative was successful as speed limit reductions were achieved (with all average speeds within the precinct generally at about 40km/h) and there was a high level of community acceptance for the project. No further evaluation is currently planned for this area at this time.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 5/7/2017

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17- 572

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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- 6 JUL 2017
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COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Ms Lawder MLA on 29 June 2017: Ms Meegan Fitzharris MLA took on notice the following question(s):

Ref: Hansard Transcript - 29 June 2017 – Page 47 and 48

In relation to: Cost of Speed Humps

MS LAWDER: How much does it cost to install a speed bump, the materials, the man hours or labour, and the signage?

Ms Fitzharris: We will take it on notice.

MS LAWDER: And could you provide a list of, by suburb, how many have been installed each year over the past five years?

Ms Fitzharris: We will take that on notice and see how much work is involved. Yes, yes.

Minister Fitzharris MLA: The answer to the Member's question is as follows:–

Depending on the number of panels used, the Territory spends between $6,000 - $9,000 on rubber speed humps per site, and $40,000 on concrete speed humps per site.

The estimated number of speed humps installed in each suburb over the last five years is as follows:

SUBURB	NO OF SPEED HUMPS
ACTON	6
AMAROO	1
BELCONNEN	9
BRUCE	5
CALWELL	1
CAMPBELL	1
CANBERRA CENTRAL (RURAL DIST.)	5
CASEY	4

CHAPMAN	4
CHARNWOOD	2
CHISHOLM	7
CITY	6
CONDER	1
COOMBS	1
CURTIN	4
DENMAN PROSPECT	11
EVATT	3
FADDEN	8
GREENWAY	10
GOWRIE	5
GUNGAHLIN	5
HARRISON	1
HOLT	2
KALEEN	3
LAWSON	2
LYNEHAM	5
MACGREGOR	1
MACQUARIE	2
MONCRIEFF	1
NGUNNAWAL	2
RICHARDSON	8
SCULLIN	2
SPENCE	1
STROMLO (RURAL DIST.)	1
TURNER	2
WANNIASSA	2
WESTON	5
Total over the past five year	**139**

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:

Date: 5/7/2012

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17- 573

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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- 6 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Andrew Wall MLA on 29 June 2017: Ms Meegan Fitzharris MLA took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 – Page 50

In relation to: Road Safety Policy

THE CHAIR: So the policy costing which was Treasury costing number 49, which was released for the election costing commitments—

Ms Fitzharris: Yes, yes.

THE CHAIR: —was entitled "Labor's election commitment for road safety around schools". This costing included higher expenses than what has been funded for in the budget. So budget papers for this year show, I think, total funding expenses of $2,221,000, yet as it was costed by Treasury, the capital is the same but the expenses were $2,979,600. Why is there a difference in the expenses if it is the same policy, and how has that change come about?

Ms Fitzharris: It will be the—it is the same policy, and it will be some of the modelling that has been done to delivering the more efficient way, but I can take the specifics on notice. It may be that the costing—

Minister Fitzharris MLA: The answer to the Member's question is as follows:–

A pilot School Crossing Supervisor program is currently under development and will be introduced in the ACT.

Transport Canberra and City Services (TCCS) is currently investigating the type of models used by other jurisdictions in Australia, and internationally, to ensure the model selected is appropriate for the ACT school environment.

The model to deliver the program will be determined following a consultation process with key stakeholders in July and August 2017.

The funding provided in the 2017-18 budget is the result of further research and refinement of the costing estimates.

The final cost to deliver the program will be dependent on a number of factors, including how the supervisors are employed, the hours they work and the type of employees used to deliver the service. This will not be finalised until after the stakeholder consultation process.

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Signature: Date: 5/7/2017

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17- 574

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Ms Le Couteur MLA on 29 June 2017: Ms Meegan Fitzharris MLA took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 – Page 55

In relation to: Active Travel Funding

Ms Fitzharris: Yes, I know what you mean. But, you know what, I think there was a recommendation, made over a number of years, but around being more explicit in the budget papers on active travel expenditure. In last year's budget, major road duplications did have the amount separated out for active travel infrastructure, but my intention would be to have a clearer statement on that in next year's budget, so it is very clear.

MS LE COUTEUR: Well, and hopefully if you take this on notice, but for this year's budget, particularly bearing in mind it was a parliamentary agreement item to spend an extra $30 million and apart from anything else, I am just trying to work out—

Ms Fitzharris: We will get there.

MS LE COUTEUR: —where we are and it is a bit incomprehensible on that.

Ms Fitzharris: Yes. And a well, there are—the town centre, sorry I omitted to mention the town centre upgrades, which are also—at the group centre at Kambah's case. Tuggeranong, Gungahlin and Canberra also have active travel components in that $8 million worth of upgrades, so I think from that you can take that there are a range of different projects across a number of different directorates that have that. We will provide you with, on notice, the specifics and I am also looking towards next year's budget on having a clearer statement on that.

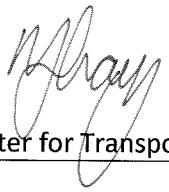
MS LE COUTEUR: Thank you. That would be really good. The other thing I wanted to talk to you about, about road and community path maintenance, as you obviously are aware the Auditor-General recently did a report basically saying there should be more of it. How can we get more of it, because I would suspect that she is correct, particularly as someone who, as Ms Cody said, spent a lot of last year walking on these paths and the number of people who complained about the safety of the paths near them was one of the things that has really surprised me after last year's doorknocking.

Minister Fitzharris MLA: The answer to the Member's question is as follows:–

There are a range of Active Travel projects across a number of Directorates. Work will be undertaken in preparation for the 2018-19 Budget to provide a clearer explanation of Active Travel initiatives.

For TCCS there are a number of projects titled 'Active Travel" in the 2017-18 Budget, as well as other projects and initiatives that include Active Travel components, for example town centre improvements.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:  Date: 17/7/17

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17-575

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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- 6 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Ms Bec Cody on 29 June 2017: Ms Meegan Fitzharris MLA took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 Page 63

In relation to:

MS CODY: Official park and pedal. I am sure people have been unofficially doing that stuff for a while. How is that going and are we planning to—I think I heard that we are going to do a few more across Canberra?

Ms Fitzharris: Yes, we have got four.

Mr McHugh: Yes, four on the plan. Yes. So obviously we have been keeping an eye on the usage of the initial site and there were some, I guess, fine tuning to some of the issues that we identified there earlier but there has been pretty good take up of that. On any day 30 to 40 vehicles appear to be using it which, at this early on in an initiative like that, we think is very positive. And we have identified three other sites at the moment which we are planning to roll out shortly. So I do not have the details of each of those on me at the moment but we are happy to share that.

MS CODY: If it is an easy task if we can take it on notice that would be really fantastic.

Ms Fitzharris: We will take that on notice, yes.

Ms Meegan Fitzharris MLA: The answer to the Member's question is as follows:–

Stage 1 Park & Pedal was launched in February 2017 at the Lindsay Pryor National Arboretum carpark.

Following its success, Stage 2 was launched in April 2017 at the following four carparks:

- Caswell Drive, Glenloch Interchange
- Hackett Shops, Hackett
- Kellaway Street, Hackett
- Palmerville Heritage Park, Evatt

The ACT Government will be seeking community feedback on where additional Park & Pedal carparks should be located for Stage 3. Key criteria for determining carpark locations include:

- good connections including to the active travel network and road access;
- distance from town centres (5-10 kilometre radius);
- utilisation of existing formed parking locations, with the use of existing spare capacity while enabling continued use for short-term users; and
- security arrangements for parked cars and Park & Pedal users.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 5/7/17

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17-576

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE
DURING PUBLIC HEARINGS

Asked by Ms Caroline Le Couteur on 29 June 2017: Mr Duncan Edghill took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 Page 63

In relation to:

MS LE COUTEUR: Thank you. I have got some questions about the buses. What percentage of services have bike racks on them? I mean, I know you recently put out a media release which said the percentage of buses but I am actually asking about the percentage of services as distinct from buses. And if you want to take that on notice then do so.

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

MS LE COUTEUR: But, yes, I am just trying to make the distinction between a bus and a service.

Mr Edghill: I think we will have to take that on notice. Sorry, Duncan Edghill, Deputy Director-General, Transport Canberra.

Ms Meegan Fitzharris MLA: The answer to the Member's question is as follows:–

Transport Canberra has estimated the number of services with bike racks is approximately 95%.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: MFitz Date: 5/7/17

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17- 577

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE
DURING PUBLIC HEARINGS

Asked by Mr Alistair Coe MLA on 29 June 2017: Ms Meegan Fitzharris MLA took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 Page 72

In relation to:

MR COE: Back in the night riders, so I think they are not really, you know, it is hard to compare '15 to '16 because they are, of course, different services. But I think there more people who boarded in '15 than '16. Is that right, or not?

Mr Edghill: I think the other way.

Ms Fitzharris: No, the other way. It was '16 was higher.

MR COE: Yes? Okay. So what were the total numbers?

Ms Fitzharris: We will take that on notice. I am sure of the hundreds of questions that have been put to us over the last couple of months, that was in there.

MR COE: Right, okay. But there are 140 Uber payments made, is that correct?

Ms Fitzharris: I will take that on notice.

Ms Meegan Fitzharris MLA: The answer to the Member's question is as follows:–

The total patronage boardings for Nightrider in 2015 was 2,309 and in 2016 was 2,465.

During the period of the campaign the UBER promo code was used a total of 142 times.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: [signature] Date: 5/7/2017

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17-578

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Alistair Coe MLA on 29 June 2017: Ms Meegan Fitzharris MLA took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 Page 81

In relation to:

MR COE: So did the government actually rank all the options in terms of potential stage 2?

Ms Fitzharris: From memory, no, but I will take the question on notice around whether or not we ranked them. It is obviously that the number one priority was Civic to Woden.

MR COE: I am just wondering why that is obvious? Why is not Belconnen to the city obvious?

Ms Meegan Fitzharris MLA: The answer to the Member's question is as follows:–

The route options for Light Rail Stage 2 were assessed on a qualitative and quantitative basis against multiple criteria associated with their alignment to Territory aspirations, potential benefits and potential risks. The route options assessment was provided to Government for consideration following which the Civic to Woden corridor was selected as the preferred second stage in the development of Canberra's light rail network.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: [signature] Date: 4/7/2017

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17-579

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
- 6 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Alistair Coe MLA on 29 June 2017: Ms Meegan Fitzharris MLA took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 Page 90

In relation to:

THE CHAIR: Minister, I want to ask about the local industry participation on the stage 1 of construction. Are you satisfied with Canberra Metro's local engagement to date? And how many local businesses have we actually got working on construction work at the moment?

Mr Edghill: Certainly. Sorry, we just—I brought too many pieces of paper. I just wanted to have the precise figures in front of me. But generally speaking I think one of the—we carried a few key aspirations through the procurement process. So from—and into the project itself. So on day one at EOY we very clearly articulated to the market and to all the participants in the process that what did we want to achieve through this project, what were our aspirations. There was one around customers. There was one around urban design. There was one around affordability. And there was one around the community and local industry participation.

So I think certainly from within the project team, we always wish we were doing more in the local industry space. We have set, I think, a high benchmark for ourselves. We think that some of the targets that we put into the contract by comparison to similar projects elsewhere really emphasise the importance that we place on local industry participation.

I think what we are seeing is a good take-up from the local region with Canberra Metro. I think there is still a degree of—education is not the right word, but this is kind of a new project for Canberra in that we do not have a hugely long history of kind of mega-infrastructure projects involving tier 1 D&Cs who have their own kind of bar which they work towards, but I think certainly what we are seeing is pleasing, and we are very happy that we are actually leaving a good industry legacy for Canberra through this project.

Ms Fitzharris: We might take that on notice. Actually I do not have it.

THE CHAIR: Okay. If you have not got them in hand and you do need to take it on notice, can you please take on notice the works that have been let on Capital Metro to date, the—

Ms Fitzharris: The number of contracts?

THE CHAIR: Well, yes, the number of contracts, and which company has won each of those contracts.

Mr Edghill: We could certainly provide you with the numbers. I am not—because those are commercial arrangements between ourselves and Canberra Metro I would need to check something that is within our domain to put back out.

THE CHAIR: Okay. Well, at an absolute minimum, the numbers of local businesses that have been awarded contracts.

Ms Meegan Fitzharris MLA: The answer to the Member's question is as follows:–

On 24 August 2016 in a local industry forum hosted by the Canberra Business Chamber 75 work packages targeting local businesses were launched. Since then, Canberra Metro has revised a number of these packages to be more reflective of how the project is being delivered by splitting them into 292 smaller packages. Current figures indicate that 221 work packages have been awarded, 127 (57%) of which to local businesses.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 5/7/17

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17-580

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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- 6 JUL 2017
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COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Andrew Wall MLA on 29 June 2017: Ms Meegan Fitzharris MLA took on notice the following question(s):

Ref: Hansard Transcript 29 June 2017 Page 91

In relation to:

Ms Thomas: The relationship with Canberra Business Chamber is not just about attracting local business and creating those opportunities and helping local business interact with Canberra Metro, the consortium, but it was also looking at helping businesses along the corridor to remain sustainable businesses during construction.

So they have been very active in working with those businesses and talking to us and talking to Canberra Metro and about helping businesses throughout the construction process, and also talking to businesses about the future opportunities that light rail creates from being there.

So the role of the Canberra Business Chamber is across a number of different facets of business and its interaction with light rail, and it is not just a single dimension. Yes.

THE CHAIR: Okay. Has there been any requirement of the Business Chamber then to acquit the funding that was provided to them by government on how they have spent it and where?

Ms Fitzharris: Yes.

THE CHAIR: Are you able to provide that to the committee?

Ms Fitzharris: We can provide you with an overview of that.

Ms Meegan Fitzharris MLA: The answer to the Member's question is as follows:–

The contract for the Canberra Business Chamber (CBC) Light Rail Business Link Program requires CBC to acquit the funding on an annual basis at the end of the financial year.

The report is expected to be received in the first quarter of the 2017-18 financial year.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: MFitzharris Date: 5/7/17

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QTON No. E17-581

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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14 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by **Andrew Wall MLA** on 3 July 2017: John Knox took on notice the following question(s):

[Ref: Hansard Transcript [3 July 2017] [PAGE 1047-1048]]

In relation to: ActewAGL service contracts – cost of the agreements

Andrew Wall MLA: What are the numbers today?

Mr Knox: The exact numbers?

Mr Sasche: They would be circa $20 million and the $7 million we have previously discussed.

Andrew Wall MLA: Surely, you can put a finer point on what the actual figure is?

Mr Knox: I can, actually. Could I take it on notice? I will continue to scan my papers and come back to it, if I May?

Andrew Wall MLA: That would be fine. Also, Mr Knox, what are the increases going forward and how are they built into the contract?

Mr Knox: Yes.

Andrew Wall MLA: Whether they are a percentile increase or otherwise.

Mr Knox: Yes.

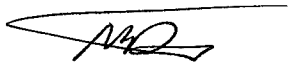
Andrew Coe MLA: Could you please provide how much has been paid each year for those contracts and how much is scheduled to be paid for each year going forward?

Mr Knox: Certainly. I will that that on notice.

Mick Gentleman MLA: The answer to the Member's question is as follows:-

Icon Water has already provided certain information regarding the cost of the agreements during the Committee hearings and in written response to other questions. I am advised by Icon Water that as the agreements are commercial-in-confidence they are unable to provide further information in this regard.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:  Date: 14/7/17

By the Minister for the Environment and Heritage, Mick Gentleman MLA

*Estimates - QTON No. E17-582

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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14 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by **Andrew Wall MLA** on 3 July 2017: John Knox took on notice the following question(s):

[Ref: Hansard Transcript [3 July 2017] [PAGE 1052-1053]]

In relation to: ActewAGL service contracts – performance bonuses

Andrew Wall MLA: Mr Knox, to come back to Mr Coe's previous question of whether performance bonuses or incentives were paid within ActewAGL on the signing of these contracts, I draw your attention to the privilege statement, of which you have indicated that you are aware. It states:

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

Will you answer the question: were bonuses or incentives paid within ActewAGL for the signing of that contract?

Mr Knox: As I mentioned, I believe the question is outside the remit of the Assembly, but I am happy take it on notice and seek legal advice to that effect. As we have discussed, we are not a government agency: ActewAGL matters are for ActewAGL. I am not here to comment on what occurs in ActewAGL; that is not within my responsibility of attending this Assembly.

Mick Gentleman MLA: The answer to the Member's question as provided by Icon Water is as follows:-

I am advised by Icon Water that Mr Knox appeared before the Committee in his capacity as Managing Director of Icon Water Limited. He is also a former employee of ActewAGL. Mr Knox is unable to provide the information requested as he is bound by both contractual covenants and common law obligations that endure and restrain him from providing confidential information obtained while in the employ of ActewAGL.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 14/7/17

By the Minister for the Environment and Heritage, Mick Gentleman MLA

*Estimates - QTON No. E17-583

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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10 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by **Alistair Coe MLA** on 3 July 2017: John Knox took on notice the following question(s):

[Ref: Hansard Transcript [3 July 2017] [PAGE 1056-1057]]

In relation to: ActewAGL service contracts – material disadvantage

Alistair Coe MLA: What is the format of that agreement that is in place about material disadvantage? Where is it documented?

Mr Knox: It does not state anywhere in the agreement about "material disadvantage".

Alistair Coe MLA: But where is it documented? Where is an arrangement or an agreement between Icon and ActewAGL that neither will be materially worse off –

Mr Knox: It does not say that in the agreement, Mr Coe.

Andrew Coe MLA: I am not asking about the agreement; I am asking: where does it say that? Where is it stipulated? You have stressed that you both have an agreement that there be no material disadvantage. I want to know where that agreement is documented.
Mr Knox: I will take it on notice, Mr Coe.

Andrew Barr MLA: The answer to the Member's question is as follows:–

Icon Water has advised the concept of 'no material disadvantage between Icon Water and ActewAGL' was an agreed principle in the negotiations but it is not expressly stipulated or documented in the service agreements.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Andrew Barr Date: 10.7.17

By the Treasurer, Andrew Barr MLA

*Estimates - QON No. E17-584

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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RECEIVED
18 JUL 2017
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COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mr Alistair Coe MLA: To ask the Minister for Transport and City Services

Transport Canberra and City Services, Budget Statement H, pp. 50-58, ACTION, Output Class 1: Bus Operations

In relation to: CCTV and Transport Canberra buses

1. How many Transport Canberra buses have CCTV cameras installed?

2. On average how many CCTV cameras are installed on each standard bus and each articulated bus?

3. Is the footage from the CCTV cameras saved? If so, outline how the footage is saved and for what period the footage is retained?

4. Is the footage from the CCTV cameras monitored or only reviewed if there is an incident that requires investigation?

5. If the footage is monitored, please advise the frequency of that monitoring?

6. For those buses equipped with WiFi, is the footage from any CCTV cameras installed on those buses transmitted for monitoring or saved and downloaded separately?

7. What protocols are in place for ensuring the privacy of Transport Canberra passengers?

Minister Fitzharris: The answer to the Member's question is as follows:–

1. CCTV cameras are installed on 427 standard and articulated buses. A further 18 special needs transport buses and 4 Transport Officer incident response vans are equipped with CCTV.

2. There are between 4 and 12 CCTV cameras installed on standard and articulated buses.

3. Bus CCTV camera recordings are generally stored for 30 days on recording infrastructure onboard buses, however some bus recordings are stored for less time due to digital storage limitations.

4. There is no capability to monitor bus CCTV remotely. Recordings are only viewed if there is an incident that requires investigation.

5. CCTV recordings from buses are not monitored in real time.

6. Recordings are downloaded through wireless connection at the depot. The bus CCTV system does not integrate with the public Wi-Fi system.

7. CCTV recordings are only accessed as a result of an incident by authorised people. Recordings are released to police and legal entities that are able to demonstrate a lawful need through an established process.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 17/7/17

By the Minister for Transport and City Services , Ms Meegan Fitzharris MLA

*Estimates - QON No. E17-585

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSON MLA

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14 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mr Alistair Coe MLA: To ask the Minister for Sport and Recreation

Environment Planning Sustainable Development Directorate Budget Statement E, Pages 11 and 17, Output Class 1.1: Planning Delivery

In relation to: Building on ovals

1. Please identify whether there are any plans or plans being considered to build on suburban ovals in the ACT, including Macquarie Oval and Garran Oval, and outline:
    a. The nature of the plan, and building and/or proposed use;
    b. The timeframe for decision;
    c. The community consultation that has or will be undertaken;
    d. The timeframe for construction; and
    e. Any planning limitations or restrictions.

MS BERRY: The answer to the Member's question is as follows:–

1) I have been advised by the Transport Canberra and City Services Directorate that the information sought to provide a response on each individual sportsground/oval (approximately 120 in total) in the ACT would require considerable resources to complete. Furthermore, what is considered as "any plans being considered to build" is subject to interpretation. As a result the following responses are specific to Macquarie Oval and Garran Oval only.

1a. There are currently no plans being considered to construct any new buildings at Garran Oval and Macquarie Oval.

1b. Not applicable.

1c. Not applicable.

1d. Not applicable.

1e. Macquarie Oval and Garran Oval are located in the PRZ1 – Urban Open Space zone. Any development on an oval must comply with the requirements of the Territory Plan and can only be for uses (as defined in the Territory Plan) permitted in that particular zone. For instance: in the PRZ1 zone outdoor recreation facility, community activity centre and playing field are examples of permitted uses, while indoor recreation facility and residential use are examples of prohibited uses.

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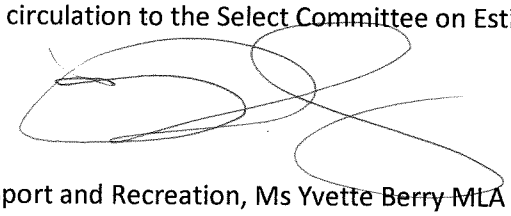
Signature: 

Date: 14/07/17

Minister for Sport and Recreation, Ms Yvette Berry MLA

*Estimates - QON No. E17-586

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mr Alistair Coe MLA : To ask the Minister for Planning and Land Management

Environment Planning Sustainable Development Directorate Budget Statement E, pp 11, 17, Output Class 1.1 Planning Delivery

In relation to: lease variation charge

1. Is the increase in lease variation charges (LVC) expected to impact the number or frequency of development applications submitted in 2017-18?
    a. If so, please outline what changes the Government is expecting due to the change in LVCs.
    b. If not, please provide an explanation why not.

2. Is there a risk that the increase in LVCs will be a disincentive for blocks to be rezoned to allow additional dwellings?
    a. If so, please outline how this risk is being mitigated; and how the directorate will be altering its planning functions or roles to manage the risk or rezoning changes.
    b. If not, please provide an explanation why not.

3. Is there a risk that the increase in LVCs will place further pressure on housing affordability through significant cost of additional dwellings on sites?
    a. If so, please outline how this risk is being mitigated; and how the directorate will be altering its planning functions or roles to manage the risk or address housing affordability.
    b. If not, please provide an explanation why not.

4. Where lease variations have been submitted prior to 1 July 2017, will those applications be subject to the increased LVC?

5. Please provide the total number of lease variations that were submitted in:
    a. June 2015;
    b. June 2016;
    c. June 2017.

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1. The number of lease variation charge (LVC) development applications will be determined by market forces.

2. This increased LVC charge only applies to applications to specify the number of dwellings to permit unit titling on certain residential leases. The change will improve consistency with the 'per unit' charges which apply to other types of residential lease.

   The LVC change does not allow additional dwellings on a block, and is only required for unit titling on certain blocks that are already allowed a certain number of dwellings. The LVC change does not apply to rezoning.

3. As noted, the LVC change does not allow additional dwellings, and is only required for unit titling on certain blocks. The LVC change does not apply to rezoning and is intended to bring the charge for this type of variation in line with other variation charges.

   As the lease variation charge taxes unearned wealth, it should have no impact on production or consumption decisions and hence no impact on affordable housing policies.

4. The increased LVC amount applies to development applications that are submitted to the planning and land authority through its online lodgement system on or after 1 July 2017. To ensure fairness and equity for developers who were notified of the change when the 2017-18 Budget was announced, the previous charges continue in effect for variations if the relevant development application was submitted before 1 July 2017.

5. The total number of lease variations (not just restricted to specifying the number of dwellings) lodged for the below months are:
   a. June 2015 – 18.
   b. June 2016 – 21.
   c. June 2017 – 28.

   This does not include applications that were submitted but have not yet undergone a documentation check.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 17/7/17

By the Minister for Planning and Land Management, Mick Gentleman MLA

*Estimates - QON No. E17-587

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
13 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mr Alistair Coe MLA : To ask the Minister for Planning and Land Management

Loose-fill Asbestos Insulation Eradication Scheme, Budget Statement E, page numbers 14, 21, Output Class 3.1

In relation to: commercial Mr Fluffy affected properties

1. Please outline why the Ainslie shops were not included in the extension of the Loose-fill Asbestos Insulation Eradication Scheme (the Scheme) to eligible impacted properties when the flat above the shops was residential in nature.

2. Was the Ainslie shops residential flat ever considered for inclusion as part of the Scheme?
   a. If so, what date was it considered, and why was it excluded from the Scheme when the flat was residential in nature?
   b. If not, why was the flat not considered when it was residential in nature?

3. Please outline how the Loose-fill Asbestos Insulation Eradication Scheme has interacted with Work Safe on the monitoring or management of the site; and whether there has been any sharing of resources between the two bodies.

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1& 2 The Loose Fill Asbestos Insulation Eradication Scheme (the Scheme), like the original remediation program conducted in the early 1990s, does not encompass commercial premises.

Block 1, Section 27 Ainslie (1 Edgar Street, Ainslie Shops) is a commercial building. Unlike houses that were part of the original remediation program, it continues to have bulk loose fill asbestos insulation in the roof space.

The Scheme's Voluntary Eligible Impacted Property Buyback Program only applies to separate dwellings adjoining an affected property that is recorded on the Affected Residential Premises Register established under the *Dangerous Substances Act (2004).*

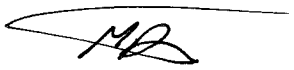
I am advised when Worksafe ACT issued the prohibition notice on the upper floor of Block 1 Section 27 Ainslie in 2014 because of loose fill asbestos contamination, the relevant areas of 1 Edgar Street were used for commercial purposes.

3 Scheme Policies and Guidelines have no relevance to Ainslie Shops.

WorkSafe ACT has extensive powers for regulating and enforcing commercial property owners' compliance with their significant obligations in relation to asbestos under the *Work Health and Safety Act (2011)* and the *Dangerous Substances Act 2004*, to ensure public safety.

The Asbestos Response Taskforce works collaboratively with WorkSafe and has shared information with WorkSafe ACT in relation to interactions with the owners of commercial premises, and in relation to the management (including demolition) of buildings affected by loose fill asbestos insulation.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:  Date: 13/7/17

By the Minister for Planning and Land Management, Mick Gentleman MLA

*Estimates - QON No. E17-588

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
13 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mr Alistair Coe MLA : To ask the Minister for Planning and Land Management

Loose-fill Asbestos Insulation Eradication Scheme, Budget Statement E, page numbers 14, 21, Output Class 3.1

In relation to: block sales

In Question on Notice 33 of the Planning and Urban Renewal 2015-16 Annual Report hearings, it was stated that,

> The grouping of blocks for auctions is developed in consultation with two sales agents appointed by the LDA based on factors including location, market considerations including holiday periods, and logistic of auction events. Blocks are brought to the market as they become available with a view to facilitating physical and social rebuilding in the fifty-six affected suburbs, as well as defraying the overall costs of the Scheme...

1. Please provide a detailed explanation of the rationale used to determine the blocks be sold in a small number of large scale auctions, as opposed to more auctions with fewer blocks, and include:
    a. What market analysis has been relied upon;
    b. What analysis has been undertaken by the Government on the effectiveness of the auctions;
    c. Trends that have been identified during the sales process;
    d. Why it is necessary for the sales to be conducted at large auctions; and
    e. Why it is necessary sale to take place within a compressed time frame.

2. In the Auditor-General's Report No. 7/2017 on the Public Housing Renewal Program, one of the significant risks associated with the program was that if the properties were sold in a compressed timeframe it would affect the sales return achieved. Is there a similar risk present with the Mr Fluffy properties when they are auctioned off in bulk during a small number of sessions?
    a. If so, why are they being auctioned off in the current manner, and how is the risk being mitigated?
    b. If not, why is this not a risk factor for the Mr Fluffy properties?

3. Please provide the total number of sales of Mr Fluffy blocks by type, including:
    a. Properties sold at auction;
    b. Sold following post-auction negotiation; and
    c. Sold over the counter.

4. Please provide the total number of properties that were passed over at auction in the first instance, for:

a. 2014-15;
b. 2015-16; and
c. 2016-17.

5. Please provide the dates of each auction of Mr Fluffy blocks, and the number of blocks that were available for auction during:
   a. 2014-15;
   b. 2015-16;
   c. 2016-17; and
   d. Planning during 2017-18.

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1. The Taskforce, in consultation with the two appointed sales agents, continues to explore a range of sales strategies to maximise the return per block and minimise any delays in receipting cash from sales. The progress currently being achieved under the demolition program has resulted in a higher level of inventory being available for sale. This increased level of inventory has allowed for the Taskforce to facilitate a number of larger auction events and to target and group complementary products together.

   Sales campaigns are scheduled to run between four and six weeks, in line with industry standards. Sales of remediated land to the value of $211 million were achieved in the 2016-17 financial year. The average price per block exceeded expectations. Strong sales continue to be observed in the Inner-Canberra suburbs where sales have resulted in increased revenue to the Territory.

2. Risks associated with the Sales Program continue to be monitored and strategies reviewed to maximise the number of blocks released to the market. Accordingly, large auction events allow for multiple blocks to be released at a single event creating a larger buyer pool, increased excitement and strong anticipation from the community including from builders. The use of larger auction events allows for more strategic packaging of products to be undertaken and for marketing to be targeted accordingly. Of the 408 blocks released to date, only 82 remain for sale over the counter.

3. A total of 408 blocks have been released publically for sale. Of this, 198 blocks were sold under the hammer at auction, 21 blocks were sold following post auction negotiations, and 189 blocks were passed in and made available for sale over the counter. Of the blocks made available over the counter, 107 blocks have since sold.

4. A total of 189 blocks were passed in at auction. Of this, 18 blocks were auctioned in 2015-16, and 171 blocks were auctioned in 2016-17.

5. A total of 408 blocks have been released publically for sale across 26 auction events as follows:

Auction date	Number of blocks auctioned
12/04/2016	5
14/04/2016	5
26/05/2016	9
31/05/2016	9
28/06/2016	8
30/06/2016	11
26/07/2016	12
30/08/2016	10
31/08/2016	7
27/09/2016	12
29/09/2016	12
02/11/2016	9
03/11/2016	11
29/11/2016	17
01/12/2016	16
07/03/2017	22
08/03/2017	1
16/03/2017	18
20/03/2017	33
21/03/2017	31
23/03/2017	17
30/03/2017	18
22/05/2017	28
23/05/2017	38
24/05/2017	27
25/05/2017	22

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 13/7/17

By the Minister for Planning and Land Management, Mick Gentleman MLA

*Estimates - QON No. E17-589

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mr Alistair Coe MLA : To ask the Minister for Planning and Land Management

Loose-fill Asbestos Insulation Eradication Scheme, Budget Statement E, page numbers 14, 21, Output Class 3.1

In relation to: ACT Asbestos Health Study

1. Please provide an update on how the Government has responded and what actions will be undertaken following the release of the ACT Asbestos Health Study Final Report by the National Centre for Epidemiology and Population Health, and include:
    a. A summary of strategies that will be implemented and the timeframe for implementation;
    b. The cost of implementing the strategies;
    c. Further health monitoring and assistance;
    d. Further financial assistance; and
    e. Details of any further actions, preventative or reactive, the Government will be undertaking.

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1. The ACT Government responded to calls from affected residents for detailed information about the health impacts associated with living in a property contaminated with loose-fill asbestos insulation by providing funding of $415,807 to the ANU's National Centre for Epidemiology and Population Health (NCEPH) to support the ACT Asbestos Health Study. The Government notes the findings of the final report of the Study that indicate an increased risk of mesothelioma among men living in a Mr Fluffy property.

The Asbestos Response Taskforce distributed the report and advice from the Chief Health Officer on health implications to homeowners, residents and registered former residents. This correspondence advised that people concerned about their health should seek advice from a qualified medical practitioner who can provide an assessment of individual circumstances. Information on other support services available was also provided, including help for people experiencing psychological distress.

a) The results of the Study reinforce the need for people who continue to live in affected properties to have Asbestos Management Plans (AMPS) prepared by a licensed asbestos assessor in place, and to make sure that any remediation work recommended in these plans is carried out. WorksafeACT will continue to monitor compliance with AMPs in these properties. The Taskforce's Personal Support Team continues to provide information and advice to assist homeowners experiencing psychological distress and health concerns, and to connect them with the free support services provided through community partners, such as the Capital Health Network.

b) Costs are part of ongoing processes.

c) The Chief Health Officer's advice remains that mesothelioma is a rare disease and people concerned about the effect of possible exposure to asbestos should consult their general practitioner. In terms of ongoing health monitoring, the Chief Health Officer (CHO) has also advised that previous large-scale screening studies using chest X-rays and CT scanning have proved ineffective for detecting early stage malignant mesothelioma. Repeated X-rays and CT scans also mean additional exposure to radiation, with potential adverse health outcomes.

   In respect of re-running the study, advice received from the NCEPH and CHO is that mesothelioma takes a long time to present, so while it might be useful to re-run the data linkage and analysis, this should not occur for several years. However, the data sets are being preserved in keeping with the relevant ethics committee approval requirements, and to facilitate revisiting the issue in the future.

d) No additional financial assistance outside that already available through the Loose Fill Asbestos Eradication Scheme (the Scheme) is being considered at this time.

e) The Government remains of the view that demolition is the only enduring solution to mitigate the health risks posed by the presence of loose fill asbestos insulation in residential properties.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 17/7/17

By the Minister for Planning and Land Management, Mick Gentleman MLA

*Estimates - QON No. E17-590

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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13 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mr Alistair Coe MLA : To ask the Minister for Planning and Land Management

Loose-fill Asbestos Insulation Eradication Scheme, Budget Statement E, page numbers 14, 21, Output Class 3.1

In relation to: assistance and maintenance provided under the Loose-fill Asbestos Insulation Eradication Scheme

1. Please provide the total value of the Relocation Assistance Grants distributed under the Loose-fill Asbestos Insulation Eradication Scheme (the Scheme) in (i) 2014-15; (ii) 2015-16; and (iii) 2016-17 to:
    a. Vacated owner occupiers; and
    b. Vacated tenants.

2. Please provide the total number of (a) households and (b) dependent children that have been covered under the Relocation Assistance under the Scheme in (i) 2014-15; (ii) 2015-16; and (iii) 2016-17.

3. Please provide the total value of Stamp Duty concessions given to participants of the Voluntary Buyback Program Scheme in (i) 2014-15; (ii) 2015-16; and (iii) 2016-17.

4. Please provide the total value of concessions provided by (a) Icon Water and (b) ActewAGL under the Scheme or as an associated measure in Scheme in (i) 2014-15; (ii) 2015-16; and (iii) 2016-17.

5. Provide the total value of monetary support the ACT Government provided to participants or providers under the Scheme in (i) 2014-15; (ii) 2015-16; and (iii) 2016-17 in relation to:
    a. Buying and selling property;
    b. Financial assistance;
    c. Rebuilding, repairs and maintenance;
    d. Local businesses offering concessions.

6. Please provide the total amount spent maintaining the properties in (i) 2014-15; (ii) 2015-16; and (iii) 2016-17:
    a. Prior to demolition; and
    b. Post demolition.

7. Please provide a list of the types of maintenance work that is carried out by the Territory on Mr Fluffy blocks the Government has assumed responsibility for, and the cost of each type in:
    a. 2014-15;
    b. 2015-16; and

c. 2016-17.

8. Please provide the number of complaints about Mr Fluffy properties the ACT Government has assumed responsibility for in:
   a. 2014-15;
   b. 2015-16; and
   c. 2016-17.

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1. (a) (i) $6,271,447.
(ii) $2,672,729.
(iii) $553,833.
(b) (i) $930,282.
(ii) $444,398.
(iii) Nil.

2. (a) (i) In 2014-15, 617 households had their Relocation Assistance Grant payments finalised.
(ii) In 2015-16, 307 households had their Relocation Assistance Grants payments finalised.
(iii) In 2016-17, 66 households had their Relocation Assistance Grants payments finalised.
(b) In total, it is estimated that Relocation Assistance Grant payments have been finalised for households where 745 dependent's have been confirmed.

3. (i) In 2014-15, 395 Concessions worth $9,391,738.45
(ii) In 2015-16, 194 Concessions worth $4,621,001.55
(iii) In 2016-17, 60 Concessions worth $1,917,840.05

4. The Government does not hold information regarding the value of concessions provided by Icon Water or ActewAGL.

5. (i) 2014-15,
(a) Buying - $599,000 for Legal Assistance ($1,000 per property), Selling – No monetary support
(b) Owners and Landlords received $6,617,452.
(c) A small number of homeowners utilised a portion of their Relocation Assistance Grants to undertake minor repairs on affected properties in response to the findings of initial asbestos assessments. The level of monetary support is included in the Financial assistance support detailed above.
(d) Nil.
(ii) 2015-16,
(a) Buying - $287,000 for Legal Assistance ($1,000 per property), Selling – No monetary support
(b) Owners and Landlords received $2,2772,492
(c) Nil.
(d) Nil.

(ii) 2016-17,

(a) Buying - $44,000 for Legal Assistance ($1,000 per property), Selling – No monetary support.

(b) Owners and Landlords received $587,433.

(c) Nil.

(d) Nil.

6. (a) (i) 2014-15 $854,595.64
(ii) 2015-16 $3,290,887.40
(iii) 2016-17 $1,531,754.23

(b) (i) 2014-15 $0.00
(ii) 2015-16 $157,277.09
(iii) 2016-17 $1,552,336.99

7. Works carried out include:

- Make safe
- Security
- Mowing
- Garden maintenance
- Removal and disposal of rubbish
- Temporary Fencing
- Replacing fixed fencing
- Removal of unapproved structures
- Body Corporate Fees

The total costs are provided in response to Question 6. Due to the procurement methodology utilised for managing the maintenance of properties i.e. works are often bundled up and issued under a single work order per property, a further breakdown is not available.

8 (a)

2014-15	
Total number of complaints: 4	
Type of Complaint	*Resolution*
Ombudsman (4)	The ACT Ombudsman determined that no further investigations of the complaints were warranted.

(b)

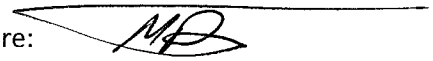
2015-16	
Total number of complaints: 6	
Type of Complaint	*Resolution*

Ombudsman (3)	The ACT Ombudsman determined that no further investigations of the complaints were warranted.
Privacy (2)	The Office of the Australian Information Commissioner (OAIC) determined that no further investigations were warranted.
Human Rights (1)	The Human Rights Commission conducted mediation.

(c) No complaints have been made about the Taskforce in 2016-17.

All complaints have been managed in accordance with legislation, policy and procedures. The ACT Ombudsman's Office was consulted in the development of the Taskforce's complaints handling procedures and policy.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:  Date: 13/7/17

By the Minister for Planning and Land Management, Mick Gentleman MLA

*Estimates - QON No. E17-591

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
13 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mr Alistair Coe MLA : To ask the Minister for Planning and Land Management

Loose-fill Asbestos Insulation Eradication Scheme, Budget Statement E, page numbers 14, 21, Output Class 3.1

In relation to: settlement

1. Please provide the total number of households that opted into the Voluntary Program with a delayed settlement in:
    a. 2014-15;
    b. 2015-16; and
    c. 2016-17.

2. Please provide the average length of time a homeowner or tenant remained in the property during the delayed settlement period.

3. Please provide an outline of what is included in an Asbestos Management Plan (the Plan), and include:
    a. Whether the Plan is site specific, or there is a version of the Plan that can be implemented across any site;
        i. If there is a generic Plan, please provide a copy.
    b. The average cost of creating a Plan;
    c. The total amount spent on creating Plans to date;
    d. The monitoring measures in place to determine whether the Plan is effective; and
    e. Other relevant details pertaining to monitoring the health of the individuals residing in a Mr Fluffy property.

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1. A total of 922 affected properties have been surrendered to the Taskforce. Of this, 599 properties were surrendered in 2014-15, 283 properties were surrendered in 2015-16, and 40 properties were surrendered in 2016-17.

2. Of the affected properties surrendered to the Taskforce, the owners of 454 properties elected to delay settlement past the standard 30 day contract exchange to settlement period. Of these properties, there was an average time frame of 120 days between contract exchange and settlement.

3. An Asbestos Management Plan is specific to each site. The cost of creating this Plan in not known to the Taskforce as the transaction occurs directly between the homeowner and the appointed asbestos assessor. Monitoring arrangements to ensure compliance with the Regulations are reviewed and conducted by ACT Worksafe. Should individuals that continue to reside in a Mr Fluffy property have concerns regarding their health, they should discuss these concerns directly with their General Practitioner.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 13/7/17

By the Minister for Planning and Land Management, Mick Gentleman MLA

*Estimates - QON No. E17-592

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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14 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mr Alistair Coe MLA : To ask the Minister for Planning and Land Management

Loose-fill Asbestos Insulation Eradication Scheme, Budget Statement E, page numbers 14, 21, Output Class 3.1

In relation to: staffing profile

1. Please provide the total number of FTEs in the Asbestos Response Taskforce by classification bracket.

2. Please provide an outline of the nature of each role, and whether the role is (a) ongoing for the duration or (b) only for a stage of the Loose-fill Asbestos Insulation Eradication Scheme.

3. Please provide the projected end date of the Loose-fill Asbestos Insulation Eradication Scheme and how long the Asbestos Response Taskforce is expected to remain operational, and detail the staffing requirements necessary for each stage, including:
    a. Number of employees; and
    b. Nature of expertise.

4. Have any external consultants or contractors have been part of the administrative structure of the Asbestos Response Taskforce?
    a. If so, please provide the nature of the role, why it was necessary to source external expertise, the cost of the contract, and the duration of the contract

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1. Appropriation for 43 FTEs are factored into the 2017-18 Budget. The classifications of these positions are:

Position Level	Number of Staff (FTE)
SES 3.7	1.00
SES 2.6	1.00
SES 1.3	1.00
SOG A	6.00
SOG B	4.00
SOG C	8.00
ASO 6	4.00
ASO 5	9.00
ASO 4	9.00

2. The Taskforce appropriated structure provides for:

- 3 Staff – Executives.
- 3 Staff – Executive support officers.
- 15 Staff – Acquisition, Demolition and Sales
- 8 Staff – Personal Support Team.
- 4 Staff – Communications and Engagement.
- 8 Staff – Program, Governance and Risk Management.
- 4 Staff – Finance Team.

3. Affected homeowners have until 30 June 2020 to surrender their properties to the Government under the Voluntary Buyback Program. The Loose-fill Asbestos Eradiation Scheme will operate until the last of the properties surrendered under the Voluntary Buyback Program is demolished and the remediated land is sold.

The Asbestos Response Taskforce will continue to operate in its current form until 30 June 2018. It is anticipated that from 1 July 2018, the remainder of the Scheme will be delivered through normal Directorate structures.

4. Yes.
(a) Xact Project Consultants Pty Ltd were engaged to assist in developing a project management strategy to support the safe, efficient and effective demolition of up to 1,000 loose-fill asbestos houses across the Canberra region. The services were engaged to assist the Taskforce with the timely and effective management of the demolition and sales program.

The value of this contract was $0.327 million and the services were provided over a 10 month period between October 2015 to August 2016.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 4/7/17

By the Minister for Planning and Land Management, Mick Gentleman MLA

*Estimates - QON No. E17-593

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
- 4 AUG 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mr Alistair Coe MLA : To ask the Minister for Planning and Land Management

Environment Planning Sustainable Development Directorate Budget Statement E, page number 11, Output Class 1.1 Planning Delivery

In relation to: Planning Delivery – conditions applying to a Crown Lease

(i) Outline the conditions, if any, which apply to the Crown Lease covering the block of land where the former Giralang shops were sited.

(ii) Are there any conditions apply to the Lease referred to at question 1 above which relate to a timeframe for any current lessee to develop, or complete development, of this block?

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1. The current Crown lease for Block 6 Section 79 Giralang, being the Giralang shops site, has the following provisions. This is not exhaustive.

   (i) The current Crown lease was preceded by a lease dated 20 April 1999. A development application for the demolition and redevelopment of the Giralang shops was conditionally approved in August 2011 by the former Minister for Planning. One of the conditions of approval required the registration of a new Crown lease, consolidating the substantial block with an adjoining portion of Territory land, prior to the approval taking effect. On 12 March 2014 the new (current) Crown Lease commenced for the Giralang shops.

   (ii) In accordance with 3(b) of the Crown Lease the Lessee shall within thirty six (36) months from the date of commencement or within such further time that may be approved in writing by the Authority complete the erection of said approved development.

   (iii) The premises can only be used for one or more of the following purposes:
      (i) car park;
      (ii) community use limited to health facility;
      (iii) non retail commercial use;
      (iv) restaurant; and/or
      (v) shop provided always that the maximum gross floor area for a supermarket shall not exceed 1500 square metres and ancillary thereto storage and a loading dock.

(iv) There is currently a maximum gross floor area limit of 3,316 square metres.

A full copy of the Crown lease can be requested from the Land Titles Office.

2. According to the current Crown lease the erection of buildings should have been completed by 12 March 2017. However, completion provisions in a Crown lease can be extended. I am advised that an extension would be given in this circumstance. The following sequence of events is relevant:

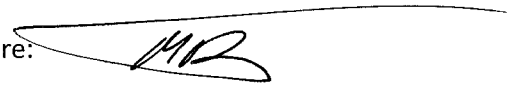
(i) A conditional development approval for Giralang shops issued on 17 August 2011 included a requirement that the approval only came into effect when a new consolidated Crown lease has been registered for the site. The new Crown lease was only registered on 12 March 2014.

(ii) Demolition of the shops also did not occur until 2014 due to legal proceedings against the development being undertaken by objectors to the development. Once the demolition of the old shops occurred, construction of the new shops began. However, these works were further delayed by more legal appeals, including appeals to the High Court of Australia by objectors to the development.

(iii) A resolution in relation to the legal proceedings was finally reached in late 2016, where in part it was agreed by all parties that the development approval granted by the former Minster for Planning would be surrendered. The development approval was surrendered on 9 September 2016.

(iv) Subsequently, a partially completed structure, with perimeter fencing, now stands on the site. Since late 2016, the planning and land authority has been working with the owners of Block 6 Section 79 Giralang to progress the lodgement of a new development application over the site. A new development application will include a request to extend the current timeframe for completion of construction.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:  Date: 21/7/17

By the Minister for Planning and Land Management, Mick Gentleman MLA

*Estimates - QON No. E17-594

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18
MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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17 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mr Alistair Coe MLA : To ask the Minister for Planning and Land Management

Environment Planning Sustainable Development Directorate Budget Statement E, page number 11, Output Class 1.1 Planning Delivery

In relation to: Planning Delivery – Development Applications for multi-unit developments

1. Please provide the total number of development applications lodged for multi-unit developments in the following financial years, broken down into residential leases and commercial and industrial leases:

    a. 2014-15;
    b. 2015-16; and
    c. 2016-17 to date.

2. For the 2016-17 financial year, please provide the total number of development applications lodged for multi-unit developments for each month from July 2016 to 28 June 2017, broken down into residential leases and commercial and industrial leases.

3. Please provide the total amount of revenue received in Leave Variation Charges in the following financial years:

    d. 2014-15;
    e. 2015-16; and
    f. 2016-17 to date.

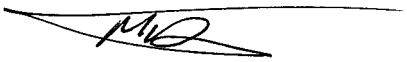
MICK GENTLEMAN: The answer to the Member's question is as follows:–

1. The planning and land authority regularly publishes development application statistics on the Environment, Planning and Sustainable Development Directorate website.

2. The total number of development applications received in the 2016-17 financial year for multi-unit sites is available on the Environment, Planning and Sustainable Development Directorate website.

3. Please refer to the budget papers for the total amount of moneys received from Lease Variation Charges for the above mentioned years.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature:  Date: 14/7/17

By the Minister for Planning and Land Management, Mick Gentleman MLA

*Estimates - QON No. E17-595

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

RECEIVED
10 JUL 2017
ACT LA
COMMITTEE SUPPORT

ANSWER TO QUESTION ON NOTICE

Mr Alistair Coe MLA: To ask the Minister for Transport and City Services

Transport Canberra and City Services, Budget Statement H, pp. 50-58, ACTION, Output Class 1: Bus Operations

In relation to: rebranding of ACTION buses

1. Will buses with ACTION branding be rebranded as Transport Canberra and City Services (TCCS) during 2017-18?

2. If the answer to question 1 is no, please provide an explanation why the buses have been exempt from the TCCS rebranding.

3. If the answer to question 1 is yes, please provide:
    a. The total number and type of buses that still have ACTION branding;
    b. The timeframe for the buses will be rebranded;
        i. If there is a schedule, please provide a copy.
    c. The length of time the buses are out of service during the rebranding;
    d. The total cost of the bus rebranding for 2017-18;
    e. Where the allocation of funds was reported in the 2017-18 Budget;
    f. The cost of the rebranding per bus; and
    g. The reasons why the buses still have ACTION branding.

Minister Fitzharris: The answer to the Member's question is as follows:–

1. There are no plans to re-brand ACTION buses at this time.

2. Transport Canberra livery and branding is being applied to new buses entering the bus fleet.

3. N/A.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: [signature] Date: 10/7/2017

By the Minister for Transport and City Services, Ms Meegan Fitzharris MLA

*Estimates - QON No. E17-596

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2017-18

MR WALL MLA (CHAIR), MS CODY MLA (DEPUTY CHAIR), MR COE MLA, MS LE COUTEUR MLA, MR PETTERSSON MLA

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13 JUL 2017
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ANSWER TO QUESTION ON NOTICE

Caroline Le Couteur MLA : To ask the Minister for Planning & Land Management

Output 1.2 - Planning Policy (EPSDD Budget Statement E, 16-17)

In relation to the most recent Statement of Planning Intent which states that the Directorate will "review the Parking and Vehicular Access General Code", and in particular requirements to have a minimum number of parking spaces available in new developments:

1) Do you have a current estimate of how much an average car parking space in a basement costs for the developer?

MICK GENTLEMAN: The answer to the Member's question is as follows:–

The current construction costs of basement carparks in Canberra are generally in the vicinity of $30,000 to $35,000 per car space. The variables depend on the number of ramps required, amount of mechanical ventilation required and fire sprinkler systems.

This figure generally aligns with the ACT Government's '*Building (General) (Cost of Building Work) Determination 2015*', which provides an amount of $1350 per square metre for basement carpark construction.

The construction of Podium carparking is considerably cheaper, at approximately $22,000 per car space, due to savings with natural ventilation and sprinkler requirements.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 13/7/17

By the Minister for Planning and Land Management, Mick Gentleman MLA

*Estimates - QON No. E17-597

LEGISLATIVE ASSEMBLY
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27 JUL 2017
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ANSWER TO QUESTION ON NOTICE

Caroline Le Couteur MLA : To ask the Minister for Climate Change & Sustainability

Government Sustainability

In relation to page 20 of Budget Statement E, and the targets for emissions reductions under the Carbon Neutral Government Program:

1) Has there been engagement with the program across all of the Directorates?
2) Which Directorates have led the way in terms of reducing their own emissions?
3) Which Directorates have failed to meet their targets in terms of reducing their own emissions?
4) Noting that the accountability indicators under Output 2.2 have set goals for reductions in electricity consumption, do you have an estimate of the amount of greenhouse gas emissions reduced under the Carbon Neutral Government Program?

SHANE RATTENBURY: The answer to the Member's question is as follows:–

1) Meeting the ACT Government target of net zero emissions by 2020 is the collective responsibility of all agencies.

   Each Directorate has a Resource Management Plan, which identifies priority energy-using sites in their portfolio. An energy reduction target (previously referred to as 'carbon budget') is submitted annually by Directorates, with quarterly reporting on progress towards their target; these energy reduction indicators are also included in Directors-General performance agreements.

2) All ACT Government Directorates have engaged with the Carbon Neutral Government (CNG) Program, with many Directorates developing and implementing energy efficiency projects under the CNG Loan Fund. CMTEDD recently commenced an all-electric upgrade of the Heating, Ventilation and Cooling system at the North Building, Civic, supported by the Carbon Neutral Government Loan Fund. This project will assist the ACT Government to reduce future emissions from natural gas. The Education Directorate has now installed a combined total of 1.5 MW of solar PV across ACT public schools, reducing electricity consumption as well as emissions. EPSDD has demonstrated energy efficiency upgrades in an office building by achieving a NABERS Rating of 5.5 for Dame Pattie Menzies House. The Health Directorate has installed a 500 kW solar PV system at the Canberra Hospital, supported by the Carbon Neutral Government Loan Fund. Justice and Community Safety Directorate has incorporated energy efficiency measures such as solar hot water systems

and high efficiency condensing boilers at the Alexander Maconochie Centre, which has led to a 17.4% reduction in energy emissions per detainee since 2012-13.

All Directorates continue to identify opportunities for further electricity, natural gas and transport fuel reductions in their operations.

3) Carbon Budgets formally commenced in FY 2016-17 to inform Director-General Key Performance Indicators. Data for the FY2016-17 will not be available until September 2017 due to the timing of utility billing cycles and therefore data availability.

4) Emissions modelling undertaken as part of the internal Review of the CNG Framework shows that since 2012–13, the ACT Government has reduced its greenhouse gas emissions by approximately 6,000 t CO_2-e per year. Annual emissions savings are projected to increase rapidly in coming years as energy efficiency activities sponsored by the CNG Fund are implemented and emissions from electricity decrease under the ACT's 100% renewable electricity target by 2020.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 26/7/17

By the Minister for Climate Change and Sustainability, Mr Shane Rattenbury MLA

*Estimates - QON No. E17-598

LEGISLATIVE ASSEMBLY
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ANSWER TO QUESTION ON NOTICE

Caroline Le Couteur MLA : To ask the Minister for Climate Change & Sustainability

Output 2.2 - Climate Change & Sustainability (EPSDD Budget Statement E, 13, 20)

In relation to page 95 of Budget Statement E, and the allocation of $2,000,000 in funding toward the implementation of the ACT Climate Change Adaptation Strategy, delivering "priority actions":

1) What are the details of these "priority actions"?
2) How will these actions be delivered?
3) Will the Government engage with community groups on the adaptation measures?
4) Will the Government engage with the private sector on the adaptation measures?

SHANE RATTENBURY: The answer to the Member's question is as follows:–

1. The *ACT Climate Change Adaptation Strategy*, released in 2016, identifies a series of 27 actions to be implemented from 2017 to 2020. The actions focus on the following sectors: Disaster and Emergency Management; Community Health and Wellbeing; Settlements and Infrastructure; Water and Natural Resources and Ecosystems, plus other necessary actions in awareness raising, education, monitoring and evaluation.

The allocation in the 2017-18 budget is to fund the execution of the actions over the three years to 2020 including undertaking new research. The priority actions are those that require immediate attention:

Action #3 climate risk assessments – to undertake or update assessments of risk and resilience (with upgrade proposals) for government owned or leased buildings, utilities and services.
Action #11 city resilience – increase the built environment's resilience and amenity by reviewing design standards and introducing requirements to reduce urban heat.
Action #15 living infrastructure – develop and implement a strategy, including targets for urban tree canopy cover.
Action #25 innovation – in projects across the city for new or existing public infrastructure, initiate trials to innovate in materials and surfaces, capture and use rainwater, and make landscape treatments more resilient.
Action #27 monitoring and evaluation – establishing a longitudinal community survey and determining measurable and repeatable indicators to track increasing resilience.

2. The 27 actions are deliberately cross cutting and affect multiple government Directorates and their agencies. The actions are aimed at all Directorates in showing leadership and advancing quickly to reduce vulnerability to risks and increasing resilience to shocks and stresses. The responsibility for providing climate data, guidance, governance, monitoring and reporting on all the actions rests with the Climate Change and Sustainability Division in the Environment, Planning and Sustainable Development Directorate (EPSDD). In progressing the adaptation actions all Directorates are involved through the ACT Government Adaptation Steering Committee, represented by Directors-General, as well as the senior officer level Adaptation Working Group. Both groups meet quarterly to consider progress on actions, as well as inter-dependencies that cut across all government agencies. EPSDD has responsibility for delivering the majority of the 27 actions. To do this EPSDD will use existing staff, new staff employed with the 2017-18 budget allocation, and consultants such as the CSIRO, to undertake specialist research.

3. The development of the ACT's climate change policies is continuing to be done with extensive community engagement, including targeted activities with key stakeholders and close involvement of Directorates. The *ACT Community Engagement Strategy on Climate Change* 2014 sets out the Government's commitment to ongoing engagement and the 2016 Adaptation Strategy action #23 recommits to this, stating "more effective sharing of information across all stakeholders through sustained promotion and engagement efforts...". This action is being delivered through ongoing coordination of engagements activities with the broader community.

4. The Adaptation Strategy action #24 initiated the Sustainability Alliance. This Ministerially invited grouping of peak bodies, business leaders and knowledge brokers come together to participate in policy development and information sharing. This 'brains trust' is already contributing to the development of the blueprint to lead the community to net zero emissions by 2050, at the latest, and with the resources enabled by the 2017-18 budget funding, will be able to add their ideas to the Climate Change Adaptation Strategy priority actions.

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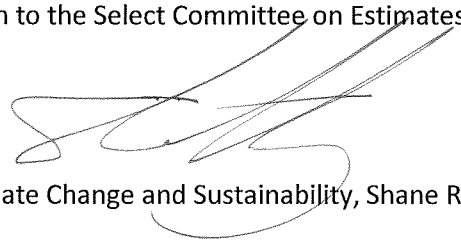
Signature:  Date: 26/7/17

By the Minister for Climate Change and Sustainability, Shane Rattenbury

*Estimates - QON No. E17-599

LEGISLATIVE ASSEMBLY
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ANSWER TO QUESTION ON NOTICE

Caroline Le Couteur MLA : To ask the Minister for Environment & Heritage

Conservator of Flora & Fauna (EPSDD Budget Statement E, 14, 20)

In relation to page 14 of Budget Statement E, and the kangaroo cull:

1) What mechanisms are in place to enforce the code of practice for the killing of kangaroos as part of this year's kangaroo cull?
2) Noting that the Chief Veterinarian is present for at least one night of the cull, for how many nights is there an animal welfare expert in attendance during the cull?
3) Noting a report into compliance with the code of practice was released in 2015, was a similar report done for 2016?
   a) Was this report released?
   b) Where is this report available for the public to view?
4) Noting a number of reports that shooting was occurring on the Molonglo River corridor near Oaks Estate during this year's cull period, is culling is taking place in this area in 2017?
   a) Which Kangaroo Management Unit is this area part of?
   b) Is this land privately leased or unleased Territory land?
   c) Did the land manager need to obtain a specific license for shooting there or is the license a general one granted for shooting on unleased land?
   d) Has signage been erected to warn of shooting on this land?
   e) Have ACT Policing and Queanbeyan Police been informed of the intention to cull in this area?
5) Noting a number of reports that horses previously housed at Rose Cottage Horse Paddocks (RCHP) have been moved, does this indicate culling will occur in this area as part of this year's cull?
   a) Has a licence been issued for shooting on the RCHP in 2017?
   b) If so, what Kangaroo Management Unit is the RCHP considered part of?
   c) Has signage been erected to warn the public of shooting on the RCHP?
   d) Has ACT Policing been informed of the intended shooting on the RCHP?
6) Noting a number of reports that shooting was occurring in the Karabah area near Queanbeyan, some distance from Googong and East Jerrabomberra, is there a cross-border agreement or coordination between the ACT Government and relevant authorities in the Queanbeyan area to synchronise ACT shooting with licenced shooting in Queanbeyan where Kangaroo Management Units cross the NSW border?

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1) An independent veterinarian undertook an audit of all contractors and PCS officers involved in the culling of kangaroos on unleased land during this year's cull to ensure compliance

with the Code of Practice. Approximately 13% of all kangaroos culled were observed by the veterinarian for compliance with the Code of Practice during the cull.

Compliance with the Code of Practice is also a mandatory requirement of all licences that permit the culling of kangaroos on private land and PCS has developed a robust monitoring and enforcement program to ensure compliance with the Code. That program includes unannounced inspections as well as planned compliance audits conducted by Rangers who are experienced shooters. The *Nature Conservation Act 2014* has strong enforcement provisions and any alleged breaches are referred to the PCS Compliance Unit for investigation and, where necessary, enforcement.

2) An independent veterinarian was in attendance during six nights of the cull to ensure the cull was undertaken humanely and in accordance with a strict Code of Practice. Approximately 13% of all kangaroos culled were observed by the veterinarian for compliance with the Code of Practice during the cull.

3) The ACT Government Chief Veterinarian was present onsite during the 2016 cull; however, a formal report was not compiled. An independent veterinary audit was not undertaken during the 2016 cull.
    a. A formal veterinary report was not compiled in 2016.
    b. As there was no formal report compiled in 2016, there was no document available for public release.

4) A licence was issued for a private landholder to undertake culling on private ACT land in the Oaks Estate area. The issue of a licence does not in itself serve as confirmation that culling is being undertaken in an area. Licensees are required to provide a culling report back to the Licensor after the completion of the culling period on the 31 July.
    a. The area around Oaks Estate does not form part of a Kangaroo Management Unit.
    b. A licence was issued for culling on private land in the ACT area around Oaks Estate.
    c. All killing of kangaroos in the ACT requires individual licences to be issued for both private lease and unleased lands.
    d. Erection of signage is not a condition of licences for culling on private lands.
    e. It is a condition of culling licences that all the licence holders contact ACT Policing within 24 hours prior to commencement of culling.

5) Horses are moved regularly for routine management in ACT Government contractor-managed horse paddocks, such as RCHP. This does not equate to the occurrence of culling in the area.
    a. A licence has been issued for culling of kangaroos at RCHP, although culling has not taken place at this point in time.
    b. The RCHP forms part of the Mugga-Isaacs Kangaroo Management Unit.
    c. Erection of warning signage is a requirement for culling in the ACT Government contractor-managed horse paddocks prior to culling commencing. Signage is not required if culling is not taking place.
    d. It is a condition of all culling licences that the licence holder contacts ACT Policing within 24 hours prior to commencement of culling.

6) This year the ACT Government undertook culling at the ACT Government managed Googong foreshores. This cull is licensed under the NSW National Parks and Wildlife Act 1974.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: Date: 14/7/17

By the Minister for the Environment and Heritage, Mick Gentleman MLA

*Estimates - QON No. E17-600

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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ANSWER TO QUESTION ON NOTICE

Caroline Le Couteur MLA : To ask the Minister for Environment & Heritage

Output 2.1 - Environment (EPSDD Budget Statement E, 12-13, 19)

In relation to page 14 of Budget Statement E:

1) Is the Directorate involved in ongoing discussions with federal, state and local governments about the declaration of Ginninderra Falls as a National Park?
2) Is the ACT Government in negotiations with NSW to have that area included within the ACT's borders?
3) What are the barriers to that declaration going ahead?

MICK GENTLEMAN: The answer to the Member's question is as follows:–

1) Ginninderra Falls is located in NSW and the Directorate is not involved in any ongoing discussions about the declaration of Ginninderra Falls as a National Park.

2) There are no formal negotiations with the NSW Government.

3) Declarations are a NSW Government (National Parks and Wildlife Service) process. The ACT Government is not involved in any declarations.

Approved for circulation to the Select Committee on Estimates 2017-18

Signature: [signature] Date: 14/7/17

By the Minister for Environment and Heritage, Mick Gentleman MLA