ESTIMATES 2008-2009

Question on Notice

Health

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Cost of employing Public Servants

MR SMYTH: To ask the Minister for Health:

In relation to the cost of employing public servants:

What is the average salary, including superannuation and all other on-costs, for each of the following categories of public servant:

(a) A general registrar
(b) A specialist registrar
(c) A Visiting Medical Officer
(d) An enrolled nurse
(e) A registered nurse

MS GALLAGHER: The answer to the Member's question is as follows:–

(a) There is no employment classification in ACT Health of "general registrar".
(b) There is no employment classification in ACT Health of "specialist registrar".
(c) Visiting Medical Officers are not employees of ACT Health and therefore do not attract salary.
(d) and (e) There are two classifications of Enrolled Nurse and fourteen classifications of Registered Nurse. Rates of pay can be found in the ACT Public Sector Nursing & Midwifery Staff Union Collective Agreement 2007-2009 (relevant pages are attached). Superannuation costs cannot be easily averaged out as the amount is dependent on an employees start date and scheme.

Schedule 1

Nursing and Midwifery Classifications and Rates of Pay

	Pay rates March 2007	First full pay period commencing on		
		22 March 2007 (4.5%)	6 March 2008 (3.75%)	5 March 2009 (3.75%)
Enrolled Nurses Level 1		$	$	$
	39,005	deleted	deleted	deleted
Year 1	39,719	41,506	43,063	44,678
Year 2	40,434	42,254	43,838	45,482
Year 3	41,147	42,999	44,611	46,284
Year 4	41,860	43,744	45,384	47,086
Year 5	42,574	44,490	46,158	47,889
Enrolled Nurse Level 2		$	$	$
	43,287	45,235	46,931	48,691
Registered Nurse Level 1		$	$	$
Year 1	44,000	45,980	47,704	49,493
Year 2	45,788	47,848	49,643	51,504
Year 3	47,757	49,906	51,778	53,719
Year 4	50,097	52,351	54,315	56,351
Year 5	52,436	54,796	56,850	58,982
Year 6	54,775	57,240	59,386	61,613
Year 7	57,115	59,685	61,923	64,245
Year 8	59,454	62,129	64,459	66,877
Registered Nurse Level 2		$	$	$
Year 1	61,888	64,673	67,098	69,614

Year 2	63,165	66,007	68,483	71,051
Year 3	64,440	67,340	69,865	72,485
Year 4	65,715	68,672	71,247	73,919
Registered Nurse Level 3 Grade 1				
Year 1	71,135	74,336	77,124	80,016
Year 2	72,599	75,866	78,711	81,663
Year 3	74,062	77,395	80,297	83,308
Registered Nurse Level 3 Grade 2		$	$	$
	80,417	84,036	87,187	90,457
Nurse Practitioner		$	$	$
	86,118	89,993	93,368	96,869
Registered Nurse Level 4 Grade 1		$	$	$
	80,417	84,036	87,187	90,457
Registered Nurse Level 4 Grade 2		$	$	$
	86,118	89,993	93,368	96,869
Registered Nurse Level 4 Grade 3		$	$	$
	91,813	95,945	99,543	103,275
Registered Nurse Level 5 Grade 1		$	$	$
	80,417	84,036	87,187	90,457
Registered Nurse Level 5 Grade 2		$	$	$
	86,118	89,993	93,368	96,869

Registered Nurse Level 5 Grade 3		$	$	$
	91,813	95,945	99,543	103,275
Registered Nurse Level 5 Grade 4		$	$	$
	98,326	102,751	106,604	110,601
Registered Nurse Level 5 Grade 5		$	$	$
	109,727	114,665	118,965	123,426
Registered Nurse Level 5 Grade 6		$	$	$
	121,125	126,576	131,322	136,247

Rate of unplanned return to the operating theatre

MRS DUNNE MLA: To ask the Minister for Health

In relation to : **ACT Health Output Class 1 Health and Community Care 1.1 Acute Services ACT Strategic Indicator 2**

Maximising the quality of hospital services

Under this heading there are four sub indicators which deal with patient safety and service quality.

1. Rate of unplanned return to the operating theatre [BP4 p147]

This deals with an unplanned return to the operating theatre within a single episode of care due to complications in a patient's condition and 'provides an indication of the quality of theatre and post-operative care.'

Q1.

Why is the Canberra Hospital still failing to meet its target [<0.7% for 2007-08 as against the estimated outcome for 2007-08 of 0.8%] and why is TCH continuing to be significantly outperformed by Calvary Public Hospital. Calvary has notably exceeded its target of <0.46% in its estimated outcome for 2007-08 of 0.35%. Further, why is Calvary setting a target of <0.5 per cent for 2008-09?

MS GALLAGHER MLA: The answer to the Member's question is as follows:–

A difference of 0.1% in the rate of unplanned return to the operating theatre is not statistically significant given the small sample size and therefore will be represented in small fluctuations.

TCH and Calvary cannot be compared as the nature and complexity of the services provided illustrate they are not peer hospitals.

MRS BURKE MLA: To ask the Minister for Health

In relation to : **ACT Health Output Class 1 Health and Community Care 1.1 Acute Services ACT Strategic Indicator 2**

2. Rate of unplanned hospital readmission [BP4 p148]

This deals with the proportion of people who after leaving the hospital [separating] are re-admitted within 28 days of their separation due to unforeseen complications of their condition and 'provides an indication of the effectiveness of hospital based and community services in the ACT in the treatment of persons who receive hospital-based care.'

Q2
Given that the length of hospital stay in the ACT is on average less than in other Australian jurisdictions, is this a factor in the estimated 1.1 per cent of patients for 2007-2008 who have to be re-admitted within 28 days to the Canberra Hospital and the 0.7 per cent who have to be re-admitted to Calvary Public Hospital.

MS GALLAGHER MLA: The answer to the Member's question is as follows:–

There are many influencing factors and variables that may lead to a hospital re-admission during the 28 day period after discharge including progressive conditions, which through their nature may lead to unexpected or unplanned need for further treatment during the 28 day period.

TCH benchmarks unplanned and unexpected re-admissions within 28 days against peer organisations through the Australian Council on Healthcare Standards (ACHS) twice a year, in the most recent data, from the period July-December 2007, where it was observed that TCH out performed its peer organisation by 1.00% against 2.19%.
There is currently no evidence to suggest a direct connection between a shorter than average length of stay in ACT hospitals and the rate of unplanned hospital readmission.

75 Health Burke

Rate of post-operative pulmonary embolism

MRS BURKE MLA: To ask the Minister for Health

In relation to : **ACT Health Output Class 1 Health and Community Care 1.1 Acute Services Strategic Indicators 2**

Maximising the quality of hospital services

3. Rate of Post-operative pulmonary embolism [BP4 ,148]

The proportion of people admitted to hospital for longer than seven days who underwent a surgical procedure during that stay and subsequently experienced a post operative pulmonary embolism ‘provides an indication of the quality of care and the effectiveness of the hospital system in meeting the needs of patients, as pulmonary embolism are [sic] to some extent avoidable through the use of appropriate prophylaxis.

Q3
(i)Are there occasions when the appropriate prophylaxis is not provided to surgical patients and in what circumstances?

(ii)Can you provide figures on the number of cases as well as the proportion of case in which the appropriate prophylaxis is not provided or does that exactly mirror that rate of post-operative pulmonary embolism?

(iii)What are you doing to improve the figure of one per cent of people [estimated Outcome for 2007-2008] admitted to hospital for longer than seven days and why is the result for Calvary Hospital twice as bad at two per cent [estimated outcome for 2007 2008]?

(iv)Why are these statistics only collected for patients admitted for longer than seven days rather than for patients admitted for any length of stay as the risk of pulmonary embolism is very real after even the most minor surgery rather than being related to length of stay? Does ACT Health collect statistics for this wider group and not report it in the budget papers. If so, why and what are those figures?

MS GALLAGHER MLA: The answer to the Member's question is as follows:–

(i) All surgical patients are required to have a Venous Thromboembolism (VTE) risk assessment and management plan in place. This assessment takes into account the patients risk factors, co-morbidities and any contra-indications to VTE prophylaxis. A decision is then made on an individual management plan appropriate to the case by the treating team.

(ii) There is no data definition of appropriate prophylaxis, therefore we do not have figures on the number of cases, or data on the proportion of cases in which appropriate prophylaxis is not provided.

(iii) The relevant indicator relates only to patients with length of stays greater than seven days (as per the national definition for this measure). Due to the nature of Calvary's role, this comprises about 20-40 patients per month (compared with over 120 per month at TCH due to its role as the major trauma referral and tertiary hospital in the region). As such, small monthly variations can result in big changes to Calvary's results. For example, over the last 32 months, Calvary has averaged 1.5 pulmonary embolism cases per month. However, during 2007-08, Calvary has noted one month (November 2007) in which four cases were reported. This will result in a full year total of approximately 2% compared with the target of 1%. However, the variation, given the small numbers and the impact that small increases can have of the results, are not statistically significant. Should Calvary consistently report an average of 3 or 4 pulmonary embolisms a month regularly, without a major change to the types of services provided at the hospital, our Patient Safety and Quality Unit would undertake a significant review of practices and procedures to identify and address system issues.

(iv) PE rates are reported using an indicator definition that was taken from the Australian Council on Healthcare Standards (ACHS). There is no alternative benchmarking methodology for VTE Prophylaxis that is measurable, appropriate, evidence based and validated. For this reason the rate of PE for a wider patient profile is not collected at this time.

Hospital acquired infection rate

MRS BURKE MLA: To ask the Minister for Health

In relation to : **ACT Health Output Class 1 Health and Community Care 1.1 Acute Services ACT Strategic Indicator 2**

Maximising the quality of hospital services

4. Hospital acquired infection rate (bacteraemia)

This deals with the proportion of people admitted to hospitals who acquire 'a bacteraemial infection during their stay and 'provides an indication of the safety of hospital-based services.'

Q4.

It was reported in the Sydney Morning Herald on February 13 this year that a leading surgeon who chairs the Royal Australasian College of Surgeons infection control advisory committee has warned that patients in Sydney's intensive care units face the 'almost inevitable' risk of catching a drug-resistant infection and the public is being 'kept in the dark over the risks of infection in hospital when disclosure would be more likely to drive the change of attitude necessary to combat hospital borne germs such as MRSA' [methicillin-resistant Staphylococcus aureus]. [The Sydney Morning Herald February 13 2008] The SMH noted that his call followed a report published late last year in the federal Health Department's Communicable Disease Intelligence journal based on the most recent available evidence, collected in 2005, on the prevalence of MRSA. This research showed that NSW and ACT hospital patients are 25 per cent more likely to have an antibiotic-resistant type of the golden-staph bug than patients in other states. ***'In NSW-ACT hospitals, 43.4 per cent of golden staph specimens are found to have MRSA, compared with a national average of 31 per cent.'***

(i) It is stated at BP4 p148 that the estimated outcome for hospital acquired infections if 0.10 per cent of people admitted to TCH and 0.15 per cent of people admitted to Calvary for 2007-2008. How do you arrive at this figure? Can you give us the most up to date figures for the number of hospital acquired infections for both TCH and Calvary?

(ii) In public health, the likelihood of a particular risk factor such as smoking is emphasized to dissuade people from taking up or continuing to indulge in unhealthy behaviour. Do you not agree that proactive leadership and culture is needed to press for the resources necessary to fight infections effectively? Western Australia has shown the way in this area. [WA has the most stringent anti-MRSA measures and not coincidentally the fewest cases of the germ.] Will you embark on the appropriate 'search and destroy' program for the ACT's public hospitals along the lines already being implemented in Scandinavia and in Western Australia?

(iii)With about half of clinical staff still failing to wash their hands each time they look at a new patient, what is being done to address this issue in the ACT's public hospitals? For example, I have heard that the nurses entering or returning to the system are not given a physical demonstration of how best to wash their hands and I have heard that soap dispensers are themselves dirty.

(iv) Will there be any move to publish score-cards for the ACT's public hospitals in order to drive the necessary reforms in infection management?

(v) TCH's Dr. Colignon last year commented on ABC Radio that around 30 single bed rooms at TCH have been given over to offices. Does this not make it difficult and sometimes impossible to follow infection control protocols properly by placing patients with infectious conditions apart from other patients? On how many occasions in the past year have infectious patients been placed in areas with other patients?

MS GALLAGHER MLA : The answer to the Member's question is as follows:–

(i) TCH routinely monitors whole of hospital blood stream infections that are acquired in both the health care facility and the community. The figures referenced in the question include all inpatients in the hospital longer than 48 hours and the infection is considered to be health care related. The denominator is non same day occupied bed days per 1000.

TCH has had a total of 127 BSI infections and 63 MRSA for the 2007 calendar year.

Calvary has had a total of 22 hospital acquired infections.

(ii) TCH is illustrating proactive leadership in similar work to the "search and destroy" program with screening indicators such as:

- Prompt notification to the Infection Control Unit, by the Microbiology Department of all new isolates of MRSA. This notification facilitates the patient to be placed in a single room.
- For known patients with MRSA, an Alert is registered on their file in ACTPAS (ACT Patient Administration System) making that information readily available to clinical staff.
- The Infection Control Unit receives a twice daily printout of inpatients, which includes notification of future admissions of patients with MRSA.

This screening captures all patients transferred to the acute setting from nursing homes, other health care institutions and return patients who are known to have MRSA.

Additionally, the Intensive Care Units (ICU) routine surveillance of multi resistant organisms on all patient admissions and discharges from the ICU. Additionally, patients undergoing joint replacement and cardiac surgery are routinely screened for MRSA, facilitating treatment before surgery.

In March 2008, TCH introduced a Terminal Cleaning Team to undertake the cleaning of rooms that housed patients identified with MRSA. The introduction of this team ensures the rooms receive a high level clean, assisting in the reduction of bioburden of environmental organisms.

Calvary undertakes pre-admission screening; pre-admission precautions and treatment; and pre-admission and in-hospital lifestyle changes to minimise the risk of acquiring or introducing infection.

(iii)The Infection Control Unit at TCH provides updates on the hand hygiene practices in the monthly TCH Orientation. In conjunction, routine in-services are undertaken throughout TCH for all staff on the practices of hand hygiene. The in-service emphasises the types of products used within TCH with diagrams to illustrate the correct technique for hand hygiene.

Cleaning services monitor and attend to the cleaning of soap dispensers.

Alcohol hand rub is available at the entrance to all clinical areas, patient rooms and at the ends of patient beds. In all out patient clinical areas, hand rub is available at the respiratory hygiene stations. The amount of hand hygiene product used is reported monthly to the Infection Control Committee and provided to the clinical areas.

Calvary highlights hand-washing and cleanliness in its Orientation program and through an E-Learning hand washing module available to all staff. Alcohol wipes and Chlorhexidine Cluconate dispensers and wipes are placed throughout the hospital to supplement the normal hand washing facilities and products.

(iv) ACT Health already provides a report on these measures in the public quarterly reports on Health system performance.

ACT Health participates in national policy from the Australian Commission on Safety and Quality in Health Care (ACSQHC) on National Surveillance of Health Care Acquired Infections.

The Infection Control unit at TCH is undergoing preliminary discussion with Royal Hobart Hospital to benchmark blood stream infections, MRSA and Clostridium difficile. This is planned to commence from 1 July 2008.

(v) Patients with MRSA are not placed in rooms with other non MRSA patients. Newly identified infectious patients are promptly moved to a single room or are placed with like infectious patients and cared for following appropriate guidelines for infectious patients.

Waiting times for treatment by triage category

JACQUI BURKE MLA : To ask the Minister for Health:

In relation to : **ACT Health Output Class 1 Health and Community Care 1.1 Acute Services ACT Strategic Indicator 21**

Strategic Indicator 21

Emergency department timeliness

Waiting times for treatment by triage category

The percentage of Emergency Department patients seen within the recommended time was 52 per cent compared with the national figure of 69 per cent and the median waiting time for ED patients was almost twice the national figure [46 minutes compared with 24 minutes nationally]. So as the AMA pointed out in its report last year, there is 'little to show for spending that is well above average [$865 recurrent expenditure per person compared to $665 nationally.' p16 AMA Public Hospital Report Card]

Q1.

(i)Why is the ACT getting so little bang for its buck and why is expenditure not translating into results. In a small population with the highest per capita income in Australia, one would expect the best health service not one scoring four last places amongst other Australian jurisdictions in the key elective surgery and emergency department indicators.

[Note we score last in Australia for

- percentage of elective surgery admissions that waited longer than one year
- median waiting time for elective surgery
- percentage of ED patients seen within the recommended time
- median waiting time for ED patients

see p16 AMA Public Hospital Report Card 2007]

(ii)The Minister has maintained publicly that emergency departments in the ACT's public hospitals are not coping with demand because she asserts most people presenting do not need to be there and could be treated by GPs if they were available.
Ms Gallagher stated on ABC Radio on April 15 this year, "We know that 87 per cent are category 4 or 5 patients, that is patients who could be seen by GPs. That paints a bigger picture for us. This is not unusual for emergency departments around the country."

Where does the Minister get these extraordinary figures of nearly nine in ten people presenting at ED who could go elsewhere? This rate is not in accord with Australian Institute of Health and Welfare figures which put non-urgent cases at 12 per cent and anecdotal reports from emergency physicians who report about ten per cent of patients in ED as non-urgent. The AMA states that people who present at emergency overwhelmingly need to be there.

(iii)If the Minister is conflating Category 4 (semi-urgent) and Category 5 (non-urgent), on what basis can she make a judgment about these cases. For example, a study which followed up a

group of people who left a Melbourne hospital's emergency department without treatment found that two thirds had significant pain.

KATY GALLAGHER MLA : The answer to the Member's question is as follows:–

(i) The AMA report that you have quoted refers principally to data from two to three years ago. The recent results achieved by our health system over recent quarters demonstrates the effectiveness of the considerable increased investment in our public health services.

In your question you note that the ACT has the highest percentage of elective surgery admissions who waited longer than one year and the highest median waiting time for elective surgery. As these figures relate to people admitted for surgery (not people still waiting for care), the ACT figures demonstrate the effectiveness of the Government's strategy to address those patients with the longest waits, which has been a major focus of the additional $49 million added to the health system over the period since we came to Government to 2008-09 to improve access to elective surgery. As we increase the number of "long wait" patients accessing surgery, the median waiting times and the proportion of patients with waiting times longer than one year will increase. As an example, for the first ten months of 2007-08, we have provided elective surgery for 2,648 long wait patients classified as category two and three patients, which is 20.4% (449) more than for the same period in 2006-07. This increase in access to elective surgery is occurring over a period during which our public hospitals have maintained their excellent record in relation to category one patients (with 96% seen within 30 days so far this year) and an increase in the total number of people accessing elective surgery.

The Government's investments in our emergency departments and associated areas of our public hospitals has also resulted in improvements in the waiting times for emergency department services over recent years. Our emergency departments now have close to full complements of emergency department physicians and have been funded to increase the level of available nurses. In addition, we have funded a range of initiatives to further improve waiting times such as providing new specialised services (such as the Medical Assessment and Planning Unit and inpatient observation units adjacent to emergency departments), as well as increasing the number of beds available in our hospitals as a means to improve access to emergency department care. These initiatives are showing signs of working with the ACT now equalling or exceeding national targets for category one, two and five emergency department presentations. While more work needs to be done to improve waiting times for category three and four patients, I am happy to report improvements over recent quarters in these categories as well. In the third quarter of 2007-08 (this year) 56% of category three emergency department presentations were seen on time – up 8% on the result in the same quarter last year and 13% better than two years ago. For category four patients for the same quarter, 54% were seen on time this year, up from 50% last year and 48% two years ago.

In addition, there are a range of reasons why the cost of services at ACT public hospitals is higher, in proportional terms, than the rest of the nation. These include the relative sizes of the systems and inherited costs such as the Commonwealth's superannuation scheme. However, despite these inbuilt factors, over recent years we have been able to expand services to the people of the ACT while decreasing the relative costs of our services. Over the last three years, the average cost of ACT public hospital services has dropped from 30% above the national average cost per casemix adjusted separation (excluding depreciation) in 2002-03 to 15% above the national average, using the latest available national data (2005-06).

(ii) My comments on ABC Radio on 15 April 2008 noting that "we know that 87 percent are category four or five patients, that is the patients who could be seen by GPs…" related to the proportion of patients who did not wait for care who were category four or five patients – not all category four and five presentations. I have never suggested – nor ever would suggest – that 87 per cent of category four and five patients seen by our emergency department should be treated by elsewhere.

(iii) As noted in my answer to question (ii) above, the figures I quoted were in relation to a specific question about people who attend emergency departments who do not wait for care. The fact that people do not wait for care in emergency departments does not suggest that these people do not receive treatment within a community setting, nor did I make any suggestion that such patients did not suffer significant pain.

78 Health Burke

Patients from Categories 4 & 5

JACQUI BURKE MLA : To ask the Minister for Health:

In relation to ACT Health Output Class 1 Health and Community Care 1.1 Acute Services ACT Patient Activity [BP4 p164]:

Q1. How many patients from Categories 4 and 5 were admitted to hospital from the Emergency Department?

KATY GALLAGHER MLA : The answer to the Member's question is as follows:–

For the first 10 months of 2007-08 (to 30 April 2008), 5,181 people who presented at ACT public hospital emergency departments who were classified as either category four or five patients were admitted to hospital out of a total of 48,203 category four and five presentations. This represents 10.7% of category four and five presentations.

79 Health Burke

Acute Services ACT Patient Activity - bed cost

JACQUI BURKE MLA : To ask the Minister for Health:

In relation to : ACT Health Output Class 1 Health and Community Care 1.1 Acute Services ACT patient activity [BP4 p 164]:

Question: What is the cost of an acute care bed?

KATY GALLAGHER MLA : The answer to the Member's question is as follows:–

The average cost of an acute care bed at ACT public hospitals using the latest available nationally published data (2005-06) was $1,460 per patient day. This has been calculated by dividing the total number of acute care patient days at our public hospitals by the total level of expenditure on acute care services. It must be remembered that this figure is an average only. An intensive care bed costs several times this amount per day and a regular renal dialysis episode would cost only a proportion of this average cost.

80 Health Burke

Acute Services ACT Patient Activity - elective surgery

MRS BURKE : to ask the Minister for Health

In relation to: ACT Health Output Class 1 Health and Community Care 1.1 Acute Services ACT Patient Activity [BP4 p164]

The percentage is given for category one elective surgery patients who receive surgery within 30 days of listing but no information is given as to the results for categories 2, 3, 4 and 5 in which the ACT has rated very poorly and last in the country over the last few years. What are the latest figures for those categories 2 through 5 and why were they not included?

MS GALLAGHER : The answer to the Member's question is as follows:–

For the first ten months of 2007-08, 46 percent of category two patients admitted for surgery were admitted within 90 days and 68 percent of category three patients were admitted within 365 days.

This demonstrates the effectiveness of the Government's commitment in improving access to elective surgery for people with extended waiting times.

National reporting for elective surgery is split into three categories:

> Category one – surgery required within 30 days
>
> Category two – surgery required within 90 days
>
> Category three – surgery required at some time in the future. For reporting purposes, ACT adopts a timeframe of 365 days for these patients

As such, there are no category four or five elective surgery patients.

As the Member would be aware, the Government publishes figures for all elective surgery waiting list waiting categories and times in the publicly released quarterly report on health service performance.

Only category one patients are included in our accountability indicators given the life threatening nature of these conditions.

81 Health Burke

Acute Services ACT Patient Activity - NSW based patients

JACQUI BURKE MLA : To ask the Minister for Health:

In relation to ACT Health Output Class 1 Health and Community Care 1.1 Acute Services ACT Patient Activity [BP4 p164]:

Q1. How many NSW-based patients were treated at the ACT's public hospitals in the 2007-2008 budget year?

KATY GALLAGHER MLA : The answer to the Member's question is as follows:–

For the first nine months of 2007-08 (the latest available fully coded data), our public hospitals reported 16,474 admitted patient separations by residents of NSW.

Paediatric Emergency Department waiting area

Mrs Burke: to ask the Minister for Health

In relation to: **ACT Health Output Class 1 Health and Community Care 1.1 Acute Services Changes to Appropriation – Department BP4 p168**

Q1. Paediatric Emergency Department Waiting Area

In the context of a paediatric waiting area in the Emergency Department, the Minister spoke of having already opened a Medical Assessment and Planning Unit [MAPU] 'a ward specifically designed to relieve pressure off the emergency department'
[Estimates Hearing June 29, 2007].

Last December, it was announced again with the Government saying that the paediatrics at the Canberra Hospital "will also be enhanced by a $1.5 million ACT Government program to provide a children's waiting room and emergency nurses to help families deal with the wait for emergency care". [City Chronicle December 4, 2007]

When is this area expected to be in use? There was no money allocated in the 2007-2008 budget.

Further, would it not be a more efficient use of resources to make the service faster rather than accept a long wait as inevitable and seek to make it more comfortable for a few while leaving other to manage as best they can with some adults being reduced to lying on the floor in pain?

Ms Gallagher: The answer to the Member's question is as follows:–

The Paediatric Emergency Department Waiting Area works are expected to be completed by July 2008. This project was funded by the Government as part the 2nd appropriation in 2007-08.

All patients who present themselves for treatment at the Emergency Department are assessed by the Triage team. Cases are then treated based on this assessment with the highest priority cases receiving treatment first.

83 Health Burke

Women's and Children's Hospital

Mrs Burke : to ask the Minister for Health

In relation to : **ACT Health Output Class 1 Health and Community Care 1.1 Acute Services 2008-09 Capital Works Program p171**

Women's and Children's Hospital

Is this better described as a hospital or does this really amount to the re-sitting and co-location of already existing women's services?

Q1

(i) How much of the estimated $90 million cost will be in shifting the present services at the Canberra Hospital to another area on site and how much, if any, will go into expanding existing services?

(ii) Can you itemise the major costs in this project?

(iii) Which services are being co-located?

(iv) What can Canberrans expect for this investment apart from the convenience of having women's and children's services sited together?

Mrs Gallagher : The answer to the Member′s question is as follows:–

(i) The detailed feasibility study which is presently being undertaken will inform this question.

It should be noted (as referred in iv below) that the relocation of the present services from Building 1 is fundamental to the necessary staging required to undertake the Capital Asset Development Plan redevelopment while maintaining services to the community. It has not been driven solely by the obvious benefit/convenience of co-location but this is an outcome which has influenced the logic of the proposed approach.

(ii) The major cost components of the project will be Design, Construction (including engineering services) and Furniture and Equipment.

(iii) The services being co-located are paediatric and adolescent inpatient and outpatient services and maternity & gynaecology inpatient and outpatient services, the fetal medicine unit and the Centre for Newborn Care, together with clinical research for women's and children's services.

(iv) Canberrans can expect from the Women's and Children's Hospital:
the development of a centre of excellence in women's and children's health care with buildings that facilitate the delivery of new models of clinical care and facilitate innovation and the translation of research to clinical care.

In addition, the space freed up by the relocation of paediatric and adolescent services to the new building will enable the expansion in the existing tower block of aged and subacute care services to meet projected demand.

84 Health Burke

Efficiencies

Mrs Burke : to ask the Minister for Health

In relation to : ACT Health Output Class 1 Health and Community Care 1.1 Acute Services

> The Minister spoke last year of achieving efficiencies in the portfolio during last year's Estimates Hearings. What efficiencies have been achieved and how? There are reports of clerical or administration processes being duplicated and worse. We also hear that management are inclined not to rehire immediately and then have to hire casual staff at great expense when there is a sudden influx of patients. Does the Minister have a figure as to how much waste and duplication is present in the system and what steps are being taken to address this?

Ms Gallagher : The answer to the Member's question is as follows:–

The Australian Institute of Health and Welfare's report on Australian Hospital Statistics 2006-07 (latest available) shows that the average cost per weighted separation for inpatient services was 13 percent above the national average – down from 30 percent above the national average just four years ago. This provides evidence that the Government's commitment to increase the efficiency of our public hospital services is working – and that we are on track to reach our target of 10 percent above national average costs by 2011-12.

These efficiencies have been achieved during a period in which the number of clinicians (working directly with patients and clients) has increased, demonstrating ACT Health's success in improving clerical and administrative processes. I would be happy to investigate any specific claims of inefficiency within the ACT Health system if the Member would provide me with the relevant details.

Poor cleaning standards in public hospitals

Mrs Burke : to ask the Minister for Health

In relation to : **ACT Health Output Class 1 Health and Community Care 1.1 Acute Services**

Poor cleaning standards in public hospitals

Q1. There are reports about cleaning deficiencies at the Canberra Hospital with messes in public areas, including corridors, such as blood, vomit and urine left sometimes for up to days. Given this regrettable situation, how confident is the Minister that the current cleaning contractors are fulfilling the terms and conditions of the contract and what steps will you take to investigate the complaints about the cleanliness (or lack thereof) of the hospital by both patients and their families.

Ms Gallagher : The answer to the Member's question is as follows:–

I would be happy to receive copies of any reports and details about cleaning deficiencies at the Canberra Hospital that Ms Burke has received.

It would be extremely unusual for deposits of vomit or blood or urine to be left for any significant period of time without attention. In ward areas, such a deposit is removed by nursing staff as soon as it is detected and this is followed by a surface clean by the responsible cleaner. In public areas and corridors, this type of deposit is removed by cleaning staff as soon as they are notified. Removal of these types of deposit is a priority requirement.

ACT Health closely manages the activities and outcomes achieved by the current cleaning contractor. I am confident that the cleaning contractor is applying appropriate management practice in the delivery of cleaning services at the Canberra Hospital and that these are diligently monitored and managed by ACT Health. This belief is supported by the fact that the Canberra Hospital currently has the second lowest occurrence of multi-resistant organism incidents when compared to other hospitals nationally. The current cleaning arrangements applied by ACT Health effectively support the containment of infectious disease and helps facilitate a safe environment for our patients, visitors and staff.

I am advised that all complaints about cleaning at the Canberra Hospital are investigated by the Environmental Services section. Officers in ACT Health are diligent in following-up complaints with complainants, regardless of whether they are a patient, family or a member of the general public.

86 Health Seselja

Staff numbers in ACT Health

Mr Zed Seselja : To ask the Minister for Health

In relation to : **Staff Numbers in ACT Health**

1. What is the estimated number of casual and contractor staff in 2007-08 in full-time equivalent terms?
2. What amount is estimated to be spent in 2007-08 on contract staff?
3. What are the estimated numbers of casual and contractor staff for 2008-09 in full-time equivalent terms?
4. What amount is budgeted to be spent in 2008-09 on contract staff?

Ms Katy Gallagher : The answer to the Member's question is as follows:–

1. The average number of casual and contractor staff, which includes Junior Medical Officers, Casual Nursing Pool staff and all temporary staff, for the 2007 – 2008 financial year to date (July 07 to May 08) in Full Time Equivalent terms is 867.77. The estimate for the full 2007-2008 financial year is consistent with the year to date average of 867.
2. The amount spent in the 2007 – 2008 financial year to date (July 07 to May 08) on casual and contractor staff, which includes Junior Medical Officers, Casual Nursing Pool staff and all temporary staff, is $76,684,403. The estimate expenditure for the full 2007-2008 financial year is $83,074,770.
3. ACT Health estimates that casual and contractor usage, which includes Junior Medical Officers, Casual Nursing Pool staff and all temporary staff, for 2008 – 2009 will be consistent with the current years Full Time Equivalent terms.
4. ACT Health estimates that the expenditure for 2008 – 2009 on contract staff will be consistent with the current years expenditure.

Occupational Health and Safety

MRS BURKE : To ask the Minister for Health

In relation to : **ACT Health Output Class 1 Health and Community Care 1.1 Acute Services ACT Health Objectives p145**

Occupational Health and Safety

(i) What are you doing to minimize the risk to patients from this building work inside TCH, particularly those with heart and respiratory conditions and those with visual impairment and why were patients allowed to be covered with concrete dust in some cases and subjected to high levels of noise from concrete drills being used in the same ward?

(ii) Why did the hospital management not ensure that the builder it contracted was observing health and safety regulations given ACT Health's stated objectives to ensure the safety of patients, staff and all within the hospital.

(ii) Why did the management of TCH not have anyone from the hospital supervising the builder's subcontractors?

(iii) Has anything been done to ensure that building workers and sub-contractors are not working without direct supervision by hospital management?

(iv) Why were the complaints of nurses who have told us of having to work in a constant 'construction site' not heeded until a member of the public complained?

(v) As building work is slated to continue over the coming weeks in the geriatric ward, what is the hospital management doing to ensure that these patients are not subjected to the same high levels of dust and noise which are not consistent with the provision of a healthy environment.

(vi) Did the dust raised by the building work enter the ventilation ducts?

MS GALLAHGER : The answer to the Member's question is as follows:–

(i) All works at TCH, irrespective of which Ward or Building are effected, are undertaken in accordance with approved Safe Work Method Statements. The issue that led to the problem in Ward 7A in late April was the consequence of an isolated failure in implementation of agreed and approved procedures as well as communication avenues (for Clinical staff) and this was addressed very quickly by ACT Health and its Project Manager.

It is to be noted that in a 24/7 environment such as a Hospital, it is not unusual for noisy works to be undertaken on a regular basis during normal business hours following consultation and agreement with relevant stakeholders, as it cannot take place at night- time. It would be unusual in any given day of the year for noisy works, including drilling and coring, not to take place at TCH as the Buildings are ageing and essential repairs etc need to be carried out when problems are identified. What was unusual in this instance is that there was a failure to implement agreed protocols.

(ii) Workcover have confirmed following the problem with the works on Level 7 that the Hospital and its Project Manager had adequate systems and procedures in place to ensure the safety of patients and Clinical staff, hence the expeditious lifting of its prohibition notice.

(ii) The work was being undertaken by a Project Manager on behalf of ACT Health and it had a supervisor supervising the work on Level 7 along with other works at TCH on the day in question. It is common practice for supervisors to superintend many projects at the same time with Clinical Staff contacting supervisors if there are any issues that need attendance with a specific job. ACT Health also has supervisors managing the Project Managers and Clinical staff have the necessary contact details in case attendance is required.

(iii) As indicated in (i) above, ACT Health took immediate steps following the problem on Level 7 to ensure that tried and tested supervision and works management protocols are followed by its supervisors, project managers and their contractors. It also recognises that there needs to be ongoing awareness training of Clinical staff to ensure they understand the means available to them to report any concerns to ACT Health supervisors in relation to any construction works that might be impacting on them or their patients.

(iv) As outlined in (iii) above there are standard protocols for Clinical staff including nurses to report any problems to ACT Health project supervisors. No complaints of any kind were received by the supervisors in relation to this work from any nurse prior to the member of the public making a complaint. If there had been it would have been actioned immediately, similar to the immediate response to the complaint that was received. It is for this reason that ACT Health will conduct some awareness training re. the avenues that are available to the Clinical Staff.

(v) There is no work scheduled for the Geriatric ward (11A) in the near future and none was scheduled for anytime in May 08.

(vi) There is no evidence that any dust from this work entered the air-conditioning system, however, if dust was to enter the air conditioning system from any source, it would be extracted by the filters in the return air plant and would not return into the Building supply air-conditioning system.

88 Health Burke

Emergency Department access block

JACQUI BURKE MLA : To ask the Minister for Health:

In relation to : ACT Health Output Class 1 Health and Community Care 1.1 Acute Services Strategic Indicator 1, Emergency department access block

This strategic indicator 'provides an indication of the effectiveness of public hospitals in meeting the need for acute care and emergency department care.' [BP4 p147]

(i) According to your own strategic indicator, you estimate that in the budget year 2007-2008 nearly, one third or 28 per cent of persons who are admitted via the emergency department wait more than eight hours from commencement of treatment for admission to a ward. Why is this outcome so dismal considering the ACT's expenditure on health which ranks amongst the top in the Australian jurisdictions.

(ii) On the basis of the ACT's past performance in the last few years, is your target for 2008-09 of 25 per cent not particularly ambitious and is it based on anything else apart from wishful thinking?

(iii) The stated long-term target of 20 per cent is expected to be achieved when or is this meant to signify 'on the never-never'?

KATY GALLAGHER MLA : The answer to the Member's question is as follows:–

(i) The estimated outcome for access block for 2007-08 of 28% is consistent with the 28.4% reported for 2006-07, 4.9% better than the 2005-06 result of 32.9% and 12.7% better than the 40.7% reported in 2004-05. This improvement is principally related to the funding of an additional 147 beds for our hospital system to 2007-08 since 2001-02, which more than compensates for the 114 beds removed from the ACT public hospital system by the previous administration. With the additional funding in the 2008-09 budget, ACT public hospitals will be reporting more than 850 beds in the system by June 2009 compared to the 670 beds available when we first came to Government in 2001-02.

In addition, the Access Improvement Program established in 2006 has resulted in the implementation of initiatives which improve processes and increase access to emergency department services. This program, which uses our own staff and patients to identify barriers to effective care, has already established new processes in our emergency departments such as:

- "fast track" (which provides quicker access to specialised care for people with less urgent needs)
- The registrar review clinic (which provides a specialised service for patients who have to return to the ED for further assessment by specialist clinicians
- The new Medical Assessment and Planning Unit (which provides a specialist referral service for people who present at the ED with complex issues which require a number of assessments and interventions)

In addition, we have introduced new bed management systems which enable the better allocation, monitoring and turnover of beds to maximise access to acute services for people who present at the emergency department.

(ii) The target of 25% is based on the ACT's capacity to increase bed capacity in a measured way over time, which is necessary due to the considerable staff recruitment programs required to fund the replacement of beds closed by the previous administration and the opening of additional beds to meet emerging demands for care.

(iii) The timing of the achieving the target of 20% is reviewed annually based on each year's performance. At this stage there in no specific date for when it will be achieved.

89 Health Foskey

ACTCOSS

DR FOSKEY: To ask the Minister for Health -

> 1. ACTCOSS has called for an "increase in community based expenditure" – and given that one of the budget's key strategic priorities is "ensuring that clients' needs are met in a timely fashion and that care is integrated across hospital, community and residential support services" – could the Minister please (explain) why the ACT Government isn't awarding more funding to community based mental health services that are delivered by community organisations?

MS GALLAGHER: The answer to the Member's question is as follows:–

The ACT Government has increased funding on mental health services delivered by community organizations through each budget since first coming into government in 2000. We inherited a mental health service that was seriously underfunded in all sectors.

The *National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2005* provides a twelve year view of trends and performance at the national, state and territory levels over the period of 1993 to 2005. In 1999-2000, the ACT had the lowest per capita spending on mental health services of $66.70, compared to the national average of $81.85. By 2005 the ACT Government's commitment to mental health was reflected in the ACT achieving the second highest per capita spending of $129.63, well above the national average of $117.27. The estimate per capita spending on mental health for 2008-09 is $193.00. The ACT currently spends 80% of total mental health expenditure in community mental health services; the national average is 51%.

ACT Government funding to ACT community organisations to provide mental health services also reflects this commitment. As a percentage of total spending on mental health services, the ACT has increased from 5% to 13 %. This is 6.7% above the national average and makes the ACT the leading jurisdiction with the highest funding percentage of total mental health spending in the NGO sector.

In 2005 the ACT per capita spending on all community mental health services was $103.16, which is significantly higher than the national average of $59.15.

In addition the ACT has the highest number of mental health supported public housing places, with 34.4 per 100,000 compared to the national average of 17.9.

In the 2007-2008 Budget the ACT Government provided $1.21M for the establishment of Adult and Youth 24 hour staffed Step Up/Step Down facilities in addition to providing an additional $140K to the Mental Health Community Coalition to enhance the mental health community "peak" body.

In the current 2008-2009 Budget the ACT Government will provide additional recurrent funding of $528K per year to community organisations. The funding will enable; the continued implementation of the *Consumer and Carer Participation Framework*, enhancement of vocational rehabilitation services and employment support programs, additional capacity in community supported accommodation programs to address complex needs consumers, and to support for community mental health well-being programs for parents during the perinatal and early childhood period.

The ACT Government is mindful that since 2006 community based mental health services that are delivered by community organisations have had significant expansion through Commonwealth Government funding of the National Action Plan on Mental Health initiatives.

In 2008-2009 the ACT Government will provide a total of $8.05M in direct funding to mental health community organisations through service funding agreements. The ACT Government's commitment to mental health and community based mental health services in particular, is reflected in the *National Mental Health Report 2007*. Since 2000 this Government has expressed this commitment through the steady growth in funding to the mental health sector including those community based mental health services that are delivered by community organisations.

90 Health Pratt

Health budget 2008-09 Promotion

Steve Pratt MLA : To ask the Minister for Health

In relation to : **Health Budget 2008-09 Promotion**

1. What will ACT Health be spending to promote or explain measures contained in the 2008-09 budget?
2. What proportion of the promotional spend will be committed to promotional activities that finish before 19 October 2008?
3. What are the total estimated marketing costs for ACT Health for the 2008-09 year and how is that funding broken down by estimated spend on different mediums such as television, radio, newsletters, cinema, newspapers, display stands, posters, billboards, online advertising, direct mailings, delivery costs, market research and communications consultancies?
4. How many copies of the 20 page "Your health – our priority" booklet will be produced, how will they be distributed and what was the total cost of production and distribution?
5. What is the timeframe for delivery of most of the booklets to the community?
6. Given that the Minister's message page in the "Your health – our priority" booklet contains an endorsement from the Chief Executive of ACT Health, as is recognised as such as electoral matter, will the cost be invoiced to the ACT Labor Party for this page in the booklet?
7. What other printed materials published by ACT Health in the year-to-date 2007-08 have featured images of the minister or a message from the Minister? What was the number of copies of each item produced?
8. How many copies are to be printed of the "Your health – our priority" postcard, how will they be distributed and what was the total cost of production and distribution?
9. What is the timeframe for delivery of most of the postcards to the community?
10. What printed materials are currently under preparation by ACT Health, or planned for release before the end of the 2008-09 year which will feature images of the minister or a message from the Minister? What is the number of copies of each item to be produced?

Katy Gallagher MLA : The answer to the Member's question is as follows:–

1. Approximately $60,000.
2. The majority of activities will be undertaken before 19 October 2008.
3. The total estimated cost for general marketing activities undertaken through the Communications and Marketing Unit is $193,000: advertising - television $25,000, radio $10,000, print $5,000 and bus $18,000; direct mailing $15,000; Consultants $15,000; 4 editions of *Healthy Territory* $40,000; printing (brochures, booklets, posters, etc) $50,000; promotional products (pens, notepads, bags, etc) $15,000.
4. 3000 copies have been printed to date, with no decision on a further print run. Distribution has been at forums, conferences, workshops and relevant events, to stakeholders and through health centres, shopfronts etc. The document was written and designed in-house at not cost, printing was $9960.50 and there were no distribution costs.

5. On going.
6. The page referred to carries an 'authorisation', not an endorsement. The authorisation by the Chief Executive of ACT Health complied, at that time, with the Electoral Act 1992 for the production of the booklet.
7. I am not prepared to authorise the use of numerous hours of staff time that could potentially be needed to check through the large amount of documents produced by ACT Health that may feature either an image of the Minister or a message from the Minister.
8. To date 1000 copies of the postcard have been printed at a cost of $275. The postcard was developed and designed in-house and no distribution costs have been incurred. 150,000 copies may be printed for a letterbox drop at a cost of approx $4500 with distribution costs of approx $10,000.
9. July 2008.
10. None.

91 Health Smyth

Health Services for the AMC

MR SMYTH: To ask the Minister for Health

In relation to : **Health Services for the Alexander Maconochie Centre (page 77, BP3)**

1. Prior to the introduction of this budget measure, what was the annual level of ACT funding for prisoner health services, including in the form of payments to NSW for services provided interstate?
2. To what extent has existing funding been used to offset the costs of these new services, and to what extent is that funding additional to this measure or counted as an offset against the total cost of the measure?
3. How many staff will be funding under this measure in full-time equivalent (FTE) terms, broken down by the number of FTE staff for each type of role, including administrative staff, General Practitioners, nurses, specialist doctors, psychologists and allied health professionals?
4. What is the annual staff funding under this measure in dollar terms, broken down by type of roles, including funding for administrative staff, General Practitioners, nurses, specialist doctors, psychologists and allied health professionals?
5. What is the amount of contingency funding for health services that are purchased on an as-needs basis from external providers?
6. What is the amount of funding under this measure for equipment and supplies?
7. What are the anticipated numbers of consultations and treatments to be provided each year and on average how many consultations and treatments are expected to be provided per prisoner?
8. What is the timeframe for recruitment of staff and which of the positions have been filled?

MS GALLAGHER : The answer to the Member's question is as follows:–

1. Approximately $2.4m is currently spent supporting ACT prisoner health services in the ACT and NSW.

It should be noted that the amount referred to in Budget Paper 3 (page 77) is the amount currently provided for interstate services through the Department of Justice and Community Safety. That funding is being transferred to ACT Health.

2. All of the funding referred to in (1) is available for prisoner health services in the Alexander Maconochie Centre. The cost of providing the service in the ACT is estimated to be $2.7m in 2008-09. This is due to the recruitment of additional clinical and allied health staff to ensure the services provided to the prisoners and remandees are equivalent to those provided to the rest of the community. The additional cost ($0.300m) is being funded from within base funding available in ACT Health.

3. Indicative Staffing and VMO for the provision of prisoner health services at the AMC is:

STAFF ROLE	FTE
Mental Health Medical	0.8 FTE
Mental Health Nursing	6.00 FTE
General Medical	0.8 FTE
General Nursing	10.0 FTE
Pharmacist	0.2 FTE
Dentist	0.25 FTE
Dental Assistant	0.30 FTE
Administration	1.00 FTE
VMO Costs: 1,032 hours plus oncall and call back allowance	

4. It is estimated that the overall cost of staff and visiting medical officers, including superannuation, will be $2.350m. This is split between medical officers (including visiting medical officers) $0.700m, nursing $1.500m, dental $0.060m, pharmacy $0.030m and administrative $0.060m.

5. There is no contingency funding retained for the purchase of services from external providers. In the event that some of the services have to be sourced from external providers, that will be funded from the existing budget and would simply mean a switch from staff costs to administrative expense.

6. Funding for equipment and supplies is estimated to be $0.350m.

7. YTD, the average level of general health interventions (ACT) is approximately 23 per prisoner per month. It is anticipated that this level of health service will continue in the Alexander Maconochie Centre with an anticipated 5400 interventions per month. It should be noted that the majority of general health interventions are supervised medications.

8. Recruitment of staff has commenced with the appointment of a Medical Director, under section 21 of the *Corrections Management Act 2007.* Recruitment of registered nursing positions has commenced and will continue up to the commissioning of Alexander Maconochie Centre.

92 Health Smyth

Hospitality spending

Brendan Smyth MLA: To ask the Minister for Health

In relation to: **Hospitality Spending by ACT Health**

1. Not counting spending related to patient care, what is ACT Health spending on hospitality costs (including catering, venue hire, promotion and accommodation) in the 2007-08 year and what is the provision for expenditure in 2008-09?
2. How many events were hosted by ACT Health in the 2007-08 year to date involving hospitality expenditure of over $500 (including catering, venue hire, promotion and accommodation)? When and where were each of those events held, how many people attended each event and what was the total expenditure for each event?

Katy Gallagher MLA: The answer to the Member's question is as follows:–

1. Expenditure coded to "Hospitality" in 2007-08, to the end of April, is $41,221. Of this amount, $16,083 was funded from donated funds. ACT Health does not set a specific budget for Hospitality. Expenditure will be incurred based on events and functions proposed and approved during the financial year.

2. There were 12 events at a cost in excess of $500 in 2007-08. See the attachment for the detail you requested.

93 Health Smyth

Growth in demand for elective surgery

MR SMYTH: To ask the Minister for Health

In relation to : **Growth in Demand for Elective Surgery (page 74, BP3)**

1. How many new staff positions will be funded under this budget measure?
2. What is the estimated number of operations this measure will fund in each of the years 2008-09, 2009-10, 2010-11 and 2011-12?
3. What is the breakdown of spending by staff, equipment, supplies and other surgery inputs for each of the years 2008-09, 2009-10, 2010-11 and 2011-12?
4. What will be the estimated reduction in number of elective surgery cancellations for each of the years 2008-09, 2009-10, 2010-11 and 2011-12?
5. After implementation of this budget measure, what will be the remaining estimated number of elective surgery cancellations for each of the years 2008-09, 2009-10, 2010-11 and 2011-12?
6. What processes and approaches will be used as part of this measure to maintain optimal use of surgery throughput?

MS GALLAGHER: The answer to the Member's question is as follows:–

1. It is not possible to provide an accurate breakdown of additional staff required to meet this commitment. Some of the additional surgery will be undertaken by current staff, staff redirected from other areas and new recruits. In addition, a large proportion of our surgery is performed by visiting medical officers under contract to ACT Health. As demand for services increases some currently contracted visiting medical officers are able to provide additional services.

2. It is not possible to provide a specific target for the number of additional operations that will be provided as part of the additional elective surgery funding in the 2008-09 budget. The additional funding for elective surgery is being allocated to improve access to emergency surgery within the ACT. This will, as a result, provide for additional capacity to increase access to elective surgery.

3. As noted in the answer to question 1 above, there it is not possible to provide accurate figures for each item requested. However, the Government will ensure that the necessary staff and equipment is available to ensure that the people of the ACT can continue to access emergency and elective surgery in record numbers.

4. The Government has a target of a maximum of 10% for elective surgery postponements for 2008-09. This target is based on current levels of performance. This target will be revisited during 2008-09 following review of the impact of the introduction of additional emergency surgery services funded in the 2008-09 budget.

5. As notes in the answer to question 4 above, this will be reviewed following an assessment of the impact of the additional funding in meeting the increasing demand for emergency surgery services.

6. As noted in the answer to question 2, the additional funding for elective surgery is being allocated to ensure that our hospitals can maintain their current excellent record in providing emergency surgery services for the people of the ACT. This will ensure that our

hospitals have the capacity to meet emerging demand for emergency surgery without impacting on the level of time available for elective surgery. This strategy is being put in place to manage the significant increase in emergency and elective surgery provided by this Government over the last six years pending the redevelopment of our hospital facilities to ensure that we have the capacity to meet surgical services demand well into the future.

94 Health Smyth

Sleep studies laboratory

MR SMYTH : To ask the Minister for Health

In relation to: Sleep Studies Laboratory

1. Has the department already commissioned or received a scoping study, feasibility study or designs in relation to the proposed Sleep Studies Laboratory?
2. Where will the laboratory be located and what will be the size of the facility?
3. How much of the capital amount is to be spent on building fitout and how much is to be spent on plant and equipment?
4. What is the total capital cost and how much of that cost has been offset by existing depreciation provisions in the ACT Health budget?
5. How many new staff will be employed at the facility and what is the recruitment timeframe?
6. How many existing staff will be redeployed to the facility and what units and health services will these staff come from?
7. What research has ACT Health done on equivalent facilities interstate and overseas?
8. Has ACT Health sought to purchase reports and data from external research institutes on sleep issues and how much will ACT Health spend in 2008-09 on purchase of external data?
9. How many hospital patients per year will pass through the facility or gain access to its services?
10. What will be the average processing time to move hospital patients through the facility or to deploy services to them?
11. What are the revenue sources?
12. What will be the fee structure for revenues for the facility?
13. What are the total recurrent costs for the facility including new and existing funding for each of the years 2008-09, 2009-10, 2010-11 and 2011-12?

MS GALLAGHER: The answer to the Member's question is as follows:–

1. A comprehensive business case was prepared by the Department of Thoracic Medicine with respect to the requirements for Sleep Laboratory. The Canberra Hospital (TCH) has on staff Dr Carol Huang, who is a trained staff specialist sleep physician.
2. The Laboratory will be located on Level 6 of the Tower Block in TCH in a recently vacated office area of approx. 45 m^2.
3. Of the total $540,000, approximately $150,000 is required for purchase of the equipment and the remainder will be used to fit out the designated area.
4. The total capital cost of the Sleep Laboratory is $540,000. There is no offset by existing depreciation provisions.
5. The total staff required when the unit is fully functional is 4 FTE. Given the lead time to procure equipment and fit out, the recruitment will be progressed in the second half of the financial year.
6. The Sleep Laboratory is part of the Thoracic Medicine unit at TCH and the current lead Scientific Officer and Staff Specialist Sleep Physician will oversee the new staff recruited to the service.
7. Dr Mark Hurwitz, Director of Thoracic Medicine at TCH and Dr Carol Huang, Sleep Physician prepared a comprehensive business case for the requirements for a Sleep Laboratory within the ACT and used data from equivalent units, both in Australia and overseas, to inform the case.

8. No data or reports from external sleep research institutes have been purchased and ACT Health does not expect to expend funds on the purchase of such data in 2008-09.
9. The Sleep Laboratory when fully functional will have the capacity to undertake 3 patients 4 nights/week including one of these nights for Paediatric patients. This is total of approximately 600 studies/year (45 weeks/year).
10. Patients will be booked in based on clinical need and bed availability.
11. Revenue sources will be available through billing of private patients referred to the service, along with government payment for outputs appropriated in the 2008-09 budget.
12. Fee structures are based on the ACT Government Determination of Fees and the CMBS (Commonwealth Medical Benefits Schedule) as appropriate.
13. The total recurrent costs are identified in Budget Paper No3 (see table below). Once the fit out has been completed infrastructure support and overheads will be provided from within the existing base budget of TCH.

Sleep Studies Laboratory	2008-09 $'000	2009-10 $'000	2010-11 $'000	2011-12 $'000
Expenses	88	367	386	405

95 Health Smyth

Acute activity and price adjustment

MR SMYTH : To ask the Minister for Health

In relation to : Acute Activity and Price Adjustment (page 77, BP3)

1. Will there be an annual funding model reconciliation to adjust funding to reflect actual activity growth and inflation in prices and wages? If so, when will that review occur and when will annual adjustments be made? If not, how will any surplus funds be directed?
2. What percentage funding growth is provided for in each of the four forward years, as a ratio against the base funding for the respective preceding years?
3. What is the breakdown of new funding by estimated expenditure on activity growth, versus expenditure on labour indexation, versus expenditure on administration indexation for each of the years 2008-09, 2009-10, 2010-11 and 2011-12?
4. What wage price index number numbers have been used for each year as the assumed rates of indexation for the costing of this measure?
5. What administrative price inflation numbers have been used for each year as the assumed rates of indexation for the costing of this measure?
6. What numbers have been used for each year as the assumed increase in activity and what is the percentage increase each year in activity for the purpose of costing of this measure?
7. How many new staffing positions will be supported by this funding in each of the four forward years?

MS GALLAGHER : The answer to the Member's question is as follows:–

1. The Government monitors the performance of all agencies against budget as a matter of course. This is done on an ongoing basis throughout the financial year.
2. ACT Health expenditure is budgeted to increase by 6.4% in 2008-09, 5.7% in 2009-10, 6.0% in 2010-11 and 5.9% in 2011-12.
3. Activity increases are anticipated to average 3% during the 4 year period of this budget. Labour and administrative indexation rates are outlined in (4) & (5).
4. Labour costs for the existing workforce are indexed at 3% consistent with Government policy.
5. Administrative indexation is set at 3% for 2008-09 and 2.5% in each of the outyears.
6. Refer to (3), (4) & (5).
7. ACT Health has estimated an increase in each year of this budget of approximately 80 FTE per year.

Refurbishment of Health Centres

MR SMYTH: : To ask the Minister for Health

In relation to : **Refurbishment of Health Centres (page 55, BP5)**

1. What health centres have been identified for refurbishment?
2. What is the scope of work planned for each centre?
3. Will any of the work increase the capacity for staff or patient numbers at any of the centres and what are the details of increased capacity delivered under these refurbishments?
4. In what areas will the change in scope for centres involve a reassignment of expenditure between particular kinds of health services and what are the amounts of redirected funding within each centre?
5. How much depreciation funding with the ACT Health budget has been used for this work and what is the total project budget, including new funding and depreciation?

MS GALLAGHER: The answer to the Member's question is as follows:–

1. Work is expected to occur at all health centres.
2. The scope of the refurbishment program will depend upon the outcome of the community health clinical services plan and will include the proposed primary care walk-in centres announced in the budget (BP3 p75).
3. This will be determined by the Community Health clinical services plan.
4. This will be determined by the Community Health clinical services plan.
5. The depreciation expense reported each year by ACT Health is an unfunded item that reflects the reducing value of the Department's assets. The depreciation amount identified in the 2008-09 Budget Paper 5 is the estimated depreciation schedule once the new work in completed. The total project budget for the refurbishment of the centres is $5,000,000 plus an estimated full year depreciation provision of $1,000,000 upon completion. An amount of $150,000 has also been provided to undertake a scoping study for primary care walk in centres (BP3 p75).

97 Health Smyth

Capital asset development plan

BRENDAN SMYTH : To ask the Minister for Health

In relation to : Provision for Project Definition Planning for the Capital Asset Development Plan

1. How many major contracts will be let to deliver this budget measure (not counting sub-contracts) and what is the value and the nature of the services required under each contract and when will each contract be entered into?

2. Have any contracts already been let, what are the value of those contracts and the nature of goods and services commissioned under the contracts?

3. Approximately how many square metres of construction are planned for each year?

4. What are the facilities which are to be constructed under this measure and when does construction of each facility commence and conclude?

5. What is the cumulative value of capital items each year, against which depreciation arises for each of the years 2008-09, 2009-10, 2010-11 and 2011-12?

6. What contingencies have been included in this measure, including for price changes and for unforeseen and unanticipated costs?

KATY GALLAGHER: The answer to the Member's question is as follows:–

1. The major contract to be let will be to engage the Project Director. The value of this contract has not yet been determined. The Project Director will be responsible for developing a schedule for the capitals works program across all facilities, undertaking all feasibility plans and forward design, technical specifications and costings for each component of works. This planning will cover the full program of works i.e. the estimated $1billion over 8-10 years. It is expected that this contract will be let in September 2008.

2. No contracts have been let.

3. To be determined as part of the work undertaken by the Project Director.

4. To be determined as part of the work undertaken by the Project Director.

5. To be determined as part of the work undertaken by the Project Director.

6. To be determined as part of the work undertaken by the Project Director.

QTON - Statistics and tolerance relating to strategic indicators

Mrs Dunne (pg 61): To ask the Minister for Health

In relation to : Statistics and tolerance relating to strategic indicators

You said that in answer to Mr Mulcahy's question that perhaps for instance the .8 percent, rather than .7 percent may not be statistically significant. What are the statistical significant figures for this area? I mean what is the tolerance in which you say that is not statistically significant?

Ms Gallagher: The answer to the Member’s question is as follows:–

Indicator rates based on small sample sizes can be influenced by relatively few additional cases. Therefore Clinical Indicators such as ‘unplanned return to the operating theatre’ that have a low number of events are particularly likely to vary due to small fluctuations in rates.

The rate of 0.8% for this indicator falls within the Confidence Interval or plausible value for the rate. This means that it is not statistically significant and may represent very few additional cases per month or an isolated and non-sustained increase in the rate over a short period of time.

188 Health Dunne

QTON - Cessation of Medicare benefit for dental chronic disease

Ms Dunne (pg 104): To ask the Minister for Health

In relation to : Cessation of Medicare benefit for dental chronic disease

To provide the Committee with information on cessation of the Commonwealth Medicare benefit for dental chronic disease

Ms Gallagher : The answer to the Member's question is as follows:–

Medicare dental items (85011 to 87777) for people with chronic conditions and complex care needs are being withdrawn from the Medicare Benefits Schedule (MBS). These Medicare dental items are closed to new patients and no Medicare benefits will be payable for dental services provided to new patients after 30 March 2008. A "new patient" is a person who has not received services under the Medicare dental items 85011 to 87777 on or before 30 March 2008. A GP referral dated on or before 30 March 2008 is not sufficient for a patient to be considered to have commenced treatment. Patients who have already commenced treatment under Medicare dental items 85011 to 87777 (ie patient who have received services between 1 November 2007 and 30 March 2008) will be able to continue to receive Medicare benefits for dental services provided up to and including 30 June 2008.

No Medicare benefits will be payable for any dental services provided under items 85011 to 87777 after 30 June 2008.

This is the first step in establishing the Australian Government's new Commonwealth Dental Health program, which will be introduced from 1 July 2008. The Australian Government is replacing the previous Government's limited chronic care dental scheme with a scheme that works cooperatively with states and territories to address public dental waiting lists and provides up to one million additional services.

189 Health Dunne

QTON - Workplace Culture survey

Mrs Dunne (pg 17): To ask the Minister for Health

In relation to : Workplace Culture Survey

On that subject first of all Mr Cormack do you think that you could provide for the committee a copy of the letter that goes to staff that points out those things?

Ms Gallagher : The answer to the Member's question is as follows:–

With respect to the issue of confidentiality of the Workplace Culture Survey and how that was communicated to staff, I have attached copies of relevant communication with ACT Health employees, including a copy of the front page of the survey form, that is clearly marked "Confidential".

(For details of attachment, please contact Committee Office.)

190 Health Barr

QTON - Notices served on food businesses

Mrs Burke (pg 25): To ask the Minister for Health

In relation to : Notices served on food businesses

How many notices, if any, have been issued to food businesses in the last 12 months?

Ms Gallagher : The answer to the Member's question is as follows:–

Between 25 May 2007 and 24 May 2008 officers of the Health Protection Service issued nine Improvement Notices and three Prohibition Notices under the *Food Act 2001*.

QTON - Golden staph rates in ACT, MRSA

Mr Smyth (pg 95): To ask the Minister for Health, Ms. Katy Gallagher MLA

In relation to : Golden Staph rates in ACT, MRSA

I read somewhere that in New South Wales and ACT, 43 per cent of golden staph specimens were found to have MRSA compared to the national average of 31 per cent. Is there a reason that it is so high in the ACT?

Ddo we know what our rate is?

Ms Gallagher : The answer to the Member's question is as follows:–

MRSA is a subset of *Staphylococcus aureus* ("golden staph"), distinguished by its resistance to most antibiotics. It is often hospital acquired but increasingly it can also be community acquired.

It is not clear where the statement "*in New South Wales and ACT, 43 per cent of golden staph specimens were found to have MRSA compared to the national average of 31 per cent*" has arisen. Professor Peter Collignon of the Canberra Hospital suspects that this was from an article in a recent Australian Infection Control Journal, where a first attempt was made to estimate a population risk for MRSA by states. The NT and ACT were calculated to have the highest rates. However, Professor Collignon believes these comparative rates to be erroneous. The rates were calculated by dividing the number of episodes by the population, so it does not take into account that about 25% of our hospital patients are from surroundings NSW. In addition, in NSW in particular, many major hospitals with large numbers of MRSA infections per year did not submit their data to be included.

It is also difficult to compare MRSA rates between states and territories, given the limited amount of published data available nationally. A national study of 17 hospitals, published in 2005 showed that **the rates of MRSA blood stream infections** (i.e. MRSA bacteremia, a serious type of infection) **averaged 0.32 per 1000 admissions nationally** - it should be noted that this national average included much smaller hospitals where one would expect lower rates. The rate of hospital onset MRSA bacteremia at the Canberra Hospital was below the national average.

At TCH, there was a doubling of MRSA infections during 2006, with 25 episodes of MRSA compared to 12 episodes in 2005. After concerted efforts by Infection Control and others, there was a 50% reduction in the MRSA rate at the Canberra Hospital in 2007 compared to 2006.

Rates for TCH MRSA bacteremia are as follows:

- 2004 0.23 per 1000 admissions
- 2005 0.23 per 1000 admissions
- 2006 0.44 per 1000 admissions
- 2007 0.24 per 1000 admissions.

In summary, Professor Collignon believes that the ACT has lower rates of MRSA than seen in other Eastern States of Australia. However lower rates of MRSA than the ACT are seen in Western Australia and Hobart. The ACT is believed to have similar rates to South Australia and

some Queensland hospitals. Nearly all major hospitals in Victoria and NSW looking after adults are likely to have much higher MRSA rates than seen at ACT hospitals.

192 Health Smyth

QTON - Dual diagnosis - no of clinicians

Dr Foskey (pg 125): To ask the Minister for Health

In relation to : Dual Diagnosis – number of clinicians

Ms Gallagher: The answer to the Member's question is as follows:

There are four clinicians (x1 Crisis Assessment and Treatment Team, x1 Forensics, x1 Belconnen Mental Health Team and x1 Psychiatric Services Unit) who are currently participating in Alcohol and Drug face-to-face training provided by Turning Point. The training takes 16 days in total and is followed by a 10 day supernumerary placement within the Alcohol and Drug Program to consolidate the learnings with clinical practice.

In addition, 20 staff in 2007 and 14 in 2008 have completed training in Motivational Interviewing.

193 Health Smyth

QTON - Cost per weighted separation

Mr Smyth (pg 101): To ask the Minister for Health

In relation to : Cost per weighted separation

To provide the Committee with the cost per weighted separation over the last five years indicating that the ACT's rate of growth has moderated significantly

Ms Gallagher : The answer to the Member's question is as follows:–

The following table sourced from the Australian Institute of Health and Welfare's (AIHW) *Australian Hospital Statistics* reports reflects the ACT's cost per casemix adjusted separation and the national cost per casemix adjusted separation by year (2001-02 to 2005-06)

Cost per casemix adjusted separation (excluding depreciation), by year

	ACT	**Total Australia**	**% difference between the ACT and Total Australia**
2001-02	$3,769	$3,017	25%
2002-03	$4,128	$3,184	30%
2003-04	$4,002	$3,293	22%
2004-05	$4,237	$3,410	24%
2005-06	$4,250	$3,698	15%

Source: Australian Hospital Statistics, AIHW

194 Health Smyth

QTON - Strategic indicator no. 2.3

Mr Smyth (pg 93): To ask the Minister for Health:

I was just going to say just on that strategic indicator number 2.3, I notice Canberra met its target of 1 per cent but Calvary seems at 2 per cent to be struggling. Is there a reason for that?

Ms Gallagher : The answer to the Member's question is as follows:–

During the hearing, Mr Cormack, Chief Executive of ACT Health, noted "we are happy to give you some advice on that. But we report this in our public performance reports and there is a rider on that, that because of the low number of admissions or the lower number of admissions at Calvary you get a little bit more of variability. But I am happy to provide you with a more detailed response to that".

Further to Mr Cormack's explanation, I can advise that the relevant indicator relates only to patients with length of stays greater than seven days (as per the national definition for this measure). Given Calvary's role, this comprises about 20-40 patients per month (compared with over 120 per month at TCH due to its role as the major trauma referral and tertiary hospital in the region). As such, small monthly variations can result in big changes to Calvary's results. For example, over the last 32 months, Calvary has averaged 1.5 pulmonary embolism cases per month. However, during 2007-08, Calvary has noted one month (November 2007) in which four cases were reported. This will result in a full year total of approximately 2% compared with the target of 1%. However, the variation, given the small numbers and the impact that small increases can have of the results, are not statistically significant. Should Calvary consistently report an average of 3 or 4 pulmonary embolisms a month regularly, without a major change to the types of services provided at the hospital, our Patient Safety and Quality Unit would undertake a significant review of practices and procedures to identify and address system issues.

195 Health Burke

QTON - Prohibition notice to contractor

Mrs Burke (pg 58): To ask the Minister for Health

In relation to : Prohibition Notice issued to contractor at Canberra Hospital

Is it not true that complaints were made to you many days prior, possibly a couple of weeks prior, why were those complaints not heeded at the time?
Were they from nurses, patients or all of the above?

Ms Gallagher : The answer to the Member's question is as follows:–

The first recorded complaints are on 29 April 2008, one from a constituent and one from an ACT Health employee. ACT Health initiated an investigation on that same day at 12.30 pm. The prohibition notice was issued to the contractor on 30 April 2008.

QTON - Dental matters

Mr Mulcahy (pg 61): To ask the Minister for Health

In relation to: Dental Matters

Can I just ask a question which might need a dentist specialist but looking at page 151 as I read it there the …(indistinct)… rate for children is running higher than the Australian average in the ACT. Which is troubling and I know there is a trend that is starting to emerge in this regard but obviously we are deteriorating at a quicker rate than the Australian community. Is there any comment you can give on that? Or anything that you are doing to try and address that issue

Do you have the material about the hazards of non fluoridated water?

Ms Gallagher : The answer to the Member's question is as follows:–

National data on children's dental health is collected by the Australian Institute for Health and Welfare, Australian Research Centre for Population Oral Health (ARCPOH) and reported independently by them. The most recent data published by them was in 2002. More recent national data is not available. The time lag for national reporting is a recognised issue but outside of local control. In the 2002 report it was acknowledged that the small sample size for the ACT was not representative of the ACT population and therefore the data needed to be cautiously interpreted.

The DMFT Index is a measure of the mean number of teeth with dental decay, missing or filled teeth. Internal ACT reports show that the dental disease rate (DMFT Index) for 12 year olds was 0.95 in 2006 compared to the 1.27 in 2002 which shows a positive improvement. Similarly for 6 year olds the DMFT Index in 2006 is 1.76 compared to 2.30 in 2002. Though national figures are not available, the data for 2006 compares favourably with other jurisdictions.

Notwithstanding the improvements in children's oral health there is still a national trend for poorer oral health. The ACT Health Dental Health Program has developed strategies to target those 20% of children at greatest risk of dental decay with prevention programs to reduce their incidence of dental disease.

With regard to the hazards of non fluoridated water, the National Health and Medical Research Council (NHMRC) says in their 'Public Statement" entitled "The Efficacy and Safety of Fluoridation 2007" that "the existing body of evidence strongly suggests that fluoridation is beneficial for reducing dental caries" and recommends the fluoridation of drinking water as the most effective and socially equitable means of achieving community wide exposure to the caries prevention effects of fluoride".

Further support for the safety of fluorides was also published by the NHMRC which stated that "there is no evidence of adverse health outcomes attributable to fluoride in communities exposed to a combination of water fluoridation and other contemporary sources of fluoride. The national fluoride guidelines were published in 2006 and state that " fluoride is the cornerstone in the prevention of dental caries".

197 Health Smyth

QTON - Staff presentations at the Canberra Hospital and Calvary Hospital

Mr Smyth (pg 45): To ask the Minister for Health

In relation to : A copy of the PowerPoint presentation that was used at staff presentations at the Canberra Hospital and Calvary Hospital on the Capital Asset Development Plan

Ms Gallagher : The answer to the Member's question is as follows:–

A copy of the PowerPoint Presentation is attached.

(For details of attachment, please contact Committee Office)

198 Health Dunne

QTON - Acute services ACT Patient

Mrs Dunne (pg 49): To ask the Minister for Health:

In relation to : ACT Health Output Class 1 Health and Community Care 1.1 Acute Services ACT Patient Activity [BP4 p164]

[Could you provide the Committee with] .. a mud map, how do these things [such as the Emergency Medicine Unit and the Medical Assessment and Planning Unit] fit together and how are people articulated through these systems.…that would be useful.

Ms Gallagher : The answer to the Member’s question is as follows:–

Please note the attached graphical representation of the pathways through the emergency department.

(For details of attachment, please contact Committee Office)

199 Health Dunne

QTON - Waiting lists for aged care facilities

MRS DUNNE (pg 42): To ask the Minister for Heath:

In relation to waiting lists for aged care facilities

- On the subject of residential aged care facilities, do you have a feel for the size of the waiting list at the moment?

MS GALLAGHER : The answer to the Member's question is as follows:–

- Residential aged care facilities are not required to participate in a coordinated waiting list. Aged Care and Rehabilitation Services (ACRS) manage a priority waiting list for the ACT. This list consists of clients who are in urgent need of a placement.

- The total number of people waiting for priority residential aged care placement in April 2008 was 35. This represents 24 people waiting in Canberra Hospital and 11 in Calvary. These figures are representative only of the clients awaiting placement that ACT Health has been made aware of.

- In January 2008 ACRS put strategies in place to improve the placement times, particularly for community (non-acute) clients. These strategies included:

    - Contacting individual residential aged care facilities by email and phone to establish numbers of vacancies in facilities

    - Working more closely with the individual residential aged care facilities to communicate client care needs so that they are moved to appropriate environments

    - When there is client or Enduring Power of Attorney/Guardian consent, ACRS provide the individual residential aged care facilities with a list of clients and their needs on a weekly basis.

200 Health Smyth

QTON - Bullying and aggression

Mr Smyth (pg 18) : To ask the Minister for Health

In relation to : References for national trends and research relating to bullying and aggression

Can you give us some references that I might look at. The question for the Minister is Minister if we have come up with some solutions, but we have not done the specific work in the ACT will you direct the department to do some research in the ACT?

Ms Gallagher : The answer to the Member's question is as follows:–

Below are some of the references utilised by ACT Health in designing the Preventing and Managing Aggression and Violence Policy and Framework. It is not considered that research conducted by ACT Health would produce significantly different findings and as such, I do not consider directing ACT Health to conduct such research would be an efficient use of public resources.

- ACT WorkCover July 2004 Preventing Workplace Bullying A guide for employers and employees
- ACT WorkCover October 2000 Guidance on Workplace Violence
- Klee A., Benveniste, Hibbert P. 2004 - *Aggression and Violence in Health in Health Care - Insights from the Australian Incident Monitoring System*
- National Audit Office, 2000 - *A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression*
- NHS zero tolerance zone 2000 - *We don't have to take this - Resource Pack*
- NHS zero tolerance zone 2000 - *Withholding treatment from violent and abusive patients in* NHS *Trusts*
- NSW Health, 2003 *Zero Tolerance - Response to violence in the NSW Health workplace - Policy and Framework Guidelines*
- NSW Heath, Department *Policy and Guidelines (No: HRB 92-26)*
- Mayhew C., Chappell D. 2001 – *Prevention of Occupational Violence in the Health Workplace.* School of Industrial Relations and Organisational Behaviour and Industrial Relations Research Centre, The University of New South Wales
- Victorian Government Department of Human Services, 2004. *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services.* http://www.health.vic.gov.au/mentalhealth/atoz.htm
- Workers Compensation Board of British Columbia, 2000. *Preventing violence in health care: five steps to an effective program.*

- Mayhew C., Chappell D 2003 - *Workplace Violence in the Health Sector – A Case Study in* Australia

- The *Journal* of Occupational Health and Safety — Australia and New Zealand 2003, vol 19(6).

- Health and Safety Executive 2006 RESEARCH REPORT 440 *Violence and aggression management training for trainers and managers. A national evaluation of the training provision in healthcare settings.*Prepared by the University of Nottingham for the Health and Safety Executive 2006

- McDonald, D June *2000* No163 *Violence as a Public Health Issue Australian Institute of Criminology*

- McSherry, B July 2004 No.281 *Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour*

201 Health Smyth

QTON - Corrections Health and Mental Health Services

Mr Smyth (pg 44): To ask the Minister for Health

In relation to: Corrections Health and Mental Health Services:

What percentage of detainees are considered to have mental health problems?

Ms Gallagher : The answer to the Member's question is as follows:–

Currently 25-30 % of detainees who are remanded at the Belconnen Remand Centre and Symonston Temporary Remand Centre, exhibit moderate to severe mental health problems, including psychosis, depression, anxiety and self-harming behaviour. Roughly half of this subgroup (ten percent of the total remand population) meet criteria for ongoing clinical management in the community and this subgroup require intensive psychiatric care during periods of custody. In addition to people diagnosed with mental illness, a large number of remandees display subclinical signs of psychopathology and this group requires episodic support and / or general counselling services.

With regard to estimates for the AMC, the *Adult Corrections Health Services Plan 2007-2010 (draft)* addresses the issue. In section 3.2.3, the document points out:

Several international studies have found an over-representation of the mentally ill in prisons. A recent review of 62 prison based mental health surveys found that prisoners were more likely to have a psychotic illness, major depression, or a personality disorder than the general population.

202 Health Smyth

QTON - Cost of long-term waits

Mr Smyth (pg 88): To ask the Minister for Health

In relation to : Cost of long-term waits

Information available, or any studies undertaken, regarding the economic cost of people on extended waits on elective surgery waiting list

Ms Gallagher : The answer to the Member's question is as follows:–

Information relating to the above question is not available within ACT Health. A brief search of reports published by the Commonwealth also reveals that the Commonwealth have not undertaken any costing studies relating to extended waits on elective surgery.

QTON - No of suicides with mental health issues

Mr Smyth : To ask the Minister for Health

In relation to : Responses to Questions Taken on Notice during hearing – 21 May 2008

(1) What are the numbers of suicides for people who have been identified with mental health issues and under care in the ACT for the past five years.

(2) What are the numbers of suicides for people not under care in the ACT for the past five years.

Ms Gallagher : The answer to the Member's question is as follows:–

(1) The ACT Government can provide statistics on the number of suicides for people identified with a mental health issue and that are under the care of Mental Health ACT as reported to the General Manager of Mental Health ACT. Statistics are not available for those under the care of GPs, Calvary 2N or private psychiatrists.

Year	Number identified
2002 - 2003	10
2003 - 2004	8
2004 - 2005	6
2005 - 2006	Incomplete*
2006 - 2007	Incomplete*

*The ACT Coroners Court is still concluding a number of cases from 2006 to 2008 inclusive. As such the final numbers are not currently available.

(2) The ACT Government does not collect statistics on the number of people identified with a mental health issue that are not under the care of
Mental Health ACT who commit suicide.

The National Coroners Information System identifies the total number of confirmed suicides in the ACT for the last five years as follows:

Year	Total Number
2002 - 2003	32
2003 - 2004	29
2004 - 2005	31
2005 - 2006	31
2006 - 2007	30

204 Health Foskey

QTON - Public health dental services

Dr Foskey (pg 101): To ask the Minister for Health

In relation to : Public Health Dental Services
My questions are, how much will actually be allocated specifically to public dental services and what measures is the government undertaking to address the need for preventative dental, particularly for the socially disadvantaged members of our community?

Ms Gallagher : The answer to the Member's question is as follows:–

The ACT Government is committed to improving access to public dental services and has provided ongoing additional and recurrent funding to achieve this goal. The budget specifically allocated to public dental services is:

2008-09 $8,629,149

In the 2007-08 budget, the Government added a further $1.7 million to the dental program over the next four years to further increase access to care. This funding will:

- Provide funding for an additional 415 treatment places;
- Maintain and increase the number of dentists participating in the restorative referral scheme; and
- Increase support for "payment plans" for clients referred to the dental service.

With regard to measures the government is undertaking to address the need for preventative dental, particularly for the socially disadvantaged members of our community, I can advise the following:

The Dental Health Program (DHP) provides a range of dental services to all children under the age of 14 years who live in or attend an ACT school. Young people between the age of 14 - 18 with access to a Centrelink-issued Pension Concession or Health Care Card can also access these services.

The DHP's adult dental service offers a range of treatments for ACT residents including aged persons and those with chronic disease. The eligibility criteria is primary holders of a Centrelink-issued Pension Concession or Health Care Card.

In addition the DHP provides urgent and emergency dental services. These services are provided Monday to Friday (except public holidays). A Saturday morning emergency clinic is available at the Phillip Dental Clinic. All clients are assessed via telephone triage and those with the most urgent needs are offered an appropriate appointment. Clients with non-urgent dental needs are placed on a waiting list for general restorative treatment.

The Dental Health Program has developed strong partnerships with private dental service providers in the ACT. These partnerships are integral in supporting and maintaining the reduction in waiting times for general dental restorative treatment.

Denture services are also available thought the DHP to eligible ACT residents. Denture services including denture repairs, denture relines, adjustments and the making of both partial and complete new dentures.

The Dental Health Program also provides services to special need groups including these eligible ACT residents with chronic health conditions. Referral processes to access the special needs services include that clients meet eligibility criteria and provide a letter of referral from medical practitioner, case manager or responsible organisation.

205 Health Dunne

QTON - Well women's checks

Mrs Dunne (pg 63): To ask the Minister for Health:

How many "Well Women's Checks" are there?

Ms Gallagher: The answer to the Member's question is as follows:–

The Well Women's Clinics provide cervical screening, education and information regarding breast awareness, appropriate referral and advocacy.

The total number of "Well Women's Checks" and breakdown of the number of women from culturally and linguistically diverse (CALD) backgrounds is:

2007/08 year to date:

- 2391 women received services through the Well Women's Checks (annual target is 2490)
- 28 % of these women were from CALD backgrounds (the target is 25% - a positive variance of 3%)

206 Health Dunne

QTON - Health and Community Care

Mr Smyth (pg 38): To ask the Minister for Health:

In relation to : ACT Health Output Class 1 Health and Community Care 1.5 Cancer Services, Breast Screening Services, radiographer positions within the breast screen program

Can you provide the number of radiographer positions in the breast screen program, the number current filled, and the retention rates for these positions?.

Ms Gallagher : The answer to the Member's question is as follows:–

At present, BreastScreen ACT has 9.1 full time equivalent radiographer positions. Of this total, 8.5 full time equivalent positions are filled.

Over the last two years, radiographers occupying 1.6 full time equivalent positions have retired, 1.4 full time equivalent positions have been vacated due to moves interstate.

207 Health Smyth

QTON - Discharge planning

Mr Smyth (pg 107): To ask the Minister for Health:

In relation to : ACT Health Output Class 1 Health and Community Care 1.3 Community Health, Accountability indicator 1.3.h – discharge planning

What I would like to know is: how many people are discharged from hospital to a community health program? Then we can work out what 30 percent of that is in terms of the raw number of discharge plans. And in indicator 23, you want 75 percent of the 20 percent, so can we find out how many that is in terms of number of plans.

Ms Gallagher : The answer to the Member's question is as follows:–

In relation to accountability indicator 1.3.h, over the first nine months of 2007-08 discharge planners provided a total of 5,047 referrals to a community health program out of a total of 17,338 patients that were discharged in total from the specific wards included in this measure (for a total of 29 percent against the target of 30 percent).

In relation to the new strategic indicator (number 23) relating to discharge planning for persons with lengths of stay greater than 30 days, I can advise that this cohort of patients equals approximately 1,100 separations a year. The target of 75 percent for 2008-09 would suggest a total of about 825 completed discharge plans in 2008-09, rising to 90 percent in the following years as procedures are bedded down.

QTON - Discharge planning - break down

Mrs Burke (pg 110): To ask the Minister for Health:

In relation to : ACT Health Output Class 1 Health and Community Care 1.3 Community Health, Accountability indicator 1.3.h – discharge planning

“Can you break down those to percentages back to my original question on page 159. we know that 80% of patients discharged do not need a plan. We therefore say 20% do. You have now targeted three groups, you have that broken down. What was the percentage of the 20% for each grouping, would you have any idea?.

Ms Gallagher : The answer to the Member’s question is as follows:–

The number of discharge plans completed by the discharge liaison nurses for patients referred to Community Health Programs (accountability indicator 1.3.h) to the end of the third quarter of 2007-08 comprised 29% (5,047) of the 17,338 discharges from the wards covered by this indicator.

In relation to discharges plans for persons over 75 years from the Aged Care and Rehabilitation Service, ACT Health reported that 93.7% of all patient discharged received a completed discharge plan (672 out of 717 for the first three quarters of 2007-08). Significantly, the result for the third quarter of 2007-08 shows that 100% of the 286 discharges reported under this indicator had a completed discharge plan.

Of the 836 patients discharged from a mental health inpatient unit in the ACT to the end of the third quarter of 2007-08, 621 had a post inpatient follow-up within seven days of discharge at a Mental Health ACT service. This represents 74% of all separations (against a target of 75%). This is a very good result given that a significant proportion of mental health clients seek follow-up care from the private sector.

With the extension of our focus on discharge planning to persons with stays of greater than 30 days, our hospitals would report on performance in providing plans for approximately another 1,100 patients per year. In the first year of this measure, 2008-09, we are estimating that 75% of all of these patients would have a completed discharge plan (or about 825 people), rising to 90% in the following year.

209 Health Smyth

QTON - Budget different

Mr Smyth (pg 61): To ask the Minister Health

In relation to : Output 1.7

Explain the difference between the 2007-08 budget ($40.061m) and the 2008-09 Budget (40.013m)?

Ms Gallagher: The answer to the Member's question is as follows:–

The 2008-09 Budget is reduced for:

a) a reduction in Commonwealth funding for the catch-up program of the Human Papillomavirus Vaccine program of $2.700m;
b) a reduction in Commonwealth funding for Pneumococcal vaccine (which is expected to be reinstated shortly) of $1.080m; and
c) other reductions to the Australian Immunisation Agreement of $0.390m;

These are offset by increases for:

d) Indexation of $0.772m; and
e) An increase in the distribution of corporate overheads of $3.350m.

210 Health Dunne

QTON - No of impatient services

Mrs Dunne: To ask the Minister for Health:

In relation to admitted patient separations can you provide the number of clients that you are providing services to?

Ms Gallagher : The answer to the Member's question is as follows:–

The table below shows the total number of inpatient services provided at our public hospitals across all ACT Health outputs (acute services, mental health, cancer services and aged care and rehabilitation services) over the last five years.

Table 1
ACT Public Hospital Separations by year

Year	Separations	Variation	% change
2003-04[1]	62 655		
2004-05	63 634	979	2%
2005-06	72 140	8 506	13%
2006-07	75 767	3 627	5%
2007-08[2]	78 765	2 998	4%

1. This is the level of activity excluding chemotherapy activity which moved from inpatients to outpatient care in 2004-05

2. Estimated full year activity based on activity to end March 2008

Source: ACT Health Admitted care data set for each year (excluding well babies as per national definitions)

211 Health Smyth

QTON - Sub and non acute unit at Calvary Public Hospital

Mr Smyth: To ask the Minister for Health

In relation to : activity in the sub and non acute unit at Calvary Public Hospital

At page 167 output class 1.6(a) in Budget Paper 4, in relation to cost-weighted admitted patient separations, I notice that note 2 says that the 2008-09 target includes Calvary sub-acute activity previously included in output 1.1. How big is that, what is that number?

Ms Gallagher : The answer to the Member's question is as follows:–

The total estimated activity for 2007-08 reported under cost weighted patient separations for output 1.6(a) of 4,300 includes an estimated level of cost weighted separations within the sub and non acute service at Calvary Public Hospital of 1,200 cost weighted separations.

212 Health Smyth

QTON - Rate of growth in acute services

Mr Smyth (pg 74): To ask the Minister for Health

In relation to : Rate of growth in acute services

To provide the Committee with the rate of growth (percentage growth) over the last five years for acute services

Ms Gallagher : The answer to the Member's question is as follows:–

The current structure of health outputs has only been in place for the last three full financial years. Prior to 2005-06, all acute services were provided from within a single output. The total number of acute hospital separations over the last five years in noted below in table 1. This includes general hospital, cancer, aged care and rehabilitation acute services.

Table 1
Admitted patient separations (inpatients) at ACT Public Hospitals by year

Year	Separations	Variation	% change
2003-04[1]	62 655		
2004-05	63 634	979	2%
2005-06	72 140	8 506	13%
2006-07	75 767	3 627	5%
2007-08[2]	78 765	2 998	4%

1. This is the level of activity excluding chemotherapy activity which moved from inpatients to outpatient care in 2004-05
2. Estimated full year activity based on activity to end March 2008

Source: ACT Health Admitted care data set for each year (excluding well babies as per national definitions)

The growth in the level of acute care services provided under output 1.1 – Acute Services, since 2005-06 is noted below in table 2. This shows an average growth over the last two years of approximately six percent per year.

Table 1
Admitted patient separations (inpatients) at ACT Public Hospitals by year

	Cost weighted separations	Variation	% change
2005-06	67 931	67 931	
2006-07	71 715	3 784	6%
2007-08[1]	76 000	4 285	6%

1. Estimated full year activity based on activity to end March 2008

Source: ACT Health Admitted care data set for each year (excluding well babies as per national definitions)

Cost weight separations presented in round 9 national public hospital cost weights

QTON E08-234

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2008-2009

ANSWER TO QUESTION TAKEN ON NOTICE

Mr Smyth (pg 2): To ask the Minister for Health

In relation to : The third dot point on page 162, BP4, says, "Ensuring the rate of hip fractures declines over the long term".

Is it currently declining, and how will you achieve this?

Ms Gallagher : The answer to the Member's question is as follows:–

The target group for reducing hip fractures is persons 65 years and older. Information from our hospital admissions data indicate that the rate of hip fractures in ACT residents 65 years and over admitted to ACT hospitals have steadily decreased from 409 fractures per 100,000 persons in 2002 to 302 fractures per 100,000 persons 2006.

This rate is expected to decline over the longer term in response to ACT Health initiatives to decrease falls in this target age group. These initiatives include enhanced staffing and operation of our falls clinics, conducting educational and follow up programs to minimise the risk of falls in the elderly and increased attention to reducing falls in the hospital environments. In addition we have in place a mechanism for monitoring falls in the elderly to inform programs and policy development.

Approved for circulation to the Standing Committee on Estimates 2007-2008	
Signature: K. Gallagher	Date: 29/5/08
By the Minister for Health, Ms Katy Gallagher MLA	

Note: Answers to questions on notice should be lodged with the Committee Office within 5 working days, electronically and in hard copy.

Page 1 of 1

344 Health Smyth

QTON - Development applications - Minister for Health Intervention powers

Mr Smyth (Pg 8): To ask the Minister for Health

In relation to : -Development Applications-Minister for Health Intervention Powers

In regard to your legislation, where does the interaction occur, and what are the statutory obligations that would either allow you to intervene or become involved with your own initiative, or are there obligations under the land and planning that would involve this?

Ms Gallagher: The answer to the Member's question is as follows:–

There are certain powers under the *Public Health Act 1997* (Public Health Act) *and Planning and Development Act 2007* (Planning and Development Act) that are activated, if the Minister for Health believes that a proposed development is likely to have a significant effect on public heath.

Section 134 of the Public Health Act gives the Minister for Health the power to make a declaration (a section 125 declaration) for the purposes of the Planning and Development Act, in relation to a development application for a development proposal under that Act.

Section 125 of the Planning and Development Act enables the Minister for Health to declare that the impact track applies to the development proposal rather than the merit track, as would normally be the case. This means that a development proposal must include a completed environmental impact statement (EIS), unless the application is exempted by the Minister for Planning under section 211 of the Planning and Development Act.

If the development application is exempted by the Minister for Planning, the Minister for Health can not proceed with an EIS.

Under section 134 of the Public Health Act, the Minister for Health has the power to request the establishment of a panel to conduct an inquiry about an EIS. The Minister for Planning must establish the panel to conduct an inquiry in relation to the effects of the development proposal on public health.

QTON - Bed No. for the Women's and Children's Hospital

Ms Dunne (pg 25): To ask the Minister for Health

In relation to : Current and projected bed numbers for the Women's and Children's Hospital

Ms Gallagher : The answer to the Member's question is as follows:–

	2008 bed numbers	Projected requirements	Comments
Maternity (antenatal, post natal & gynaecology)	40	40 Much of the future gynaecology requirements will be managed in an Extended Day Stay Unit at TCH	To be determined based on model of care
Labour ward/Community Midwifery program	13	To be determined based on model of care. Capacity will be increased from 2,500 to 3,500 births per annum	
Neonatal Intensive Care	8	12	
High Dependency/Special Care Nursery	16	18	

	2008 bed numbers	Projected requirements	Comments
Paediatric inpatient (includes adolescent)	40 (34 beds + 6 surge capacity)	50 (40 beds plus surge capacity)	There will also be an additional 20 beds in the Young Persons Inpatient Mental Health facility
Maternity outpatient	18	26	
Paediatric outpatient	30*	31*	* - this number reflects a combination of consulting rooms, day stay and extended day surgery unit beds

346 Health Smyth

QTON - Gas fired power station

BRENDAN SMYTH (pg 9): To ask the Minister for Health

In relation to the Gas Fired Power Station, when was ACT Health first made aware of potential impacts on people arising from the activities

KATY GALLAGHER : The answer to the Member's question is as follows:–

ACT Health was invited to comment on an Option for ActewAGL to purchase by direct sale Part Block 1671 Tuggeranong for a Data Centre and Gas Fired Power Station in October 2007.

As part of the subsequent assessment process, the ACT Health Protection Service received a copy of the Preliminary Assessment and Development Application from the ACT Planning and Land Authority (ACTPLA) on 10 April 2008 for comment.

Further to this, on 6 May 2008 I sought specific advice from ACT Health on potential health impacts of the proposal.

348 Health Seselja

QTON – The bush healing farm

Zed Seselja MLA : To ask the Minister for Indigenous Affairs (Re-direct to Minister for Health)

In relation to : The Bush Healing farm

1. When did the promised feasibility study for the bush healing farm commence and conclude and how did the final cost compare to the initial budget of $100,000?
2. What were the findings of the $100,000 feasibility study into establishing a bush healing farm?
3. What site options have been identified as options for the bush healing farm and which ones were then assessed?
4. What is the intended size of the bush healing farm site and the nature of facilities?
5. Did the Land Development Agency have any role in helping suggest locations for the bush healing farm, and what was the extent of their role?
6. Why was the Kama site evaluated as less suitable than other options and what is the status of the Kama site? Will the auction process recommence and when will this occur?
7. To what extent will the bush healing farm include farm facilities, equipment, lifestock, agriculture or horticulture? To what extent will there be permanent staff with farming duties and to what extent will the entity produce marketable products and engage in trade?
8. Is the bush healing farm still to be in partnership with ACT Mental Health and what will be the accountability and reporting structure for the facility once operational?
9. What other agencies have been involved with the development of the bush healing farm proposal?
10. Given that the purpose of the farm was to avoid compartmentalised service delivery, which of the following services will be included in the farm?
    - Prevention of alcohol and drug misuse,
    - Education,
    - Rehabilitation
    - Outreach programs with Aboriginal and Torres Strait Islanders people
    - Spiritual support
    - Training
    - Job search support
    - General health services